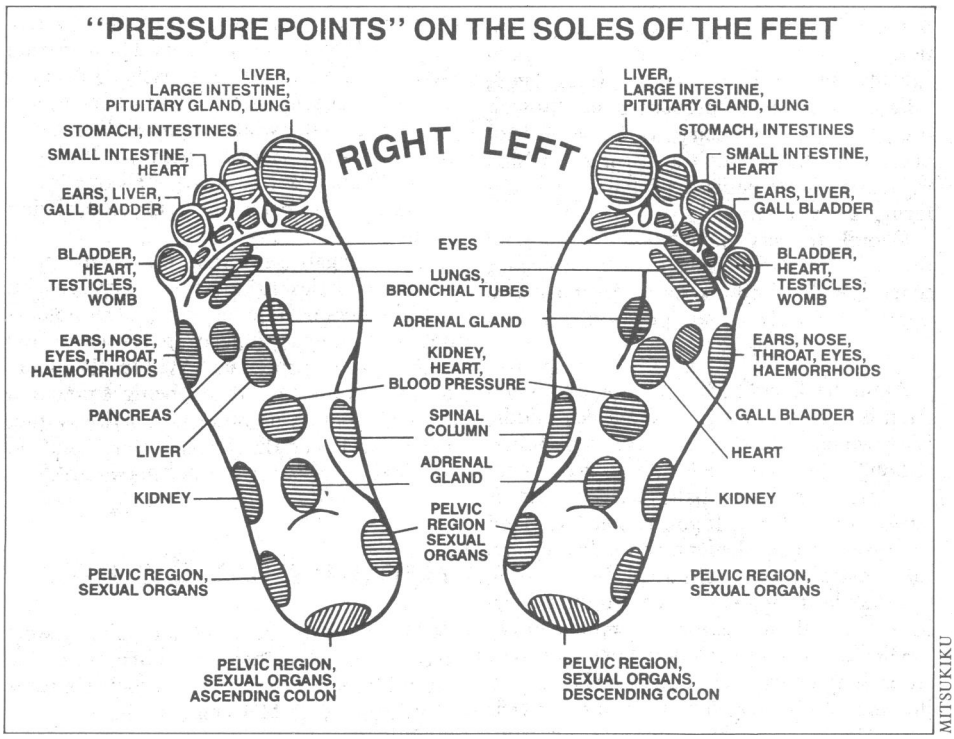
Europe looks at complementary medicine

Follow almost any aspect of health care a few years down the road and you will find the Single European Act of 1992 looming over it. Complementary medicine is no exception. Until recently about all that governments knew of it was that its popularity was increasing. Now with proposals for harmonising its practice throughout Europe governments are having to take a closer look.

Most have no idea of how many of their population use complementary medicine, why they use it, how much it costs them, how it affects the total costs of health care, and whether its use should be encouraged or discouraged. The little that is known shows wide variation.



Time for Europe to get in step over complementary medicine

Belgium

In Belgium anyone who practises medicine—complementary or orthodox—without being enrolled with the Belgian General Medical Council is committing a criminal offence. Recognised doctors have clinical and diagnostic freedom to carry out whatever treatments they think fit. Those who choose complementary medicine may still find themselves in conflict with their professional organisation, which requires them to treat patients "taking all reasonable care given the current state of scientific knowledge."

About one in four Belgians visit a complementary practitioner. Homoeopathy is the most popular treatment, followed by natural remedies, manipulative treatments, acupuncture, and phytotherapy. Middle aged women belonging to higher socioeconomic groups are overrepresented. General practitioners offer most of the available homoeopathy (85%) and acupuncture (63%), with specialist doctors delivering the rest. Physiotherapists provide most of the osteopathy.

Although the social security system does not directly reimburse for specific complementary treatments, doctors can indirectly include such reimbursement in their fees. There has been no serious research into the financial implications of complementary medicine as a health care alternative.

Denmark

There are about 2000 registered complementary practitioners in Denmark with a ratio of alternative practitioners to family doctors of 1 to 1·6. About one in 10 Danes resort to complementary medicine in one year. Zone therapy is the most popular, followed by natural medicine including homoeopathy, massage, and acupuncture. Women use complementary medicine more than men. There are no major social differences between users of orthodox and complementary medicines, although using complementary medicine is more expensive than using the public health services.

Finland

Finnish law does not recognise alternative medicines. Only medically qualified doctors are allowed to practise medicine, which is interpreted as the right to diagnose and take fees. Acupuncture, however, is accepted as part of orthodox medical practice and is included in the medical curriculum.

More than a quarter of the Finnish adult population have used some form of complementary medicine. This may be subdivided into traditional folk medicines (massage, bone setting, and "cupping") and more recently introduced forms (natural medicine, manipulation, acupuncture, and hypnosis).

