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NEWS


Hillary Clinton, nominee for the Democratic party’s presidential candidate and New York senator, last week announced her plan to reform health care. She would require insurers to provide coverage for anyone who applied and would bar companies from charging people who have greater healthcare costs more for their premiums. Speaking to the annual convention of the American Association of Retired Persons, in Boston, she said, “Health care should not be a privilege for a few, but a right for every single person. There are 47 million uninsured in this country, and covering them is a moral imperative.”

Mrs Clinton told a story about a constituent who came to her after her son was diagnosed as having leukaemia. The insurance company had agreed to pay for a stem cell transplant but refused to pay for the search to find a suitable donor. But after Mrs Clinton took up the cause the . . .


Fibromyalgia and anxiety neurosis are the illnesses with the lowest prestige among doctors, according to a survey of Norwegian doctors. The survey found that heart attacks top the prestige league, closely followed by leukaemia, and that neurosurgery is regarded as the most prestigious specialty (Social Science & Medicine doi: 10.1016/j.socscimed.2007.07.003). “Results show that there exists a prestige rank order of diseases as well as of specialties in the medical community,” write the authors. “Our interpretation of the data is that diseases and specialties associated with technologically sophisticated, immediate and invasive procedures in vital organs located in the upper parts of the body are given high prestige scores, especially where the typical patient is young or middle-aged.” They say that any such ranking among doctors could have effects on practice. In the study, the authors, from the University of Oslo and the University of Science and Technology, Oslo, sent . . .


Sir Leszek Borysiewicz, who was knighted for his research into developing vaccines, is the new chief executive of the UK Medical Research Council (MRC). The deputy rector of Imperial College, London, is to take over from the current holder, Colin Blakemore, whose term of office finishes at the end of this month. “I’m excited by the chance to work
across the whole spectrum of biomedical science and to help to make a difference in relation to healthcare for individuals in the UK and globally,” said Professor Borysiewicz. He joined Imperial College London in 2001 as principal of the faculty of medicine before becoming deputy rector three years later. His research interests are in viral immunology, infectious diseases, cell mediated immunity, virus associated malignancy, and vaccine development. He was knighted in 2001 for his research into developing vaccines, including one to stop the development of cervical cancer. He holds a number . . .

The UK government is considering moving to a system where people will be presumed to have consented to the use of their organs for transplantation unless they have opted out. The health secretary, Alan Johnson, has asked the organ donation task force to look at the ramifications of moving from the present “opt-in” system, in which organs can be used only if people have given their prior consent, to the sort of opt-out regime currently operating in some other countries, including Sweden and Austria. The task force, set up in 2006 to look at barriers to organ donation, will examine the legal, ethical, practical, and medical issues, including whether the family of somebody who has died should be given the final say on organ donation. At present the family’s consent is required unless the potential donor has signed up to the organ donor register or otherwise expressed a wish to . . .

The BMA has clashed with the UK General Medical Council about draft guidance from the GMC for doctors who object to providing certain medical services on the ground that they conflict with their personal beliefs. In its response to the draft of Personal Beliefs and Medical Practice the BMA argues that the guidance goes beyond doctors’ widely accepted right to opt out of certain procedures that involve matters of life and death, such as abortion, contraceptive services, and the withdrawal of life prolonging treatment. The association claims it could confuse patients and give doctors a licence to discriminate. But the GMC insists that the draft guidance does not contradict current guidelines in its core text, Good Medical Practice, which does not limit conscientious objections to life and death matters. It says that the new guidance is intended to supplement Good Medical Practice by giving more detailed and practical information . . .

A new statutory right for patients to say in advance what treatments they would want to refuse if they later lose the capacity to take decisions came into force this week. Doctors will have to abide by the new advance decisions to refuse treatment (ADRTs) or risk criminal or civil proceedings in the courts. The measure forms part of the Mental Capacity Act 2005, which from October 1 also gives individuals the right to create a lasting power of attorney by appointing a trusted friend or relative to take healthcare decisions for them in the event that they become incapacitated. Advance directives or “living wills” to refuse treatments are already binding under common law, but the act sets up a statutory framework that aims to give doctors and patients greater certainty. Patients will not be able to demand any particular treatment or require a doctor to do anything unlawful. NHS . . .

By the age of 16 at least 10% of girls in England have become infected with one or more strains of the human papillomavirus (HPV), a major study of HPV prevalence in girls and young women has shown. Researchers from the Health Protection Agency tested 1483 women and girls aged 10 to 29 years from across England for four strains of the virus: types 6, 11, 16, and 18. Types 6 and 11 are associated with genital warts in particular, while types 16 and 18 are thought to be causative agents in an estimated 70% of cervical cancers. Their findings are reported in the British Journal of Cancer (doi: 10.1038/sj.bjc.6603955). A separate modelling study by the Health Protection Agency indicates that up to 70% of cases of cervical cancer and 95% of cases of genital warts in men and women could be prevented if vaccination against HPV were included . . .

