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**NEWS**

**Burton, B. (2007).** Diabetes expert accuses drug company of "intimidation". *British Medical Journal, 335(7630),113.*

The former chairman of research and development at GlaxoSmithKline, Tadataka Yamada, has been asked by a US Senate committee to explain his role in what it describes as the “intimidation” of John Buse, a professor of medicine at the University of North Carolina. In 1999 Dr Buse raised questions about the cardiovascular safety of the diabetes drug rosiglitazone, which is marketed as Avandia (BMJ 2007;334:1237 doi: 10.1136/bmj.39244.394456.DB). He was speaking at a symposium organised by the American Diabetes Association. A report by the Senate Finance Committee staff has shown that a company official emailed Dr Yamada proposing that a “firm letter” be written to Dr Buse containing a warning that “the punishment will be that we will complain up his academic line and to the CME [continuing medical education] granting bodies that accredit his activities.” In response Dr Yamada wrote: “I think there are two courses of action . . .

**Charatan, F. (2007).** Merck to pay $5bn in rofecoxib claims. *British Medical Journal, 335(7629),1011.*

The US drug company Merck announced last week that it will pay $4.85bn to settle 26 600 lawsuits, representing 47 000 plaintiffs, in addition to 265 possible class action cases, arising out of the use of rofecoxib (Vioxx). The agreement is to cover cases filed in federal and state courts, and depends on 85% of all plaintiffs donating their case to a Washington-based settlement fund for claims that qualify. In a statement the company said, “This is not a class action settlement. Claims will be evaluated on an individual basis.” Chris Seeger, one of six lawyers for the plaintiffs who helped to negotiate the settlement, said that it was the largest ever in the drug industry. Rofecoxib was approved by the US Food and Drug Administration in 1999 for the relief of the symptoms of osteoarthritis, management of acute pain in adults, and treatment . . .

**Cohen, D. (2007).** EU residents may be able to travel to any member state for care from 2010. *British Medical Journal, 335(7630),1115.*

European Union residents will be able to travel to any of the 27 member states for non-emergency health care if new European Commission proposals are adopted. A draft copy of the proposals seen by the BMJ attempts to set down legislation on patient mobility after the European Court of Justice ruled that health care should be part of a European free market. Under the plans, which are expected to be published next week, patients should be able to receive health care similar to what they would be entitled to in their home country, with the costs covered up to “at least” the price of the similar care in their own country. However, member states will have to decide what the cost of treatment entails and whether, for example, it would include accommodation, food, and travel. Although the proposals do not supersede earlier regulations—which allow local health authorities to sanction and . . .

**Cole, A. (2007).** A third of people in UK with HIV don’t know they are infected. *British Medical Journal, 335(7630),1116.*

Around a third of the 73 000 adults in the United Kingdom who now have HIV remain unaware of their infection, despite a big increase in the number of people being tested, the latest figures from the Health Protection Agency indicate. The agency’s annual report on HIV and other sexually transmitted diseases shows that the number of new infections of HIV fell a little last year, from 7900 in 2005 to an estimated 7800. But the incidence among gay men continues to rise, with 2700 new cases reported in 2006—nearly two thirds of all HIV infections thought to have been acquired in the UK. The report also notes that the incidence of other sexual infections among gay men has also risen sharply in the last five years, especially syphilis (up by 117%), chlamydia (97%), gonorrhoea (25%), non-specific urethritis (24%), and genital warts (21%). Almost half of all new diagnoses of HIV in the UK were . . .

**Dobson, R. (2007).** Danish men consult GPs less than women but attend hospital more and have greater mortality. *British Medical Journal, 335(7629),1010-1011.*

Men of all ages have less contact with their family doctor than women, with the gap narrowing with age, and they are more likely to be admitted to hospital and have a greater mortality, according to a study of more than 30 million contacts with GPs and hospital admissions in Denmark in one year (Journal of Public Health 2007 Nov 2 doi: 10.1093/pubmed/fdm072). “This is compatible with a scenario in which men react later to severe symptoms than women so that they are more likely to be hospitalised for or die from these conditions,” say the authors. They say that population based studies indicate that in many aspects men have better health than women—men are stronger, report fewer diseases, and consistently report better health status than women. Although women have greater rates of acute illness, women’s mortality is lower than men’s for all age groups. “A prominent hypothesis . . .


