common. And the pattern of cancers, the main cause of natural deaths, is similar to that found among the Inuit population of Alaska and of the Northwest Territories (Canada), with a high incidence of nasopharyngeal cancers. Pulmonary and cervical cancers are increasing in frequency.

A Council for Health Promotion was set up in 1986 to tackle some of the major health problems. A third of all deaths in Greenland are violent deaths, mostly drownings and suicides (the latter accounting for more than 10% of all deaths in the country). Abortion, free since 1975, is also very common (up to 113·8/1000 for women between 18 and 19 years old), mainly because of low usage of contraceptive methods. Alcohol consumption is equally high and plays a part in a great proportion of drownings and fatal accidents.

Claudio Csillag

Croatia: Broken hospitals, unbroken workers

My work as Special Representative of WHO in the former Yugoslavia has taken me to many hospitals. The hospital in Slavonski Brod is one of the older type distributed in several buildings on a campus with many shade trees. I visited the block where the acute inpatient work is conducted. This normally has 800 beds but only 400 are currently in use, of which all are in the basement or on the ground floor. Since March 15 this block has been a front-line field hospital with a catchment population of about 500 000. Many wounded of both sides of the fighting come across the bridge from Bosnia, where there is heavy fighting and no accessible hospital facilities. As of Sept 19, the staff had treated 5182 wounded of all degrees of severity, including 83 children and young people under 15. 754 deaths due to war wounds had passed through their mortuary; 30 were in children. The fortitude and high morale and the calmness with which all the staff—cooks, nurses, and doctors alike—faced their duties was most impressive. The operating theatre, the delivery room, and the prem nursery were in the capacious and spotless basement. Despite 20 direct hits and many near-misses, neither patients nor members of staff have been injured. I was particularly shocked by the case of a woman I met who had been repeatedly raped by enemy troops in a village in Bosnia and had been released when eight months pregnant. The baby, whom the mother has refused to see, is to be adopted. There is a need for diagnostic medical equipment, and the top priority, a portable X-ray machine, has, since my visit, been supplied and delivered by the UK Overseas Development Agency.

As I approached the Vinkovci hospital, the first impression was that of a small British district general hospital of 1970 vintage, but a closer view showed something terribly wrong: every window was shattered and the concrete was pierced by gaping holes in several places.

During the attacks Vinkovci was within 500 metres of the front line and the tanks and mortars were clearly visible. There can be no question that this hospital had been subjected to a deliberate and persistent attempt to destroy it with heavy weapons. I was shown the wires of two hand-guided rockets, one of which had destroyed, by a carefully aimed direct hit, the medical library on the sixth floor. The most urgent needs are external fixators, and if it is permissible, mine detectors because the hospital is adjacent to large minefields.

At Vukovar some signs of life have returned to the town—the open market is beginning to function again and thanks to a large influx of funds from Hôpitaux sans Frontières, there has been an amazing regeneration of the hospital—an up-to-the-minute intensive care unit, full cardiac monitoring, and two new operating theatres on the way. The team is fulfilling an important local function by providing about 70 beds for the enemy population. But how will this all end?

Donald Acheson

Australia: Unexpected cut in research funds

Medical researchers are distressed by a cut in the 1993 research budget of about $1 million. The money, which is distributed by the National Health and Medical Research Council (NHMRC), is the sole source of funds for some researchers and the main source for most. The cut has come about through a combination of planning and mishap. The initial announcement was that the budget would contain an increase of about $3 million on last year's figure of $105 million, which is a significantly smaller increase than NHMRC has received in recent years. This was disappointing, in that the Labor Government had been responsible for expanding funding to the NHMRC so that it could develop a career structure for researchers. Such a small increase would put some aspects of that structure, such as scholarships and fellowships for young researchers at different stages of their careers, in doubt. Now two problems have emerged that the Health Department, in deciding the budget allocation, had not foreseen. The first is that changes in rules governing superannuation mean that it has become compulsory for all employers to contribute on behalf of their employees. The NHMRC's contribution to superannuation rose by more than $1 million in the past financial year. That money has to come from funds to be distributed for research. The second arises from an error made in the 1992 budget allocation. The NHMRC was granted about $3 million more than it should have been according to the formula used within the Finance Department. The error was not noticed by the NHMRC, or by the departments of finance and health, until the money had been committed. This year the Finance Department decided to claw that money back, but the Health Department was not aware of that until after the allocations had been made. Consequently the NHMRC has received, instead of a rise of $3 million, a cut of $1 million.

This drop has not impressed medical researchers, who have worked hard to establish a career structure. The past chairman of the NHMRC, Prof John Chalmers, predicts that about 100 new research projects are going to miss out. "Groups of researchers will be dissipated. Skills will be dissipated. Technologists and researchers will lose their jobs. About 100 projects . . . that is equivalent to at least 100 jobs, or maybe more". A former chairman of the NHMRC's medical research committee, Prof John Coghlan, says: "We have tried to create a career system to attract the best and the brightest into medical research. All that has been put under incredible pressure. The medical research committee may have to cut grants to young researchers. That would be a great pity because it took 10 years to expand the system, with strong support from (former health minister) Dr Neal Blewett. To lose that would be a terrible waste". The president elect of the Australian Society for Medical Research, Dr Wayne Tilley, says: "The career structure is crucial to encouraging good people to stay in the system. That is all in jeopardy".

Those hardest hit are likely to be those scientists whose careers are in transition from PhD student to post-doc, or who have returned from their overseas training and are hoping to become independent researchers. Specific fellowships have been established for these people—the numbers granted could be halved.