Whereas the newer forms are attractive to a younger urban population, traditional medicines find favour with an older, less well educated, rural population. There are no payments for complementary medicines from public or private health insurance.

France

In France the practice of complementary medicine is illegal unless by an orthodox medical practitioner. A medical practitioner is free to prescribe whatever treatment is appropriate. Homoeopathic remedies are used by one in six of the population and prescribed, alongside conventional remedies, by medical practitioners.

Acupuncture and homoeopathy are taught in some medical faculties. Chiropractic remains illegal, yet 13% of the population go to chiropractors and are reimbursed by health insurance schemes. About one in four general practitioners care for patients using complementary treatments. The cost of acupuncture, when legally given by a qualified medical practitioner, is reimbursed by the social security system. Homoeopathic remedies qualify alongside allopathic remedies for a state subsidy of 70% of their price.

The Netherlands

Orthodox and complementary medicine are integrated in The Netherlands, and this has been actively encouraged by the government. Clinical and sociological research has been commissioned to provide a basis for policy decisions. Complementary medicines are flourishing in response to public demand, with acupuncture, anthroposophical medicine, homoeopathy, manipulation, naturopathy, and paranormal healing the most popular. As in most other European countries practice is currently restricted to medical doctors with a university training.

More women than men visit complementary practitioners; it is generally poorer members of the population who use paranormal healing. The cost of complementary treatments is reimbursed by private and state health insurance when prescribed by a general practitioner. This includes homoeopathic and anthroposophic medicines.

United Kingdom

There is no restriction on complementary practitioners under British law, and doctors may now refer patients to complementary practitioners provided they maintain ultimate responsibility for the management of the patient.

About one in eight of the British population use complementary medicines, the most popular being herbal remedies, manipulation, homoeopathy, acupuncture, hypnotherapy, and spiritual healing. Middle aged, middle class women predominate, although users of complementary medicine do not necessarily differ from those using orthodox medicine. Some patients probably use both forms of health care.

Complementary medicines are not paid for by the NHS. Some private insurance schemes will reimburse patients who attend approved complementary practitioners.

* * *

Amid the diversity there are some common strands. For example, middle aged, middle class women are the most frequent users, although this may mean only that a certain minimum level of disposable income is needed to pay for it. If governments decided to subsidise complementary medicine then many more people might use it. Substituting one medical approach for another may have financial implications—complementary medicines are often considered to be cheaper. At present, however, its costs may be masked in some countries by doctors reclaiming their costs under statutory provisions for non-specific reimbursement.

Criteria to judge quality of care will be needed. Some European Community states already have them; what is needed is a forum for them to share their experience. Sooner or later the nettle of scientific validation of complementary medicine will have to be grasped. So far little has been done: complementary practitioners have generally been unwilling to submit their work for assessment, and governments have lacked the political will to fund research.

Three initiatives originating from the Economic Community are likely to hurry things along. The first is a directive to review all drugs and remedies—including herbal, homoeopathic, and anthroposophic medicine—by the end of 1990. The second is a research programme, adopted by the Council of the Ministers of the European Communities, to look at how complementary medicine may be integrated within existing systems of health care delivery. The third is a directive that complementary practitioners should have completed three years of government approved tertiary education. This should lead to common European standards.—DAVID ALDRIDGE, *Herdecke, West Germany*

Health reform group

Almost nine months to the day since *Working for Patients* first saw the lights of a television studio a group of doctors has been formed to support the white paper's implementation. Its prime mover is Cheltenham general practitioner Dr Clive Froggatt, who is also research officer with the Conservative Medical Association and a staunch supporter of his party's plans for the health service. He is keen, however, that the Health Reform Group is seen as non-political.

"That is why they wanted me as their chairman," Professor Richard Lilford, of St James's University Hospital, Leeds, told me. "I'm not a member of the Conservative Medical Association, and I don't have private patients." Dr Froggatt approached Professor Lilford after two articles by him, favourable to aspects of the white paper, had appeared in the *Health Service Journal*. Professor Lilford's hospital is keen to go self governing, but he does not belong to its implementation group.

Dr Froggatt says that the group grew out of a series of meetings with general practitioners keen to become budget holders and consultants similarly in favour of key white paper proposals. Within 24 hours of the group's existence being known, a fortnight before its official launch was due, Dr Froggatt said that he had been inundated with calls of support.—TONY DELAMOTHE

Ambulance dispute

As we went to press union officials were discussing what further industrial action ambulancemen could take in their six week pay dispute with NHS management.