Travelling abroad for organ transplants provided on a commercial basis—so called transplant tourism—may now account for at least one in 20 of all transplants, according to a report from the World Health Organization (Bulletin of the World Health Organization 2007 Nov 1 doi: 10.2471/BLT.06.039370). Advertising of package deals that include a transplant—for example, a package costing £16 000 for a kidney transplant in Pakistan—is flourishing, and the trade in organs is growing, the report found. “The results suggest that the international organ trade no longer represents sporadic instances in transplant medicine,” it says. “The total number of recipients who underwent commercial organ transplants overseas may be conservatively estimated at around 5% of all recipients in 2005.” Reliable information on numbers and clinical outcomes is scarce, the report noted, but it reviewed information from media reports, journal articles, conference papers, reports from health ministries, . . .

A pilot project to test the acceptability of screening people for bowel cancer has shown a low uptake, with less than half of the men who were invited to take part doing so. Uptake was also low in deprived areas and in some ethnic groups, says the report on the second round of the UK colorectal cancer screening pilot (British Journal of Cancer doi: 10.1038/sj.bjc.6604089). The first round of the pilot took place in 2000-3 in two sites, one in England and one in Scotland (BMJ 2004;329:133 doi: 10.1136/bmj.38153.491887.7C). Of those who were invited to take part in the second round 84% had taken part in the first. The report also warns that screening will significantly increase the need for services, especially endoscopy. “Our results suggest that ongoing effort will be required to minimise inequalities in uptake by targeting deprived and certain ethnic groups, and to . . .


Alan Williams, the consultant pathologist whose failure to disclose the results of microbiological tests on one of Sally Clark’s two baby sons led to the quashing of her murder convictions, lost his High Court appeal last week against a finding of serious professional misconduct. Mrs Clark was convicted in 1999 of killing babies Christopher and Harry but was cleared on appeal in 2003 after spending three and a half years in prison. She died earlier this year at the age of 42. A coroner ruled this week that the cause of her death was acute alcohol intoxication. A General Medical Council fitness to practise panel found Dr Williams, aged 58, guilty of serious professional misconduct in 2005 for not disclosing the results of tests on her second son, Harry, at or before her trial. Dr Williams was banned from doing Home Office forensic pathology or coroners’ work for three years, . . .


Guidance from the Department of Health that makes it harder for doctors who trained abroad to compete with UK medical graduates for NHS training posts was ruled “unlawful and of no effect” by the Court of Appeal last week. Lords Justices Sedley, Maurice Kay, and Rimer ruled that a government department could not impose restrictions unsanctioned by parliament which went further than the immigration rules. The guidance to NHS employers was that doctors on the highly skilled migrant programme (HSMP) whose leave to remain in the United Kingdom was due to expire before the end date of any training post on offer, should be offered the post only if there were no suitable UK or EU candidates. The guidance was first challenged earlier this year but rejected (BMJ 2007;334:333 doi: 10.1136/bmj.39125.369178.DB). A spokeswoman for the Department of Health said that it was considering its next move. But the . . .


Doctors from the UK Royal College of Paediatrics and Child Health and workers in child health from Gaza and the West Bank recently attended a ceremony for seven doctors and two nurses who received Palestinian certificates in child health. The presentation, given by the college’s president, Patricia Hamilton, in a ceremony in the West Bank, marks the culmination of seven years’ work to offer a course in child health to Palestinian doctors and nurses. The training was put together by the college and offered partly by distance learning. The Protectionist Tony Waterston, of Newcastle University, who leads the college’s project, says the certificate is loosely modelled on the diploma in child health, which is offered to British GPs. “It’s not quite that standard, but it is a high standard.” Unlike the UK diploma, the Palestinian certificate is offered to nurses as well as doctors. The college hopes to extend the . . .