International health agencies launched a coordinated appeal last week for $85m to help more than 2.2 million Iraqis who have fled to neighbouring countries. The appeal comes as another 1.2 million Iraqis have been internally displaced, partly as a result of the rapid spread of a cholera outbreak that began in the Kurdish north of Iraq. Cholera was confirmed by laboratory testing of samples from a 25 year old woman in Baghdad last week, and it is likely that more cases will be
confirmed there soon, the World Health Organization said last Friday. On the same day the first case of cholera appeared in Iraq’s second city, Basra, when a 7 month old baby tested positive for cholera. Diyala province, the scene of heavy fighting, is also reporting a surge in diarrhoeal disease. In the northern provinces of Erbil, Sulaymaniyah, and Kirkuk, more than 1500 cases of cholera . . .


A consultant radiologist who failed to carry out breast examinations according to NHS guidelines was last week allowed to continue working under conditions, after a General Medical Council fitness to practise hearing found his employer had failed to provide adequate resources and support. Lan Keng Lun missed warning signs and failed to carry out standard procedures on Ms A, a patient referred to him after an abnormal mammography result in March 2003. She was diagnosed as having breast cancer seven months later. Independent experts who reviewed the case for the GMC concluded that a proper examination would have had a 30% chance of detecting cancer in Ms A. The Epping NHS Breast Screening Service in Essex, at which Dr Lan was the sole consultant radiologist for six years, also failed to meet national standards in the breast screenings of eight other women, the GMC found. But an external review commissioned . . .


The Scottish sculptor David Annand stands with his statue the Listening Lady, which sits in a circular frame and acts as a resting place for patients and visitors at the Marie Curie Cancer Care Hospice in Belfast. The seat is inscribed with a poem written specifically for the project by local poet and Nobel prize winner Seamus Heaney. It reads:

Still yourself, take time, be at rest.
Enter the circle, unalone, a guest.

The 40 year old hospice has just been redeveloped in a two year project funded by the National Lottery through the Arts Council of Northern Ireland. It has doubled the size of the hospice, which now includes an outpatient and day therapy area as well as a modern inpatient unit offering 17 new, fully serviced rooms with ensuite bathrooms.


Prime Minister Gordon Brown pledged to make the NHS more personal this week, promising quicker test results and better access to GPs, “because we know that being unwell is not just a nine to five problem.” In his first speech to the Labour party conference as prime minister, Mr Brown promised an expansion of the screening services for breast and bowel cancer, quicker access to cancer treatment for more people, and £15bn for research over the next 10 years. His long term plans include a regular health check for every adult in Britain. “Our great achievement of the 1940s was a service universal to all. In 2007 we need a service that is accessible to all and personal to all,” said Mr Brown in an impassioned speech, during which he expressed his gratitude to the NHS for saving the sight in one of his eyes. He added, . . .


Reform of health and social services in England needs to slow down to allow the full engagement of staff and the public in the process, says a report from the independent health research organisation the Nuffield Trust. The report, which examines the health and care needs of people in England in the next 15 years, says that reform of health and care services in England “is in danger of stalling.” But although further change is needed, this should proceed with a “re-engagement with consumers, health workers and citizens, in re-imagining and co-creating a shared vision of their future health and care services.” Sandra Dawson, one of the report’s authors and professor of management studies at Judge Business School in Cambridge, said that morale among health and care staff was particularly low and they needed to feel involved in designing future services. She welcomed the review of the NHS currently being . . .


Doctors in the United Kingdom have for the first time been given guidance on their roles and responsibilities when treating children and young people. The General Medical Council, which regulates doctors in the UK, developed the standards after a three month consultation with children and adolescents aged under 18 years, doctors, parents, organisations, and the general public. The GMC received more than 950 individual responses. Young people have also taken part in workshops around the UK and been involved in drafting the guidance. Graeme Catto, president of the GMC, said, “This is
the first time the GMC has set standards for doctors specifically about children and young people. Previously our advice has only referred to children and young people where their position is different from that of adults; this document recognises that children are individuals with rights that should be respected.” He continued: “Young people told the GMC that doctors . . .

