Service (NHS) and to propose competitive strategies to solve them. The Abril Report thus had much in common with recent surveys in other European countries, such as Sweden, the United Kingdom, and the Netherlands. The final document, with findings and recommendations, was presented to the Spanish Parliament last August. The main findings were the ineffectiveness of primary care, overuse of diagnostic and therapeutic resources, insufficient public-health activity, excessive centralisation, poor management (partly because of a deficient information system), and a failure to adopt the managerial and financial techniques required for modern health care. In its 64 recommendations the committee called for decentralisation of the NHS, with separation of financing from budgeting; it favoured introduction of some features of enterprise management, to promote personal responsibility for efficient use of human and other resources; it wanted more attention given to consumer satisfaction; it asked for more publicity about the costs of health care (so that the aspirations of the public would be more in tune with economic realities); and it urged more participation by and links between health professionals in the service.

These apparently reasonable proposals were greeted with almost uniform hostility by politicians (including the socialists now in government), trade unions, and professional organisations. The explanation for this astonishing consensus lies in three recommendations on financial matters. Firstly, it is proposed that pensioners shall pay 40% of the price of medicines prescribed by their physicians, as the rest of Spaniards do; until now they have obtained their medications free of charge. Pharmaceutical expenditure was nearly £2·3 billion in 1990 and the 20% of the Spanish population who are pensioners account for 70% of the bill. It has been suggested (but not proved) that there is widespread fraud, whereby medicines are obtained for the whole family via prescriptions made out to the pensioner. Although the Abril committee emphasises that removal of the pensioners' privilege should be accompanied by an increase in the retirement pension, or alternatively that pensioners should be reimbursed in full after payment, the recommendation was rejected by all political parties. The second contentious proposal was that a small fee should be payable for each service provided by the NHS, to make citizens aware that, although health is priceless, it is not costless. The third was that, if the whole population was to have access to a certain minimum level of health care, it would be necessary to identify the basic services that must be provided free of charge, the others being paid for. To many people the two last proposals—a charge for medical services and a reduction in coverage by the NHS—were totally unacceptable.

Critics of the report declare that the Abril Committee was too preoccupied with economic issues and oversympathetic to privatisation of medical services. Although the former Minister of Health, Julián Garcia Valverde, stated that the report was "no more than a framework for parliamentary debate", the Government, fearful of social turmoil, had to announce that the recommendations would not be applied to the NHS. Mr Garcia Valverde said he was opposed to the part-payment of prescriptions by pensioners and the payment of a small fee for each medical service; nevertheless, he did accept that the organisation and the management of the NHS needed updating, that pharmaceutical expenditure needed to be curtailed, and that hospitals should draw up their own budgets. These assertions are now of doubtful relevance since he had to resign in January (for other reasons). The new Minister, José-Antonio Griñán, has defended several aspects of the Abril Report and favours privatisation of some NHS services.

Although the report has not been fully adopted, some of its recommendations are already being acted upon. For instance, a restricted list of medicines has been designed for the NHS as a way of reducing pharmaceutical spending; the Government is discussing a Bill on this topic with pharmaceutical firms. The likelihood is that, in the long term, most of the Abril recommendations will win through.

Josep E. Baños

Sweden: Pre-employment drug tests

A campaign for a drug-free workplace is meeting with considerable opposition from the *Landsorganisation* (Trade Union Congress—LO). Thirty major employers have now adopted a policy of testing all job applicants for narcotics. The thirtieth—the huge Skandia insurance company—last week announced the launch of its testing policy in Stockholm, with similar tests nationwide as soon as facilities can be arranged. The unions, however, see such tests as an infringement of employees' rights.

The testing scheme applies only to new job applicants. "We are not going to test our existing staff", Skandia's chief personnel officer Christina Torsslow told the media, "but if someone comes after a job and tests positive, he will get no post in Skandia."

The idea of a "drug-free workplace" is strongly backed by the *Svenska arbetsgivareföreiningen* (Swedish Employers' Federation—SAF) and also by the *Naringslivets beredskapsbyra* (a kind of workplace security service), whose chief, Lennart Borg, says that he considers drug-testing to be a "stamp of quality" of workplace safety.

The LO, however, says that the employers are not thinking about the workers' safety so much as their own profits. Even if safety were really the motive, the LO says, it would still be against the general testing of employees, both as an infringement of civil rights and also because an employee could be deprived of the chance of a job if his blood or urine gave a false positive. Drug-testing in special doping laboratories (as used for international sporting events) is an expensive business, costing about US$200 to process each sample. Dr Mats Carle, head of Sweden's specialist doping laboratory at the Huddinge Hospital, who has developed a mobile test unit for pre-employment tests, maintains, however, that there is little risk of an applicant being unfairly rejected. Those who test positive, he says, will have their specimens sent to Huddinge for a second set of tests by the country's top laboratory in the field.

LO remains unconvinced but with unemployment running at (for Sweden) a frightening 3%, employers who introduce testing are unlikely to find difficulties with recruitment.

London Vera Rich

Australia: For or against euthanasia?

Debate over euthanasia has peaked in Australia in the past month because of two coincidental events.

A urologist in Victoria, Dr Rodney Syme, admitted publicly that on several occasions he had prescribed lethal doses of medication to terminally ill patients who he knew intended to take their lives. He said that he supported

euthanasia and was willing to go to court to defend the right to die an easy death. He was convinced that no jury would convict him, even though in Australia euthanasia is illegal.

