NEWS

US launches new attack on tobacco

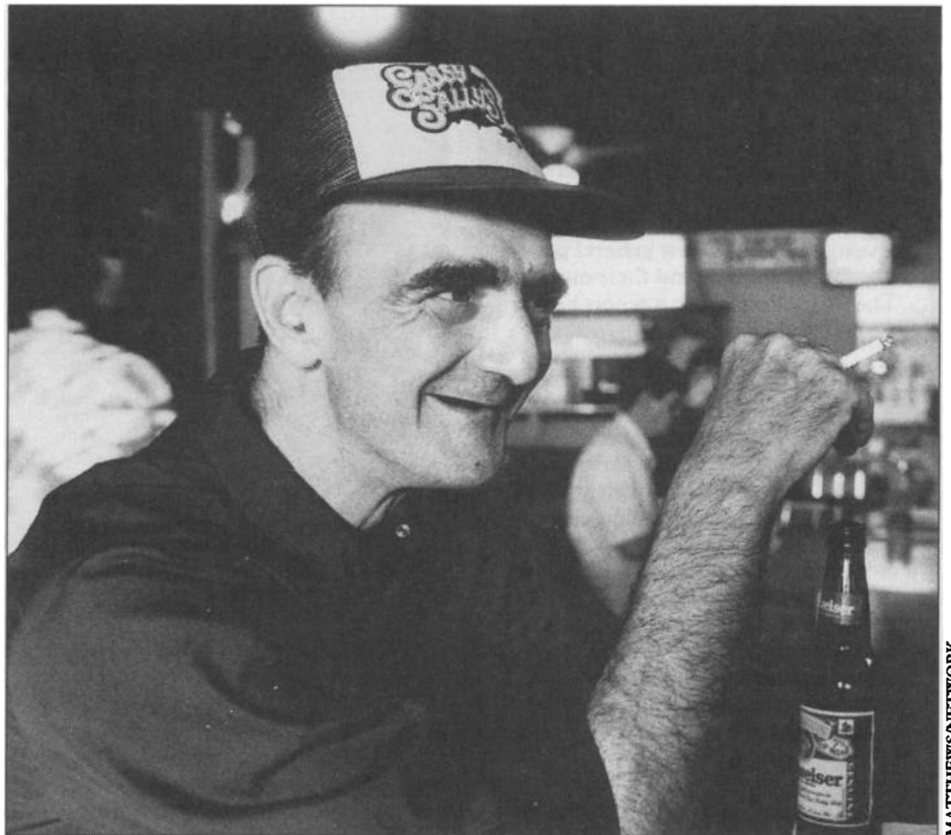
The American government last week began another offensive against the tobacco industry. Food and Drug Commissioner David Kessler told Congress that at least one American tobacco company had intentionally boosted the addictive aspects of cigarettes by developing a tobacco plant with a high nicotine content. As a result, he said, his agency may move to regulate the activities of cigarette makers.

Kessler said that Brown and Williamson Tobacco had tried to patent a species of tobacco, called Y-1, that it had developed in Brazil. Leaves of Y-1 contain about twice the amount of nicotine as normal American tobacco, Kessler said. Although the tobacco maker had withdrawn its application for a patent and had never grown the plant in the US, Kessler said that it had about £4m worth stored in US warehouses and that it added the tobacco to at least five brands of cigarettes.

The Food and Drug Administration (FDA) has previously said that if the tobacco industry alters levels of nicotine to promote cigarette smoking it will assume regulatory power over tobacco production in the US. Kessler's accusation comes two months after seven executives of tobacco companies publicly denied that they altered nicotine levels in their cigarettes. US Attorney General Janet Reno announced last week that her lawyers would investigate whether the tobacco makers had lied to Congress in their testimony.

Brown and Williamson's chairman, Thomas Sandefur, said that the problem was Kessler's "personal or political agenda." The company also said in a written response to Kessler that tobacco plants such as Y-1 were developed because public health experts had previously said that tar products, not nicotine, represented the greatest hazard to smokers. Higher nicotine levels would allow for a relatively lower tar content per cigarette. In addition, Kessler disclosed documents from the tobacco industry that said that ammonia was added to cigarettes as an "impact booster" to release more nicotine into the smoke.