Bodies that oversee medical research are harming public health by imposing constraints on the use of patients’ data that go further than the law demands, doctors were told at a meeting last week organised by the cardiothoracic section of the Royal Society of Medicine. Charles Warlow, professor of medical neurology at Edinburgh University, quoted David Smith, deputy information commissioner at the UK Information Commissioner’s Office, as saying that the Data Protection Act does not apply to patients’ data unless the data are used as part of research. Dr Smith had also approved comments by the medical law expert Philip Havers QC that “researchers should be bolder,” Professor Warlow said. Mr Havers had said at a symposium in 2006: “The courts are likely to be highly receptive to arguments that the law justifies breaches of confidence and privacy with regard to secondary data research, provided [that] the infringements are no more than . . .


Clinicians in England and Wales are confused when different sets of guidelines are published at the same time on the same topic, a parliamentary committee heard at an inquiry into the National Institute for Health and Clinical Excellence (NICE). Richard Taylor, MP, health select committee member, said that for two topics NICE and the Department of Health had recently published recommendations one soon after the other. One was about venous thromboembolism and the other on the use of alcohol in pregnancy. NICE’s clinical guidelines on the prevention of venous thromboembolism in patients having orthopaedic surgery and the Department of Health’s report of the independent expert working group on the prevention of venous thromboembolism in patients admitted to hospital were both published in April. “What clinicians are bothered about is when they get two substantially different bits of advice,” said Dr Taylor. Michael Rawlins, chairman of NICE, said that the department’s . . .

A senior Croatian academic and obstetrician has escaped punishment over allegations of plagiarism in his published work by Zagreb University’s “court of honour” because the alleged offences took place some years ago and he retired in August. The allegations against Asim Kurjak were originally made in the BMJ by Iain Chalmers in the James Lind Library in Oxford last year (2006;333:594-6 doi: 10.1136/bmj.38968.611296.F7). In the late 1980s Dr Chalmers noticed that the text and data in a 1974 paper on epidural anaesthesia, coauthored by Professor Kurjak, were identical to those in a paper by another group of authors that had been published three years earlier. He reported his observations to the editor concerned and to Professor Kurjak’s university. Both asked for the matter to be handled discreetly. But 14 years later Dr Chalmers was prompted to write the BMJ article when he discovered that Professor Kurjak had continued . . .


The former United Nations special envoy for AIDS in Africa has issued a scathing condemnation of UNAIDS (the joint UN and World Health Organization programme on HIV and AIDS) for its “catatonic passivity” in the face of the epidemic. He has also delivered a blistering criticism of the agency’s latest report on prevalence. Stephen Lewis, who worked for the UN for more than two decades, held the post of special envoy between 2001 and 2006, attacked UNAIDS for “delaying and dithering” in producing revised figures on the prevalence of HIV and AIDS. He said the resulting report, the 2007 AIDS Epidemic Update, had served to divert the world’s attention away from the “continuing apocalypse for sub-Saharan Africa” by focusing instead on the mathematical models and reasons for the adjusted figures. The report, which was released last week (bmj.com, 24 Nov, News Extra doi: 10.1136/bmj.39406.611296.F7), in the late 1980s Dr Chalmers noticed that the text and data in a 1974 paper on epidural anaesthesia, coauthored by Professor Kurjak, were identical to those in a paper by another group of authors that had been published three years earlier. He reported his observations to the editor concerned and to Professor Kurjak’s university. Both asked for the matter to be handled discreetly. But 14 years later Dr Chalmers was prompted to write the BMJ article when he discovered that Professor Kurjak had continued . . .

Kmietowicz, Z. (2007). More than four in 10 women were not offered the choice of a home birth, report says. British Medical Journal, 335(7630),1112.

Pregnant women in England are not being offered the choice and care laid down in national guidelines, a survey of new mothers shows. The survey, which was carried out by the Healthcare Commission, showed that women are generally fairly happy with maternity services. Overall the percentage of women who said that their care was excellent, very good, or good was 89% during pregnancy, 90% during labour and birth, and 80% after the birth. But the commission said that in some areas the feedback from women was less positive and that there was wide variability in satisfaction between trusts. More than four in 10 women were not offered the choice to have their baby at home, as recommended in guidelines from the National Institute for Health and Clinical Excellence (NICE). But while the percentage who were not given this option was as low as 8% in some trusts, in others it . . .