**Kmietowicz, Z. (2007). Advice to pregnant women to avoid eating peanuts should be withdrawn, says Lords committee. British Medical Journal, 335(7621), 633.**

Department of Health advice for pregnant women with a family history of atopic diseases to avoid eating peanuts and food that contains peanuts and not to give such food to their children until the age of 3 years is out of date and should be immediately withdrawn, says a report from the House of Lords. The health department advice, which was first issued in 1998 and is repeated in government booklets given to pregnant women and new parents, is totally without evidence, the House of Lords Science and Technology Select Committee heard during its inquiry into allergy in the United Kingdom. Avoiding food that contains peanuts in early life could in fact be helping to fuel the rise in peanut allergy seen in the UK, says the report. The prevalence of peanut allergy in England increased by 117% between 2001 and 2005, and an estimated 25,700 people are affected. . . .

**Kmietowicz, Z. (2007). Polyclinics are not the answer for NHS in London, says BMA. British Medical Journal, 335(7622), 691**

Proposals by the health minister Ara Darzi to set up polyclinics in London to bring health services closer to patients threaten to fragment existing community services, which have a track record of delivering high quality care, says the BMA. In a response to Lord Darzi’s recent review of health care in London the BMA warns that the proposed plans may not produce the predicted savings or improvements in the care of patients that the government envisages (BMJ 2007;335:61 doi: 10.1136/bmj.39273.467697.DB). “We concede that health care in London is not perfect, but we have several problems with Ara Darzi’s proposals,” said Hamish Meldrum, chairman of the BMA Council. Establishing polyclinics, a key component of Lord Darzi’s plans for London, would require considerable “up front” investment in new buildings, equipment, and staff, and it is difficult to see how they would be cost effective, the BMA’s response says. Community hospitals . . .

**Leng, M., and Dorothy Logie. (2007). Africans die in pain because of fears of opiate addiction. British Medical Journal, 335(7622), 685.**

Attempts to improve palliative care services in Africa are being hampered by the fear that many African professionals have of using morphine therapeutically and by poor access to the drug, a conference was told last month. Many countries in Africa have no access to morphine so that palliative care is reduced to the level of supportive care without pain relief, delegates from 35 countries heard. They were attending the second palliative care conference for Africa, in Nairobi. While the world’s 20 richest countries consume 86% of global therapeutic morphine, countries such as Rwanda use just 0.039 mg per capita, one of three lowest users in the world. Opiophobia—the fear of using morphine therapeutically—is a big obstacle facing palliative care services in the continent, the conference heard. Fear of addiction, excessive bureaucracy, inadequate requisitioning, and a reluctance to use oral morphine outside hospital are widespread throughout Africa. In addition, the lack . . .

**Mayor, S. (2007). UK hip fracture audit is launched to improve care and reduce costs. British Medical Journal, 335(7621), 634-635.**

A new UK-wide audit has been launched to improve the care of patients with hip fracture. The audit aims to help reduce the currently low and variable rates of investigation and treatment of osteoporosis in elderly people who are admitted to hospital with fragility fractures. The audit system, called the national hip fracture database, will gather data submitted voluntarily by hospitals around the United Kingdom. Its design is based on an audit of myocardial infarction care, the myocardial infarction national audit project (MINAP), which has had a major role in improving the management of heart attack, including reducing the “door to needle time” for use of thrombolytic drugs. The hip fracture database will audit hospitals against six standards proposed in a guide to best practice, TheBlue Book on the Care of Patients with Fragility Fractures, published last week by the British Orthopaedic Association and the British Geriatrics Society. . . .


The multinational and medical device manufacturer Johnson & Johnson has been advertising its products in a resource book used by children in Australian classrooms. The book, BodyWhys, is sponsored by Johnson & Johnson and contains several advertisements for Johnson & Johnson products, including tampons,
sanitary pads, toothbrushes, and pimple cream. Along with the advertisements, BodyWhys, which was recently distributed to 10 year old children in a state school in Sydney’s wealthy eastern suburbs, contains text about personal development. Johnson & Johnson says it has been sending copies of the book to schools on request for several years. This year more than 130 private and public schools across Australia have received copies. Johnson & Johnson, which began life as a producer of surgical dressings in the 1880s, now boasts annual sales profits of $11bn. Controlling more than 250 operating companies, it now . . .


Doctors and health workers have a duty to draw attention to climate change and try to change people’s behaviour to avert disaster, an expert on the issue told a conference in Chicago last week. Anthony McMichael, director of the National Centre of Epidemiology and Population Health at the Australian National University, Canberra, said that doctors had a particular responsibility because they had influence and because the health sector would have to deal with some of the worst effects of climate change. Addressing the annual interscience conference on antimicrobial agents and chemotherapy in Chicago, Dr McMichael acknowledged that 5-10 years ago the topic would not have been on the agenda, “but the evidence is accruing rather more rapidly than we would have anticipated.” Speaking to the BMJ he said that the medical profession was still held in high regard and had influence. He pointed to its leadership on the nuclear disarmament . . .