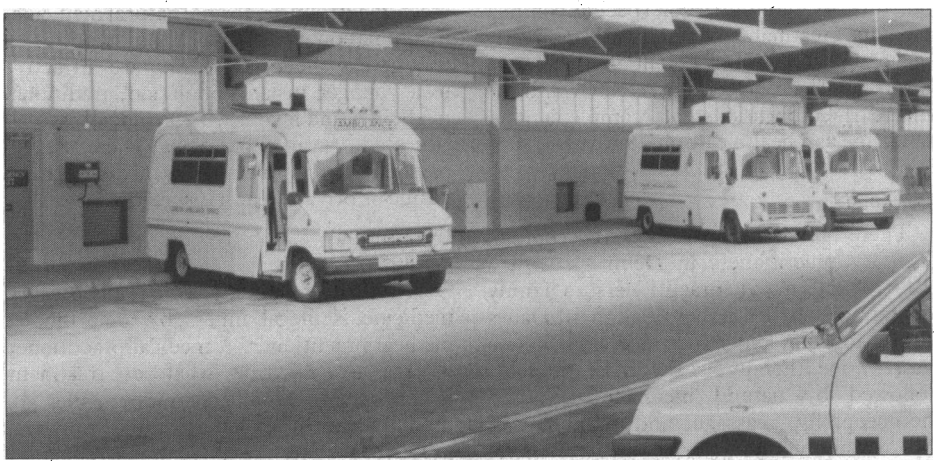
The dispute highlights once again the difficulties faced by essential service unions under prevailing pay determination systems. The unions reject the management's offer, the management refuses arbitration—the unions have little alternative but to take industrial action. But organising industrial action has always been a path beset by lions for health service unions. On the one hand, industrial action, if it is to be effective, must hit services. On the other, public sympathy is easily dissipated by stories of heartless strikers. And few workers would willingly risk the lives of patients, among whom may be numbered their family and friends.

The union response to this dilemma has been to conduct campaigns within codes of conduct designed to protect public health and safety. A 1981 code formulated by the Trades Union Congress health services committee states that any action restricting patient services must be consistent with "human life, safety and dignity." It urges unions to arrange in advance with management to maintain emergency services and services to high dependency patients. Emergency services are those which "directly involve the life, limb or ultimate safety of a patient," and these include responses to 999 calls.

The unions made clear that observing this code required reciprocal restraint on the part of health service management. This may involve managers refraining from exercising their full legal rights. For example, they may agree to pay normal wages to workers who maintain emergency cover, despite their failure to perform some contractual duties. This "Queensberry rules" approach to disputes may go further; research on the handling of the protracted 1982 national dispute revealed a wide range of informal deals, including agreements to restrict non-emergency admissions, or private patients, in return for assured cover for emergencies. This approach had its critics. Some would argue that all patients are potential emergencies and that restricting services is never justified. But, in general, the approach avoided serious disasters—although, some would say, in the face of a recalcitrant government it lost the unions the fight.

In London last week the management response was much more aggressive than in 1982. Ambulancemen who remained willing to answer emergency calls were sent home without pay because they were working to rule. In any essential service this is a high risk strategy that can be used only when substitute labour is immediately at hand. On this occasion the police were brought in. This was a move of questionable constitutional propriety—the police are supposed to be impartial in disputes, not used as a tool to defeat industrial action. Their ability to cope with serious disasters is also uncertain; thankfully, the regular emergency ambulance service was restored before this was put to the test. But the dispute remains deadlocked and the campaign continues.

This dispute reinforces the need for a stable system of determining pay in the ambulance service. For the past decade increases in police pay have been linked to the index of average earnings. Firemen, too, have a pay formula; their pay is linked to the



LONDON AMBULANCE SERVICE

upper quartile of manual workers' earnings. These groups are the nearest comparators to the ambulancemen. Yet ambulancemen are left to fight their corner in the Whitley negotiating councils. In practice, the combination of cash limits and representatives on the management side appointed by the secretary of state means that there is restricted scope for genuine negotiation.

The government is opposed to extending index linking, which it regards as overrigid and inflationary. It also opposes binding arbitration, an alternative to public service strikes in some other jurisdictions, which it sees as subcontracting the decision as to what the nation can afford. And yet this opposition is not uniform. The police retain the right of access to unilateral arbitration—as do staff at the House of Commons and Government Communications Headquarters. Moreover, the reports of pay review bodies, which cover doctors, nurses, and several other health professionals, may not be binding but they create strong political pressure on the government to implement their recommendations. The government may argue that these systems are rewards for refraining from industrial action. But workers who lack alternative procedures cannot be expected not to withdraw labour. Ambulancemen are condemned by ministers for taking industrial action because of the vital service they provide. At present their terms and conditions of employment do not reflect the value of that service.—GILLIAN MORRIS, *lecturer in law, Brunel University*

AMAPI→BrAPP→FPM

Some countries are avid in launching new journals, others in creating new medical colleges and faculties. Britain is certainly among the latter: last week's inauguration of the Faculty of Pharmaceutical Medicine (FPM) brings the total of medical faculties to 16, and there are rumours of at least one, and possibly two, more. Such developments may make it difficult for the profession to speak with one voice, but they have enabled groups to establish their identities without interference. And, given the wartime failure of the proposal for a unified academy of medicine, individual solutions to individual problems were inevitable. As a working party has pointed out, pharmaceutical medicine has to take account of economic, financial, and political issues—factors that up to now have been of less concern to other branches of medicine.

