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**Referral patterns, cancer diagnoses, and waiting times after introduction of two week wait rule for breast cancer: prospective cohort study**
The incidence of lung cancer in Scotland is more than 35% higher than in the United Kingdom as a whole, and overall is about 50% higher in men than in women. And the incidence of prostate cancer in Wales is 13% more than the UK average, according to a report from the Office of National Statistics for 2002-4. Overall, there were about 278,000 newly diagnosed cases of cancer and 154,000 deaths from cancer each year in the UK between 2002 and 2004, says the report. The three most common cancers for men were of the prostate, lung, and colorectum; for women they were of the breast, lung, and colorectum. Breast cancer in women had the highest incidence of all (118 per 100,000), almost 30% higher than the incidence of prostate cancer (93 per 100,000). Lung cancer caused most mortality in men and women (56 and 30...
concentrations of PSA are higher in the summer, resulting in a higher likelihood of referral for a biopsy of up to a quarter. “We show that being screened during summer increased by 23% the likelihood of having a higher PSA than the cut-off value [for biopsy],” the authors write. “It may be prudent to confirm any isolated test result before biopsy, and even more so if this was obtained in summer.” They add: “The present observation . . . is troubling as it suggests that rigid PSA cut-offs are ill-adapted to routine clinical practice.” The authors say that measurement of PSA serum concentrations is . . .


A new report calls for urgent international help in tackling health problems in the Palestinian territories. It shows an increase in infant mortality and a doubling of the number of cases of mental illness. The authors also report increases in the numbers of cases of food poisoning, sexually transmitted diseases, and contaminated drinking water; a deterioration in nutrition; failure to achieve targets on mortality from heart disease and strokes; and poor provision of services for elderly and disabled people (Public Health doi: 10.1016/j.puhe.2007.04.017). The report, which looks at the state of Palestinian primary health care and the achievements of the Palestinian national strategic health plan 1999-2003, says, however, that a number of significant improvements have occurred, including a leap in the number of people being vaccinated, a drop in the incidence of HIV infection, and lower rates of smoking. The authors, from the University of Crete School of . . .


A record race discrimination award against the BMA won five years ago by a surgeon who qualified in India was overturned last week by three appeal court judges. Rajendra Chaudhary was awarded £814,877 compensation—the highest ever for a race discrimination claim—by an employment tribunal in 2002 for the BMA’s failure to support him in claims of race discrimination over his specialist training. The finding was upheld by the Employment Appeal Tribunal in 2004 (BMJ 2004;328:786 doi: 10.1136/bmj.328.7443.786-a). But last week the appeal court judges said that the BMA had refused to back his claims not because of race discrimination, but because the claims were not well founded. Lord Justice Mummery, delivering the unanimous judgment of the court, said, “The essential ground is that no reasonable tribunal . . . could have concluded that the BMA was guilty of indirect race discrimination against . . .


Iraqi doctors last week gathered in London with representatives of international relief agencies to discuss health policy and humanitarian aid efforts in their war-torn country. The Iraq Health Crisis Conference, organised by the health charity Medact, also heard from Sabah Sadik, a psychiatrist from Kent, whom the Iraqi government has named as the country’s next health minister. Dr Sadik, currently the medical director of Kent and Medway NHS and Social Care Partnership Trust, is expected to leave Britain this summer to start his new job. He is the sole nominee for the post vacated by Ali al-Shemari, one of six ministers loyal to Shiite cleric Moqtada al-Sadr, who left the government in April. Last August US forces arrested seven bodyguards of Dr al-Shemari, accusing them of running a kidnapping ring. This February US forces arrested the deputy health minister Hakim al-Zamili in his office, citing his alleged involvement in the . . .


