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Legal ruling prevents women taking second abortion pill at home

Clare Dyer BMJ

The United Kingdom's largest independent provider of abortion services has lost its High Court bid to force the secretary of state for health Andrew Lansley to let women having early medical abortions in England, Scotland, and Wales take some of the treatment at home rather than in a clinic.

BPAS (formerly the British Pregnancy Advisory Service) had asked Mr Justice Supperstone to reinterpret the 1967 Abortion Act in line with advances in medical science, to allow the second dose of the two drug treatment, mifepristone and misoprostol, to be administered by the woman at home (*BMJ* 2011;342:d264). The charity argued that this would be in line with practice in some other countries and that the restriction meant that women faced the possibility of miscarrying on the way home from the second round of treatment.

The charity argued that "treatment" under the act covered the prescription but not necessarily the administration of the drugs. Mr Lansley argued that the act required both the first and second doses to be taken under supervision at a hospital or other medical premises.

The judge upheld the government's interpretation that the administration of both doses constituted "treatment" that must be carried out by a registered medical practitioner on premises approved under the act.

A spokeswoman for BPAS said that the charity was disappointed and was taking legal advice on a possible appeal. But it was "very pleased" that the judge ruled that the act gave the health secretary "the power to approve a wider range of place, including potentially the home, and the conditions on which such approval may be given relating to the particular medicine and the manner of its administration or use."

Since the case went to court the Royal College of Obstetricians and Gynaecologists has produced new evidence based guidelines noting the weight of evidence in support of home use of misoprostol for abortions up to nine weeks' gestation and the importance of giving women a choice of method.

Cite this as: *BMJ* 2011;342:d1045

MARK THOMAS

Doctors and students protested about the Health and Social Care Bill in London on Valentine's Day

Price competition may drive down quality, MPs are told

Jacqui Wise LONDON

MPs have been told that competition on price between public and private providers of healthcare services in England would be dangerous and should be introduced only slowly and in a limited way, if at all.

The criticism comes as the Department of Health sought authorisation from parliament for £1.8bn (€2.1bn; $2.9bn) to be set aside to cover the costs of the reforms. This is a substantial increase on the £1.4bn stated in the impact assessment published alongside the Health and Social Care Bill (*BMJ* 2011;342:d418). Secretary of state for health Andrew Lansley has repeatedly denied claims that the restructuring of the NHS will cost between £2-3bn (*BMJ* 2010;341:c7262).

The £1.8 bn figure is detailed in the Spring Supplementary Estimates whereby all government departments seek parliamentary authority for increases to spending for the coming financial year.

A spokesman for the Department of Health said: "This doesn't alter how much we expect changes to the NHS to cost—this is expected to be a one-off cost of £1.4bn over the next two years, which will result in savings of £1.7bn each and every year in future. In five years alone, these changes are expected to save over £5bn."

He added: "However, it is standard accounting practice to set aside money in departments' annually managed expenditure and it does not mean we will definitely incur costs at this estimated level. This practice applies not just to health but to any government department."

The Department of Health said it had asked for an extra £2.5bn for 2011/12, which comprised £1.8bn for "redundancy and non-redundancy costs identified in the impact assessment," £150m for increased impairments resulting from market valuations, and £600m for increased payouts to those affected by contaminated blood.

Giving evidence to the Health and Social Care Bill committee, Sue Slipman, director of the Foundation Trust Network, whose members include foundation trusts and organisations preparing for foundation trust status, said: "One thing that could drive down quality is if you have price competition.

Giving evidence later in the afternoon, John Black, president of the Royal College of Surgeons, and Richard Thompson, president of the Royal College of Physicians, also expressed concern that introducing price competition would be harmful and would drive down quality.

Mr Black said, "I think a provider should only be allowed to compete if it can provide a comprehensive quality service. That provider should also provide training, research, audit, outcome measures, and the ability to deal with emergencies arising from the particular condition treated."

For the latest information visit the *BMJ* NHS reforms microsite at bmj.com/nhsreforms.

