Study shows two drugs are best for HIV infection

People with HIV infection and AIDS who start treatment with two antiretroviral drugs had increased survival rates of over 40% during an average 26 month period of follow up, according to the interim results of an international multicentre trial released this week. The delta trial, started in 1992, was unblinded after the independent monitoring committee advised the trial's coordinators that the differences between the treatment groups—those taking combination therapy as opposed to those taking just zidovudine—were substantial and that the results should be made public.

"We have been criticised for not getting a paper together, but it will take about three months to collect all the data and another month to analyse it," said Dr Tim Peto, a consultant physician at the John Radcliffe Hospital in Oxford and member of the international coordinating committee of the delta trial. "We are saying that what we have seen so far is so clear cut it will change clinical practice."

The delta trial is split into delta 1, which is being carried out in patients who have never taken zidovudine, and delta 2, which is in patients who have taken zidovudine for at least three months. Both delta 1, which included over 2000 patients, and delta 2, which included 1083, are randomised and split into three arms. The patients were given either zidovudine alone or zidovudine plus either didedoxynosine (ddI) or didedoxycytosine (ddC).

In delta 1 survival was significantly better with the combination therapy—17% of 703 participants in the zidovudine group died compared with 10% of 720 in the zidovudine plus ddI group and 12% of the 708 in the zidovudine plus ddC group. More patients in the monotherapy group went on to develop AIDS. In the delta 2 trial there were no significant differences among the three groups either in death or in progression to AIDS. The average follow up was 26 months.

"People with HIV or AIDS who have yet to take any drug and who are at the stage when they are considered to need treatment need two drugs rather than one," said Dr Peto. "We do not know the size of the effect of taking a combination of drugs in people who have already taken AZT [zidovudine]. It's not sufficiently clear in delta 2 whether people who have had AZT before have missed the boat. We also have not fully answered the question of which combination of drugs is better."

HIV: two drugs better than one

NIBSC/SPL

Previous trials of drugs in AIDS and HIV infection have been criticised for being stopped prematurely, but Dr Peto says that follow up on these patients will continue. The delta research team is also waiting for data from the Nucombo trial in the US, which has a similar protocol and is expected to indicate which combination is best. There are suggestions from the delta trial that zidovudine plus ddI is better.

Patients with AIDS, and specialists, have been waiting for some time for evidence that combination treatment improves survival rates. "The hypothesis is that it delays the onset of resistance to AZT," said Dr Peto. "It's like the tuberculosis model, in which monotherapy is useless and you need two drugs to be in business and three to get a cure. We're not saying HIV is identical, but we have shown the model is partly true."

The patients given ddI were more likely to develop peripheral neuropathy than the others, and although compliance was about 70%, people given combination treatment were more likely to stop treatment because of gastrointestinal side effects.

Both ddI and ddC are licensed as second line drugs for patients in whom zidovudine fails to work. It will be up to the drug companies (Bristol-Myers Squibb makes ddI and Hoffman-La Roche makes ddC) to apply to the Medicines Control Agency for a change in licence. Treating patients with ddC or ddI would cost an extra £200 a month.—LUISA DILLNER, *BMJ*

GPs accept out of hours offer unanimously

General practitioners in Britain have unanimously accepted a revised offer from the health secretary to resolve the problem of providing out of hours care (see also p 824). The issue has been at the top of their agenda for the past three years. Members would have been balloted on whether to take sanctions if the offer had been rejected.

The chairman of the General Medical Services Committee, Dr Ian Bogle, will write to all general practitioners emphasising that, although the settlement may have solved the immediate problem, there will now be a much wider debate on other contractual issues, including separating out of hours work from in hours work. The health secretary, Mr Stephen Dorrell, has already recognised the need for further debate. In his offer to Dr Bogle he said that if the proposals were accepted he hoped "to go forward into more wide ranging discussions on the future of general practice in the light of the primary care led NHS initiative." At its meeting last week the GMSC gave Dr Ian Bogle and the four other negotiators a standing ovation. Earlier this year doctors had overwhelmingly rejected what the health minister, Mr Gerald Malone, called a final offer. But the

Headlines.

