British hospital doctor wins hours settlement

The solicitor for Chris Johnstone, the former junior hospital doctor in Britain who last week won an out of court settlement over long working hours, is urging others to follow in his footsteps. Peter Taylor, a partner in the law firm Hempsons, cites research in 1987 which found that one in four junior hospital doctors was clinically depressed. "They've all got a claim now," he said.

Dr Johnstone made legal history six years ago when he sued Bloomsbury (now Camden and Islington) Health Authority for damaging his health by making him work long hours in an obstetric unit. Last week, days before the case was due to start in the High Court, he accepted the health authority's £5600 payment into court.

In 1989, while working as a senior house officer at University College Hospital, London, Dr Johnstone found himself "desperate for sleep" and sliding into clinical depression. Within days of finishing a working week of 111 hours he fell asleep at the wheel and wrote off his car. He dropped out of medicine for 18 months and then decided to complete his training in general practice.

Dr Johnstone, aged 32, had been claiming £75 000 damages including interest. But he said that the money was not important and that he wanted to avoid the experience of a two week trial. "This is a tremendous victory not just for junior doctors but for all who are pushed beyond their limits in unsafe working conditions. In paying me damages the health authority has publicly acknowledged that my working conditions were not only unsafe but also unlawful."

The case is estimated to have cost the health authority more than £150 000 for Dr Johnstone's costs and its own. Camden and Islington said in a statement: "In the light of the substantial costs that would be incurred by a two week trial, the health authority took a financial view and paid into court a nominal sum of £5600, making no admission of liability. It was open to Dr Johnstone to ignore this payment and continue with his action if he felt that he had a strong enough case against the authority."

Mr Taylor of Hempsons said that he had urged Dr Johnstone to reject the payment into court and press on with the trial. He added: "He took the money because he and the BMA, which funded the case, thought it was a good, clear, certain win. If you take the money it's a 100% win. If you continue to trial there's a risk you might lose."

The case has been through 10 court hear-

Chris Johnstone: settled out of court

ings in the past six years after the health authority tried to strike it out, arguing that Dr Johnstone had accepted a contract expressly requiring him to work long hours. But he established a legal precedent in 1990, when the Appeal Court ruled that an employer cannot require an employee to work so much overtime "as it was reasonably foreseeable would damage his health."

At the trial he would have had to prove that he suffered injury as a result of unsafe working conditions and that the injury was reasonably foreseeable. He planned to produce evidence from four psychiatrists that he had been depressed. Mr Taylor said that junior doctors in a similar situation could sue their employers with the help of new rules allowing solicitors to take cases on a "no win, no fee" basis. "If 28% of 4000 doctors are depressed and that 28% issued proceedings in the county court next week, the long hours would stop."—CLARE DYER, legal correspondent, *BMJ*

European Union considers laws to curb working hours

The European Commission is considering legislation, which would apply to the entire European Union, to set an upper ceiling on the number of hours junior doctors may work. The measure is part of a three year social action programme, drawn up by the social affairs commissioner, Padraig Flynn, and adopted last month. The programme includes a list of priorities ranging from labour standards and the creation of jobs to public health and initiatives to help disabled people.

The commission is keen to encourage high labour standards by reviewing and extending its existing laws on working time. This sets out maximum weekly and fort-

Headlines

WHO investigates cannabis cancer risk: The World Health Organisation is investigating a link between cannabis and cancer after reports of an increase in the number of "unusually young" patients with cancer in their 30s and 40s. Professor Donald Tashkin, who is leading the research at the University of California, says that smoking one joint of marijuana is equivalent to smoking about four tobacco cigarettes.

Measles fades out: The British chief medical officer, Dr Kenneth Calman, says that there have been only 21 confirmed cases of measles in Britain this year, compared with an expected 200 000, and the disease could be eradicated after last year's immunisation campaign of 5 to 16 year olds.

Dutch court rules in test case: A Dutch court has laid down conditions whereby a doctor could end the life of a seriously handicapped baby without being prosecuted: the baby must be suffering unbearably, and any action must be at the consistent, repeated, and express request of the parents.

Royal College of Surgeons elects new president: The Royal College of Surgeons of England has elected Sir Rodney Sweetnam as president to succeed Professor Sir Norman Browse from July.