Medical students in the United Kingdom will need to scale down their career expectations in future, the deputy chief medical officer has warned, in the light of this year’s problems in allocating junior doctors’ training. Speaking after an off the record press briefing on Monday, Martin Marshall told the BMJ that this year’s job allocation process—including the flawed Medical Application Training Service (MTAS)—would have an impact on people’s expectations when they consider a career in medicine in future because it has highlighted the tough competition for certain specialties, “This has brought these issues to the fore,” he said. “I think it will change some expectations. But if that means we’ll have more graduates applying for specialties that have been less popular in the past, that is a very good outcome.” His comments came as the NHS sought to downplay the effect of the job changeover on 1 August, when some . . .


Specialist stroke centres and GPs’ supersurgeries won’t mean hospital closures in London, the health secretary, Alan Johnson, has told MPs. At this first opportunity to be grilled by his peers since taking up the post a month ago, Mr Johnson reassured the health select committee that the proposed reforms do not carry a hidden agenda for more cuts (BMJ 2007;335:61, 14 Jul doi: 10.1136/bmj.39273.467697.DB). Doug Naysmith, MP for Bristol North West, was one of the many committee
members who feared that they might. Stroke centres would offer scans in three hours, he said. “That must reflect on the future of large hospitals because we can’t have 10 or 12 of those in London because we just don’t have the facilities, and that means concentrating down.” “That is true, but it does not mean other hospitals closing down,” replied Mr Johnson. “For example King’s [College Hospital] has a very . . .


GPs in the United Kingdom are seeing fewer patients than they were 14 years ago but spending more time with each patient, a survey has shown. The survey also shows that full time GP partners are working an average of 44.4 hours a week, similar to in 1992-3. The BMA has said that the longer consultations reflect the increasing complexity of general practice and the fact that GPs are treating more patients who used to be cared for in hospital. Laurence Buckman, chairman of the BMA’s GPs’ committee, said, “What has changed is the way we work. Intensity has rocketed. Patient care that used to routinely take place in a hospital setting—such as diabetic care, cardiac care, and asthma care, is now routinely done in general practice. It used to be commonplace to be called to a child with uncontrolled asthma or a patient with heart failure and . . .


Patients’ groups and health organisations proclaimed victory this week after an Indian court dismissed a petition by the drug company Novartis challenging a section of the Indian law on patents. Novartis had questioned section 3(d) of the law, which prohibits patents on new forms or new uses of known substances, arguing that it was in violation of the Indian constitution and that it did not meet international trade rules. The Madras High Court dismissed the petition, ruling that the clause was not unconstitutional and that the issue of whether it complies with international law should be determined by the World Trade Organization. Health agencies say the verdict is a victory for global public health. “This is a huge relief to millions of patients and doctors in developing countries who depend on affordable medicines from India,” said Tido von Schoen-Angerer, director of the campaign for access to essential medicines at Medécins . . .

O'Dowd, A. (2007). Inquiry to be held after deaths of cancer patients from apparent overdose. *British Medical Journal, 335(7614), 274.*

An inquiry has been launched after the deaths of two patients who may have been given an overdose of a drug intended to ease the side effects of cancer treatment. The two men—Baljit Singh Sunner (aged 36) and Paul Richards (35)—both died within a day of being treated in an oncology ward at Birmingham’s Heartlands Hospital. The Heart of England NHS Foundation Trust is not issuing details of the cases and would not say what drug or drugs had been involved. However, the Birmingham Mail has claimed that the men were given five times the dosage they should have received (http://icbirmingham.icnetwork.co.uk/mail, 2 Aug, "Patients die after drug dose blunder"). In a statement the trust’s chief executive, Mark Goldman, said, “Following the deaths of two patients at Heartlands Hospital we are carrying out a detailed investigation into the clinical care given to both of these patients. “This . . .