The new faculty has had a long evolution, fraught with acronyms. The Association of Medical Advisers in the Pharmaceutical Industry (AMAPI) was formed in 1957, well before the Dunlop committee and the establishment of the Medicines Commission and the Committee on Safety of Medicines (CSM). Arranging scientific lectures and meetings, it has also had a prominent role in organising training courses for pharmaceutical physicians (a term first used in the 1970s) and for the diploma established by the three medical royal colleges in 1976. Two years ago, however, an AMAPI working party concluded that some other body was needed to fulfil the academic and professional requirements of the discipline, with three main remits:

- To develop and maintain standards
- To act as an authoritative body
- To promote knowledge of pharmaceutical medicine.

A referendum by the British Association of Pharmaceutical Physicians (BrAPP, as AMAPI had now become) resulted in an 87% vote favouring such a faculty, and the Faculty of Pharmaceutical Medicine was inaugurated on 26 October, with 175 founder fellows and 201 founder members. Sponsored by the three royal colleges of physicians in the United Kingdom and housed in London, it has among its first officers as president Professor Sir Abraham Goldberg, formerly chairman of the Committee on Safety of Medicines, and as academic registrar Dr Felicity (Flic) Gabbay, one of the main driving forces behind the initiative.—STEPHEN LOCK

Volunteer drug trials and students

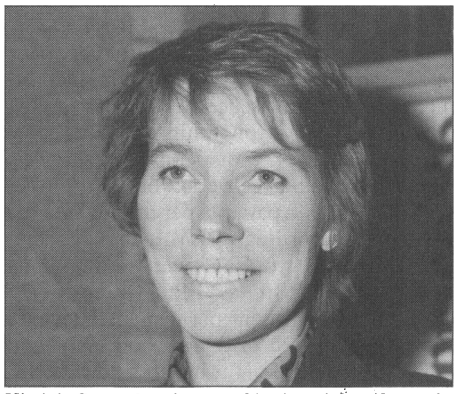
Advised by the Association of Independent Clinical Research Contractors, the National Union of Students (NUS) has drawn up a set of guidelines for students taking part in drug trials. Several years ago two students died in close temporal association with drug trials, and there have been an unknown number of "near misses" since. A recent study has reported that about 28% of subjects in healthy volunteer studies were students (*Br J Clin Pharmacol* 1989;**27**:125-33).

According to Dr Tim Mant, medical director of the Guy's Drug Research Unit, both the Royal College of Physicians and the Association of the British Pharmaceutical Industry have produced excellent guidelines for testing drugs in healthy volunteers. The problem is that no mechanism exists to ensure that investigators observe them. Drug companies belonging to the ABPI risk expulsion if they don't keep to the guidelines, but foreign companies can do drug studies here without registering with the ABPI.

Last year the Association of Independent Clinical Research Contractors was set up "to establish, promote, and monitor the highest professional, ethical, and operating standards in all aspects of human drug evaluation studies." Of the 70-odd contractors doing drug volunteer studies in the United Kingdom, so far fewer than one third have joined the association.

Speaking at the launch of the new guidelines Ms Sarah Adams, of the NUS, said: "If students are going to participate in medical drug trials it is important that they are as fully protected as possible. We do not seek to prevent such trials, only to ensure the welfare of students taking part in them."—TONY DELAMOTHE

Next through the revolving door



UNIVERSAL PICTORIAL

Virginia Bottomley, from psychiatric social worker to the Department of Health

Further ministerial change at the Department of Health came last week in the aftershock of the resignation of the Chancellor of the Exchequer, Mr Nigel Lawson.

Mrs Virginia Bottomley was appointed second in command as minister of state in place of Mr David Mellor, who has moved to the Home Office. Mrs Bottomley has won rapid promotion after only 15 months as parliamentary secretary at the Department of the Environment.

Before becoming the member of parliament for Surrey South West in 1984 she had been a professional psychiatric social worker in child guidance. Her husband, Peter Bottomley, is a junior minister in Northern Ireland.

In the space of 15 months this is the seventh change at the department while a major review of the NHS has been in progress. Since Mr Clarke took over from John Moore in July 1988 four ministers have been moved, Mrs Edwina Currie has resigned, and Lord Trafford has died.—JOHN WARDEN

FPCs may limit use of commercial deputising services

The BMA has lost a test case challenging the right of family practitioner committees (FPCs) to set a limit on the use general practitioners can make of commercial deputising services. The High Court has ruled that FPCs are entitled to restrict doctors' use of such services to a fixed number of calls per patient per month, although there are no such fetters on their right to use non-commercial deputies and locums.