Cite this as: *BMJ* 2011;342:d996

The ombudsman received 1620 complaints about the care of elderly people in 2010, 18% of the total

VETTA/GETTY IMAGES

"Harrowing accounts" show NHS is failing elderly patients

Zosia Kmietowicz LONDON

Ten investigations into complaints about NHS care of elderly people in England have found that pain control, discharge arrangements, communication with patients and their relatives, and nutrition are often highly inadequate.

The health service ombudsman, Ann Abraham, says that her report shows the gulf between the principles and values of the NHS Constitution and the reality of being an older person in the care of the NHS in England. The 10 patients whose cases were looked into endured unnecessary pain, indignity, and distress while in the care of the NHS, she said.

The ombudsman, who deals with complaints against the NHS that cannot be resolved by individual trusts, carried out the 10 investigations that took place in 2009 and 2010. Nine of the 10 patients died during or shortly after the experiences investigated.

The report says of the patients, "Poor care or badly managed medication contributed to their deteriorating health, as they were transformed from alert and able individuals to people who were dehydrated, malnourished or unable to communicate."

One relative told the investigation, "Our dad was not treated as a capable man in ill health but as someone whom staff could not have cared less whether he lived or died."

Ms Abraham says in the report, "The findings of my investigations reveal an attitude—both personal and institutional—which fails to recognise the humanity and individuality of the people concerned and to respond to them with sensitivity, compassion and professionalism. The reasonable expectation that an older person or their family may have of dignified, pain-free end of life care, in clean surroundings in hospital, is not being fulfilled. Instead, these accounts present a picture of NHS provision that is failing to meet even the most basic standards of care."

Care services minister Paul Burstow said: "This report exposes the urgent need to update our NHS. We need a culture where poor practice is challenged and quality is the watchword. The dignity of frail older people should never be sidelined."

He said nurses would be carrying out new spot checks to root out poor practice in the care of older people and ensure patients are treated with dignity.

The 10 investigations are not isolated cases, says the report. Of the nearly 9000 complaints to the ombudsman about the NHS last year 18% concerned the care of elderly people. Altogether the office accepted for investigation 226 cases

Marmot warns that cuts will damage child development

Zosia Kmietowicz LONDON

The public health expert Michael Marmot has pleaded with the UK government not to do "anything that will make things worse" in terms of health inequalities.

Professor Marmot said he welcomed the government's white paper on public health, *Healthy Lives, Healthy People*, which puts the responsibility for public health in England in the hands of local authorities (*BMJ* 2010;341:c6938), but he admitted that he had "great difficulty" talking about the fact that only 56% of children are rated as having achieved a good level of development by the age of 5 years.

Professor Marmot was speaking at the launch of new charts designed to track the effect of government policies on health inequalities. The charts were put together by the London Health Observatory at the request of the Marmot review team.

They show that the boroughs of Solihull and Richmond upon Thames had the highest percentage of children achieving a good level of development at age 5, but this was still only 69%. The worst performing authority was Haringey, where only 42% of 5 years olds were ready for school.

Professor Marmot's review on tackling health inequalities in England over the next decade, published last February, made six key recommendations, the most important of which was focusing on early child development to enable better progress at school and ultimately give people better control of their lives (*BMJ* 2010;340:c818).

He said he was not happy about cuts to the Book Start programme, which gives free books to preschool children, and to Sure Start children's centres, which provide support to parents. Reading to young children every day can reverse half the deficit in readiness for school, he said.

"There is no question that cuts to services will make things more challenging. The government says it is urgent to cut the deficit. But as you cut it look at the likely impact on the fair distribution of health," urged Professor Marmot. "Please make sure there is investment in the early childhood agenda."

The charts show key indicators for monitoring health inequalities for all 150 "upper tier" local authorities in England. They provide authorities and the government with a baseline measure of health, and they would need to be carefully monitored to show that effect of policies, said Professor Marmot.

Bobbie Jacobson, director of the observatory, said that the decision as to whether the charts would be compiled next year had not yet been taken as the white paper was under consultation until the end of March.

The difference in average life expectancy at birth between people living in the healthiest local authorities in England and those in the least healthy is 11 years for men and 10 years for women, show the new charts.