Tuberculosis rates in the United Kingdom have levelled for the first time in 20 years but rates remain at their greatest since 1987, according to figures from the Health Protection Agency published last week. The agency’s annual report on tuberculosis reported 8113 new cases in England, Wales, and Northern Ireland in 2006, which is the same as in 2005. There were 20 more cases in Scotland in 2006 (384 cases) than in 2005, giving a UK-wide figure for 2006 of 8497 cases. Ibrahim Abubakar, head of the tuberculosis section at the agency’s Centre for Infections, said, “It is too early to judge whether this is a sign of a slowdown . . .

Mayor, S. (2007). Targeted screening may be a cost effective way to detect glaucoma. British Medical Journal, 335(7630),113.

Targeted screening of particular groups for open angle glaucoma would be more cost effective than testing the general population, a UK modelling study concludes. The study compared different strategies for screening for open angle glaucoma (the commonest type of glaucoma, which is the leading cause of irreversible blindness) by reviewing the existing research evidence for effectiveness and cost effectiveness. One strategy was for a glaucoma screening technician to measure intraocular pressure and then do a second test from a range of possible tests to screen people considered to be at risk of open angle glaucoma. The United Kingdom doesn’t currently have glaucoma screening technicians, but the researchers assumed that staff could be trained and accredited in a similar way to retinal screening technicians who screen for diabetic retinopathy. A second potential strategy—which costs more—involves patients at high risk being invited to be assessed by a glaucoma optometrist. Positive results of . . .


Researchers and policy makers should make greater use of observational studies to identify environmental and lifestyle causes of disease, a report by leading UK scientists recommended this week. But the design of studies needs to be improved for a better understanding of causal pathways, it says. The study assessed evidence on the use and interpretation of research in the field, reviewed the literature, and held workshops involving a wide range of stakeholders. “The evidence is clear cut,” the report says. “Environmental influences are both strong and important in the causal processes leading to most common diseases. Nevertheless, the knowledge on the specifics of environmental influences, and of the biological pathways through which they exert their causal effects, is decidedly limited.” The authors, a working group from the Academy of Medical Sciences (an independent group of medical scientists from hospitals, academia, industry, and the public service), warned, “Scarcely a day goes . . .

Failed asylum seekers in the United Kingdom could be refused access to primary care services, under proposals being considered by the Home Office, a human rights charity has warned. The Medical Foundation for the Care of Victims of Torture says that it is concerned that the government is considering proposals to refuse unsuccessful asylum seekers still living in the UK the right to access primary health care. Under current regulations, failed asylum seekers have a discretionary entitlement to basic health care, including GP visits, dental care, and midwife support, although some restrictions are imposed on the secondary care services that they are entitled to receive. The charity has warned that the government is considering curbing access to primary care, however, which it says if implemented could have “irreparable consequences.” In March the Home Office published a document, Enforcing the Rules: A Strategy to Ensure and Enforce Compliance with our Immigration . . .


The government may adjust its 18 week target for treatment by the NHS in England so that it does not apply to all patients, a health minister said last week. The target of guaranteeing patients treatment within 18 weeks of being referred by their GP, first announced in 2004, is due to be met throughout England by December 2008. The health minister Ben Bradshaw, however, has now said in a radio interview that a “clarification” of the target was needed, to mean 90% of patients. Some patients may be “clinically justified” in waiting longer than 18 weeks for treatment, he said on BBC Radio 5 Live, to allow hospitals a “buffer zone” and to enable clinicians to take account of individual patients’ needs. The Department of Health confirmed that it is looking at a threshold for meeting the target of 90% of patients who require hospital admission and 95% of . . .