Meanwhile, the tobacco industry last week launched a campaign against the FDA, which already regulates pharmaceuticals and many foods. In newspaper advertisements picturing alcoholic beverages, coffee, and hamburgers, R J Reynolds Tobacco states, "Today it's cigarettes. Tomorrow?" The industry is implying that the FDA will eventually prohibit tobacco production, and Americans still recall the crimes of the 1920s when the government tried to prohibit alcohol. Kessler denied that he or the FDA planned to prohibit tobacco, but he said that the levels of nicotine, an addictive substance, probably should be regulated. — JOHN ROBERTS, North American editor, *BMJ*


MATTHEWS/NETWORK

Did tobacco companies boost the addictive power of cigarettes?

Judges make historic ruling on euthanasia

Doctors in the Netherlands may agree to requests for euthanasia from patients who are neither terminally ill nor suffering physically, according to a historic judgment in the Dutch Supreme Court. In the test case, decided by the country's highest legal authority, psychiatrist Dr Boudewijn Chabot was found guilty of having helped with the suicide of a healthy and competent woman who had wished to die since the death of her two sons. But the court chose not to punish him, though suicide assisted by a doctor carries a three year jail sentence. Dr Chabot had already been acquitted twice, but the public prosecution pursued the case to the highest court.

The Supreme Court accepted that Dr Chabot had followed guidelines to establish that his patient was competent, was suffering unbearably, and had a voluntary, well considered, and durable wish to die. It recognised the care that he had taken to consult colleagues and the efforts he had made to persuade his patient against suicide. But it refused to accept that he had acted in an emergency—the normal defence for Dutch doctors—because the doctors from whom he had sought second opinions had not themselves seen and examined his patient.

Johan Legemaate, legal adviser to the Royal Dutch Medical Association, welcomed the "pragmatic decision," which, he said, was important in clarifying three issues. He explained that it was now clear that mental suffering could be a basis for a request for euthanasia and assisted suicide, the patient did not have to be in a "terminal phase" of life, and doctors giving a second opinion in cases of mental suffering should always see the patient themselves.

In an interview for the *BMJ* Dr Chabot said that it was unfortunate that his exceptional case had become a test case. Instead, he argued, there was a need in the Netherlands for a test case relating to people who were elderly or had AIDS and who, though currently healthy, wished to die rather than

Headlines

WHO to start trial of oral rabies vaccines: Next year the World Health Organisation will start trials of oral rabies vaccines. The vaccine will be put in the bait for millions of free roaming dogs, which cannot easily be immunised by injection. Over 33 000 people die of rabies each year.

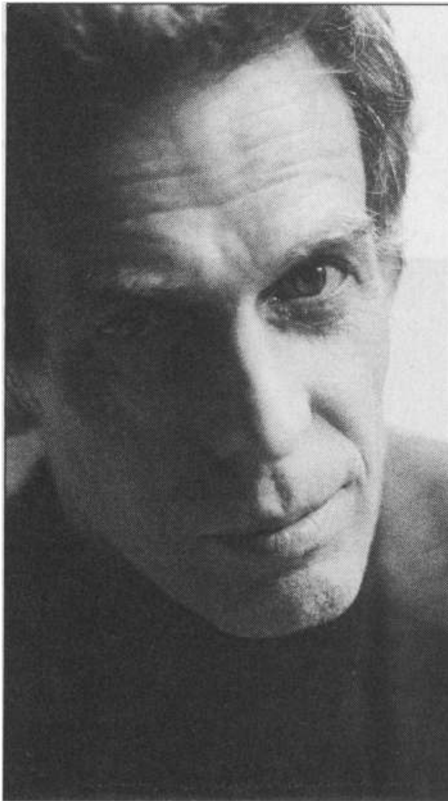
Audit Commission will review fundholding: The Audit Commission is to conduct a two year investigation into how general practice fundholders spend their money. The plan is to publish a report before the next general election.

Inquiry will look into effects of abortions: A private commission of inquiry, chaired by Lord Rawlinson, looking at the psychological consequences of abortion has recommended that centres should initiate independent and long term follow up of those clients considered to be most at risk of experiencing distress. Women considering abortion, says the commission, should have to wait a week before the operation so that they do not take decisions under pressure.

