The regional secure units received a big capital boost this year—up from £3 million to £18 million. If, and it is a big if, another £18 million was spent next year, the number of places would be lifted to 1000. Courts already have a right to remand suspects to hospitals for an assessment rather than prison, but few use it. A change of attitudes is needed by both bench and local hospitals. There have been successful pilot projects in Peterborough and Horseferry Road (London) courts, where duty psychiatrists are used to avoid prison remands. And where only three decades ago there were only 2 forensic psychiatrists, there are now 70.

Yet the problems remain daunting. By ruling out extra cash, the service can kiss goodbye to the proposed 80 extra consultant forensic psychiatrists plus 175 other consultant posts to meet the needs over the next 5 years. Just what happens if 400 extra secure unit places are opened remains to be seen. Given the labour-intensive service, 400 extra beds would require 400 extra staff. The restructuring of the health service will not help. Mental illness may have been a priority of ministers, but GP fund-holders and the purchasing departments of health authorities have set their own. A review of purchaser and provider plans shows that fewer than half of all district health authorities include assessment facilities to help prevent the mentally disordered from being remanded to prison for reports, let alone increases in treatment provision. The report talks airily of hospitals ensuring that there are enough social workers to cope with the mentally disordered, but there are not enough social workers to deal with such politically popular causes as abused children, or vulnerable old people. Even the officials on the review were forced to raise doubts about what will happen in the new market model. "Uncertainty" was their only certainty.

This report published last week was the last of 12 from the review exercise chaired by Dr John Reed. Two other advisory groups are busy working away, the first on high security and related psychiatric provision, and the second on the treatment needs of psychopaths. Is it too cynical to ask why, if there is no cash and no sense of ministerial urgency?

Malcolm Dean

Round the World

WHO: Director-general's travels

Dr Hiroshi Nakajima is a much-travelled man—35 countries visited in the past eleven months. And he could give an emphatic affirmative to the question of whether such journeying is really necessary. It seems to have assured him of substantial backing in his bid to be re-elected for a second five-year term as WHO director-general. Next month's session of WHO's 31-member executive board looks like giving him majority support in his endeavour by recommending, through a secret ballot in closed session, that this be so. The USA (which contributes 25% of the agency's budget), the European Community, and Canada are among those for whom the prospect is unwelcome. They favour Dr Mohamed Abdelmoumene (Algeria), who was "relieved of his functions and title" by Nakajima in July, after clearly becoming a candidate for the top job. The board's choice will, of course, have to be formally endorsed by the World Health Assembly, again in camera, in May; this could be the setting for a further attempt by the western industrialised nations to convince the majority of WHO's 182 member countries that they would be better served by far were the Algerian at the helm. To date, however, the annual assembly has never rejected an executive board recommendation for the DG post—even though, as happened in 1988 with Nakajima, the choice was controversial.

As it is, the organisation seems to be suffering from a disturbing lack of fully competent leadership. This has resulted in abysmally low morale, with even regional directors telling the DG to his face that they had no confidence in him. Global travel has, not surprisingly, entailed his being absent from headquarters 171 days so far this year (181 in '92). Particularly by comparison with Dr Halfdan Mahler, his predecessor, he is far from dynamic or articulate—even, according to his own countrymen, in Japanese. Apart from drumming up support for a second term, his visits to developing countries have often been characterised, reliable sources say, by his giving little more than minimum attention to health institutions before turning to acquiring more artifacts, contemporary and antique, for his considerable collection amassed over many years. He has occasionally been accompanied by an aide who happens also to be highly expert in this field.

Although Nakajima is known to have old and influential friends in the ruling Liberal Democratic Party, the degree of support he enjoys from the Japanese Government has confounded western diplomats. "Never before in this context have we seen anything like it", one remarked. He said that a virtual task force, with as many as 18 people on occasion, has been deployed by Tokyo in a campaign using both carrot and stick—senior officials from various countries have been invited for VIP treatment; other countries, including Jamaica (coffee) and the Maldives (fish), have been tacitly advised that their exports to Japan might suffer should they fail to toe the line. In Washington, Japanese diplomats have said to their US contacts, "Just tell us what's wrong (with the DG's management) and we'll fix it", also sometimes going as far as to hint that their Government might have to consider cutting its funding to WHO—though no more has been heard recently of this latter tack.

The explanation for the Government's attitude seems simply to be that, conscious of its economic strength and of the growing role of UN agencies, Japan is flexing its political muscles.

Alan McGregor

Australia: Bolam principle overturned

On Nov 19 the High Court of Australia handed down a judgment that doctors here have worried about since proceedings started five years ago. The case concerned Maree Whittaker, who had been blind in one eye since an accident at the age of nine. In 1984 she saw Dr Chris Rogers, an ophthalmic surgeon, who said that an operation might fix it. She asked about all the dangers, pestering him incessantly about any risk to her good eye. She was particularly worried about him operating on the wrong eye, or accidentally damaging it with a scalpel. She asked if she could have a guard over her good eye to prevent any damage. Despite repeated questioning, Rogers did not tell Whittaker about the 1 in 14 000 chance of sympathetic ophthalmia. She

testified that, if she had known that there was any risk of total blindness, she would not have had the operation.