US will remove guaranteed aid to poor children: The US Senate is due to pass a welfare reform bill this week that would remove guaranteed federal aid to poor children. States would be given a set sum to design their own welfare programmes, with aid limited to five years.

More NHS trusts offer nurses 3%: The Royal College of Nursing has claimed that 300 NHS trusts have now offered nurses an unconditional 3% rise. The college said that it had secured a national rise after turning down the government's offer of 1% with up to a further 2% locally.

Medicare will pay for new technology: From 1 November Medicare will pay for studies of the newest pacemakers, hip implants, and other devices for the benefit of people over 65 in the US. The scheme will also pay the hospital charges, the doctors' fees, and the cost of the devices.

Drug tests of prisoners will be compulsory: Compulsory drug testing of Scottish prisoners will begin in Edinburgh prison and Cornton Vale, a women's jail, early next year. About 10% of prisoners will be chosen randomly by computer, and warders will be able to test inmates whom they suspect of using drugs.

NHS is recruiting more foreign nurses: The Royal College of Nursing says that hospitals are recruiting nurses from South Africa and Australia because of shortages, that one in five nurses is planning to leave the NHS, and that urgent steps are needed to retain them.

South Americans fly to US for medical care: People from central and South America have been accused of travelling to the public Jackson Memorial Hospital in Miami for treatment as medical emergencies. The hospital's chief financial officer estimates that the hospital lost about \$2m (£1.3m) in treating migrant patients last year and had \$39m (£26m) in unpaid medical costs.

AIDS conference hears of development costs: The third international conference on AIDS in South East Asia has heard that HIV and AIDS will rob Thailand of nearly nine years of economic development. Peter Godwin of the United Nations' development programme said that HIV had a more devastating effect than malaria and tuberculosis.

GMSC's leaders were instructed to make one more attempt, addressing six particular issues (17 June, p 1553), which Mr Dorrell has now agreed to.

Doctors want the out of hours component of their pay to be identified separately and paid "acceptably." Although the contract will remain a unified one covering 24 hour responsibility, in its report next year the review body will price out of hours care separately on the basis of evidence from the profession and the health departments.

General practitioners also want to be able to transfer their responsibility for organising out of hours care. New laws would be needed for doctors to opt out of out of hours care, but the government has agreed that doctors may transfer responsibility to another doctor on a family health services authority's or health board's list and that approval would be withheld only in exceptional circumstances and after consultation with the local medical committee.

All doctors will now have access to £45m of development money in 1995-6 for out of hours services. Local medical committees will be consulted on the use of the funds, and there will be special arrangements for doctors working in isolated rural areas.

Under the revised offer the £20 night consultation fee will be payable to principals and doctors eligible to be principals for all face to face consultations. Trainees, assistants, associates, and locums employed by the patient's doctor or a doctor on the same out of hours rota will also be able to claim the fee. Some doctors—for example, deputies, who are not vocationally trained—will not qualify for the fee.

In its revised offer the government has also tried to meet doctors' demands for a proper balance between workload and remuneration. It said that many aspects of the new package, particularly the development fund, will help to reduce workload, and it

has agreed to reduce immediately the data reporting requirements of the health promotion programme and to review the need to collect other information before the end of the year. Mr Dorrell has also agreed to an education campaign to encourage patients to use the service appropriately.

Dr Bogle told the GMSC, "I do not believe that I can negotiate a better deal." He emphasised, however, that the problems of general practice would not disappear.

Not all the GMSC's members accepted the offer with open arms. But the majority of the committee agreed that accepting the offer was the best way forward to the next negotiating round.—LINDA BEECHAM, *BMJ*

US drug companies battle over dyspepsia drugs

The recent decision by the US Food and Drug Administration to approve several drugs for dyspepsia for sale over the counter has led to increased rivalry among drug manufacturers. Three products have now been approved for non-prescription use, and a fourth goes before the administration later this month.

Remedies for dyspepsia rank only just behind analgesics and preparations for use in common colds on the nation's pharmacy shelves. The first drug of its class to receive approval for non-prescription use was famotidine, which went on sale in pharmacies in June. It is an H₂ antagonist marketed by Rowland for Johnson and Johnson-Merck. Famotidine sells in 10 mg tablets and is claimed to control the production of stomach acid for nine hours. Store rebate

Ian Bogle and Norman Ellis (BMA under secretary) announce the new offer

coupons are also offered, reducing the retail price of the packs of 6, 12, 18, or 30 tablets. Package inserts warn users not to take the maximum daily dose (two 10 mg tablets) for more than two weeks without the advice and supervision of a doctor.