Compulsory HIV tests ruled out: A report from the Greater Glasgow Health Board has rejected compulsory testing of health workers for HIV after investigating the case of a surgeon diagnosed as HIV positive last December. But it recommends a review of the guidelines which place an onus on health workers to consult occupational health services if they know they are infected with HIV.

London ambulance staff reject changes: Changes to the London ambulance service will go ahead despite staff voting to reject them by 764 to 421. Emergency crews will be concentrated on busy areas at busy times, and health authorities have promised funding to recruit 300 extra staff.

Richard Horton becomes the editor of the *Lancet*: Richard Horton, currently North American editor of the *Lancet*, has been made the new editor. At 33, Dr Horton is the journal's youngest editor since Thomas Wakley, founded the journal in 1823.

nightly hours that may be worked and the rest periods that must be granted. Under its terms, people are entitled to 11 consecutive hours of rest in any 24 hour period and the average weekly working time, including overtime, should not exceed 48 hours in any seven day period.

But numerous professions are exempt, particularly those that require a permanent presence or continuity of service or production—for example, the fire and police services. Now the commission believes that there is enough interest to extend the limits on working hours to some of the excluded categories, specifically to doctors in training. It plans to consult those concerned and to table legislative proposals by 1997.

The 38 page action programme is the result of an extensive 18 month consultation exercise throughout the European Union, though many issues have already been aired in the commission's first statement on public health, issued in November 1993. These cover the need to integrate health requirements into other European Union policies—a debate, for instance, on the health implications of lead free petrol; the feasibility of a European Union programme on rare diseases; and a system for the surveillance of communicable diseases.

This latest programme, however, is geared to examining for the first time the health insurance schemes used in many countries to supplement public facilities. The commission would like these to be simplified to remove obstacles that arise when policyholders move from one country in the union to another.

With European public opinion still uncertain of the wisdom of more decisions made in Brussels, however, Mr Flynn is thought unlikely to push policies for which there is little enthusiasm. That is especially true of public health issues, in which the European Union's powers are limited.—RORY WATSON, Brussels bureau chief, *European*

Specialist medical training will require changes to the law

The British government has proposed setting up a council of the medical royal colleges to carry out the specialist training functions required by European law. The proposal is in a consultation paper published last week, which sets out other changes to legislation to enable the key recommendations in the Calman report on specialist medical training to be implemented.

Three years ago the European Commission questioned the way that specialists were trained and accredited in Britain, 20 years after the European Community approved directives for the mutual recognition between states of minimum periods of training. This led the chief medical officer, Dr Kenneth Calman, to set up a working group, which reviewed all arrangements for post-graduate training.

A certificate of completion of specialist training (CCST) will be introduced for doctors who have successfully completed a higher specialist training programme, and the General Medical Council will maintain and publish a new specialist list. There will be a variety of ways of entering the list, including obtaining a CCST, holding an existing consultant post, and obtaining higher specialist training qualifications. Only doctors on the new specialist list will be eligible to take up a consultant appointment.

In future the new college council will be the competent authority in Britain for all training functions listed in the medical directive relating to specialist medical training. The day to day running of the system will remain with individual colleges and faculties, but the new council will have to ensure that their publications and activities comply with the medical directive. Under a specialist medical order the college council will have to satisfy itself that the training leading to the award of the CCST meets the requirements set out in the directives and to advise the General Medical Council of those doctors who have "fully and satisfactorily completed the specialist training programmes," which will be defined by the relevant college. In future the GMC will be legally obliged to issue the CCST to doctors who apply for it, subject to receiving appropriate information from the college council. Doctors will be able to appeal against the decision of the new council not to put forward their name to the GMC for the award of the CCST or for inclusion in the new specialist list.

The consultation document also suggests transitional arrangements for moving from the current to the proposed new system and how existing consultants and specialists should be integrated into the new arrange-

Calman: his report is still not implemented

ROUSSEAU/PRESS ASSOCIATION

ments. The GMC's current list of specialists would be closed once the new order was in place, with no automatic entry for doctors holding the existing certificate of specialist training. Doctors currently working as consultants, those who are accredited, and those who meet the required standard would be added to the new list.