Dr Anthony Spencer, a general practitioner in Coventry and medical secretary to the BMA deputising service, brought the case to court with BMA backing after many FPCs, on suggestions from the Department of Health, reduced the number of visits per patient per month which doctors could delegate to a commercial service.

Under NHS regulations doctors must give personal service unless treatment is delegated

to another doctor acting as deputy or another competent person. The regulations provide that a doctor must obtain the FPC's consent before making arrangements with a deputising service and that the committee may impose "such conditions as it considers necessary or expedient to ensure the adequacy of such arrangements." In 1984 the Department of Health issued a circular giving guidance to FPCs on limits that might be imposed on the use of deputising services. These included a restriction on the number of visits per 1000 patients per month.

At first, according to BMA deputy secretary Michael Lowe, FPCs were setting limits of 20 or 25. "But as FPCs went to the department for their performance reviews they were told 20 or 25 was too high, and many started putting the number down to 15. The use of deputising services was putting £25 million a year into the expenses pool. If it could be cut by a third it would save over £8 million."

Dr Spencer appealed to the secretary of state when Coventry FPC set a limit of 15 visits per 1000 patients, which in his case would have permitted 63 calls per month. When his appeal was turned down he applied for judicial review of the secretary of state's decision.

Dr Spencer's counsel, Mr Francis Ferris QC, argued that the wording of the regulations meant that the committee could impose only conditions designed to ensure that the service was adequate to carry out the work. If it was too small or inefficiently administered or did not employ sufficiently well qualified doctors then conditions could be imposed to overcome these defects.

"We believed that was the original intention of that safeguard and we decided to test the right of FPCs to lay down blanket rules," said Michael Lowe. "After all, a GP could contract with a retired doctor to do all his night and weekend work, and because it was not a commercial service there would be no controls."

But Lord Justice Watkins and Mr Justice Hutchison accepted the argument of Mr John Laws, counsel for the department, that the FPC could take into account wider considerations. Mr Justice Hutchison said that the doctor's primary obligation was to provide personal treatment, subject to limited exceptions. He could not accept that a sensible construction of the regulations was that "provided only the commercial deputising service is large and efficient enough, the FPC are in practice obliged to give their consent, even though they know that the doctor in question intends to delegate his entire practice to such an organisation."

Any sensible construction of the terms of service would mean reading the paragraph on commercial services in the light of the paragraph laying down the doctor's obligation to give treatment personally and to take reasonable steps to ensure continuity of treatment, he added. The challenge to the decision of the minister and the FPC and to the propriety of the circular was "misconceived." There was sufficient evidence to justify the conclusion that imposing a limit of 15 calls per 1000 patients was necessary or expedient to ensure the adequacy of the arrangements with the deputising service.

Following the ruling, which is not expected to be appealed against, the Department of Health has written to FPC managers and administrators reaffirming the guidance in the 1984 circular. The department is undertaking a review of the procedure for approving and monitoring the use of deputising services.—CLARE DYER, *legal correspondent*

On the streets

About 1700 homeless young people each year use Centrepoint Soho's emergency overnight shelter in London. Less than half of a sample surveyed last winter had come from family homes, most had slept rough at some stage, a third had been approached about prostitution, and on average they had less then £2 in their pockets. Compared with a similar group in 1987 nearly twice as many had been in local authority care. The report's title, *Homeless and Hungry*, echoes the begging signs displayed by the many young people sitting in London's tube stations and doorways. The charity mostly blames the recent removal of eligibility for income support from unemployed 16 and 17 year olds on the assumption that they will be on youth training schemes.

Two other charities have confirmed the extent of the problem. Shelter, the National Campaign for the Homeless, estimates that up to 150 000 young people will be on the streets over the next year. It is launching a nationwide report next week.

The Children's Society, founded in 1881 to provide homes for "waifs and strays," is probably needed now even more than in Victorian times. Over 500 young people were referred to its safe house for young runaways, the Central London Teenager Project, in 1985-7. Like those seen by Centrepoint, many had been in local authority care and had encountered similar dangers on the streets. They often gave vague reasons for leaving when first interviewed: "I was fed up," "I didn't like the way I was treated." Once they had developed trust in the house staff, however, many admitted to serious problems and nearly one in five had suffered sexual abuse.—TRISH GROVES

KATALIN ARKELL/NETWORK

Sweet dreams aren't made of this

Homeless and Hungry: A Sign of the Times. Centrepoint Soho, 140A Gloucester Mansions, Cambridge Circus, London WC2H 8HD, price £2.50. *Hard Times.* Shelter, 88 Old Street, London EC1V 9HU. *Young Runaways: findings from Britain's first safe house.* The Children's Society, Edward Rudolph House, Margery Street, London WC1X 0JL, price £7.95.