Last June the Food and Drug Administration approved a non-prescription version of cimetidine. The manufacturer, SmithKline Beecham, began marketing the drug (100 mg cimetidine) in August at a recommended dose of two tablets daily. SmithKline Beecham claimed recently in a full page advertisement in the New York Times that doctors had "endorsed" its product compared with famotidine. Litigation between SmithKline Beecham and Johnson and Johnson-Merck, each accusing the other of false advertising claims, is currently going through the courts.

In July Glaxo-Warner Lambert's half strength preparation of ranitidine was also recommended for non-prescription use. A spokesperson for the company said, "Marketing will start immediately we receive final FDA approval." Only the 75 mg dose of the drug would be available over the counter.

A fourth antiacid drug, nizatidine, made by Eli Lilly, goes before the Food and Drug Administration later this month.

James R Allen, vice president for scientific affairs at the American Medical Association, said that the association had not formally taken any position on over the counter drugs. He was not aware of any recent studies on abuse of these drugs. He said, "There is a tendency in the US politically more and more to let Americans make their own decisions, so there's a corresponding tendency to make more drugs available over the counter without prescriptions."—FRED B CHARATAN, freelance journalist, Florida

Medical student lies for university place

A Glasgow man seems set to lose his place at medical school after it emerged that he lied about his age. Brian MacKinnon, 32, had claimed to be 17 year old Brandon Lee and had used this identity to get back into the fifth form of his old school and retake his exams. He was accepted by Dundee University's medical school after passing his Higher examinations.

Mr MacKinnon persuaded the headmaster of Bearsden Academy, Norman MacLeod, that he was a teenager who had been living in Canada until his parents died, after which he moved to Glasgow to live with his grandmother. The woman he was living with was actually his mother, Mary MacKinnon, aged 70.

His motive seems to have been to get into medical school, and he may have been worried that he would be too old. When called in by the headmaster to account for his actions "he did not give me a satisfactory explanation. He just talked about how he had always wanted to be a doctor, how he

Brian MacKinnon alias Brandon Lee, with a school friend

had to do it to become a doctor."

The deception was uncovered after he finished his second schooling with five A grades in his Higher examinations and had started at the University of Dundee Medical School. He went on holiday to Tenerife with three girls he had known at Bearsden Academy. While comparing passport photographs they looked at the passport in his luggage. After their return Mr MacLeod received an anonymous telephone call denouncing MacKinnon.

Mr MacKinnon's place at Dundee medical school now seems to be under threat. He began the course last October. After four months he left for personal reasons but applied to restart and was due to begin his first year again next month. A Dundee spokeswoman said: "The university takes a very firm line about the conduct and honesty of its medical students."

At Bearsden Academy he had been a model pupil, starring in a school play and writing for the magazine. His qualifications had been as good the first time round: he left Bearsden for the first time in 1980 with four As and two Bs in his Higher examinations and a place to study medicine at Glasgow University.

MacKinnon told a local newspaper this week that he carried out the hoax because he was bitter that he had had to abandon his training at Glasgow University three years into his course after becoming ill.

He then returned to Glasgow University in 1986 to study biological science. He passed his final exams in 1989, but as he failed to register he never officially graduated. He enrolled at Bearsden for a second time in May 1993.

Although 40 of the current teaching staff were there when he first joined in 1972, none recognised him. Among Bearsden pupils he was known as "thirtysomething" for his mature, slightly aloof manner.—OWEN DYER, freelance journalist, London

Colombian hospital did not steal child's corneas

A hospital in Bogotá is suing the makers of a French documentary film over accusations that it removed the corneas from a 12 year old boy, Jaison, and that they were transplanted into another patient illegally. The Salazar de Villeta Hospital asked three French professors of medicine to examine the blind boy, who comes from Colombia. They all agreed that his sight had been lost because of infection and that his corneas had not been removed.