The NHS Executive has asked for comments on the document *Hospital Doctors: Training for the Future—Proposals for Implementing Legislation: the Specialist Medical Order*, by 2 June.—LINDA BEECHAM, *BMJ*

NHS hospitals invest in arms trade

Dozens of health authorities and hospitals across Britain are major shareholders in Britain's arms industry, according to research by the pressure group Campaign Against the Arms Trade. Britain's second biggest weapons manufacturing company, General Electric Company, lists among its shareholders the British Heart Foundation (400 000 shares) and St Bartholomew's Hospice in London, whose special trustees hold 200 000 shares in General Electric Company worth about £3 each. The trustees of St George's and St Thomas's Hospitals, London, have also invested in the company.

General Electric Company helps British Aerospace in making Hawk ground attack aircraft. This weapon has been used with devastating effect by Indonesia against the civil population of East Timor, which it has occupied in the face of UN condemnation since 1975. An estimated 200 000 Timorese have been killed in the process.

Other British companies involved in the arms trade include Vickers, which recently completed a contract for tanks with Nigeria after the country's military rulers annulled an election that had returned a civilian government to power. Racal Electronics, Lucas Industries, Thorn EMI, and Rolls-Royce are also prominent. All firms count NHS and other health organisations among their shareholders.

The biggest single arms investor among Britain's health institutions is British United Provident Association (BUPA). The association holds 930 000 shares in General Electric Company, 201 600 in Rolls-Royce, 165 000 in Lucas, 94 400 in Thorn EMI, 75 375 in Vickers, and 65 500 in Racal. These investments are worth around £4m.

These figures have been compiled by the Campaign Against the Arms Trade, mostly from information freely available at Companies House. Its list names 126 health authorities, NHS trusts, hospitals, and medical charities with total holdings in the arms industry of over five million shares. The group has studied these holdings as part of its "clean investment" campaign, launched last year. It seeks to persuade charities, public services, and religious organisations to divest themselves of shares in the arms business.

Aboriginal health does not seem to be getting any better

The momentum towards ethical investment is growing. The Catholic diocese of Westminster recently sold off 11 000 shares in British Aerospace, which it managed for various religious trusts. South West Surrey and Nottingham Health Authorities sold their interests in Lucas, while Northampton and South West Thames authorities have rid themselves of holdings in Racal.

Ray Rowden, director of the Institute of Health Services Management, suggests that in many cases senior NHS managers are unaware of the exact nature of stock that their organisation holds. "Often these things are handled at one remove—for instance, by an independent financial adviser." He notes that trustees have a duty to maximise their income but says, "I'm sure that needn't extend to immoral investments such as arms. It's quite wrong that public health organisations should spend public money on this sort of thing."

Sue Brown of the Campaign Against the Arms Trade said that there was already a precedent for ethical investment in the health service. "Most NHS organisations already avoid investing in alcohol and tobacco manufacturers because they have a detrimental effect on health, but what could be more detrimental to health than arms manufacture?"

Michael Livingstone of the British Heart Foundation disagreed. "We are concerned with matters of the heart, so to speak. We are vociferous in our opposition to tobacco companies and won't even take donations from them. Other issues, be it arms, animals, or the rain forest, may be very worthy causes but it's really not our place to campaign for them."

David Bryant, a spokesperson for BUPA, said, "Our investments are managed with the objective of obtaining the best return for our members. We have no reason to doubt the integrity of these companies."—OWEN DYER, freelance journalist, London

Aboriginal health gap widens

The difference between the health of Aboriginal and non-Aboriginal Australians has widened, making Australia an anomaly in the developed world, according to a new report. Despite a national Aboriginal health strategy costing £115m, a study by the Australian Institute of Health and Welfare indicates that Aborigines continue to suffer considerable health inequalities.

"During recent decades the indigenous populations of other Westernised nations have made large strides in the improvement of their health," says the study. "In comparison Aboriginal populations have lagged considerably. Not only has the decline in infant and maternal mortality slowed down in the past few years, but a concomitant increase in young to middle aged adult mortality, particularly among males, has led to stagnancy in health trends."