The charts can be seen at www.marmotreview.org.

Cite this as: *BMJ* 2011;342:d971

CHRISTOPHER FURLONG-POOL/GETTY IMAGES

concerning elderly people, more than twice as many as for all the other age groups put together.

One of the investigations looked at the care of Mr D, who had advanced stomach cancer and wanted to die at home. When his daughter arrived to collect him from Royal Bolton Hospital she found him sitting behind a closed curtain in distress. He had been left for several hours, was in pain, and was desperate to go to the toilet but was unable to ask for help because he was so dehydrated that he couldn't speak or swallow. The emergency button had been placed out of his reach, and his drip feed had been removed and had fallen and had leaked all over the floor. With Mr D at home the family discovered that he had not been given the right pain relief and had spent the weekend driving around trying to obtain the correct treatment before he died.

The ombudsman concluded: "These often harrowing accounts should cause every member of NHS staff who reads this report to pause and ask themselves if any of their patients could suffer in the same way. I know from my caseload that in many cases the answer must be 'yes.' The NHS must close the gap between the promise of care and compassion outlined in its Constitution and the injustice that many older people experience. Every member of staff, no matter what their job, has a role to play in making the commitments of the Constitution a felt reality for patients."

Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people **is available at ombudsman.org.uk/care-and-compassion/downloads.**

Cite this as: *BMJ* 2011;342:d1064

Gordon Brown launched 3000 Sure Start centres across the UK in 2009. Cuts to such services will worsen inequalities, said Michael Marmot

Neuroscience is to lose government funds of £4m a year

Geoff Watts LONDON

More than 80 leading neuroscience researchers have written to the Biotechnology and Biological Sciences Research Council, the United Kingdom's main funding agency for research in the non-clinical life sciences, to protest about its recently announced plans for the future distribution of research grants.

The researchers say that the plans are "aimed at reducing the strength of an area of research in which the UK excels, simply because it is too successful."

The council's announcement on 24 January concerned proposed changes in its grants procedures. The council said, "In the case of neuroscience [it had] reluctantly concluded that demand-led funding is resulting in too great a proportion of funding going to that one area, and we are seeking to focus our investment in the areas most relevant to our strategic priorities."

The priorities listed in the council's strategic plan include food security, bio-energy, industrial biotechnology, and the basic biosciences that underpin health and wellbeing.

The 80 scientists say in their letter, which was coordinated by the British Neuroscience Association, that they cannot understand why the council "should conclude that success in open competition for BBSRC [the council] funds should be a reason to withdraw support." They add, "Surely that success is an indication of the quality of neuroscience research in the UK."

On questioning the council about the likely effect of the new policy the British Neuroscience Association was told that some 13% of expenditure currently goes to support neuroscience. This is predicted to fall by about a fifth.

Speaking at a press briefing called to publicise the letter, Colin Blakemore, a former head of the UK Medical Research Council, said that this might mean a loss of about £4m (€4.7m; $6.4m) a year in cash terms, equivalent to the running costs of some 30 research groups. He described the council's proposals as "a desperate measure to try to balance the books."

Another of the speakers, David Nutt, of Imperial College London, offered a reminder that neuroscience in Britain is already under threat through the withdrawal from the country of some drug companies. The most recent blow was Pfizer's decision to close its operations at Sandwich, Kent (*BMJ* 2011;342:d771).

The council's announcement is at www.bbsrc.ac.uk/news/policy/2011/.

Cite this as: *BMJ* 2011;342:d975

GMC allows Baby P doctor to remove herself from register

Clare Dyer BMJ

The paediatrician accused of missing Baby P's broken back two days before he was found dead has been allowed to avoid a public misconduct hearing by removing herself voluntarily from the UK medical register.

A General Medical Council fitness to practise panel accepted that Sabah Al-Zayyat was too ill to attend a hearing, that her absence was "genuine and involuntary," and that in the "exceptional" circumstances of the case she should be permitted to take her name off the register.