African-American leaders launched a call to action to address HIV/AIDS in the black community at a Capitol Hill news conference last month. The aim is to halve the rates of new infections, reduce the stigma of AIDS, increase by a half both the number of people who know their HIV status, and who are receiving care for HIV infection. “AIDS is a black disease no matter how you look at it—through the lens of gender, or sexual orientation, or age, socioeconomic class, education, or region of the country—black people bear the brunt of the epidemic,” said Phill Wilson, executive director of the Los Angeles based charity the Black AIDS Institute. “Some 30% of new cases among gay men are among black men; 40% of new cases among men are black; 67% of new cases among women are black; and 70% of new cases among youth are black. That is why . . .


The Health Council of the Netherlands, a scientific advisory body, has recommended that the Dutch government introduce an integrated programme of preconception care, to reduce perinatal mortality, miscarriage, premature birth, and congenital abnormalities. The Dutch government commissioned the council to draw up its advice because the Netherlands has lost its pre-eminent position on perinatal mortality compared with other European Union countries, partly because of a higher proportion of older mothers and mothers belonging to ethnic minorities (Ned Tijdschr Geneeskr 2004;148:1855-60). The council’s key message is that current antenatal care, which starts after the eighth week of pregnancy, can miss chances to improve the health of the mother and child. Information on health interventions should be brought forward until at least a month before any planned conception to allow the health benefits a chance to have effect, it says . . .


Doctors and health service managers have produced a blueprint for shaping any further reforms of the NHS, which will ensure that they encapsulate the best clinical practices. The Joint Medical Consultative Council, which includes representatives of the medical royal colleges, medical schools, and the BMA, has produced a report with the NHS Confederation that sets out rules for successful reform of working practices in the NHS. The decision to produce the report came about because so many clinicians were unhappy about NHS reforms and felt that they had not been involved in the design of these changes, Bill Dunlop, chairman of the consultative council, explains in his foreword. The study asked doctors what it would be like to work in an NHS that was based on their own vision or on their personal experiences of bringing about a change themselves . . .


Aboriginal people in the Northern Territory (NT) are facing considerable changes to their lives, including loss of control of their lands and withheld welfare payments, as part of extensive new policies aimed at tackling the sexual abuse of children. The Australian government’s “national emergency response” to an inquiry into the sexual abuse of indigenous children in the territory also involves widespread restrictions on alcohol, the abolition of a community employment scheme, and a ban on X rated pornography. The government initially also
announced plans to conduct compulsory checks on the sexual health of Aboriginal children, but after an outcry from health and medical groups it is now organising optional general health checks. The intervention, announced on 21 June without consultation with indigenous or medical groups, was followed by the rushed passage in August of enacting legislation. It has provoked alarm among many indigenous and public health experts as well as . . .


The US State Children’s Health Insurance Program, subject of a fight between President George Bush and Congress, was extended to 16 November. The programme was to expire on 30 September, the end of the government’s fiscal year and the end of the programme, which began 10 years ago and needs renewal every five years. Congress passed a “continuing resolution” to extend it and several other programmes. The current programme, funded partly by the federal government (about 70%) and partly by the states (about 30%), covers more than six million children. The proposed expansion would cover another four million. Last month Congress voted to renew and expand the programme to cover more children in families with incomes too high to qualify for Medicaid insurance but too low for them to afford private health insurance. The Congressional plan would cost an additional $35bn over the next five years. Proposing a . . .


Annual physical examinations, a staple of medical care in the United States for decades, cost too much and are not necessary for conveying messages on preventing illness, says a new study. Patients get most messages on prevention through other visits, explains the study, published in the Archives of Internal Medicine (2007;167:1876-83). But annual gynaecological exams may be helpful for women, it says. Ateev Mehrotra and colleagues from the University of Pittsburgh Medical Center examined data from 2002, 2003, and 2004 from the US national ambulatory medical care survey and the national hospital ambulatory medical care survey, which record visits made by patients with health insurance to office based physicians and to hospital outpatient departments for annual check-ups and gynaecological examinations. Dr Mehrotra, the lead author and an assistant professor at the University of Pittsburgh Centre for Research on Health Care, said that no major North American clinical organisation recommends check-ups . . .


The US president, George Bush, opened his press conference last week by announcing that he would veto bills that would renew and expand the US state children’s health insurance programme (SCHIP). The programme was passed earlier this year by the House of Representatives and the Senate, with wide support from Democrats and Republicans. The federal programme, which has been going for 10 years, was to expire on 30 September. The House and the Senate passed different bills. As usual, they reached a compromise bill last weekend, on which they were expected to vote on Tuesday and Thursday. A presidential veto can be over-ridden by a two thirds vote in both House and Senate, but it is not clear whether there are enough votes in the House to over-ride the veto. Several health policy experts told the BMJ that Bush’s veto and confrontation with Congress were part of a negotiating strategy . . .