The authors warn that, because of poor data collection and inadequate identification of Aboriginal people, the state of indigenous health might be even worse than their report suggests. Their paper is the fourth in recent months to show that mortality, life expectancy, and infant and maternal mortality are all much worse among indigenous people.

At birth an Aboriginal boy has a life expectancy up to 18 years less than that of his non-Aboriginal counterpart, and rates of admission to hospital for males are up to 60% higher. Aboriginal mothers account for almost 30% of all maternal deaths but less than 3% of confinements, and Aborigines account for 73% of all infant deaths in the Northern Territory but only 38% of all births.

The authors say that Aborigines are also vulnerable to non-infectious diseases. "The growing impact of non-communicable dis-

eases, particularly cardiovascular disease and diabetes, without much decline in infectious disease mortality is a phenomenon peculiar to Aborigines," they say.

The authors conclude that the need for effective ways of improving indigenous health is urgent.—CHRISTOPHER ZINN, Australian correspondent, *Guardian*

4.5 Million outpatients miss appointments

The failure of patients to keep appointments at outpatient clinics is causing longer waiting times for other patients, says an official study of hospitals in England and Wales by the National Audit Office. Last year over 1 in 10 outpatients failed to attend. With 40 million outpatient consultations a year, this suggests that over 4.5 million patients fail to turn up. The proportion of clinics cancelled at the six hospitals in the study ranged from 0.3% to 8.2%. In some instances, such as medical staff sickness, cancellation at short notice was unavoidable.

The study found that waiting times for the first outpatient appointment vary among hospitals and specialties, with some patients waiting longer than the health authority targets. The patient's charter requires that patients should wait no longer than 30 minutes from the time of their appointment. At the hospitals visited performance against the standard ranged from 71% to 86%.

The report states that general practitioners can help by encouraging patients to honour their appointments. It advocates the use of guidelines giving family doctors a summary of available services, a list of consultants, and the times for clinics. In contracts with hospitals, purchasers should insist on action to reduce waiting times.—JOHN WARDEN, parliamentary correspondent, *BMJ*

NHS Outpatient Services in England and Wales. Report by the Controller and Auditor-General is available from HMSO bookshops, price £8.15.

French doctors lack knowledge of AIDS

Two new surveys have concluded that French doctors know little more about the AIDS epidemic than the general public and probably less than the average 15 to 18 year old. The surveys show that more than 13% of French general practitioners believe that HIV can be transmitted by saliva. Findings also show that 7.2% of them believe that it could be transmitted during a stay in the same ward as an infected patient; 6.1% by donating blood; 2% by a mosquito bite; and 1.5% in public toilets. But more than half of doctors believe that infection cannot occur during dental treatment.

Outpatients: not everyone turns up

This "insufficient knowledge" about the transmission of HIV was shown by the two surveys ordered by Dr Jean-François Girard, director general for health. The studies, based on a sample of 400 general practitioners and 50 gynaecologists, indicate that doctors over the age of 45 who have no seropositive patients are particularly likely to underestimate the risk of infection and order fewer tests than younger doctors, who are better informed.

Dr Girard concluded that much remains to be done in terms of continuing medical education about AIDS, "an epidemic that imposes strong involvement by doctors because it is close to personal aspects of life."

The survey has also shown that only 61% of doctors recommend a test to patients they know to misuse drugs, only 79% recommend testing to patients who have received a blood transfusion or organ graft, and 73% recommend testing to patients consulting for a sexually transmitted disease. Only 70% of doctors recommend that pregnant women should take the test, but 12% admit that they have requested HIV tests without a patient's knowledge.

Nevertheless, a great majority (80%) of doctors say that they are satisfactorily informed about the prevention of AIDS; but 40% of them added that they would like guidance on talking to patients.

MG-France, the main union of general practitioners, protested against publication of the survey, but Dr Girard said that it was informative. "This study strengthens the idea that continued medical education needs to be developed and totally integrated into the professional life of doctors," he said, insisting that an HIV test should be proposed routinely to pregnant women: when it is, it is hardly ever refused.