The documentary, *Voleurs d'Yeux* (Eye Thieves), won the Albert Londres award and was widely praised in the press. First shown in 1993, it reported that the boy's eyes were "stolen" at the hospital and threw suspicion on the renowned ophthalmological clinic founded in the Colombian capital by Professor Jose Barraquer. The Salazar de Villeta Hospital and the Colombian embassy in Paris sued the CAPA agency, the producer of the film, and Marie-Dominique Robin, its director, for slander. Last month Jaison, now a pupil in an institute for blind people, was flown to Paris and examined. The three professors submitted their report to the Colombian embassy, which made it public.

Jaison first went into hospital at the age of 5 months, suffering from diarrhoea, dehydration, and malnutrition. When the Salazar de Villeta Hospital transferred him to the Paediatric University Hospital of Bogotá he was found to have bronchopneumonia, septicæmia, perineal dermatitis, severe bilateral keratitis, and deep ulceration of the cornea.

The French professors excluded the possibility that corneas could have been taken from an infant with such severe infection. They said that a cornea was never removed

alone, adding that such a removal from a living patient was impossible without general anaesthesia.

Voleurs d'Yeux was filmed in Argentina, Mexico, and Colombia. So far only Colombia has taken legal action against the producer and the director. They, in turn, are suing the attorney of the Colombian hospital for libel for having accused Ms Robin of paying Jaison's mother to obtain a false testimony from her. Ms Robin says that she did give some money—the equivalent of less than £30—to the mother because she did not have time to buy Jaison a present.

Verdicts in the legal actions are not expected for several weeks.—ALEXANDER DOROZYNSKI, freelance journalist, Paris

South Pacific leads the world in rates of youth suicide

In the past week two conferences have heard that the island nations of the South Pacific lead the world in rates of youth suicide, vitamin deficiencies, and diabetes. The *State of the Pacific Children*, a report by Unicef, says that the children of the Federated States of Micronesia, Kiribati, and the Marshall Islands have some of the highest rates of vitamin A deficiency in the world.

"The tragedy of this entirely preventable situation is not only that children go blind but their chances of dying from measles or diarrhoea are increased by 23%, compared to those who get enough vitamin A in their diets—especially from fruit and vegetables," says the report. The report, presented to the South Pacific Forum meeting in Papua New Guinea, said that the rate of diabetes in the region, where 40% of the population is aged under 15, is also among the highest in the world.

But some of the most extreme figures are for suicide. The report says that in Micronesia, which has a small, scattered population, males aged between 15 and 25 kill themselves at a rate of 200 for every 100 000 population—20 times the comparable rate in the United States. In Brisbane the Australian tropical health and nutrition conference was told that the transition from traditional to modern society was creating pressures that caused many young people to commit suicide.

Dr Heather Booth, a demographer at the Australian National University, said that islands, including Western Samoa, and the Indian population of Fiji had particularly high rates. "The cash economy, the nuclear family, all these changes are breaking down traditional society," she said. "There are limited opportunities for upward mobility, for emigration, and there is a lot of frustration."

In Western Samoa, with a population of 160 000, suicide rates are 30 for every 100 000. About 80% of suicides are caused by drinking the weedkiller paraquat.

"The young men sometimes commit suicide in public, drinking paraquat as a kind of

MACINTYRE/HUTCHINSON

Young people in the South Pacific are at higher risk of suicide

display," said Dr Booth. "The trouble is that it is so poisonous only a small amount is needed and they die. Attempts by the health department to get it banned in 1982 failed." Dr Booth said that the political will to tackle the suicide problem had largely been inadequate.—CHRISTOPHER ZINN, Australian correspondent, *BMJ*

NHS trust faces bill for compensation in home takeover

An NHS trust that plans to turn a house in a residential street into sheltered accommodation for five psychiatric patients could face a massive claim for compensation from neighbouring home owners after a High Court ruling last week. Mr Justice Chadwick refused six residents of Southwell Park Road in Camberley, Surrey, an injunction to stop Heathlands NHS Trust's sheltered housing scheme, but he ruled that they can seek compensation for any reduction in their homes' value when the patients move in.