A study examining the practice patterns of overseas doctors working in Australia has shown that they work longer hours, prescribe more drugs, and order more tests than their counterparts who trained in Australia. Australia relies heavily on medical graduates from overseas, said the study’s lead author, Clare Bayram, from Sydney University’s Family Medicine Research Centre. They make up 25% of the total workforce of doctors, but information on how they practise in the Australian setting is virtually non-existent, she said. She and her colleagues compared 89 overseas trained doctors who were enrolled in a specific training programme with 1032 fellows of the Royal Australasian College of General Practitioners (Australian Health Review 2007;31:441-8). Each participant provided the details of 100 encounters with patients. “We found that [overseas trained doctors] were significantly younger, had spent fewer years in general practice, worked more sessions per week, and were more likely to work . . .


The rising number of morbidly obese people in the UK population has prompted anaesthetists to write new guidelines for managing these higher risk patients, emphasising the need for training and suitable equipment. In England nearly 3% of women and 1% of men are morbidly obese (with a body mass index (BMI) of >40), and well over a fifth of the population are obese (BMI >30), government
figures show. The new guidelines, issued by the Association of Anaesthetists of Great Britain and Ireland, say that each hospital should have a named consultant anaesthetist responsible for making sure that staff and facilities are appropriately prepared for the perioperative management of morbidly obese patients. Each operating theatre should also have a member of staff with this responsibility. “Many clinicians are aware of an increasing number of morbidly obese patients. It really is becoming significantly more common,” said Alastair Chambers, consultant anaesthetist at Aberdeen . . .


Under 16 year olds in the Netherlands could be fined for possessing alcohol in public as part of a crackdown against the rising problem of underage drinking. In specifically targeting—and punishing—youths for possession, the proposals go far beyond most European countries’ policies, such as UK bylaws to prevent drinking in public.

But with research that shows a trend towards young Dutch people drinking earlier and more heavily, the Netherlands’ Labour Party, part of the governing coalition, says that it’s time that national politicians took the lead in preventing cases of “booze, or alcoholic, coma.” The plan was launched in the Dutch parliament by the Labour MP Lea Bouwmeester, who wrote that Dutch youths are “undoubtedly among the European leaders when it comes to drinking at a very young age.” She cites data from the Trimbos Institute of Mental Health and Addiction, which shows that 47% of 12 year olds had . . .


Reactions have been rapid to proposals from the outgoing president of the Canadian Medical Association that would allow doctors to work outside as well as inside the publicly funded national healthcare system, reviving a longstanding debate about “two tier medicine.” Colin McMillan was reported in the Globe and Mail as saying that the issue has been simmering among doctors for the past two years and he wanted merely to “get it on the public discussion level” (www.theglobeandmail.com, 1 Aug, ”Debate among doctors builds over CMA health-care proposal”). Dr McMillan’s proposals were expanded on the association’s website, www.cma.ca (“CMA unveils plan to modernise Medicare” and “It’s still about Access”). The Canada Health Act, which defines the national healthcare system, is generally interpreted as prohibiting doctors from working in the public and private systems at the same time. Interest in the controversy had grown because Dr McMillan’s successor as the . . .


Two Food and Drug Administration advisory committees recommended this week that the FDA should keep rosiglitazone (Avandia), which is used to treat type 2 diabetes, on the market, despite concerns about the raised risk of heart attack in some patients. Warnings will be increased, however, about use in subgroups of patients. Whether the warnings will be of the most serious “black box” type is yet to be determined. The FDA usually follows the advice of advisory committees but is not required to. The FDA will consider the committees’ discussion and make recommendations for changes to labelling. The FDA’s advisory committees on endocrinological and metabolic drugs and the drug safety and risk management advisory committees met jointly at a crowded public meeting in a hotel near the FDA headquarters, outside Washington, DC, on Monday. The FDA brought forwards its meeting to consider rosiglitazone’s risks in light of a paper by researchers . . .