Dr Helena Daly given right to appeal: An adjudicating panel has ruled that Dr Helena Daly, a consultant haematologist, was not dismissed by the Royal Cornwall Hospitals Trust solely for personal misconduct and can therefore appeal to the secretary of state for health against her dismissal on professional grounds.

Secretary of state plans code of openness: The British secretary of state for health plans to issue a code of openness in the NHS before the end of this year; it will be preceded by a consultation paper. The code's governing principle will be that the NHS should respond positively to requests for information.

BUPA will issue guidelines on best practice: The British United Provident Association will issue guidelines to 2000 consultants on best practice in 60 of the commonest conditions, specifying techniques and treatments to be used and the expected length of stay in hospital. At present, claims for hip replacement operations range from £3800 to £9406 and stays in hospital from five days to 20.


NOLENSLAAN

Dr Chabot believes that mental suffering could be a basis for a request for euthanasia

suffer a last phase of "disfigurement and dependency."

He argued that the more open situation in the Netherlands, where doctors had legal safeguards and were increasingly reporting cases of euthanasia, resulted in less risk of patients being put under pressure. Dr Chabot, whose psychiatric training included a year's residency at London's Maudsley Hospital in 1973, said that "humanitarian" reasons had led him to offer his time to the Dutch Society for Voluntary Euthanasia, where hundreds of physically healthy people seek help each year.

Dr Chabot said that he had agreed to see his patient in the belief that he could help her but with an open mind to her wish to die. After sessions lasting more than 12 hours he could find no evidence of psychosis or of hysteria, personality disorder, or depression that would respond to antidepressants. She refused his pleas to try drug treatments and, Dr Chabot said, "there was no justification for taking a competent person into a closed ward for treatment against her will." Once convinced that her request was genuine, he sought a second opinion from four psychiatrists, a psychologist, and a general practitioner. All agreed with his diagnosis, though none saw her personally.

Dr Chabot argues that the final decision was his alone. "I don't believe that a medical committee can decide on life and death decisions by majority vote." Believing that his patient was close to death, with or without his help, he had either to help in her suicide or let her die alone. "I felt as a doctor that I should give her the pills openly and report my actions. Inherent in professional practice is the need to take responsibility and be accountable to colleagues and the public."—TONY SHELDON, freelance journalist, Utrecht

Italy's health service faces new shake up

Italy's public sector health workers, including doctors, were planning a traditional Italian welcome for their new health minister, Raffaele Costa: a strike, on 1 July. The one day stoppage, with emergency and essential services ostensibly guaranteed, has been called over pay rather than in reaction to the new government. But it highlights the principal consideration facing Mr Costa as he prepares to apply to the health sector the free market remedies for which most Italians voted last March. At a general election that effectively buried the corruption stained parties that had ruled the country since the 1940s, voters handed victory to a rightist alliance formed by the television and property magnate Silvio Berlusconi.

In common with most public sector employees, those who work for the Servizio Sanitario Nazionale are covered by framework pay agreements lasting several years. The last one expired more than a year ago. But the present government, like the previous one, has been loth to enter negotiations which it fears could lead it to increased spending.

Italy's national debt is the world's third largest, after those of the US and Japan. Yet successive governments have been unable to control the country's persistent budget deficits. The lack of cash can be expected to act as an important restraint on the government but also as a powerful incentive to reform. A shake up of the health service was among the star pledges in Mr Berlusconi's manifesto. On the hustings the self made billionaire said that he favoured selling off all state enterprises, including hospitals, that could be run more profitably or efficiently in the private sector.

The course taken by his health minister since coming to office, however, has been less radical, with the emphasis on making the existing public health service more efficient and less expensive.

Mr Costa is one of only a few politicians from the old order to have regained office under the new one. As a rank and file parliamentarian he won fame for his campaigns against "skiving" in the civil service, going so far as to have photographs taken secretly of bureaucrats nipping out of their ministries for a coffee or some shopping on taxpayers' time.

The same zeal has inspired Mr Costa's opening weeks in office. One of his first moves was to attack doctors who used the state sector as a catchment for their private practices, often, he claimed, using disreputable methods to steer patients from the one to the other. The next day he set off for a tour of some of Italy's many unfinished hospitals. The delays—which run to more than a decade in the worst cases—are a byproduct of the corrupt system of kickbacks for contracts by which parties were funded under the old order but which the new government is pledged to end.