The judgment clarifies an obscure area of the law and could have wide implications for the government's care in the community programme, reducing the choice for trusts seeking properties to convert.

The home owners, Martine Brown, James and Emily Clydesdale, Glenn Hagan, and Kenneth and Christine Williams, argued that the scheme breached a restrictive covenant, imposed when the houses were built in 1909, limiting their use to private homes or professional residences. The trust bought number 30, a three storey detached house, to house five long stay psy-

chiatric patients from Brookwood Hospital. Mrs Brown, who tried to sell her house without success, and her neighbours sought an injunction to stop them moving in.

The judge ruled that the covenant could not stand in the way of a body such as an NHS trust acquiring land for a statutory purpose, and therefore the court would not grant an injunction. But he added that those with the benefit of a covenant who suffered loss when a property was used in breach of it had a right to compensation under compulsory purchase legislation. This applied "notwithstanding that the purchase is voluntary and not compulsory."

Timothy Concannon, the home owners' barrister, said: "NHS trusts have got to operate economically and efficiently. This begs the question whether it is economical or efficient to buy properties with covenants on them."

Covenants restricting use of properties are common in residential areas, and the prospect of large compensation bills could restrict the choice of properties for sheltered housing.

To win compensation home owners will have to satisfy the lands tribunal that they are entitled to the benefit of the covenant, that the scheme breaches it, and that their properties have diminished in value. A local estate agent has pronounced Mrs Brown's house, worth £177 000, virtually unsaleable.

Robert Haughton, chief executive of Heathlands trust, said: "The trust does not consider the covenant to have been breached. The local authority did not require us to apply for planning permission for change of use. It is the trust's intention to proceed to use the property for the purpose for which we purchased it. These are people who have lost contact with family and friends and remained in hospital long after they needed to do so."—CLARE DYER, legal correspondent, *BMJ*

British children face changing health risks

Britain's children are less likely than ever before to die of infections, genetic diseases, and cancer, says a report published by the Office of Population Censuses and Surveys. But 7% of 3 year olds living in inner city areas will have moderate or severe behaviour problems, and suicide rates for young men between 15 and 19 have increased by nearly 45% in the past 20 years. One third of children will be smokers by late adolescence (age 16-19), and just under that proportion of boys will drink more than four pints of beer at least once a week.

In her introduction to the 190 page report Eva Alberman, professor of public health and epidemiology at St Bartholomew's Hospital, warns, "There has been an overall increase in childhood adverse health behaviour with high levels of tobacco, alcohol, drug, and volatile substance misuse, and early sexual activity and evidence of poor diets, falls in physical activity and increases in obesity." Between the ages of 16 and 24 only one third of men and less than one in 10 women exercise at a level currently regarded as conferring health benefits. Recent British surveys suggest that there have been significant increases in the mean body mass index of young adults, especially women. Young women from manual class backgrounds are most likely to be overweight.

Alberman says that although children have seen considerable improvements in health and are taller and have better teeth

than ever before, they are at risk from "the pervasive effects of adverse demographic, economic, cultural developments and changes in priorities....The changes in family structure have contributed to the numbers of children living in relative or absolute poverty, and reduced the numbers of supporting adults in the family."

In 1989 nearly one in four children lived in a family with no full time wage earner, and the number of homeless families rose from 53 000 in 1978 to 145 800 in 1990. Over 80% of these households had dependent children or a member who was pregnant.

The report confirms the increase in the prevalence of diseases related to allergy, in particular asthma. Hospital admissions for childhood asthma have increased 13 times since the early 1960s, and an estimated 15% of children will have episodes of wheezing each year.

But the commonest reason for a hospital admission for children aged 5-16 is still accidents, which are responsible for nearly half of all deaths in 1-9 year olds. Britain has the second highest rate of childhood deaths from road traffic accidents in Europe. Children from disadvantaged socioeconomic groups have the highest standardised mortality ratios for all types of injuries, including pedestrian accidents, drowning, and deaths from fires.

Alberman says, "Epidemiological patterns...show that often accidents are predictable and are related to poor design of housing, roads, and vehicles, and a lack of appreciation of children's perceptual abilities."—LUISA DILLNER, *BMJ*

The Health of Our Children is available from HMSO bookshops, price £21.