The drug industry is “burying its head in the sand” when dealing with health in developing countries and denying poorer people access to life saving drugs, a report claims this week. A critical report by the international agency Oxfam says that the drug industry is refusing to change the way it does business in poor countries, despite promising that it would, and is undermining its own future. Oxfam’s report looks at the world’s top 12 drug companies, including their drug pricing policies, their record in developing drugs that are relevant to health care in poor countries, and their stance on protecting intellectual property rights. The report says that the industry shows various shortcomings, including: Failure to implement a systematic and transparent tiered pricing policy that is based on people’s ability to pay. Continuing to neglect research and development concerning diseases that affect developing countries, and Inflexibility in protecting intellectual property, . . .

O’Dowd, A. (2007). NHS trusts have more than £1bn surplus to spend in current year. *British Medical Journal, 335*(7630),1117.

NHS trusts in England should be thinking about how to spend a predicted surplus in funding of more than £1bn - and possibly as much as £1.8bn—the head of the NHS has told MPs. And NHS chief executive David Nicholson said that as most of this surplus for the current financial year lay with primary care trusts it was for them to decide how it should be spent. That money was not being held centrally by the government, Mr Nicholson said, giving evidence as part of the parliamentary health select committee’s inquiry into public expenditure last week. The report says, before calling for an end to the war. One reason for the huge cost is that fewer soldiers are dying in combat from their wounds than in past wars because of better body armour, battlefield medicine, and rapid . . .


The lifetime health care of soldiers deployed to Iraq could cost the United States $650bn more than has been spent on operations in Iraq, according to projections in a report published last week. The report, Shock and Awe Hits Home, was written by Evan Kanter, a staff psychiatrist at the post-traumatic stress disorder (PTSD) outpatient clinic of the Department of Veterans Affairs, Puget Sound Health Care System, in Washington state, for the Nobel peace prize winning group Physicians for Social Responsibility. It was presented to sympathetic members of Congress was “relatively small. “Every day of continued fighting adds to the terrible price that we are paying,” the report says, before calling for an end to the war. One reason for the huge cost is that fewer soldiers are dying in combat from their wounds than in past wars because of better body armour, battlefield medicine, and rapid . . .


A decade after Israel’s health ministry first began preparing it, a bill that will make it a criminal offence to sell human organs for transplantation or to act as an intermediary in such transactions is due to be passed by the Knesset, Israel’s parliament. The bill, which prohibits trafficking in human organs in Israel and by Israeli residents abroad, was approved in committee for its final readings in the full assembly. Traffickers—but not donors or recipients in illegal transactions—will get up to three years in prison or a fine equivalent to $50 000. Legislators hope that the law will put an end to the organ sale scandals in which some Israelis have been involved. For various reasons 54% of Israelis of all religions refuse to allow organs of dead relatives to be donated; and organs are taken from or donated by fewer than 10 in every million residents . . .

Previously healthy children with stroke were 10 times more likely to have iron deficiency anaemia than children without stroke, a Canadian study has shown (Pediatrics 2007;120:1053-7 doi: 10.1542/peds.2007-0502). Also, children with iron deficiency anaemia accounted for more than half of all cases of stroke in children without an underlying medical illness. Primary prevention and early identification of iron deficiency anaemia must therefore remain a priority, say the authors. This anaemia occurs with a peak prevalence of 4-8% in children aged 1-3 years. *Establishing a link between a common and preventable childhood illness, iron deficiency anaemia and stroke due to thrombosis of the cerebral arteries or veins is an important advance in our goal to prevent childhood stroke,* said Gabrielle deVeber, a neurologist and director of the stroke programme at Toronto's Hospital for Sick Children and one of the study's authors. “This study joins our other previous and ongoing.


A website (www.mdgmonitor.org) will monitor how well nations around the world are meeting the United Nations millennium development goals for 2015, which were established at a UN summit in 2000. It will allow countries to compare themselves with others. The millennium goals are to decrease global poverty and hunger, to increase primary school education, to promote gender equality, to combat HIV/AIDS and malaria and other diseases, to ensure environmental sustainability, and to develop a global partnership for development. The website will provide information for policy makers and development experts, who can learn from each other’s successes and setbacks. It will also increase public access and attention to whether the goals are being met. The website tracks progress toward the goals in a number of categories in almost every country. The UN says that the site gives the most current data . . .