So far, though, Mr Costa's only legislative initiative has been to introduce a delay of his own. Even before Mr Berlusconi's government came into office a plan had been launched to bring managers into the bureaucratic hierarchy of the Servizio Sanitario Nazionale. The overwhelming majority of applicants, however, turned out to be people who had held jobs in the existing structure. Mr Costa has blocked appointments until the autumn to ensure the recruitment of people "with experience acquired in private enterprises."—LUCINDA EVANS, freelance journalist, Rome

BMA warns of hazards in health care

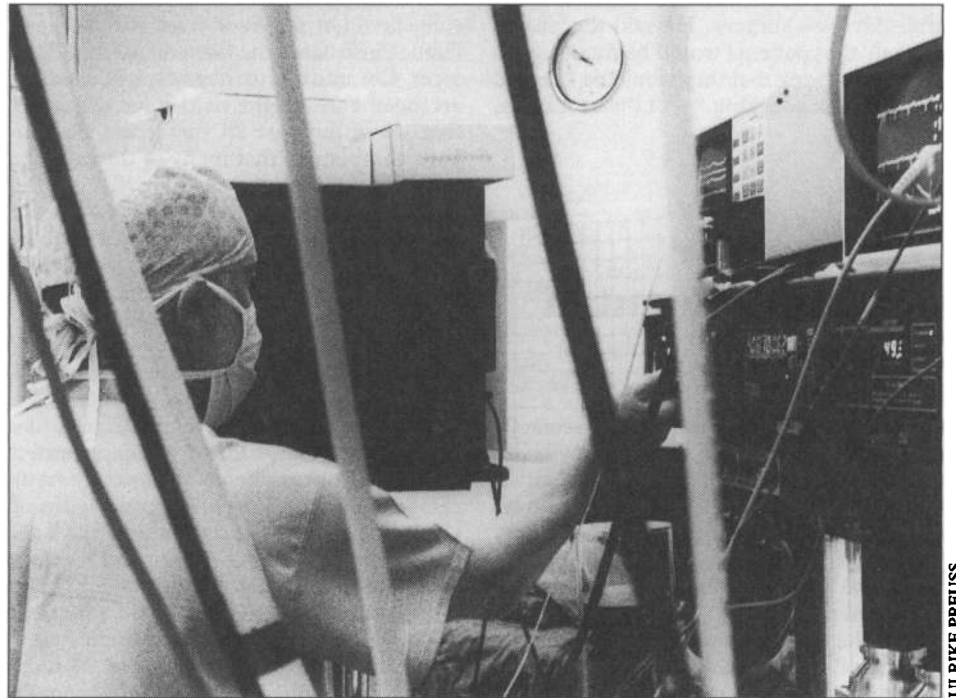
The NHS Executive should set up a comprehensive environmental policy for the NHS, says a new report on the risks of health care published by the BMA. The BMA is calling on the Department of Health to set quality standards for the health of NHS employees, including their environmental wellbeing, by the end of 1995. Each hospital should appoint an environmental officer with responsibility for coordinating environmental health and developing local policies.

The report argues that the cost of failing to manage health and safety at work is especially high in the health care industry. "Each year in Europe and the USA, thousands of health care workers become infected with hepatitis B at work," says the report. "Dealing with accidents involving chemicals and biological materials is costly in time and money and human suffering."

The BMA argues that many of the problems that it identifies in its report will not be resolved unless an occupational health service in the NHS is properly developed. "Health professionals are frequently called upon to work long hours and to make crucial decisions using sophisticated medical technology. Any potential risk may be minimised or eliminated by the interventions of the occupational health service," says the report.

"So far the 1.3 million employees in the NHS have been ignored," said David Morgan, the editor of the report. "We need a consultant led occupational health service. We know that there is low level exposure to substances such as anaesthetic agents, and we do not know what their long term effects are. Yet there is no central directive stating that staff's exposure to these agents should be kept as low as possible. We are also concerned that general practitioners are being left to develop their own health and safety standards and that they have no central place to go to for advice."