In an interview with the medical daily, *Le Quotidien du Médecin*, Dr Girard said: "It's like in school: things have to be repeated three or four times in order to be known." —ALEXANDER DOROZYNSKI, medical journalist, Paris

Nurses to vote on no strike rule

The Royal College of Nursing is to ballot its 300 000 members on ending their long-standing rule prohibiting industrial action. The college's ruling council decided unanimously last week to recommend the rule change and will take an emergency resolution to its congress later this month.

The recommended rule change would, for the first time, allow nurses to take limited industrial action without harming patients. If the resolution is passed at the congress nurses could be balloted next month.

The decision follows the government's controversial move towards local pay for nurses. The college's general secretary, Christine Hancock, said: "This is a very serious and sad moment in the history of the Royal College of Nursing. It is a measure of nurses' anger over the mean and shabby way that they have been treated that they are now prepared to contemplate industrial action."

But the college is adamant that patients' welfare will be unaffected. Christine Hancock also said: "Nurses will never abandon their patients. They will not take action which will harm their patients. But in today's health market, trusts are vulnerable to action which disrupts their administrative systems and threatens their financial viability."

The nurses are angry about what they see as the government's determination to drive through an untested system of local pay. They are especially angry at the recent pay offer for the profession of a 1% rise nationally plus up to 2% by local negotiation.

Christine Hancock said: "It is the government which has singled out nurses for this treatment. I believe that we will win our pay campaign and achieve 3% for every nurse, but a change in our rules may be the permanent legacy of the 1995 pay campaign."

—CLAUDIA COURT, *BMJ*

Working party speaks out on use of human tissue

Patients should have no property rights over any tissue taken from them and hospitals should not make a profit from the sale or use of such material, says a report by the Nuffield Council on Bioethics. Professor Dame Rosalinde Hurley, who chairs the working party, said: "We have concluded that organising the removal and supply of human tissue along commercial lines is unacceptable."

The working party, which included lawyers and lay members as well as doctors, called for clarification of the law. Ian Kennedy, professor of law at King's College, London, complained that at present the law "looks to Victorian precedents on body stealing and such arcana."

The working party called for the Department of Health to follow up its current review of tissue banking by registering and monitoring the activity of such banks. It urged the government to seek to amend the European Patent Convention's clause that excludes immoral inventions so that it takes greater account of modern medical ethics.

Dame Rosalinde, professor of microbiology at the Royal Postgraduate Medical School, Hammersmith, spoke of her "grave reservations" about a contentious patent application by the University of Pennsylvania, which has developed a technique to alter genes in sperm so that desired changes can be passed down generations. In the US some doctors already advertise "spare parts" lists. There, the main issue for debate is how the profits should be split.

A patient who suffered from hairy cell leukaemia sued the University of California after his tissue was used to generate a range of lymphokines with huge commercial potential. Although the case was settled out of court, it is widely accepted that the university won. The controversy recently spread to Europe when it was found that some French cosmetics contained tissue from human placentas.

The Nuffield working party distinguished between different kinds of donors. Patients whose tissue would be removed anyway as part of their treatment could be considered to have abandoned it. Their consent to the removal could be taken as consent to any further use of the tissue for teaching or research, so long as nobody sold it on for a profit.

Volunteer donors, however, have nothing to gain from the procedure and may be taking risks. These people should be kept particularly well informed about any dangers involved and also about the likely uses to which the tissue might be put. The committee argued that they should not be paid beyond their expenses and should not be offered payment in kind. In the past some donors have been offered "rewarded gifting," such as a lifetime's free medical care for donating a kidney.

A third kind of donor was one who could

not give informed consent, such as a patient with advanced Alzheimer's disease. The current legal test is that any action must be in the best interests of the patient. Professor Kennedy thought that this could preclude even pricking the patient with a syringe needle. He suggested that a better test would allow very minor inconvenience to such a patient if it could be shown to be in the crucial interests of sufferers generally.

The commonest form of tissue removal is blood donation. Since expired blood can be used for a number of pharmaceutical purposes the Nuffield working party concluded that the sale of excess blood and products made from time expired blood was permissible so long as the transaction was on a non-profit, cost recovery basis.