Israeli doctors oppose "black medicine" bill

The Israel Medical Association has criticised a new government bill that could make it a criminal act for a doctor to accept from a patient an "under the table" fee in exchange for preferential treatment. Known as the Black Medicine Bill, it will soon be presented to the parliament at the initiative of Health Minister Dr Ephraim Sneh.

Under existing laws, doctors who accept money illicitly and give special or speedier treatment or agree to treat a patient outside the regular duty roster violate civil laws. Sometimes doctors solicit "contributions" from patients to their department's research fund; the money is either pocketed by the department heads or divided among a wider circle of doctors to cover the cost of medical conferences abroad. In other cases a doctor may invite the patient home and explain the "risks" of facing a junior doctor's scalpel.

Only a handful of cases have reached the courts as the recipients of special attention rarely complain and the doctors certainly do not. Only if a patient dies or is harmed by what the family perceives as negligence is the family likely to file a complaint with the police. Dr Sneh wants to increase the deterrents by changing the law.

Most of Israel's hospitals are publicly owned and operated. At private hospitals patients pay extra for the doctor of their choice. Most of the public hospitals are owned by the government or by Kupat Holim Clalit, the largest health fund in the country. At these institutions doctors may not accept any gifts, monetary or otherwise, from patients. A few senior doctors are permitted to moonlight in their spare time and accept patients in private hospitals.

Jerusalem, the capital, has been an exception for decades. Its four main general hospitals are owned and run by voluntary Jewish organisations and practise a high level of medicine. Each hospital decides independently which of its doctors may be included in the SHARAP (the Hebrew acronym for private medical service) within the hospital. A patient who wants to choose his or her own doctor pays the hospital direct for a consultation or operation; the fee is regarded as being above board and is split between the practitioner and the hospital. According to the rules, these private patients may be attended to only in the afternoons and evenings so that their treatment is not at the expense of other patients who receive free treatment under the national health insurance system.

Although there may be some abuses Medical Association would like the Israeli SHARAP system to be adopted in all Israel's public hospitals, but critics fear that it would create a two tier system of medical care.

Dr Sneh argues that "black medicine" has already done this, at least partially. A public survey conducted for the health ministry found that 70% of the public thinks that black medicine is immoral and takes advan-

Asthma rates have risen dramatically in Britain

SAM TANNER

tage of patients and their families, while 26% of people say that they have been forced by public hospital doctors to pay them under the table at least once.

The issue gained prominence recently with the arrest of one of Israel's leading cardiologists, Dr Shimshon Erdman. The fraud unit of the Israel police alleges that the cardiologist, who is director of the pacemaker unit at Beilinson Hospital, a hospital owned by Kupat Holim Clalit in nearby Petah Tikva, induced a 70 year old woman and the family of a 3 year old child to pay him to operate rather than a less experienced surgeon. Dr Erdman has since been released on bail pending the completion of an investigation. The police announced a special telephone number for patients who wanted to report doctors who had demanded under the table fees from them.

Dr Yoram Lass, a Labour party member of parliament and former dean of Tel Aviv University Medical School, has prepared a private member's bill that goes even further than Sneh's, proposing full immunity for patients who inform on a doctor who accepted illicit payments from them. But the Israel Medical Association is opposing both bills on the grounds that they are antidemocratic.—JUDY SIEGEL-ITZKOVICH, medical correspondent, *Jerusalem Post*

Needle exchanges reduce HIV infection in US

Needle exchange programmes prevent HIV infection and should be supported by the federal government, said a report released last week by the National Academy of Sciences. Under current law, programmes that encourage drug misusers to exchange their needles and syringes for new ones have been banned by the federal government. But Congress said that if the academy found that locally run programmes did indeed cut the rates of new cases of HIV infection the ban could be lifted.

Injecting drug users are the fastest growing group of new carriers of HIV in the US. In 1981 they accounted for only 12% of patients newly diagnosed as having AIDS. By 1993 they made up 28%. In contrast, the proportion of people with AIDS who are gay men fell from 74% in 1981 to 47% in 1993. In some European countries, such as Italy and Spain, drug misusers account for up to 70% of cases.