In the days after Dr Syme's admission, several academics argued their points of view publicly. But the only authority giving a clear message was the Catholic Church, which said that it opposed euthanasia strongly. The office of the Victorian Attorney-General, the state's senior legal officer, declined to comment and said that it was a matter for the police. The police did not contact Mr Syme. Senior officials of the Australian Medical Association took several different positions which, if not conflicting, are confusing. They praised Dr Syme's bravery in making the issue public and sympathised with his actions. Yet they emphasised that they did not condone his actions, which were illegal. They said that they would neither take any action against Dr Syme nor support him. Any action would have to come from the Medical Board or the police. In the end, they called for more debate. The Australian Nursing Federation called for a public inquiry into euthanasia. The Victorian Premier commented only that the issue had been aired sufficiently in the past. Officials of the Australian (federal) Government wanted no part of the debate, emphasising that it was a matter for Victoria. At the same time, the Australian Government's Office of Film and Literature Classification decided to ban the import of *Final Exit*, a practical guide to suicide written by Derek Humphry, who is an active supporter of euthanasia. The book was said to be capable of influencing people to commit suicide. According to local reports, no other government has imposed censorship on the book.

Although unrelated, the two events reveal conflicting attitudes among Australian governments and institutions. They also reveal how desperately most governments and institutions want to avoid having to confront the legal position of euthanasia. Public opinion and that of health professionals, if polls can be trusted, are swaying towards euthanasia as a viable option; a survey of nurses from the Monash Bioethics Centre, for example, showed that 75% support active euthanasia. Euthanasia is no longer automatically condemned, but neither is it publicly supported. The ambivalence of governments and legal and health authorities suggests that public debate is required to allow all the issues to be clarified. The difficulty is that many are prepared to call for more debate on the issue, but few are prepared to air their views.

Mark Ragg

Medicine and the Law

Retractor design and the lingual nerve

The High Court has lately held in two separate judgments (with awards of £12 000 and £14 000) that patients with lingual nerve damage after the extraction of wisdom teeth were entitled to compensation because the operation had been negligently performed. Both cases suggest that the design of the retractors used in such operations needs to be looked at.

On July 11, 1986, a 36-year-old woman went to the Royal Berkshire Hospital to have three wisdom teeth removed under local anaesthesia. During removal of the lower third molar the lingual nerve was damaged, resulting in permanent injury. She had partial loss of taste and "pins and needles" and a "shooting pain". If she put her tongue in a certain position or if pressure was applied to certain parts of her mouth and/or tongue she could also suffer pain.

Mr Justice Mantell, on the basis of the expert evidence, held that some lingual nerve damage can happen unavoidably. For instance, placing a retractor between the periosteum and the bones surrounding the tooth to be removed, a procedure intended to protect the lingual nerve, may itself lead to temporary symptoms—and had that happened no-one would have been blamed. However, where the nerve was severed "It may very well be that such an incident could only be explained in terms of negligence". The judge accepted that, on the balance of probabilities, this injury was the result of negligence. The statistics showed that this sort of accident happened about once in every 200 cases. That something went wrong this time was no indictment of the clinician concerned, the judge said.

Of interest, in view of the second case, was the fact that the surgeon chose a retractor slightly narrower than the Howarth retractor usually used for the purpose. One expert said that "careless use of such an implement could itself have been responsible for cutting into the nerve".

In April, 1983, a patient operated on for removal of wisdom teeth at a hospital in Taunton sustained lingual nerve damage during removal of the lower third molar. This left the patient with almost complete loss of sense of taste and numbness. The judge found the possible causes of injury to be the burr coming into contact with the nerve or the elevator having been inserted wrongly. The defendants' expert claimed that the injury was probably caused by necessary and non-negligent stretching, not by direct damage to the nerve. Sir Michael Ogden, sitting as a deputy High Court judge, said that the plaintiff's claim succeeded on the facts. The defendants' theory was possible but had not been proved.

The judge wondered whether a Howard periosteal elevator, the type used in this case, offered adequate protection. It was not very wide and so had to be moved laterally. One expert claimed that unless the operator was experienced, it was not the best instrument available, and he had recommended the Rowe design.

As evidence of the likelihood of damage to the lingual nerve during the removal of lower third molars a paper by C. Blackburn and P. Bramley was cited. On p 106 of that paper the following passage appears: "One in two hundred procedures resulted in some permanent alteration of tongue sensation. The most significant factor was found to be the use of a lingual flap retractor and particularly of a Howard periosteal elevator. By tradition the main purpose in positioning a lingual flap retractor is to afford protection to the lingual nerve. Indeed some would consider that unless this is performed and recorded in the notes, it would be very difficult to defend any ensuing legal action should lingual nerve damage occur." (Sir Michael Ogden said that the last sentiment expressed amounted to "a very sad piece of defensive medicine".) The paper continues "In this series, however, not only could [the retractor] be considered to be the wounding agent in those cases which ultimately recovered, but it also appears to have been an inefficient guard against burr damage". However, in this case the judge concluded that it was unnecessary to determine whether injury was caused by the retractor or the burr.

Heath *v* West Berkshire Health Authority (QBD Mantell *J*, Nov 19, 1991). [1992] *3 Med LR*57; and Christie *v* Somerset Health Authority (QBD, Sir Michael Ogden QC, Feb 22, 1991). [1992] *3 Med LR*75.

Diana Brahams