Problems in the systems and management processes of the US Food and Drug Administration are hindering its ability to oversee clinical trials and to protect trial participants, says a highly critical report by the Office of the Inspector General at the Department of Health and Human Services, the FDA’s parent agency. The report, by Daniel Levinson, the inspector general, was first publicised in a front page story in the New York Times last week (www.nytimes.com, “Report assails FDA oversight of clinical trials,” 28 Sep). The FDA oversees the safety and effectiveness of all clinical trials of new drugs and medical devices before they are approved for sale in the United States. The report looked at the extent to which the FDA inspected clinical trials during the fiscal years 2000 to 2005 and assessed the agency’s methods for inspecting trials. The investigation was sparked by a series of five . . .

Tuffs, A. (2007). German media describe allocation of organs to Saudi patients as unfair. British Medical Journal, 335(7621), 634.

The University Hospital of Kiel, in northern Germany, has been criticised for transplanting livers from cadavers to two Saudi patients, ahead of other, native German patients who had been on the waiting list longer. The Saudi patients had been meant to receive a transplant from relatives, but they benefited from a recent change in the rules of Eurotransplant, the body that coordinates transplant allocation across seven European countries, propelling them to the top of the waiting list, even
though they had only recently arrived in Germany and had a donor relative lined up. Under the rule change, patients are given scores as to the urgency of their case that are based solely on laboratory blood test results (creatinine and bilirubin concentrations and prothrombin time). The score is given higher priority than the length of time the patient has been waiting for a transplant. The system, known as the model for . . .


The battle on assisted reproduction and prenatal diagnosis in Italy took a new turn last week, when the gynaecologist Giovanni Monni, head of the obstetrics and gynaecology department in the Ospedale Microcitemico in Cagliari, Sardinia, was ordered by the local court to provide preimplantation genetic testing to a couple carrying the gene for thalassaemia, which is common on the island. Dr Monni, the current president of the Italian Association of Hospital Gynaecologists, had unwillingly obeyed the controversial law approved in 2004, which, through guidelines, forbids preimplantation genetic diagnosis, even though he personally supported the couple’s request for it (BMJ 2004;328:9, doi: 10.1136/bmj.328.7430.9). “I am very glad of the court’s decision,” he told the BMJ. The law contains several points that have been opposed from the beginning by almost all gynaecologists. These include the stipulations that assisted reproduction techniques can be used . . .

Watson, R. (2007). UK does well on giving information to patients but poorly on access to new treatments. British Medical Journal, 335(7622), 686.

The United Kingdom ranks only 17th out of 29 countries in the latest edition of the Euro Health Consumer Index of public healthcare systems—one place behind Ireland and narrowly ahead of Italy and Portugal. It has slipped from 15th position last year. The rankings, now in their third year, were produced by the Brussels based analysis and information organisation, Health Consumer Powerhouse. They are based on 27 indicators grouped into five categories—patients’ rights and information, waiting times, outcomes, the generosity of public healthcare systems, and access to medication. The UK, with its electronic patient records, quality ranking of hospitals provided by the Healthcare Commission, and 24 hour telephone healthcare information system provided by NHS Direct is in the forefront of patient access to information. However, it scores badly on access to new treatments and long waiting times, receiving only 581 points out of a potential 1000. Arne Björnberg, the index’s . . .


Contradictory details are emerging of the impact that the three year old European Union legislation on clinical trials is having on medical science. According to research presented on 27 September at a conference in Barcelona organised by the European Cancer Organisation, the number of non-commercial clinical trials has fallen by a quarter. Markus Hartmann, from European Consulting and Contracting in Oncology, Trier, Germany, told participants that this figure was a “conservative estimate.” But data from the European Medicines Evaluation Agency show that the percentage of non-commercial trials increased between 2005 and 2006. The agency and the European Commission launched consultations at a conference in London this week to analyse problems that the EU’s clinical trials directive may have raised to determine whether amendments to the legislation might be necessary. Dr Hartmann based his research on six countries—the United Kingdom, Germany, France, Italy, Spain, and the Netherlands—all of which . . .


Doctors and other healthcare staff who take any part in executions by lethal injection should be punished by their professional bodies, says the human rights organisation, Amnesty International. In a report published to mark 25 years of the use of this method of execution, Amnesty says that leading professional organisations should push harder to outlaw the practice. The organisation opposes any form of capital punishment. The practice is condoned in only six countries. But despite an overall fall in the numbers of lethal injections in four of these, it has become the execution method of choice in the United States, says the report. There have been 919 such executions in the US since the method became legal in 1977 to the end of July this year. More prisoners are executed in China than anywhere else in the world, and the country increasingly views lethal injection as a more modern approach . . .