Vivian Fonseca, the editor of Diabetes Care, told the BMJ that he was surprised by the media’s interest in a study that says that rosiglitazone (Avandia) and pioglitazone (Actos) doubled the risk of heart failure in patients with type 2 diabetes (Diabetes Care 2007;30:2148-53 doi: 10.2337/ dc07-0141). The authors said that although drugs in the thiazolidinedione class were known to increase the risk of heart failure in patients with type 2 diabetes, the magnitude of the risk had not been evaluated. They used teleoanalysis to look at results from many different types of trials, involving 78 000 patients, and concluded that one in every 50 patients with type 2 diabetes taking one of these drugs would develop heart failure in a period of 26 months and need admission to hospital (see BMJ 2003;327:616-8 doi: 10.1136/ bmj.327.7415.616 for an explanation of teleoanalysis). Heart failure occurred at low and high doses . . .


Patients with severe Alzheimer’s disease who are living at home with family care givers and are treated with donepezil stabilise or decline more slowly than patients given placebo, according to a multinational,
randomised, placebo controlled trial published in Neurology (2007;69:459-69). Donepezil was approved by the US Food and Drug Administration last year for the treatment of severe Alzheimer’s disease as well as mild to moderate forms. The Canadian authorities approved its use for severe forms of the disease in June 2007. Sandra Black, of the University of Toronto and lead author of the paper, said that North American researchers were suspicious of the decision by the UK National Institute for Health and Clinical Excellence (NICE) not to fund donepezil for patients with mild Alzheimer’s disease. She said that researchers thought it might slow decline in these patients. NICE only recommends its use in patients who have moderate Alzheimer’s disease. And . . .


Ministers want to switch the way the NHS pays for the £8bn worth of branded drugs that it buys each year. They want to move to a system in which drug prices are based on the benefits they bring to patients—and it seems they want to do so quickly. The radical move comes after a report from the Office of Fair Trading (OFT) in February that recommended such a shift from 2010, when the current 50 year old pharmaceutical price regulation scheme (PPRS) becomes due for its five yearly renewal (BMJ 2007;334:383 doi: 10.1136/bmj.39133.543438.DB). The industry had been expecting a response but not last week’s announcement that ministers want a renegotiation now. A “value based” scheme would aim to allow higher prices for drugs that are more effective—a move that the OFT argues would stimulate innovation. Lower prices would be paid for more marginal . . .

Tuffs, A. (2007). German doctors fear that performance rating websites may be libelous. British Medical Journal, 335(7614),276.

As the number of German websites that try to judge doctors’ performances according to patients’ opinions rises, the National Association of Statutory Health Insurance Physicians (KBV) has warned doctors to contact the providers of websites that they think may be libelling them. However, doctors may not be aware of negative comments about them, because the websites are not obliged to inform the respective doctors when the comments appear. Last week a Munich agency launched a new website (www.jameda.de) listing addresses of about 170 000 doctors and 120 000 other health professionals, such as midwives and alternative health practitioners. Patients can register free of charge, search for doctors by location and specialty, and post their comments on success of treatment, waiting times, and general service. “We do not allow statements on medical competence,” says the website. “In contrast to other similar websites Jameda does not have the option of . . .


Researchers, funders, and patients will soon be able to find out which clinical trials are being held in China and India, the World Health Organization announced last week. Both countries, which are rapidly becoming key players in medical research, have joined the international network of government backed clinical trial registers, coordinated by WHO. The network aims to boost accountability and transparency for global health research and to improve the quality of data. Minimum standards of quality are required for entry to the network, said a spokesperson for WHO, adding that the International Committee of Medical Journal Editors has stipulated the registration of clinical trials before any participants are enrolled. WHO hopes that this acts as a strong incentive for companies and institutions to register their trials and acquire ethical approval. Access to the data, which WHO hopes to start publishing within the next few months, will be through a web . . .