Dr Al-Zayyat was working as a locum consultant paediatrician at the child development clinic at St Ann's Hospital in north London in 2007 when she saw Baby P, later named as Peter Connelly, two days before he died at the hands of his mother, her boyfriend, and the boyfriend's brother. But the doctor allegedly failed to carry out a full investigation because the 17 month old toddler was, she said, "miserable and cranky."

Sabah Al-Zayyat: "I failed the child and let my patient down"

She left the United Kingdom for Saudi Arabia just before the hearing into her case was due to start, saying that she was suicidal and unable to attend. She applied for voluntary erasure, but the original fitness to practise panel ruled against her. The panel concluded that her absence was voluntary and cited the public interest in investigating the serious allegations against her in a public hearing.

She won a judicial review of that decision in the High Court, and the judge ordered the GMC to rehear her application before a fresh panel (*BMJ* 2010;341:c6856).

The new panel heard that Dr Al-Zayyat had not practised medicine for three years and no longer wished to practise. A psychiatrist said that "the chances of her presenting herself for a job or being able to contemplate paediatrics or being able to contemplate any kind of work like that are vanishingly slim."

The panel quoted a letter in which Dr Al-Zayyat wrote, "I am deeply sorry from the bottom of my heart [for] the tragic death of P . . . His death will be with me till the last day of my life. I am extremely sorry with regret as I failed the child and let my patient down. I fell below the standard expected of me on the day."

Cite this as: *BMJ* 2011;342:d1015

Public is unwilling to use defibrillators, Dutch study finds

Janice Hopkins Tanne NEW YORK

Immediate defibrillation of people with cardiac arrest can save lives, but less than half the people passing through Amsterdam Central Station were willing to use publicly available automated external defibrillators, finds a new study.

The authors call for public education, because effective defibrillation requires fast action by the public, and knowledge is lacking. "Bystanders first of all need to have defibrillation in mind," they write. In the United States and most of Europe (not, for instance, in France) lay people can use defibrillators without legal liability.

The researchers, from the Department of Anaesthesiology at VU University Medical Centre in Amsterdam surveyed 1018 people at the city's central railway station: 978 visitors or travellers and 45 station and railroad staff (*Annals of Emergency Medicine* 2011, doi:10.1016/j.annemergmed.2010.12.016).

People interviewed at the station said that they were reluctant to use the defibrillators because they didn't know how the devices worked, they were afraid of harming the victim, and they feared legal consequences.

The Amsterdam station has five defibrillators. Use by laypeople is efficient and safe, the authors say.

Two interviewers, each fluent in Dutch and English, interviewed travellers passing within 3 m of two specific defibrillators in the station.

In one questionnaire people were asked what should be done if a person is lying on the floor, not breathing, and seems to have had a cardiac arrest. Only 6% spontaneously mentioned defibrillation or using a defibrillator.

In the other questionnaire the interviewer pointed to the defibrillator and asked whether the person knew what it was and what it was used for. About half (47%) correctly identified the device, and 53% knew what it was used for.

Only 47% were willing to use a defibrillator.

Cite this as: *BMJ* 2011;342:d1033

LOTHAR SCHWARTE

Defibrillators have diagrams to show where to place electrodes, and use audio and visual prompts

Defensive medical practices consume 35% of orthopaedic imaging costs

Bob Roehr WASHINGTON, DC

A third of all money spent on imaging in orthopaedics in the US is used to avoid accusations of medical negligence or malpractice, a study has found.

Although the number of defensive imaging procedures was smaller (19.7%), they tended to be more expensive magnetic resonance images. Defensive magnetic resonance images constituted 84.6% of defensive costs and 29.5% of total costs.

John Flynn, senior author of the paper and associate chief of orthopaedic surgery at Children's Hospital of Philadelphia, told the *BMJ* that surgeons who have been sued within the past five years and those who have practised at least 15 years were more likely to order defensive tests. The study was presented at the annual meeting of the American Academy of Orthopaedic Surgeons in San Diego.

Previous studies have shown that as many as 90% of doctors practise defensive medicine but they have been retrospective in their approach, either charting reviews or asking doctors to recall their motivation after the fact. Dr Flynn said, "We were trying to get into the heads of these doctors as they were actually ordering these tests."