NHS trusts in the United Kingdom must ensure that older people are given care in a way that respects their dignity, and trusts will face spot checks where there is evidence for concern, the healthcare watchdog for England has warned. The Healthcare Commission compiled a report from assessments at 23 NHS hospitals, surveys of 80 000 NHS inpatients, and nearly 130 000 NHS staff, the commission’s analysis of 10 000 complaints, and
information on safety incidents from the National Patient Safety Agency. The 23 hospitals inspected were chosen because of concerns about levels of care. Although no serious breaches of government standards were found, only five of the trusts were found to have fully complied with all the standards relating to dignity, privacy, and nutrition. Eight trusts were given letters warning them that they were at risk of not meeting the standards and that they would be scrutinised carefully again.

Zarocostas, J. (2007). Better access to drugs could save 10 million lives a year, says UN expert. British Medical Journal, 335(7621), 635.

Better access to drugs, especially in poor countries, could save 10 million lives each year, four million of them in Africa and South East Asia, an independent UN expert said as he unveiled a set of draft guidelines for pharmaceutical companies on access to drugs. The 50 draft provisions drew a mixed response from interested parties. They were welcomed by groups that advocate for access to affordable drugs but were strongly criticised by the industry. Announcing the guidelines, Paul Hunt, the United Nations' special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, said, “Almost two billion people lack access to essential medicines. Improving access to existing medicines could save 10 million lives each year. Professor Hunt, who is professor at the department of law and the human rights centre at Essex University, continued: “Access to medicines . . .

ANALYSIS


Healthcare organisations are increasingly scrutinised by external agencies, such as the Health Care Commission in England and Medicare in the United States. Such agencies increasingly concern themselves with the quality of care and not just measures of throughput, such as waiting times and the average length of hospital stay. Measures of clinical quality are also likely to be used increasingly to monitor the performance of individual doctors. But how should quality be measured? The intuitive response is to measure the outcomes of care—after all, patients use the service to improve their health outcomes. We argue that this beguiling solution has serious disadvantages because of the poor correlation between outcome and quality and that use of outcome as a proxy for quality is a greater problem when the data are used for some purposes than . . .

RESEARCH


Objective To review the accuracy of electrocardiography in screening for left ventricular hypertrophy in patients with hypertension.

Design Systematic review of studies of test accuracy of six electrocardiographic indexes: the Sokolow-Lyon index, Cornell voltage index, Cornell product index, Gubner index, and Romhilt-Estes scores with thresholds for a positive test points.

Data sources Electronic databases ((Pre-)Medline, Embase), reference lists of relevant studies and previous reviews, and experts.

Study selection Two reviewers scrutinised abstracts and examined potentially eligible studies. Studies comparing the electrocardiographic index with echocardiography in hypertensive patients and reporting sufficient data were included.

Data extraction Data on study populations, echocardiographic criteria, and methodological quality of studies were extracted.

Data synthesis Negative likelihood ratios, which indicate to what extent the posterior odds of left ventricular hypertrophy is reduced by a negative test, were calculated.

Results 21 studies and data on 5608 patients were analysed. The median prevalence of left ventricular hypertrophy was 33% (interquartile range 23-41%) in primary care settings (10 studies) and 65% (37-81%) in secondary care settings (11 studies). The median negative likelihood ratio was similar across electrocardiographic indexes, ranging from 0.85 (range 0.34-1.03) for the Romhilt-Estes score to 0.91 (0.70-1.01) for the Gubner index. Using the Romhilt-Estes score in primary care, a negative electrocardiogram result would reduce the typical pre-test probability from 33% to 31%. In secondary care the typical pre-test probability of 65% would be reduced to 63%.

Conclusion Electrocardiographic criteria should not be used to rule out left ventricular hypertrophy in patients with hypertension.

**Objective** To review the published literature on the effectiveness of interventions to promote physical activity in children and adolescents.

**Design** Systematic review. Data sources Literature search using PubMed, SCOPUS, Psychlit, Ovid Medline, Sportdiscus, and Embase up to December 2006.

**Review methods** Two independent reviewers assessed studies against the following inclusion criteria: controlled trial, comparison of intervention to promote physical activity with no intervention control condition, participants younger than 18 years, and reported statistical analyses of a physical activity outcome measure. Levels of evidence, accounting for methodological quality, were assessed for three types of intervention, five settings, and three target populations.