Professor Trevor Jones, director of the Association of the British Pharmaceutical Industry and a member of the working party, emphasised that the working party did not seek to inhibit research or the production of new drugs, only profiteering. "We can only get discoveries in modern medicine in this way. I want to dispel the idea that we are exploiting people wholesale in the industry."

A spokesman for the Department of Health said that the department broadly agreed with the conclusions of the report and would consider bringing forward any necessary legislation.—OWEN DYER, freelance journalist, London

Human Tissue, Ethical and Legal Issues is available from the Nuffield Council on Bioethics, 28 Bedford Square, London WC1B 3EG, price £10.

Oral snuff "geared to addiction," claim researchers

Researchers in the US claim that they have evidence to suggest that some tobacco companies deliberately manipulate their oral snuff products to addict adolescent smokers. Their findings appear in four papers in the

most recent edition of *Tobacco Control* (1995;4:57-79).

The researchers analysed different brands of oral snuff products for nicotine content and pH in independent laboratories and found that the pH of the samples varied significantly between brands but was constant within samples of the same brand. They say that this point is crucial in the calculation of the bioavailability of the nicotine in products.

It is well known that raising the oral pH enhances the absorption of nicotine across the buccal mucosa by increasing the amount of the drug available as free base. More recent research suggests that the addictive properties of nicotine depend not only on the amount that is absorbed but on the rate at which it reaches the brain.

If the US Food and Drug Administration, which has been hearing evidence on the subject, accepts that the manufacturers have deliberately altered the pH this will add strength to the lobby to define tobacco products as drugs.

A third paper in the journal reviews internal documents from US Tobacco—which has an 84% share of the US market in oral snuff—and concludes that there is evidence to suggest that the company's marketing strategy was deliberately designed to encourage young users to use brands with a low bioavailability of nicotine and then to lure them on to stronger products.

Only brands with a low bioavailability were sent out by the company to people who responded to its advertising aimed at new users, and evidence that this weaning effect occurs is added in a fourth paper, which reports a survey of use and brand preference among young Americans.

The telephone survey of a nationally drawn sample of almost 13 000 subjects aged from 10 to 22 found that 3.2% had used oral snuff within the past month, a figure that is consistent with other estimates of use. Analysis of this group's use of the products suggests that longer established smokers are more likely to use products with higher bioavailability and that they find it harder to quit.

Oral snuff's popularity is rising among

Appealing to young people

teenagers in the US, to the concern of the antitobacco lobby. The prevalence of use has risen from 0.7% of 18-24 year old men in 1970 to 6.7% in the same group in 1991. Use of oral snuff is associated with gingival recession, an increased incidence of oral cancer, and ischaemic heart disease.

Dr Randolph Smoak, a trustee of the American Medical Association, called on the Food and Drug Administration to "regulate nicotine as the deadly drug that it is" by reducing nicotine levels in tobacco products, introducing tougher health warnings on packaging, and increasing controls on advertising.

Legislation on the subject, however, is unlikely. The Republican legislation currently before Congress to curb the power of government will also curb its power to regulate tobacco.

Dr Ronald Davis, editor of *Tobacco Control*, is trying to persuade the federal regulatory authorities to act within their existing powers.

"The fact that this latest evidence has been produced by research workers within three different federally funded organisations strengthens our case, not least because any work they do has to undergo rigorous internal peer review before being submitted for outside publication," said Dr Davis. —DOUGLAS CARNALL, editorial registrar, *BMJ*

German heart valve scandal continues

The so called heart valve scandal continues to make headlines in Germany. A total of 250 German hospitals and about 1500 doctors and administrative directors now stand accused of having accepted bribes from the makers of heart valves, pacemakers, heart-lung machines, and hip joints.

The state attorney in Wuppertal, Horst Rosenbaum, said that about 5000 receipts for payments to hospitals and doctors had been confiscated from the industry by police, "and every day we get more." Rosenbaum blames "German thoroughness" for the fact that all records for such transfers, although clearly illegal or incorrect, were neatly collected and filed.

Rosenbaum claimed that the manufacturers of medical equipment had opened special bank accounts, which were accessible to doctors and hospital administrators who regularly ordered products from them. In other cases doctors had allegedly received remittances, which were declared as "refunds" or "research budgets." Others had spent their holidays in the Caribbean or had accepted expensive gifts. Rosenbaum said that the Charité Hospital in Berlin was sus-

pected of having received a number of heart valves without making a payment but to have charged full price for them for health insurance purposes.

