Polish code of medical ethics revised

Just two years after voting in a rigid code of medical ethics that effectively outlawed prenatal testing, Poland's doctors have reversed their views. In a package of more than 80 amendments to the 1991 code, the Third Congress of Polish Doctors last month replaced the ruling that fetal life may be put in danger only when the mother's life or health is at risk or when the pregnancy is the result of rape or incest. Instead, the code now urges that "it is a doctor's duty to try to keep the life and health of a child before its birth", and to provide pregnant women with full information about the diagnostic and therapeutic possibilities and also the dangers of prenatal testing.

The 1991 code was, in the opinion of many doctors, hurried through with insufficient discussion or consideration. It was, in effect, an attempt by the traditional Catholic wing of the medical profession to pressurise parliament, which was proving slow to repeal the "pro-abortion" legislation introduced in the Communist era. Parliament, however, continued to delay, so that doctors were left in a no-win situation: liable to be struck off if they performed an abortion on "social" grounds, or to be sued for a breach of human rights if they denied a woman her legal right to such an abortion. Eventually, a new Pro-life law was enacted, in line with the 1991 medical code. The result was inevitable: a wave of abortion tourism to Germany and the Kaliningrad region of Russia.

The 1991 code and the subsequent law on the "Protection of Unborn Life" made access to prenatal testing virtually impossible, not only because of the risk to the fetus from certain procedures such as amniocentesis, but also because it was tacitly assumed that a woman who learned that she was carrying a defective or damaged fetus would want it aborted. The fact that it also ruled out the possibility of in-utero or perinatal therapy, or even of preparing a woman for the birth of a defective child by appropriate counselling, and ruled out large areas of gynaecological and genetic research, was ignored.

The code remains silent about cases where testing reveals a gravely damaged fetus. Current Polish law permits abortion of a fetus incapable of normal independent life. The 1991 code forbade it. Now Dr Krzysztof Madaj, the newly elected head of the Polish Medical Chamber, interprets this silence as tacit consent. But if doctors are now prepared to perform abortions in such cases, they face the condemnation of the Catholic Church.

The Congress also amended a vital clause in the Polish medical oath. From the former pledge "I promise to serve human life and health from its conception" the last three words have been struck out. The moment at which that "life" begins is now deliberately vague.

Vera Rich

Proposals for Australian health insurance reforms

A Cabinet decision on changes to Australia's health insurance system proposed by the Minister for Health, Senator Graham Richardson, has been deferred. The proposed reform has been referred to an internal Labor Party committee with representation from the Australian Council of Trade Unions, but with no members from the health industry or consumer movement.

Richardson says the changes are an effort to save the private health sector, since the proportion of Australians with private health insurance has dropped from 60% 10 years ago to 40% today. Most Australians are willing to rely on Medicare, the public health insurance system. But Richardson, like most observers, believes that the gradual turn away from the private sector is increasing the strain on the public hospital system. He sees a boost to the private sector as essential if Medicare is to be maintained in its present form.

Despite talking about the need for reform for several months, no details were released publicly of the specific proposals before the Cabinet meeting. But the generalities discussed include four main changes: raising the Medicare levy for high-income earners, reducing the number of health funds, allowing gap insurance, and a move towards managed care.

Richardson is proposing an increase in the Medicare levy (presently 1·25% of taxable income) for those earning more than $50 000 a year—effectively a rise in the marginal tax rates. This proposal would be difficult to sell politically since tax cuts, promised by the Labor Party before the previous election, have not yet come into force. The silliness of simultaneously raising and lowering taxes should rule this proposal out as a serious option. Moreover, Prime Minister Paul Keating has said that he does not want changes to the Medicare levy.

The move to reduce the number of health funds is politically more palatable. Presently Australia has more than 80 separate health funds, mostly state based. Richardson is proposing a national registration system that would encourage smaller funds to merge, leaving about 20 funds, all with a national base. While economically rational, it hardly seems essential—last year the funds recorded their highest-ever profits.

The proposal to allow gap insurance is popular generally, but fuels fears of a significant increase in costs. Richardson counters that the gap will be between the current Medicare rebate and a fee agreed to by the health funds. He says this will stop doctors charging whatever they like and having the funds foot the bill.

It is the final proposal, managed care, which is most controversial for doctors. With no details released, useful discussion of the proposal is difficult. But the general mood of groups such as the Australian Medical Association is this: we've seen it in the United States, and we don't like it.

Mark Ragg

Medically acquired HIV

Public concern about HIV has surged dramatically in Australia following news that four people who had minor surgery in a doctor's rooms were infected with HIV on one day in 1989 (see *Lancet*, Dec 18/25, p 1548). It is likely the three women and one man were infected from a man treated earlier that day. He died in 1990 of an AIDS-related illness.

Most of the concern comes from the uncertainty about how the virus was spread. The NSW Health Department, which released news of the infections in mid-December, says infection-control guidelines are adequate, and that the surgeon seems to have followed them. The reassurance raises two questions. If the guidelines are adequate, what happened? And how many of the 17 000 or so people known to be infected with HIV who have had their infection ascribed to a risk category such as sexual transmission or intravenous drug use actually became infected in some other way?

Several other issues have arisen. Two of the people infected were told of the manner of their infection only on the day the news was released publicly. The NSW Health Department has been accused of making scientific publication its priority, rather than the welfare of the infected people. Dr Sue Morey, the NSW chief health officer, counters that she was primarily concerned with patient confidentiality.

The Minister for Health, Senator Richardson, has ordered a review of infection-control procedures, including the manner in which compliance is monitored. One woman who was infected with HIV, and who has developed AIDS, is suing the surgeon.

Mark Ragg