An expert panel of MPs has accused the United Kingdom’s leading research funding body, the Medical Research Council, of poor practice in its appointments process and has questioned the tenure of its chairman. The House of Commons Science and Technology Committee said in a report published earlier this week that the MRC had appointed its current chairman without adhering to the principles of transparency and accountability necessary for posts funded by public money. Sir John Chisholm, who took up his position as chairman in December 2006, told the panel that he thought his appointment had come through personal invitation from Sir Keith O’Nions, director general of science and innovation at the Department of Trade and Industry. He subsequently said in a written submission that he had been approached by a recruitment company. Sir John’s performance at the committee’s introductory hearing, at which he “appeared to show a lack of focus . . .
ANALYSIS


In the richer countries of the world, improved social conditions combined with immunisations and antibiotics have rapidly reduced the rates of death from infectious diseases. People saved from these epidemics now live long enough to face the new “epidemic” of cardiovascular disease, which is the focus of huge investment and endeavour in health promotion. The national service framework for cardiovascular disease aims to reduce the number of people dying from coronary heart disease by 40% by the year 2010 with advice that standards set out in this framework apply to all people, irrespective of age.1 But what will be the next most common cause of death—the next epidemic? Our bodies have a finite functional life and age is a fundamental cause of disease.2 By using preventive treatments to reduce the risk of a particular cause of death in elderly people are we simply changing the cause of death rather than prolonging life? Three factors fuel this possibility.


The American medical education community has reached a consensus that a shortage of doctors is looming. Several years of heated discourse, dominated by current and former medical school deans, culminated in an influential position paper by the American Association of Medical Colleges (AAMC) calling for an urgent and immediate expansion of US medical students by 30%.1 The arguments for expansion have been discussed fully elsewhere,2 3 4 5 They include the belief that patients will soon want and need more services than the current stock of doctors can provide, newly trained doctors will be unwilling or unable to see as many patients each week as in the past, and the US should not be so reliant on doctors trained abroad. But is there really a problem? The proportion of doctors that are generalists has been . . .
The two week wait rule stipulated that, by April 1999, all patients with suspected breast cancer should be seen by a specialist within two weeks of referral by a general practitioner, and, despite having little scientific foundation, this “guarantee” conveyed a genuine sense of commitment to improving cancer services in the UK. This initial optimism, however, was short lived. From the beginning, the value and effectiveness of the two week wait rule have been questioned. The number of cancers detected in this group of patients has been low, and the poor predictive value of fast track referral guidelines together with poor adherence in primary care has flooded one stop clinics with large numbers of inappropriate referrals. As a result, waiting times for those patients deemed non-urgent by the general practitioner have significantly increased, prompting considerable criticism because up to a third of cancers are ultimately diagnosed from this group. No survival benefit has been shown, and several authors have called for a re-evaluation of the system. For psychological and oncological reasons, all patients with suspected malignancy deserve to be seen promptly and treated effectively, regardless of their diagnosis. We analysed referrals from primary care to a specialist breast unit over a seven year period to evaluate the impact of the two week wait rule in our patients.


Chlamydia trachomatis is the most commonly reported sexually transmissible infection in developed countries. The asymptomatic nature of the disease means that treatment is often delayed, leading to an increased risk of complications and transmission to partners. Complications in women include pelvic inflammatory disease, ectopic pregnancy, and infertility, along with neonatal complications in their children. In April 2003 the national chlamydia screening programme began its roll-out across England. No organised screening existed before this. The programme is managed nationally by the Health Protection Agency, but the way in which screening is delivered is decided locally and run from a chlamydia screening office. The main approach is opportunistic, but in some areas general practice registers are being used to send proactive invitations to potentially eligible people or to remind them to be re-screened. Most published economic evaluations have suggested that screening for chlamydia is cost effective. The validity of this conclusion has been questioned by a systematic review showing that all but two of the evaluations used static decision analytic models. These models do not incorporate the dynamic effects of transmission of infectious diseases and can produce misleading results. Whether opportunistic screening approaches can control transmission of Chlamydia trachomatis in the long term is also debated. An alternative approach is to use population registers to proactively invite young adults to be screened. This is the only screening approach that has been shown in randomised trials to reduce the incidence of pelvic inflammatory disease. Here we report the results of an economic evaluation comparing proactive register based screening with a policy of no organised screening. The evaluation was a cost effectiveness analysis, carried out from the perspective of the National Health Service, based on “major outcome averted,” which we defined as the occurrence of at least one episode of pelvic inflammatory disease leading to hospital admission, ectopic pregnancy, infertility, or neonatal complications due to chlamydia.