The German drug company Bayer has suspended worldwide marketing of Trasylol (aprotinin), its antifibrinolytic drug, after the requests of the drug regulating authorities in Germany and Canada and the advice of the Food and Drug Administration in the United States. Infusions of aprotinin have been used to stop excessive bleeding during heart surgery. A recent Canadian trial known as the BART trial (blood conservation using antifibrinolytics: a randomised trial in high risk cardiac surgery patients), coordinated by the Ottawa Health Research Institute, was stopped because preliminary results showed an increased risk of death from the drug. The trial was started in 2001 and includes 3000 patients undergoing heart surgery. Initial results had shown that Trasylol had lessened bleeding but the drug was linked to increased risk of death from all causes compared with patients taking two other antifibrinolytics—aminocaproic acid or tranexamic acid. Bayer has announced that the suspension is temporary, . . .


Last week’s announcement that human embryonic stem cells have been successfully created by reprogramming skin cells (making them behave like embryonic stem cells) was welcomed by those scientists and others who had harboured ethical doubts about an enterprise that had previously depended on embryos. But although stem cell scientists share this enthusiasm, they go on to point out that the new technique, in its current form, is potentially hazardous. This issue will have to be dealt with before reprogramming can be applied in clinical medicine. At present the principal source of human embryonic stem cells is the pool of early embryos that are surplus to the requirements of women undergoing in vitro fertilisation. Reprogramming dispenses with the need for embryonic material. It relies instead on making ordinary body cells return to an earlier developmental stage in which they regain the potentiality to give rise to any of the body’s 200 . . .


The 11 day United Nations conference on climate change opening in Bali on 3 December will shed new light on the degree of importance that policy makers attach to public health as they seek ways to mitigate the gradual increase in the world’s temperature and prepare for the consequences. The final part (a synthesis) of the fourth assessment report of the UN Intergovernmental Panel on Climate Change (IPCC) confirms that the trend towards global warming can no longer be questioned. “Warming of the climate system is unequivocal, as is now evident from observations of increases in global average air and ocean temperatures, widespread melting of snow and ice, and rising global average sea level,” notes the synthesis, which was released on 17 November (see www.ipcc.ch). The chapter devoted to health issues confirms that humans are being directly exposed to climate change through new weather patterns and
indirectly through alterations . . .


Most trusts in England will not meet their 2008 chlamydia screening target, the director of the national screening programme admitted last week. Speaking at the fourth annual conference of the national chlamydia screening programme, in London, Mary Macintosh said that great progress had been made. “Last year only 25% of [primary care trusts] were screening [for chlamydia]. Now 78% are screening, and a further 23% will be [doing so] by the end of the year,” she said. But the government target for all strategic health authorities to have offered 15% of 15-24 year olds a test for the infection between March 2007 and April 2008 was unlikely to be met, she said. “It won’t be reached by all. But some will.” Figures presented to the conference showed that projections by the health authority had fallen well below the actual numbers reported to the Health Protection Agency for the first six . . .


Land mines and other explosive remnants of war, including cluster munitions, claimed 5751 casualties—including 1367 people killed and 4296 injured—in 68 countries in 2006. Civilians made up three quarters of all victims, a global report says. Overall, children—almost all boys—accounted for one third of civilian victims. In one place most casualties were children: In Afghanistan they accounted for 59% of casualties, Palestine 67%, Somalia 66%, Ethiopia 62%, Nepal 53%, Mozambique 49%, Vietnam 44%, the Democratic Republic of Congo 42%, and Laos 41%. One quarter of casualties were military staff. “Deminers,” carrying out clearance activities, accounted for 1%. The report estimates the current global number of survivors at 473,000, “with many needing life long care.” Last year’s total is a 16% drop on 2005, and fewer than half the 11,700 new casualties reported in 2002, it says, and attributes the drop to the positive effect of the 1997 global . . .