The report covers the health risks of ionising radiation, microbial hazards, and clinical waste. It states that more information is needed about the use of chemicals. Formaldehyde, for example, is used widely as a preservative and disinfectant in anatomy and pathology but may be carcinogenic. Concern has also been raised about cytotoxic drugs: an increase in markers of genetic damage (sister chromatid exchange in lymphocytes) has been described among nurses who regularly handle cytostatic agents. "It may be that a better way of disposing of these chemicals can be found rather than simply diluting them within the environment," says the report. — LUISA DILLNER, *BMJ*



The long term effects of anaesthetic agents are not known

ULRIKE PREUSS

Environmental and Occupational Risks of Health Care is available from BMA House, Tavistock Square, London WC1H 9JP, price £16.95.

League tables criticised as misleading

The publication of the first league tables showing the performance of hospitals has been met with scepticism by the BMA and the Royal College of Nursing, both of which accuse the government of misleading the public. "The performance indicators do not relate to the question of clinical care in the hospital," said Dr Sandy Macara, chairman of the BMA's council. "They are purely administrative indicators, and what worries me is that there will be an assumption that they indicate quality."

The indicators used in the "comparative performance guide" are based on the patient's charter and include the percentage of patients seen within 30 minutes in outpatient clinics, the percentage of patients discharged as day cases after common operations, the percentage of people admitted for treatment within three months and 12 months, and the number of people assessed within five minutes of arriving at an accident and emergency department.

"As a sign of the pace of ongoing improvement we already know that standards have been raised," says the guide. Star ratings are given to hospitals that meet the standards and whose data collection has been pronounced satisfactory by the Audit Commission. Auditors reported that 85% of the total number of indicators of performance in British hospitals were based on adequate data collection. One in three hospitals had inadequate data from accident and emergency departments and one in five had inadequate data on outpatient waiting times.

Many hospitals are given five stars for some of the indicators, particularly for admitting patients within 12 months. North East Worcestershire Community Healthcare NHS Trust is said to see 100% of its outpatients within 30 minutes of their appointment time and to assess 100% of patients in the accident and emergency department within five minutes of their arrival.

"Any league table is prone to number juggling," said a spokesperson from the Royal College of Nursing. "People want to present their hospital in the best possible light. If you take the example of accident and emergency indicators there are 101 interpretations of assessing a patient. Someone can just say 'hello' and sit you on a plastic seat. The question you want to ask is whether people are being prioritised correctly."

The National Association of Health Authorities and Trusts has welcomed the report as "useful," but its deputy director, Jean Trainer, said that more sophisticated indicators were needed. "We need more information about outcomes and real quality indicators," she said. "These league tables won't give the public much idea of the quality and effectiveness of care in a particular hospital."

Jim Johnson, deputy chairman of the BMA's Central Consultants and Specialists Committee, said that the indicators gave hospitals points for not admitting patients

after day case surgery. He said that it was unlikely that patients would be made confident by knowing that they would be "ejected as soon as practicable." — LUISA DILLNER, *BMJ*

GPs vote for flexibility in out of hours work

General practitioners have voted to retain 24 hour responsibility for their patients, but they want the choice of opting out of out of hours care. They have called for any agreement to give doctors the option of how they provide out of hours cover and to protect those who want to continue providing cover as at present.

For the past three years the annual conference of representatives of local medical committees has debated how out of hours care should be provided. Last year the conference instructed the General Medical Services Committee to negotiate alternative arrangements. Night visits have increased fivefold in the past 25 years, and doctors have complained that many of the calls are not for genuine emergencies.

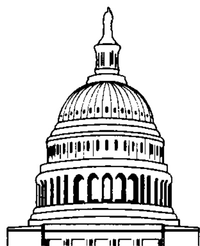
This year, however, the conference agreed that such a move would be "prejudicial to the position of general practice in the NHS." The GMSC's chairman, Dr Ian Bogle, said that it had become obvious during the negotiations that removing the contractual obligation to provide out of hours cover could damage general practice. "We felt that the government might grow to like it." Negotiators had therefore concentrated on other improvements to ease 24 hour responsibility, such as changing the terms of service to make it clearer that it is the doctor's decision whether, when, and where a consultation takes place (28 May, p 1387).