Unfortunately, Whittaker was the 1 in 14 000. She is now almost totally blind. The facts are not in dispute. The operation was technically competent, but the result was a disaster. The Supreme Court of New South Wales awarded Whittaker $808 564·38. Rogers appealed unsuccessfully to the Court of Appeal of NSW, then to the High Court, the supreme legal authority, which decided 6–0 that Rogers was negligent in not informing Whittaker of a risk she clearly wanted to know. In doing so, the High Court partly overturned a ruling on which British case law (from which Australian case law derives) is based. The Bolam principle, established in 1957, says that the law imposes a duty of care, but the standard of that care is a matter of medical judgment. Under the Bolam principle, if most doctors agreed that it was reasonable not to warn Whittaker of the risk of losing her sight, then the court would have agreed. This has now gone. The High Court says that, although the Bolam principle applies to doctors' decisions relating to diagnosis and treatment, it does not apply to the duty to inform.

The impact of this decision, legally and in practice, is unclear. Legally, it means a more rigorous test where issues regarding duty to inform arise. But of the 150 million or so medical services provided in Australia each year, only a handful are tested in court (and then usually a decade later). In practice, the reaction has been conflicting. Some medical defence experts believe that the judgment says no more than that a doctor should answer all questions honestly and reasonably, whereas others think that it means that doctors will have to spend hours listing every foreseeable complication before any procedure or therapy. Still others take the middle ground that doctors will have to be a little more informative but won't have to go overboard.

The one reaction that has been standard among medical defence experts is amazement that Rogers' lawyers and insurance company should have fought such a case so hard. With the previous arrangement under the Bolam principle shattered, the arbiter of what a doctor should tell his or her patient is now the reasonable person, the mythical "man on the Clapham bus", rather than a doctor. In reality, since few of these cases have jury trials, the de facto "ordinary man" will be a judge. And judges, with all their education and legal training, will surely decide that they would have wanted to know absolutely everything.

Mark Ragg

India: Doctors dispute trader role

Doctors are locked in a fierce controversy over patients' rights to demand compensation under the Consumer Protection Act 1986 (CPA) from private medical practitioners in cases of medical negligence. The Indian Medical Association (IMA) and Cosmopolitan Hospital, Kerala, are challenging, in the Supreme Court of India, the decision of the National Consumer Disputes Redressal Commission (NCDRC) set up under the CPA.

The case revolves round the death of a company executive on Sept 28, 1989, in Thiruvananthapuram, Kerala province. His wife filed a petition against Cosmopolitan Hospital before Kerala State Consumer Disputes Redressal Commission for compensation for "criminal negligence in diagnosis and treatment". Hospital authorities and the doctors challenged the jurisdiction of the Commission, contending that the deceased was not a "consumer" and the treatment was not a "service" as under the CPA. The Kerala State Commission rejected the hospitals' argument. This decision was challenged by the hospital and joined in by IMA as an intervening party before the National Commission.

The NCDRC, presided by Justice Balkrishna Eradi, upheld the State Commission verdict in its April 21, 1992, judgment. The IMA contends that by invoking the CPA doctors will be compelled to practise defensive medicine, which will make treatment costly. It also contends that the Medical Council of India is sufficient to deal with ethical issues and to warn doctors against treating the medical profession as a trade. But the Medical Council of India has a poor record in dealing with malpractice, and it cannot award compensation or pass criminal sentences. Consumer activists say that patients are justified in being held as consumers where doctors and hospitals treat their work like a business.

What has sparked the private medical communities' anxiety is the effectiveness and procedural ease of CPA. The complainant need not pay hefty court fees or hire lawyers. Only a written complaint to the District or State or National Consumer Disputes Redressal Commission would suffice, depending on the value of compensation claimed. The opposite party has to present its case within 30 days. The decision of the District Commission can be challenged before the State Commission, and the case can go on from there to the National Commission, whose decision can be challenged in the Supreme Court. And cases brought before a consumer court are dealt with much more speedily than civil tort or criminal cases, which can take a decade to be decided. The NCDRC decision is being viewed as a major victory for patients' rights.

So far, government and trust hospitals have been kept outside the purview of the CPA since their services are "free". But this is also being contended. Asks Dr P. V. Unnikrishnan of Voluntary Health Association of India, "How can you call them free and above public accountability when they are being paid for by the tax payers? Does the public have no right of compensation for suffering due to negligence at the hands of government doctors?" In another case, taking note of the fate of an agricultural labourer Hakim Sheikh on whom five government hospitals slammed their doors after a serious accident, the Supreme Court has recently issued notices to the West Bengal and Central Governments asking why government doctors in provincial hospitals should not be covered under the CPA.

The Supreme Court has now sought submission from the Medical Council of India and other medical associations.

Sanjay Kumar

Canada: Sexual abuse in health care

A five-year suspension for doctors found guilty of sexual misconduct and mandatory reporting of suspected cases of sexual impropriety are among tough measures introduced by the Ontario Government to "eliminate" sexual abuse in health care. The Regulated Health Professions Act (RHPA) was amended on Nov 25 to create one category of sexual offence, to be known as "sexual abuse". It will include sexual relations, touching of a sexual nature, and sexual improprieties, such as remarks of a sexual nature. "When it is found that sexual intercourse or other defined acts of