Difficult financial year for health authorities

Many health authorities in England, Wales, and Northern Ireland are again facing financial difficulties this year. Nine out of 10 health authorities surveyed by the National Association of Health Authorities (NAHA) have made, or are planning, savings over and above their formal cost improvement programmes to stay within budget. An estimated £163m will be saved in England, Wales, and Northern Ireland by using a combination of accounting measures, such as deferring payments to creditors and transferring money from capital to revenue, and reducing services and freezing recruitment.

The report says that if health authorities are to meet all their financial commitments, including pay and price shortfalls as well as planned essential developments, they will need to make savings amounting to £323m including their formal cost improvement programmes. Some health authorities are planning to save up to 6% of their revenue on top of their official cost improvements.

This survey, covering 42% of districts in England, Wales, and Northern Ireland, comes after a flurry of reports in the press concerning bed closures (77 so far at St Bartholomew's in London, for example) and other service reductions (new operating theatres in Kettering standing idle, for example). The report points out that, nationally, health authorities' allocations this year have amounted to about a 9% increase over last year's spending. It also states, however, that health service inflation this year is running at about 8%, rather than the government's forecast of 5%. Together with districts' cost improvements of about 1% this should leave room for a real increase in resources of about 2%.

This real growth has not, however, been evenly spread across the country; health authorities vary considerably in terms of their size, structure, workforce, allocations, development plans, and the health needs of their populations. Though some seem financially secure, others are making little or no developments in services this year while still having to make savings to meet shortfalls on pay and price inflation.

Perhaps the main financial problem facing districts at the moment is health service inflation, which is higher than forecast. Last December, when health authority budgets for this year were announced, the government forecast inflation to be 5%. Since then nearly 90% of health service staff have agreed

pay awards for this year, and virtually all have been higher than 5%. For example, nurses settled for 6·8%, doctors and dentists 8%, professions allied to medicine 7·7%, and administrative and clerical staff about 8% (this included a restructuring of pay grades). Shortfalls on pay this year are estimated to be about £127m despite the government's injection of £126m to partly fund the review bodies' pay awards.

But not only have health authorities had to find extra amounts for pay awards this year, they have also had to make savings to cope with underfunding of pay awards from last year. This has had a knock on effect this year as savings made last year to cope with shortfalls were not included in districts' base allocations this year. The survey estimates that these shortfalls add up to around £50m.

Non-pay costs have also tended to rise above the 5% forecast. In July this year the health service prices index stood at 7·3% higher than at the same period last year. NAHA's survey suggests that shortfalls on non-pay inflation could reach £34m this year.

Another rumbling from last year is also revealed by the survey: nurse regrading. The survey shows that nearly 70 000 nurses are still awaiting the outcome of their regrading appeals. This is about half the total number who originally went to appeal. The cost of successful regrading appeals from the beginning of April this year to September is estimated to be £27m. The survey estimates that the cost of outstanding appeals could reach £21m.

Staying within cash limits in 1989-90

	% Of health authorities	Value of saving (£m)
Drawing on reserves	27	22·6
Transferring capital to revenue	13	11·7
Budget topslicing	12	18·1
Freeze on recruitment	11	4·6
Reducing staff numbers	1	1·2
Selling land or estates	12	23·5
Deferring or deleting plans	23	9·7
Reducing services	15	22·8
Increasing creditors	20	19·1
Other (for example, income generation)	29	30·1
Total	90	163·4

Although this year looks tight financially, next year may be equally difficult. Health authorities predict that health service inflation next year will average 7·4%. On top of this they say they need about 4·3% to improve and develop services. This is equivalent to an increase of about £1·8 billion for the hospital and community health services in England, Wales, and Northern Ireland.

Government spending plans for next year (set out in the Treasury's expenditure plans published last January) show an increase in NHS spending, however, of just 4%. This figure has no doubt been improved during the current round of bilateral negotiations between the Treasury and the Department of Health over next year's NHS budget. Recent rumours suggest an increase for the whole of the NHS in the United Kingdom of between £1 billion and £2 billion. But this, it must be remembered, includes the family practitioner service and the health service in Scotland, neither of which are covered by NAHA's survey.

Overall, the survey concludes that the financial position of many districts gives cause for concern and that an (unspecified) injection of cash this financial year would relieve some of the financial pressures districts are facing.—ROWENA STANTON, *economist*

"Health Service Costs: The Autumn Survey of the Financial Position of District Health Authorities 1989" is available from NAHA, Birmingham Research Park, Vincent Drive, Birmingham B15 2SQ, price £4.00.