**Results** The literature search identified 57 studies: 33 aimed at children and 24 at adolescents. Twenty four studies were of high methodological quality, including 13 studies in children. Interventions that were found to be effective achieved increases ranging from an additional 2.6 minutes of physical education related physical activity to 283 minutes per week of overall physical activity. Among children, limited evidence for an effect was found for interventions targeting children from low socioeconomic populations, and environmental interventions. Strong evidence was found that school based interventions with involvement of the family or community and multicomponent interventions can increase physical activity in adolescents.

**Conclusion** Some evidence was found for potentially effective strategies to increase children’s levels of physical activity. For adolescents, multicomponent interventions and interventions that included both school and family or community involvement have the potential to make important differences to levels of physical activity and should be promoted. A lack of high quality evaluations hampers conclusions concerning effectiveness, especially among children.


**Objective** To examine the absolute risks or benefits on cancer associated with oral contraception, using incident data.

**Design** Inception cohort study. Setting Royal College of General Practitioners’ oral contraception study.

**Participants** Directly standardised data from the Royal College of General Practitioners’ oral contraception study.

**Main outcome measures** Adjusted relative risks between never and ever users of oral contraceptives for different types of cancer, main gynaecological cancers combined, and any cancer. Standardisation variables were age, smoking, parity, social class, and (for the general practitioner observation dataset) hormone replacement therapy. Subgroup analyses examined whether the relative risks changed with user characteristics, duration of oral contraception usage, and time since last use of oral contraception.

**Results** The main dataset contained about 339 000 woman years of observation for never users and 744 000 woman years for ever users. Compared with never users ever users had statistically significant lower rates of cancers of the large bowel or rectum, uterine body, and ovaries, tumours of unknown site, and other malignancies; main gynaecological cancers combined; and any cancer. The relative risk for any cancer in the smaller general practitioner observation dataset was not significantly reduced. Statistically significant trends of increasing risk of cervical and central nervous system or pituitary cancer, and decreasing risk of uterine body and ovarian malignancies, were seen with increasing duration of oral contraceptive use. Reduced relative risk estimates were observed for ovarian and uterine body cancer many years after stopping oral contraception, although some were not statistically significant. The estimated absolute rate reduction of any cancer among ever users was 45 or 10 per 100 000 woman years, depending on whether the main or general practitioner observation dataset was used.

**Conclusion** In this UK cohort, oral contraception was not associated with an overall increased risk of cancer; indeed it may even produce a net public health gain. The balance of cancer risks and benefits, however, may vary internationally, depending on patterns of oral contraception usage and the incidence of different cancers.

Objective To determine whether introducing chest pain unit care reduces emergency admissions without increasing reattendances and admissions over the next 30 days.

Design Cluster randomised before and after intervention trial.

Setting 14 diverse acute hospitals in the United Kingdom.

Participants Patients attending the emergency department with acute chest pain during the year before and the year after the intervention started.

Intervention Establishment of chest pain unit care compared with continuation of routine care.

Main outcome measures Proportion of chest pain attendances resulting in admission; reattendances and admissions over the next 30 days; daily emergency medical admissions (all causes); and proportion of emergency department attendances with chest pain.

Results The introduction of chest pain unit care was associated with weak evidence of an increase in emergency department attendances with chest pain (16% v 3.5%; P=0.08); no change in the proportion of chest pain attendances resulting in admission (odds ratio 0.998, 95% confidence interval 0.940 to 1.059; P=0.945); small increases in the proportion reattending (odds ratio 1.10, 1.00 to 1.21; P=0.036) or being admitted (1.30, 0.97 to 1.74; P=0.083) over the next 30 days; and evidence of increased daily medical admissions (1.7 per day, 95% confidence interval 0.8 to 2.5; P<0.001). However, this last finding was highly sensitive to changes in the method used to handle missing data.

Conclusion The introduction of chest pain unit care did not reduce the proportion of patients with chest pain admitted and may have been associated with increased emergency department attendances with chest pain.


Objectives To compare visual outcome in response to two prescribed rates of occlusion (six hours a day and 12 hours a day).

Design Unmasked randomised trial.

Setting Research clinics in two London hospitals.

Participants 97 children with a confirmed diagnosis of amblyopia associated with strabismus, anisometropia, or both.

Interventions: 18 week period of wearing glasses (refractive adaptation) followed by occlusion prescribed (“patching”) for six or 12 hours a day.

Main outcome measures Visual acuity measured by logMAR letter recognition; objectively monitored rate of occlusion (hours a day).