Although AIDS was first diagnosed in the 1980s an effective and accessible vaccine against HIV is still awaited. In 2005 more than 7600 people died daily from AIDS related causes, and about 38.6 million people worldwide are infected with HIV. Behavioural interventions for preventing sexually acquired HIV remain essential, particularly for vulnerable groups. Programmes that exclusively encourage sexual abstinence are one such strategy. These interventions are designed to teach the social, health related, and psychological benefits of abstaining from sexual activity; most also emphasise the harms of sexual activity outside marriage. Abstinence only interventions encourage both primary abstinence (delaying sexual debut) and secondary abstinence (returning to abstinence after sexual activity). Theoretical underpinnings include social cognitive theory, social inoculation (participants rehearse how they will resist peer pressure or sexual advances), the health belief model, and cognitive behavioural theory. Programme participants are typically adolescents. Settings include schools, community centres, family homes, and faith based organisations. Although the programmes’ definitions of “sex” are variable and often unclear, abstinence only interventions can encourage abstinence from oral, anal, and vaginal...
intercourse. Abstinence only programmes differ from abstinence plus programmes. Both interventions present abstinence from sex as the most effective option for HIV prevention, but abstinence plus programmes also promote safer sex strategies such as condom use. In contrast, abstinence only programmes present abstinence as the exclusive option for HIV prevention, without promoting safer sex.7


Although the use of hormone replacement therapy for control of moderate to severe menopausal symptoms is well established, its long term use for disease prevention in postmenopausal women is in dispute.1 2 3 Ten randomised controlled trials have investigated the risks and benefits of hormone replacement therapy in postmenopausal women.4 5 6 7 8 9 10 11 12 13 Three trials in the United States,4 7 12 two in the United Kingdom,8 9 and one in Estonia13 showed that such therapy does not protect against development of cardiovascular disease and may increase the risk. In the largest trial, and the only one designed to assess the prevention of cardiovascular disease, the US women’s health initiative study, women aged 50–79 years taking combined oestrogen and progestogen had a significantly increased risk of stroke, pulmonary embolism, and breast cancer and a decreased risk of hip fracture and colorectal cancer compared with women taking placebo.7 This study found that combined oestrogen and progestogen therapy might increase coronary events in older women (aged 70–79) in their first year of treatment.14 Overall, the risks seen in the women’s health initiative study were likely to outweigh the benefits, and the combined oestrogen and progestogen arm of the trial was closed prematurely after a mean of 5.2 years of follow-up. Later, the oestrogen only arm of the trial in women who had had a hysterectomy was also closed prematurely, after an average of 6.8 years of follow-up, as it showed an increased risk of stroke but no overall difference in cardiovascular disease or breast cancer.

**CLINICAL REVIEW**


Inhaled corticosteroids, although safe if given at the recommended dose, can have important adverse effects if given above it, including adrenal antagonists can be used as add-on treatment to avoid further increases in the dose of inhaled corticosteroid but can be associated with increased risk of exacerbations and hospital admission. Inhaled corticosteroids do not prevent the development of asthma. Low dose inhaled corticosteroid should not be used as preventive treatment for episodic viral wheeze. Referral to a specialist centre should be considered when a child reaches step 4 of the British Thoracic Society/Scottish Intercollegiate Guidelines Network guideline or earlier, depending on the expertise of the general practitioner and the resources available.

![Image](image-url)