**ANALYSIS**


Modern health care is recognising, albeit with difficulty, that it is a service industry and has to pay more attention to those who use it. It may have unique features—in that it deals with high stake issues—but in common with other knowledge intensive services, it has to balance the expert skills with the expectations and experiential expertise of users. Service industries have learnt that sustained profitability stems from meaningful customer focus, collaboratively designed products and services, and positive interpersonal exchanges that management science calls “moments of truth.”

**take patients’ perspectives seriously, but it’s not as simple as it may sound.**


In the past decade there has been sustained international interest in measuring quality of care. In the United Kingdom, quality indicators with financial incentives to reward good care were introduced as a result of increasing awareness of variable quality in primary care, the technical feasibility of introducing evidence based indicators within information technology systems, and a resolve by policy negotiators to use cost quality to secure additional investment in primary care.1 Similar but less comprehensive initiatives have been introduced in the United States, Europe, Australia, and New Zealand. However, as this series has shown, the use of quality measures has also created controversy. Our view is that using incentives to improve quality of care has been beneficial. We look at what needs to be done to ensure those benefits remain in the future. Options for developing quality measures. The quality and outcomes framework, which forms the basis of quality measurement in UK primary care, could . . .


Why would anyone choose to emulate the US healthcare system? Costs per capita are about twice the Organisation for Economic Cooperation and Development average. Forty seven million people are completely uninsured. Many others with insurance face high out of pocket costs that hinder care and bankrupt more than a million annually.1 Mortality statistics lag behind those of most other wealthy countries, and even for the insured population, clinical outcomes and patient satisfaction are mediocre.2 3 This dismal record arises, we contend, from health policies that emphasise market incentives. Even as the public share of health spending in the US has risen to 60% (box investor owned firms have eclipsed the public, professional, and charitable bodies that previously managed the financing and delivery of care. The development and effect of US policies that mix public funding and private management has wider relevance because politicians in Europe and beyond are pushing analogous schemes.

**RESEARCH**


200 patients were enrolled, and 178 (89%) successfully completed six weeks of follow-up. Adherence was significantly greater in the special care group than in the usual care group (unadjusted mean percentage days with correct dose 48.1%, 95% confidence interval 35.8% to 60.4%, versus 32.4%, 22.6% to 42.3%; P=0.048). Adherence was also higher among patients who had higher levels of education (P<0.001), were encouraged by family

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members (P<0.001), believed in the effect of drugs (P<0.001), and had the purpose of the drugs explained to them (P<0.001). Special training of general practitioners in management of hypertension, emphasising good communication between doctors and patients, is more effective than usual care provided in the communities in Karachi. Such simple interventions should be adopted by other developing countries that are now facing an increasing burden of hypertension.


In the Oxford region, three year mortality was lower after elective colectomy than after either no colectomy or emergency colectomy, although this was not significant. For England, mortality three years after elective colectomy for ulcerative colitis (3.7%) and Crohn’s disease (3.3%) was significantly lower than that after either admission without colectomy (13.6% and 10.1%; both P<0.001) or emergency colectomy (13.2% and 9.9%; P<0.001 for colitis and P<0.01 for Crohn’s disease). Three or more months after elective colectomy, mortality was similar to that in the general population. Adjustment for comorbidity did not affect the findings. In England, the clinical threshold for elective colectomy in people with inflammatory bowel disease may be too high. Further research is now required to establish the threshold criteria and optimal timing of elective surgery for people with poorly controlled inflammatory bowel disease.


About 5% of doctors in the former East Germany spied on their colleagues or patients as unofficial members of the East German secret police (the Staatssicherheit or Stasi), a new report has shown. The study, by the Hannah Arendt Institute for Research on Totalitarianism, Dresden, and commissioned by the German Medical Association and the German medical journal Deutsches Ärzteblatt, showed that the percentage of unofficial members of the Stasi among doctors was higher than in the East German population as a whole. “Doctors were one of the main targets of the Stasi because they were thought to belong to a reactionary class and were thought to be especially interested in escaping to West Germany,” said Francesca Weil, author of the study, at a press conference last week in Berlin. East Germany was reluctant to lose doctors to the West because they were needed to provide state health care. The . . .