Correction

Health labour after 1992

To our report (7 October, p 878) Dr Alan Rowe, chairman of the BMA's committee on the European Community, adds: "Since 1975 a directive on the mutual recognition of doctors' qualifications and conditions for practising and providing services in another member state for a short limited period has been fully active. It was followed by directives for dentists, nurses, midwives, and pharmacists. None of these directives will be affected by 1992. Mutual recognition of specific training for general practice will come into full operation in 1995. Negotiations on a directive for physiotherapists have not yet resulted in any specific measures."

Letter from Westminster

Abortion reform again

Towards the end of this month the government intends to publish in quick succession three major bills which will have important implications for all who are professionally concerned in health care. The least contentious in this respect will be the food bill, increasing food safety standards in the aftermath of the past year's salmonella and listeria episodes. Two other bills directly bearing on the medical profession will follow hard on the heels of the Queen's speech on 21 November. One, of course, is the bill to reorganise the NHS on the lines of the white paper *Working for Patients*. It will not be short of attention during the subsequent six months.

But the chances are that in terms of arousing public interest the NHS bill could be overshadowed by an unlikely contemporary, the Warnock bill on human embryology, on to which parliament is intent on grafting reform of the abortion law. This explosive amalgam of medical and moral issues infused with high political passion promises to steal the show—though I am not as cynical as those MPs who suspect the government of using it as a deliberate tactic to divert attention from the NHS bill.

Baroness Warnock, who has waited more than five years since her committee on human fertilisation and embryology reported, laments the threatened hijack of the bill by the antiabortionists, who prefer to be known as the pro-life group and claim about 80 active members among MPs. Along with their allies in the Lords, they will spearhead twin campaigns to ban embryo experimentation and limit the scope for legal abortion. Other ethical issues like surrogate motherhood, parental rights, and the legal position of medical staff will become secondary.

Although abortion was outside the Warnock committee's remit, and the government will respect this by omitting it from the bill, the way is wide open for backbench amendments. Largely, these will attempt to revive Mr David Alton's well supported moves for an 18 week limit on medical termination, with extensions for rape and severe disability. Other amendments will propose limits of between 20 and 24 weeks. The arguments will be as familiar and fierce as ever, the difference this time being that they will end in the parliamentary cliffhanger of free votes that are likely to succeed in reducing the 28 week limit of the 1967 Abortion Act.

New minister's job

The Warnock bill will begin in the House of Lords, copiloted by the Lord Chancellor and the new junior health minister Lady Hooper, whom the pro-life group count as one of their number. The government's position of neutrality on the moral or religious issues will avoid her personal views being compromised.

MONITOR

Baroness Warnock: how much of her report will be acted on?

On this occasion, however, the argument about abortion no longer concerns only the "weeks" question. There is now the added complication of fetal transplants. In dealing with this the Department of Health can claim to have stolen a march. During the summer it implemented by circular to health authorities a revised code of practice on the use of fetal tissue for research or therapy. The operative rule is that a woman's consent to the use of tissue should come after and separately from her consent to an abortion.

If fetal transplantation—for example, for the treatment of parkinsonism—proves suc-

cessful it could have a profound effect on attitudes to abortion. Women will come under new pressure once they realise that their fetal tissues may be used therapeutically. For many it could help them to come to terms with miscarriage. It will be one more influence bearing on women's decisions to have pregnancies terminated. It is anticipated that some women could contemplate becoming pregnant in order to make a fetus available for medical use.

These changes flow from the findings of a committee chaired by the Reverend Dr John Polkinghorne (5 August, p 346), which took its cue from the Warnock report. Polkinghorne also redefined the status of the fetus, dropping the category "previable," which covered research procedures up to 20 weeks' gestation without requiring the absence of signs of life. Instead, the Polkinghorne code states that from the time of implantation the live fetus should be treated according to principles broadly similar to those that apply to treatment and research conducted on children and adults. In turn, this gives the antiabortion lobby a strong debating point. David Alton argues that the Polkinghorne rule according respect to the fetus from the earliest age is inconsistent with allowing medical abortion up to 28 weeks.

The second main issue on Warnock is the future of embryo research, which so far has survived three attempts at prohibition by private members' bills. The Warnock majority favoured controlled research up to 14 days. This is based on the view that the pre-embryo does not have full human status and that research would benefit the treatment of infertility and genetic defects. The arguments against research are that the embryo has human potential and that the prospects of medical advance within a 14 day constraint are illusory or limited. The bill will be drafted so as to allow each side a free vote.—JOHN WARDEN

The Week

Readers bite back

Readers surfeited with tales of falling chancellors, resigning economists, and fumbling prime ministers can relax. This week I shall be self indulgent and dwell on less weighty matters.