Results The mean age of children at study entry was 5.6 (SD 1.5) years. Ninety were eligible for occlusion but 10 dropped out in this phase, leaving 80 children who were randomised to a prescribed dose rate of six (n=40) or 12 (n=40) hours a day. The mean change in visual acuity of the amblyopic eye was not significantly different (P=0.64) between the two groups (0.26 (95% confidence interval 0.21 to 0.31) log units in six hour group; 0.24 (0.19 to 0.29) log units in 12 hour group). The mean dose rates (hours a day) actually received, however, were also not significantly different (4.2 (3.7 to 4.7) in six hour group v 6.2 (5.1 to 7.3) in 12 hour group; P=0.06).

The visual outcome was similar for those children who received three to six hours a day or more than six to 12 hours a day, but significantly better than that in children who received less than three hours a day. Children aged under 4 required significantly less occlusion than older children. Visual outcome was not influenced by type of amblyopia.

Conclusions Substantial (six hours a day) and maximal (12 hours a day) prescribed occlusion results in similar visual outcome. On average, the occlusion dose received in the maximal group was only 50% more than in the substantial group and in both groups was much less than that prescribed. Younger children required the least occlusion.

Objective To determine the cost effectiveness of strategies for preventing neonatal infection with group B streptococci and other bacteria in the UK and the value of further information from research. Design Use of a decision model to compare the cost effectiveness of prenatal testing for group B streptococcal infection (by polymerase chain reaction or culture), prepartum antibiotic treatment (intravenous penicillin or oral erythromycin), and vaccination during pregnancy (not yet available) for serious bacterial infection in early infancy across 12 maternal risk groups. Model parameters were estimated using multi-parameter evidence synthesis to incorporate all relevant data inputs. Data sources 32 systematic reviews were conducted: 14 integrated results from published studies, 24 involved analyses of primary datasets, and five included expert opinion. Main outcomes measures Healthcare costs per quality adjusted life year (QALY) gained. Results Current best practice (to treat only high risk women without prior testing for infection) and universal testing by culture or polymerase chain reaction were not cost effective options. Immediate extension of current best practice to treat all women with preterm and high risk term deliveries (11% treated) would result in substantial net benefits. Currently, addition of culture testing for low risk term women, while treating all preterm and high risk term women, would be the most cost effective option (21% treated). If available in the future, vaccination combined with treating all preterm and high risk term women, would be the most cost effective option (21% treated). If available in the future, vaccination combined with treating all preterm and high risk term women and no testing for low risk women would probably be marginally more cost effective and would limit antibiotic exposure to 11% of women. The value of information is highest (£67 m) if vaccination is included as an option. Conclusions Extension of current best practice to treat all women with preterm and high risk term deliveries is readily achievable and would be beneficial. The choice between adding culture testing for low risk women or vaccination for all should be informed by further research. Trials to evaluate vaccine efficacy should be prioritised.

CLINICAL REVIEW


In this second overview of the current management of infertility we discuss anovulatory infertility and polycystic ovary syndrome. This syndrome (formerly known as Stein-leventhal syndrome) is the most common hormonal disturbance in women—around one fifth of women in the United Kingdom are affected. It is also the most common reason for women not to ovulate, and the combination of being overweight and having polycystic ovary syndrome can have a profound effect on reproductive health.

Summary points
Polycystic ovary syndrome is the most common endocrine problem affecting women and the most common cause of anovulatory infertility
Oral clomifene citrate remains the first line treatment to induce ovulation
Gonadotrophin treatment needs careful monitoring to reduce risk of multiple pregnancy
Despite early promise, the role of metformin and insulin lowering agents is unclear in the management of anovulatory polycystic ovary syndrome


Summary points
The lifetime risk of developing colorectal cancer is about 5%
Increasing age and a family history of colorectal cancer are the greatest risk factors for the disease
Patients presenting with suspicious symptoms and signs should be referred and investigated urgently in a specialised unit
Colonoscopy and computed tomographic colonography are of equal sensitivity for detection of colorectal cancer
Colonoscopy allows biopsy of suspicious lesions and removal of polyps
Population screening by testing for faecal occult blood has begun in the United Kingdom

Colorectal cancer is common, the presenting symptoms are non-specific, and the stage of disease at diagnosis is closely related to survival. In this review we discuss disease presentation, criteria for urgent referral of patients to specialist care, and recent developments in the implementation of national screening programmes, which aim to reduce mortality from this common disease. Many general practitioners will also refer patients with suspected colorectal cancer...
Several countries add fluoride to water supplies to prevent dental caries (boxes 1 and 2). Since the 2003 Water Act, water companies are required to add fluoride to supplies when requested—after public consultation—by a health authority in England or the Welsh Assembly in Wales.1

Summary points
Water fluoridation is highly controversial
Evidence is often misused or misinterpreted and uncertainties glossed over in polarised debates
Problems include identifying benefits and harms, whether fluoride is a medicine, and the ethical implications
This article provides professionals and the public with a framework for constructive public consultations