Not all representatives were satisfied. "The majority of general practitioners want to be rid of the responsibility of 24 hour cover," maintained Dr Roderick Donnelly from Sudbury. "The health of people in other Western countries where general practitioners do not have this onerous responsibility is good if not better than ours." Many general practitioners believe that the proposed changes to the terms of service are not explicit enough and that they should not have to visit for social reasons. In background notes the Department of Health set out hypothetical situations, such as an ill carer being reluctant to leave a dependent relative to go the surgery. Dr Bogle said that such examples were an attempt on the part of the Department of Health to get the conference to reject the deal. He supported the conference's call for clarification that a patient's clinical condition would be the only criterion for a home visit, that general practitioners would determine where out of hours treatment would be given, and that patients had no right to home visiting on demand.

The conference rejected a referendum to see whether general practitioners wanted to be able to opt out of 24 hour responsibility. — LINDA BEECHAM, *BMJ*

Focus: Washington

US health reform: how to achieve the achievable



This summer Americans are witnessing a historic debate in congress that brings out the difficulties of compromise and the reality of principle versus pragmatism. Not since 1964, when black Americans gained true voting rights, has the country witnessed the magnitude of politicking now going on in Washington over health care reform — and specifically over the meaning of universal coverage.

In 1964 President Johnson had a martyred President Kennedy and his own congressional career as assets. In 1994 President Clinton has a majority in both houses of congress and can already claim more success in pushing forward health care reform than Johnson or any other president. He has so far withstood the massive efforts of various interest groups to stop his reform plan, repeated rebuffs for cooperation by the Republican minority, and discord among his own party. Two weeks ago a committee of the House of Representatives and another of the Senate approved bills that support the president's method of achieving universal coverage for virtually all Americans. But no one seems to believe that either bill will make it as the ultimate plan.

That is because the game has shifted to backroom politics, led mostly by a master of the art — the mercurial, intellectual, and egotistic senator from New York, Daniel Patrick Moynihan. From the beginning of the debate last year, Senator Moynihan promised his president that he would crusade for the bill. But he also warned him to accept reality — that principle might have to give way to pragmatism. A perfect plan is no good if it dies, says the senator.

Because of the Democrats' majority in the 435 member House of Representatives and the 100 member Senate, the president might be able to force through a bill without a single Republican vote — as he did with his economic reform package last year. But Moynihan and others believe that a plan to restructure 15% of the US economy must have support from both parties.

Moynihan heads the Senate's finance committee, one of five committees dealing with health reform and probably the most bipartisan committee in the Capitol. Moynihan is now nursing that bipartisanship. Last week, he implicitly supported a compromise put together by conservative Democrats and liberal Republicans on his committee. By the week's end his support was explicit. And although the compromise eliminates immediate health insurance coverage for all Americans, even that most ardent reformer Hillary Clinton has not objected.

In fact, the finance committee's compromise leaves out three core parts of Clinton's plan. Firstly, it would seek to cover only 95% of Americans; 12 million people would still be uninsured. Secondly, even though almost 60% of Americans are now covered by insurance paid for by their employer, the compromise does not insist that employers should buy insurance for their workers. In fact, it puts the responsibility— though not the requirement — on citizens themselves. Thirdly, it abandons price controls — to the chagrin of liberal politicians but the delight of nearly all economists.

Clinton still insists he will veto any bill that does not carry universal coverage. But semantics are a political art form. What does "universal coverage" mean? "Full employment" in the US is defined as an unemployment rate of less than 5%. If subsidies are offered to poorer Americans (which Moynihan would do through taxes on tobacco, firearms, ammunition, insurers, and big employers) does that imply universal coverage?

In fact, the backroom bargaining is almost over. The Moynihan compromise, or something similar to it, will probably reach the floor of the Senate by the Independence Day holiday on 4 July. Other bills are already out of committee. Now Americans can watch the debate in public. The special interests — business, doctors, elderly people, and scores of others — will launch even more intensive public lobbying campaigns.

Moynihan has come down on the side of political pragmatism. Clinton still stands firm for principle. During the next two months Americans will turn on their television sets each evening to watch how 535 professional politicians will blend the two. — JOHN ROBERTS