He mailed instructions and a data sheet to all 640 members of the Pennsylvania Orthopaedic Society and asked them to record imaging orders for one day as they were being filed, noting the modality, the body part imaged, and their

Galicia faces fight to keep generics law set to save €93m a year

Aser García Rada MADRID

The Spanish government and a drug industry group have brought legal proceedings against the regional government in Galicia, which in December approved a law to limit prescribing of branded drugs. The new law could save the region €93m (£78m; $125m) each year, the regional government says.

The new law in the autonomous region of Galicia, which has a population of around 2.8 million, has been in force since January. It restricts the prescription of 427 branded drugs that contain 34 active ingredients, forcing doctors to prescribe the generic versions instead.

Doctors in Galicia write 250 000 prescriptions every day, about 40 000 of which are for drugs included in the banned list. The head of the regional health department in Galicia, Pilar Farjas, of the conservative Popular Party, said that the law aims to reduce the region's drug bill by €300 000 a day. "Part of the profits of multinational pharmaceutical companies" will be "reinvested in the pocket of the Galician" for public health activities, she said.

The measure is already resulting in savings. The region's drug bill for January fell by €6.5m from the previous month and was €9.2m less than the bill in December 2009. And savings could get larger. The law was not enforced until 17 January, to allow pharmacies to stock up on generic drugs, said Ms Farjas. If the savings gained so far were extrapolated to a full year

XULIO VILLARINO/GETTY

Doctors in Galicia write 250 000 prescriptions a day: the scheme saved €6.5m in January

they would yield more than €93m, she added.

However, the scheme has not been universally welcomed. The national cabinet has submitted an appeal to the Constitutional Court arguing that the scheme is unconstitutional because it discriminates against Galician patients and "breaches equality in access to pharmaceutical services." It says that the Galician law violates state powers, because according to Spanish law only the national government can decide which drugs are included on the health service tariff.

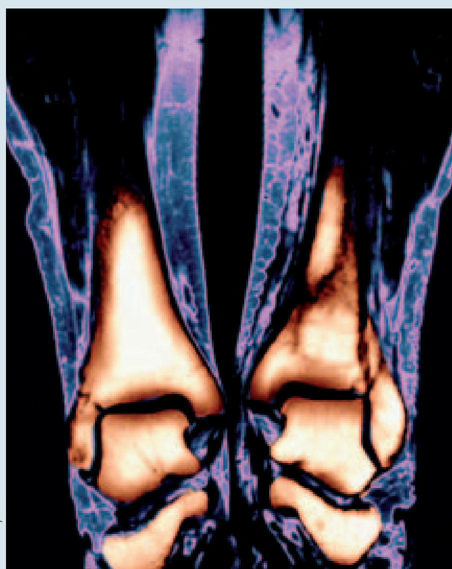
Farmaindustria, the national association of pharmaceutical industry companies, has also brought an action—this time before the High Court of Justice of Galicia—asking for the scheme to be suspended until the appeal is resolved.

Ms Farjas said the scheme is "a double exercise in efficiency" because it "keeps Galicians' health coverage intact" and saves money.

"We hope the central government extends the scheme to all autonomous communities, because we are talking about saving hundreds of millions [of euros] in Spain in a month and thousands of millions a year," she said.

Other regions are planning similar restrictions. However, the Spanish Society of Primary Care Physicians is opposed to regional policies because they limit accessibility to drugs, its president, Julio Zarco, told the *BMJ*.

Cite this as: *BMJ* 2011;342:d1036



ZEPHYR/SPL

$113 369 for defensive imaging on "one day in one state. . . is an awful lot of money," said John Flynn

judgment as to whether the test "was required for clinical care" or "ordered for defensive reasons." The data sheets were returned in an anonymous and blinded manner.

After a year of follow-up efforts the research team secured and analysed 2088 valid responses from 72 orthopaedists; 396 orders (19.0%) were considered defensive in nature.

The overall cost of imaging was $325 309 (£202 400; €240 700); 34.8% or $113 369 was labelled defensive. Magnetic resonance images (192; 48.7%) were the largest defensive order, accounting for 84.6% of total defensive costs or 29.5% of overall costs.