Firstly, I am glad to assure you that I do have some readers—well, four at least. The proof is that four doctors have written to me. One abused me: in a copy of a letter he had sent to a colleague he accused the *BMJ* of having been "in the forefront of an unpleasant and . . . near seditious political campaign [against the NHS review] which reflects no credit on the profession," moving on to castigate "the sustained bile of the egregious Scrutator like an old time agent provocateur" as being quite outrageous. For good measure I was described as a Robin Cook sound alike.

Mindful of the laws of libel, I will not pursue my likeness or otherwise to Robin Cook, the Labour party's front bench spokesman on health. I would add, however, that I am not a paid up member of any political party and during my voting adulthood have marked my cross in support of the party I thought best for the country at the time. Does that make me a floating voter or a thoughtful voter? The choice is yours. Anyway, I turned to *Chambers English Dictionary* (the *BMJ*'s lexicon) for a definition of egregious: "prominent, distinguished (arch): outrageous: notorious." As with my voting behaviour, take your pick of definitions.

Two other letters—on the same subject—were of a more comforting nature. Responding to my criticism of a northern health authority that had refused to introduce the give as you earn scheme which allows employees to give tax deductible charity donations, the authors assured me that their health authorities were participants. Thank you for the letters, and well done South Manchester and Liverpool Health Authorities. I hope that all authorities that do not operate the scheme will follow suit.

The fourth letter came from Dr Alan S Hutchison, a consultant clinical biochemist from Glasgow, who took me—and the BMA's Scottish secretary—to task for describing laboratory services as clinical support services. "Laboratory consultants," he says, "are responsible for the care of their own inpatients and run their own outpatient clinics. The diagnostic consultative service which is provided by all laboratory departments is required by virtually all hospital attending patients and a sizable proportion of those who attend their general practitioner. The laboratories are also responsible for undergraduate and postgraduate teaching, the training of staff, and clinical and pure research."

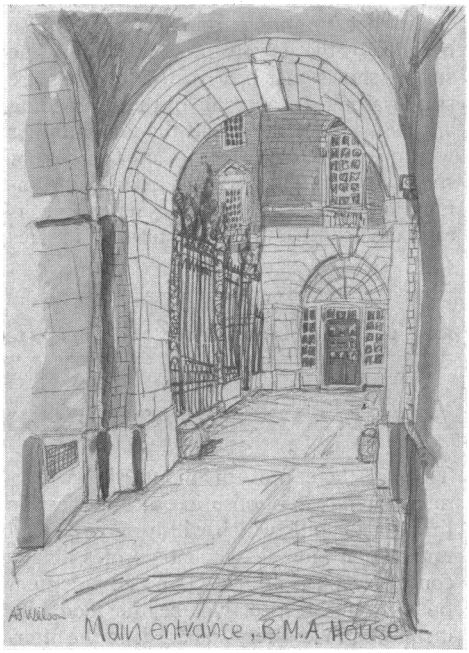
I plead guilty to and apologise for this error when on 14 October I criticised the Greater Glasgow Health Board for trying to put to tender laboratory and radiodiagnostic services (p 938). Dr Hutchison succinctly points out: "We have been trying hard to get the message across to the Greater Glasgow Health Board that we are a clinical service, as important to patient care as are paediatricians and cardiac surgeons. As we seem to have difficulty getting this message across to the British Medical Association, how on earth are we expected to get the point over to the Greater Glasgow Health Board?" Point taken, Dr Hutchison. Will the Greater Glasgow Health Board please note—and drop its foolish plans.

Public health committee?

Still on the subject of letters (but not one sent to me), Dr J Stuart Horner, a past chairman of the Central Committee for Community Medicine and Community Health and recently elected chairman of the BMA's medical ethics committee, has written to point out an error in the report of the CCCMCH.

He writes: "Thank you for revealing on p 1035 of your current column (21 October) what the initials CCCMCH really mean. If this is the present objective of my successors I must warn them that it is doomed to failure. Perhaps it is time to follow the lead of the Acheson committee and return to a simple public health committee."

The offending misprint was to describe the CCCMCH as the Control Committee of Community Medicine and Community Health. In apologising on behalf of the *BMJ* I hasten to assure Dr Horner that the error was not a subversive slip by one of our reporters frustrated after a day with the committee. In any case I agree with his suggestion and I am glad to hear that the control—sorry—central committee is considering it.



And while on the subject of errors I turn to that eternal font of misprints, the *Guardian*. (Did it invent them?) An excellent leading article (25 October) on the ambulance staff's dispute lambasted health ministers Clarke and Mellor for pulling the ministerial strings but propelling Mr Duncan Nichol, chief executive of the NHS Management Executive, up front to face the public music. Commenting on the two ministers' behaviour, the author says: "Neither [the two ministers] are known as shrinking violents [sic]; but in the ambulance dispute they have disappeared altogether." Perhaps that apt if unintended description will stick. Well done, the *Guardian*, keep it up, and pace that critic who likens me to Robin Cook.

SCRUTATOR