Last year 80 million needles were exchanged in the local programmes run in

55 cities; this was almost a fourfold increase since 1992, the last the time the cities were surveyed by the Centers for Disease Control and Prevention. In most cities, programmes are run from mobile units that provide free exchanges as well as counselling about HIV, tuberculosis, and hepatitis.

Local studies have shown dramatic falls in new cases of HIV infection after needle exchange programmes were begun. In New Haven, Connecticut, the number of new cases fell by one third. In Tacoma, Washington, new cases of hepatitis fell by over 80% after the city offered new needles and counselling.

At present, all programmes are funded by city governments or private foundations. Needle exchange programmes, say public health experts, are the cheapest and most effective HIV prevention initiatives known. As one expert said, "People can be morally compelled to support a lesser harm in order to overcome a greater harm."

But many politicians seem to disagree. The Clinton administration is still hesitant about committing money for such programmes. Dr Philip Lee, secretary for health, said that the administration was "reviewing the report...in consultation with congressional committees."—JOHN ROBERTS, North American editor, *BMJ*

Focus: Washington

Playing politics with the poor: the cities

Not since the depression of the 1930s has the United States faced so great a social turnaround in political attitudes toward the poor as is happening now. Commentators in

the media call the new move toward privatisation "the mean spiritedness of rich white men," but, whatever the motivation, privatisation is going ahead in cities across the United States.

Throughout this century Americans with no health insurance and no money have been able to turn to the 450 public hospitals run by cities, counties, and states. New York's Bellevue Hospital, Boston City Hospital, and Chicago's Cook County Hospital, for example, have grand histories as places whose doors have never closed to the poor. No one claims that these centres have been efficient: staffing is poor, day to day they are often run by junior doctors, and even simple supplies are scarce. Patients may wait most of the day to be seen by a doctor.

Public hospitals have also provided services that private institutions find unprofitable: psychiatric units, trauma centres, and public health clinics. And many of the United States' doctors owe their training to these places. So strong has been support for

public hospitals that not one has closed since 1977—until now.

In New York a commission has recommended the selling or closure of the 11 hospitals run by the city, which gives £325m a year towards their costs of £2100m. In Washington the District of Columbia General Hospital has been shrunk from 410 to 250 beds. Over 250 of its 2572 employees have been sacked, including 60 doctors. The city's leaders say that they simply don't have the money to keep up the hospital.

In Los Angeles draconian cuts were due to take effect on 1 October to save the county £1600m. The cuts would close 75% of outpatient medical services at the county's six public hospitals and shut all six of its major ambulatory medical centres and 29 of its 39 community clinics.

Many commentators see the closures as penny wise and pound foolish. A recent analysis in the *New York Times* pointed out that the poor may be sent to private hospitals, where they have never been welcome. As a result, they may wait longer to seek help, become sicker, and therefore be more costly to taxpayers in the longer run. In addition, public hospitals are usually the sites of care for the burgeoning prison population, which is unlikely to be sought after by private hospitals. Massive lay offs will mean more city dwellers without jobs—to add to the cities' dwindling tax bases.

Perhaps most worrying is the danger to

public health. When psychiatric hospitals began "deinstitutionalising" patients in the 1960s the nation saw the emergence of a whole class of homeless people. Now, health experts warn of the spread of tuberculosis and sexually transmitted diseases when the public health clinics that serve these people are shut down.

Of course, politics never ends. Just last Saturday, President Clinton, who is stumping the country to raise money for his re-election campaign, paid his 20th visit to California. While there he announced a last minute bailout of £235m to save the Los Angeles public medical system. It was Los Angeles that pushed Mr Clinton over the top to win the presidency in 1992. Critics say that the city was playing brinkmanship with the poor, knowing that the federal government would come to the rescue.

Still, public hospital leaders say that even the federal government cannot stop the move toward privatisation. All public health hospitals are under pressure amid the private sector's demand for cost efficiency and customer satisfaction. Indeed, occupancy rates have dropped from 74% in 1980 to 68% in 1993. Leaders expect that by 2005, 100-200 public hospitals will have closed because of the financial pressure on local governments. Where the poor will stand in the middle of this whirlwind is unknown—and rarely discussed.—JOHN ROBERTS, north American editor, *BMJ*