"The one that really surprised me was that orthopaedic surgeons who have been practising over 15 years were statistically more likely to practise defensive medicine," Dr Flynn said. "You would think that over time doctors would become more comfortable and confident with their diagnostic skills" and be less likely to practise defensive medicine. "Maybe it speaks to the environment in which they are practising, which is surprising and concerning," he said, referring to the rising cost of malpractice insurance and liability lawsuits.

Dr Flynn said the survey response rate of 11% was decent for this type of research. The responses were broadly representative of the rural and urban and specialties distributions within Pennsylvania, and the state is broadly representative of the country as a whole. But he is hesitant to extend the findings beyond the study population.

"The reason we went to the trouble of doing this study over more than a year is that we were trying to attach a real dollar figure to this. We are trying to get rid of waste in healthcare and this money is being spent because people are concerned about lawsuits," he said.

Cite this as: *BMJ* 2011;342:d1037

Short or long sleeves make no difference to bacterial contamination of doctors' wrists

Susan Mayor LONDON

Doctors wearing long sleeved outfits have no greater risk of bacterial contamination around their wrists than those wearing short sleeves, according to a study of doctors working in a US hospital. The findings question NHS guidelines requiring doctors to be "bare below the elbows."

The study randomly allocated 50 doctors working at Denver Health—a university hospital in Colorado—to wear freshly laundered, short sleeved uniforms and a further 50 to wear their own long sleeved white coats, which were infrequently laundered. Cultures were taken from the doctors' wrists, cuffs, and pockets at the end of an eight hour day working in internal medicine departments.

Results showed no significant difference in bacterial or in meticillin resistant *Staphylococcus aureus* (MRSA) contamination between doctors in the short sleeved uniform and those in long sleaved coats (*J Hosp Med* 2011, doi:10.1002.jhm864). The median number of colonies cultured from long sleeved white coats was 104 (95% CI 80 to 127), compared with 142 (83 to 213) from short sleeved uniforms (P=0.61), and the number at the cuffs was 58.5 (48 to 66) versus 37 (27 to 68), respectively (P=0.07).

There was also no difference in bacterial contamination of the skin at the wrists of doctors wearing the two types of garment (colony count of 23.5 (17 to 40) with white coats *v* 40.5 (28 to 59) with short sleeves; P=0.09).

"We were surprised to find no statistical difference in contamination between the short and long sleeved workwear," said Marisha Burden, interim chief of hospital medicine at Denver Health and lead author of the study.

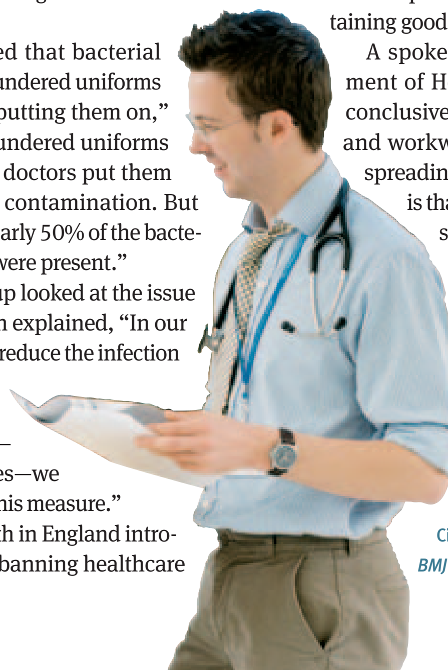
"The important findings of this study are that, contrary to our hypotheses, there were no differences in the extent of bacterial or MRSA contamination of long sleeved, infrequently washed white coats compared with short sleeved, newly laundered uniforms," she said. "And there was no difference in the extent of contamination of the wrists of physicians wearing either of the two garments."

"The study also showed that bacterial contamination of newly laundered uniforms occurred within hours of putting them on," she added. "The newly laundered uniforms were nearly sterile before doctors put them on, showing no bacterial contamination. But after three hours of wear nearly 50% of the bacteria counted at eight hours were present."