The papers formally allocating funds to the NHMRC are usually signed in October. Medical researchers are hoping for a change of heart and a restoration of their funds.

Mark Ragg

Medicine and the Law

Two lessons from cardiology

A woman in her early 30s presented to her general practitioner (GP) in August, 1988, complaining of back pain, weight loss, night sweats, and tiredness. The GP diagnosed sacroiliac joint strain and advised her to work only part-time. The plaintiff reattended on Sept 9 with the same symptoms. The GP did not re-examine her but referred her for a chest X-ray and urine tests. She was told that these were clear when she saw her GP 2 weeks later. She still complained of weight loss, night sweats, and tiredness. The GP did not examine her but prescribed an antibiotic and advised 1 week's sick-leave.

The symptoms persisted and in late October her foot became numb, with swelling around her left ankle. On Nov 8 the GP referred her to hospital for an X-ray, which showed no abnormality. On Dec 7 and Dec 20 the patient told the GP that she had high temperature, night sweats, exhaustion, palpitations, severe headaches, aching limbs, and general weariness. The GP diagnosed postnatal depression (her child had been born a year earlier), and prescribed antidepressants.

On Dec 24 the patient awoke with a loss of right-sided vision. On Jan 2, 1989, the GP examined the plaintiff at home and recorded a history of visual defect, paraesthesia in the right hand, and an episode of collapse the previous day. Her blood pressure was 110/70 mm Hg and pulse rate 90/min. Abnormalities of the nervous system were recorded. The patient was immediately admitted to hospital, where subacute bacterial endocarditis was diagnosed. As a consequence of the delay in appropriate treatment the patient was left with serious disabilities.

The defendant paid £265 000 into court without admission of liability in February, 1992, about 4 weeks before trial. Subsequently liability was admitted and a settlement agreed in the sum of £350 000.

One-quarter of that sum was awarded to the family of a 44-year-old man who died, having twice been sent home from a hospital's accident-and-emergency department with chest pain labelled as "non-cardiac" in origin.

On Dec 3, 1987, he had consulted his GP with severe chest pain radiating to his left arm. The GP diagnosed angina or myocardial infarction, prescribed diltiazem, and referred the patient to Greenwich District Hospital. He wrote a letter and telephoned. At the accident-and-emergency department an electrocardiogram (ECG) was done. The man's mother had died from myocardial infarction, he smoked and had diabetes, and he was from the Indian subcontinent. The senior house-officer who examined him thought that the pain was non-cardiac and told the patient to stop taking the tablets prescribed. His wife, a nurse, demanded an exercise ECG; this was arranged for Jan 7, 1988, and the patient was sent home.

On Dec 10, the pain returned and the patient came back to the department, where he was seen by another senior house-officer. He complained of pain in his left arm, neck, and chest and was cold and sweaty. An ECG was abnormal but the doctor concluded that the pain was non-cardiac and discharged him. On Dec 14 he collapsed and was rushed to hospital. He was certified dead a few hours later.

The defendant health authority conceded that the failure to admit the patient on Dec 10 was negligent, but not the Dec 3 episode. The family's claim was settled for £88 000. Had the man been unemployed the damages would have been very small—namely, the statutory allowance for bereavement plus a small sum in respect of pain and suffering on the part of the plaintiff before death, here estimated at £2000.

Fuller details of these cases (McEwan *vs* James and C *vs* Greenwich Health Authority) can be found in *AVMA Med Legal J* 1992 (July): 12–13.

Diana Brahams

Noticeboard

For a nation's health

Black and ethnic minorities—their patterns of disease and their health services needs and uptake—form one of the issues that the UK Department of Health's chief medical officer, Dr Kenneth Calman, focuses on in his first annual report on the state of the public health.[1] These groups account for 5% of England's population. Ethnic differences in disease patterns include a high rate of coronary heart disease and stroke mortality and a slow decline in rates of tuberculosis among those from the Indian subcontinent; a high rate of stroke mortality among those born in the Caribbean and African Commonwealth; a high rate of schizophrenia among the Caribbeans; and a high prevalance of haemoglobinopathies among those of Mediterranean, Middle Eastern, Indian, and Afrocaribbean descent. The inclusion of ethnic origin, for the first time, in the 1991 census should help improve the accuracy of demographic data. In addition, subject to further consultation, ethnicity data on day cases and inpatients will be collected by health authorities from April 1 next year. Other efforts to assess health services needs include the request to the King's Fund Centre to set up Services in Health and Race Exchange (SHARE) and that announced by the Secretary of State for Health at the launch of Dr Calman's report, to Lady Cumberlege, Parliamentary Secretary in the House of Lords, to look further into what has to be done.

The health strategy developed over the past two years, with targets for five key areas of health and a strong emphasis on lifestyle changes, has now to be implemented and its progress monitored. One line of assessment is through the annual national health survey, the first round of which covered 3250 adults and was completed last autumn. A full report is expected in the middle of 1993, for which year the survey will be extended to cover 15 000 or more. The three working groups that advised on the health strategy are continuing to meet, to review progress and to examine the feasiblity of setting targets in different areas. Another small working group has been set up to review, in the light of the organisational changes to the National Health Service, the public health function reported by the Committee of Enquiry chaired by the previous chief medical officer.

Other issues that Dr Calman draws attention to include the reorganisation of the prison medical service, the reorganisation of family planning services (prompted by the high rate of unplanned pregnancies generally and among the under-16s), and the completion of the first year of operation of the breast cancer screening service.

1. Department of Health. On the State of the Public Health. 1991. London: HM Stationery Office. 1992. Pp 184. £14.50. ISBN 0-11-321534-7.