Women undergoing caesarean delivery had an increased risk of severe maternal morbidity compared with women undergoing vaginal delivery (odds ratio 2.0 (95% confidence interval 1.6 to 2.5) for intrapartum caesarean and 2.3 (1.7 to 3.1) for elective caesarean). The risk of antibiotic treatment after delivery for women having either type of caesarean was five times that of women having vaginal deliveries. With cephalic presentation, there was a trend towards a reduced odds ratio for fetal death with elective caesarean, after adjustment for possible confounding variables and gestational age (0.7, 0.4 to 1.0). With breech presentation, caesarean delivery had a large protective effect for fetal death. With cephalic presentation, however, independent of possible confounding variables and gestational age, intrapartum and elective caesarean increased the risk for a stay of seven or more days in neonatal intensive care (2.1 (1.8 to 2.6) and 1.9 (1.6 to 2.3), respectively) and the risk of neonatal mortality up to hospital discharge (1.7 (1.3 to 2.2) and 1.9 (1.5 to 2.6), respectively), which remained higher even after exclusion of all caesarean deliveries for fetal distress.

**CLINICAL REVIEW**


Acute bronchiolitis is a clinical diagnosis. A UK Delphi process reached a 90% consensus that bronchiolitis “is a seasonal viral illness, characterised by fever, nasal discharge and dry, wheezy cough. On examination, there are fine inspiratory crackles and/or high-pitched expiratory wheeze.” Internationally, the definition is sometimes broadened to include a first episode of acute viral wheeze. It is an annual and major cause of morbidity in infancy. Acute bronchiolitis is a very common serious respiratory illness in children. Inappropriate . . .


Increasing body mass index was associated with an increased incidence of endometrial cancer (trend in relative risk per 10 units=2.89, 95% confidence interval 2.62 to 3.18), adenocarcinoma of the oesophagus (2.38, 1.59 to 3.56), kidney cancer (1.53, 1.27 to 1.84), leukaemia (1.50, 1.23 to 1.83), multiple myeloma (1.31, 1.04 to 1.65), pancreatic cancer (1.24, 1.03 to 1.48), non-Hodgkin’s lymphoma (1.17, 1.03 to 1.34), ovarian cancer (1.14, 1.03 to 1.27), all cancers combined (1.12, 1.09 to 1.14), breast . . .
cancer in postmenopausal women (1.40, 1.31 to 1.49) and colorectal cancer in premenopausal women (1.61, 1.05 to 2.48). In general, the relation between body mass index and mortality was similar to that for incidence. For colorectal cancer, malignant melanoma, breast cancer, and endometrial cancer, the effect of body mass index on risk differed significantly according to menopausal status. Increasing body mass index is associated with a significant increase in the risk of cancer for 10 out of 17 specific types examined. Among postmenopausal women in the UK, 5% of all cancers (about 6000 annually) are attributable to being overweight or obese. For endometrial cancer and adenocarcinoma of the oesophagus, body mass index represents a major modifiable risk factor; about half of all cases in postmenopausal women are attributable to overweight or obesity.

Wildman, M.J., Colin Sanderson, Jayne Groves, Barnaby C Reeves, Jon Ayres, David Harrison, Duncan Young, and Kathy Rowan. (2007). Implications of prognostic pessimism in patients with chronic obstructive pulmonary disease (COPD) or asthma admitted to intensive care in the UK within the COPD and asthma outcome study (CAOS): multicentre observational cohort study. British Medical Journal, 335(7630), 1011.

517 patients (62%) survived to 180 days. Clinicians’ prognoses were pessimistic, with a mean predicted survival of 49% at 180 days. For the fifth of patients with the poorest prognosis according to the clinician, the predicted survival rate was 10% and the actual rate was 40%. Information from a database covering 74% of intensive care units in the UK suggested no material difference between units that participated and those that did not. Patients recruited were similar to those not recruited in the same units. Conclusions Because decisions on whether to admit patients with COPD or asthma to intensive care for intubation depend on clinicians’ prognoses, some patients who might otherwise survive are probably being denied admission because of unwarranted prognostic pessimism.