Explaining why the group looked at the issue of sleeve length, Dr Burden explained, "In our hospital, we are working to reduce the infection rate, so we wanted to know if it was worth getting rid of doctors' white coats. But—despite the NHS guidelines—we could find no evidence for this measure."

The Department of Health in England introduced guidelines in 2007 banning healthcare workers from wearing white coats or other long sleeved garments as part of efforts to reduce nosocomial bacterial transmission. However, the department's report on the issue found no conclusive evidence that work clothes posed a risk of spreading infection to patients. Scotland has recently adopted a similar policy.

"Our data do not support discarding white coats for uniforms that are changed on a daily basis, or for requiring healthcare workers to avoid long sleeved garments," concluded Dr Burden, although she added that regular washing of work wear was important, together with maintaining good hand hygiene.



MARK THOMAS/SPL

A spokesperson for the Department of Health said: "There is no conclusive evidence that uniforms and workwear play a direct role in spreading infection. What is clear is that uniforms and workwear should not impede effective hand hygiene and should not unintentionally come into contact with patients during direct patient care activity. For this reason it is good practice to wear short sleeved clothing during direct patient care."

Cite this as: *BMJ* 2011;342:d1079

IN BRIEF

Cardiac imaging after heart attacks increases cancer risk: A Canadian cohort study of 82 861 patients has found that exposure to low dose ionising radiation from cardiac imaging and therapeutic procedures after acute myocardial infarction is associated with an increased risk of cancer (*CMAJ* 2011, doi: 10.1503/cmaj.100463). Even moderate levels of exposure were associated with an increased risk of cancer.

Research unit to investigate value of competition in the NHS: The independent research unit the Office of Health Economics (www.ohe.org) is setting up an expert commission on competition in the NHS to investigate for which healthcare services, and in which circumstances, competition is likely to be beneficial overall, and when it is likely to be harmful. It expects to complete its work during 2011 and will publish its report before the end of the year.

Ecstasy use does not reduce mental ability: Researchers from the US National Institute on Drug Abuse have found that ecstasy users showed no signs of cognitive impairment attributable to drug use (*Addiction* 2011; doi:10.1111/j.1360-0443.2010.03252.x). The $1.8m (£1.1m, €1.3m) study was set up to look at concerns that methods used in previous studies were flawed. The findings do not mean that ecstasy is risk free, said the author. Ecstasy is dangerous, can be harmful, is not medically supervised, and people can die from overdosing, he said.

Charity calls for more alcohol health workers in NHS: Rates of alcohol related hospital admissions will rise to 1.5 million per year by the end of this parliament, increasing NHS costs from £2.7bn (€3.2; $4.3) to £3.7bn a year if the government does not invest in alcohol services, says a report from Alcohol Concern. Putting alcohol health workers in every hospital, emergency unit, and GP practice will save the NHS £3 for every £1 spent, it says.

Former GP will not face new charges: Howard Martin, a former GP who admitted hastening the deaths of patients, will not face new charges, the Crown Prosecution Service said. He was cleared six years ago of killing three patients, but later told a newspaper he had helped two patients to die, "not because they wanted to die but because they had such dreadful suffering." Dr Martin, 76, was struck off by the General Medical Council last year.

Cite this as: *BMJ* 2011;342:d1001

A pneumococcal vaccine is launched in Africa to cut deaths

RICCARDO GANGALE/GAVI

A nurse gives a shot of the pneumococcal vaccine at the launch ceremony in Nairobi, Kenya

Peter Moszynski LONDON

A newly developed vaccine against pneumococcal disease has been launched in Kenya, marking the global roll out of vaccinations targeting the world's biggest child killer, pneumonia.

"Today's introduction of the pneumococcal vaccine in Kenya is an historic step towards improved health for children in Kenya and in other developing countries," said Kenya's health minister, Beth Mugo. "The global introduction of pneumococcal vaccination is a milestone in global health."

The pneumococcal conjugate vaccine has been specially tailored to meet the needs of children in developing countries with support from the Global Alliance for Vaccines and Immunisation (GAVI), which has committed itself to introducing the vaccines in 19 developing countries within a year. It hopes to extend coverage to more than 40 countries by 2015.