In May last year the German news magazine *Der Spiegel* claimed that all but one of Germany's 51 heart centres had accepted bribes from makers of artificial heart valves. Even at that time the association of employees' health insurances in Germany estimated that the financial loss for public health insurance could be as much as DM45m (£19m). Latest estimates are even higher.

All doctors questioned by Rosenbaum have so far denied the accusations. But the president of the Berlin Chamber of Physicians, Dr Ellis Huber, conceded last year that accepting bribes may have been "common practice" among doctors and hospital directors.

State attorneys, however, have not yet published the names of any accused doctors. Dr Karsten Vilmar, president of the German Chamber of Physicians in Cologne, thinks that they should and has appealed to public health insurers to "finally name horse and rider" instead of generating an "intolerable pogrom resentment" against doctors. Dr Vilmar also said that he could not believe that there were as many as 250 hospitals involved in the affair.—HELMUT KARCHER, medical writer, Munich

Focus: Washington

Gallo gets ready to try the other fork in the road

Americans love "dream teams," which usually come from sports. One was baseball's New York Yankees, whose great player-philosopher Yogi Berra once observed, "When

you come to a fork in the road, take it."

American medicine's dream team comes from Bethesda, Maryland, and its leader is star scientist Robert Gallo from the National Cancer Institute. Gallo, of course, is probably the world's best known virologist, both for his discovery (with the French) of HIV but also for his battle with the French over who actually was first to reach the HIV prize. Gallo and his coworkers have been leaders in retroviral research and are the undisputed discoverers of at least two other viruses that cause cancer in humans.

Gallo so far has taken the fork of government service. Over nearly 30 years he has worked to great success and fame. (Some, such as the late AIDS chronicler Randy Shilts would use the term infamy, though even Shilts admitted in his book *The Band Played On* that Gallo was critical of early successes in HIV research.) Now, at 58, he

will retire from the National Cancer Institute in July with a healthy pension, and he is still young enough to try the other fork in the road: industry. And he is being courted heavily by industry, governors, mayors, and academics.

Biotechnology has made regions rich. Scientists from Harvard created offshoot companies around Boston that have rejuvenated that city. Palo Alto, California, is the centre of the Silicon Valley, where computers have brought riches to suburban San Francisco. And perhaps most dramatic, the Research Triangle Park has taken North Carolina from a sleepy southern state to a vibrant scientific centre. Now at least four US regions are hoping to lure Gallo and his entourage of 50 scientists in the hope that he will bring fame to them as well. They include Baltimore, Maryland (whose mayor has offered \$2m to add to a state reserve fund of \$6m already offered by the governor of Maryland); Richmond, South Carolina; and Pennsylvania, where a foundation that owns the Medical College of Pennsylvania and a chain of private hospital has made an offer.

Whether Gallo's dream team will bring riches to one of these areas is clearly debatable. Controversy has followed him and his colleagues for years. Gallo waged a 10 year battle with French scientists over who

should claim credit for isolating HIV. Multiple patent fights and US government investigations finally cleared Gallo in 1994, although the US did concede a higher proportion of royalties to the French for the \$5m a year made from HIV antibody kits.

His clinical leader, Dr Robert Redfield, chief of retroviral research at the Walter Reed Army Institute of Research, has been accused of manipulating data that exaggerated the positive results of the HIV vaccine agent gp160; this was manufactured by MicroGeneSys, which had successfully lobbied Congress to get \$12m for its private research. The Army cleared Redfield (and withdrew the money from MicroGeneSys), but consumer advocates have continued the accusations against Redfield.

Gallo himself has said little about his move. He has said that money will be an important factor in his decision but certainly not the only one. He has been most open about his desire to merge HIV basic science with clinical trials, clinical care, and epidemiological research—which he says has been done better in Europe than in America.

Wherever Gallo, Redfield, and the dream team choose to go, their new hosts must hope that Yogi Berra's other famous quote does not prove true: "It was déjà vu all over again."—JOHN ROBERTS, *BMJ*