Pneumococcal disease currently causes over a million fatalities a year—including over 500 000 children under five. Pneumonia, the most common form of serious pneumococcal disease, accounts for 18% of child deaths in developing countries, making it the leading cause of death among young children, followed closely by diarrhoeal diseases.

The vaccine's introduction in the developing world has been made possible through an innovative finance mechanism called the Advance Market Commitment (AMC). With $1.5bn (£0.9bn; €1.1bn) from Italy, the United Kingdom, Canada, Russia, Norway, and the Bill & Melinda Gates Foundation, and a commitment of $1.3bn from GAVI, the Advance Market Commitment allowed the acceleration of production capacity from the two manufacturers contracted so far.

The alliance says this secured the supply of pneumococcal vaccines "within a year following the introduction of those vaccines in Europe and in the US and at a fraction of the price charged in rich countries."

The Advance Market Commitment, however, has been criticised for relying on Western pharmaceutical manufacturers rather than developing country manufacturers that could produce the vaccines more cheaply.

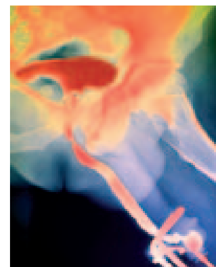
More information is at www.gavialliance.org.

Cite this as: *BMJ* 2011;342:d1075

Researchers move closer to predicting aggressiveness of prostate cancer

Susan Mayor LONDON

Researchers have identified a genetic pattern that predicts the likelihood that prostate cancer will recur. The study, published in *Lancet Oncology* (doi:10.1016/S1470-2045(10)70295-3) found that men with the highest levels of expression of a set of 31 genes associated with cell cycle progression (CCP genes) were three times as likely to have recurrent prostate cancer as those with the lowest levels.



ZEPHYR/SPL

CCP score could help to decide which prostate cancers need treating

Jack Cuzick, professor of epidemiology at Queen Mary, University of London, and the study's lead author, said, "Our findings have great potential. CCP genes are expressed at higher levels in actively growing cells, so we could be indirectly measuring the growth rate and inherent aggressiveness of the tumour through our test.

He added, "We already know that CCP levels can predict survival for breast and, more recently, brain and lung cancers. It's really encouraging that this could also be applied to prostate cancer, where we desperately need a way to predict how aggressive the disease will be."

The natural history of prostate cancer is highly variable and currently difficult to predict. Some men have indolent disease for which a "wait and watch" approach can be taken, without immediate treatment, whereas others have aggressive cancer that needs urgent and intensive treatment. Accurately differentiating between the two is difficult, despite use of

Nations with endemic malaria are urged to scrap taxes and tariffs on drugs, tests, and nets

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Antimalaria advocacy groups have renewed calls for an end to taxes and tariffs on vital products used to fight the disease, including drugs, insecticide treated bed nets, and rapid diagnostic tests.

Awa Marie Coll-Seck, executive director of the Roll Back Malaria Partnership, welcomed all initiatives to make these products affordable and accessible. Eliminating the tariffs—which in some countries add 40% to 50% to the price of antimalarial products, would help slash costs and make them affordable and accessible to poor people, experts say.

Data collected by the Malaria Taxes and Tariffs Advocacy Project (M-TAP), a two year evidence gathering and policy advocacy initiative funded by the Bill & Melinda Gates Foundation, show that just six countries—Guinea, Kenya, Mauritius, Papua New Guinea, Tanzania, and Uganda—have acted to remove all tariffs on antimalarial commodities in the decade since the Abuja declaration in 2001 identified import tariffs and domestic taxes as a major barrier to access.

CRISPIN HUGHES/HUTCHISON ARCHIVE/EYE UBIQUITOUS/ALAMY

A nurse treats a child for malaria in Kenya, one of only six countries to have scrapped tariffs since 2001

Eighteen countries where malaria is endemic currently maintain tariffs on all five categories of antimalarial commodities reviewed by M-TAP, and 24 countries maintain tariffs on three or more categories. The categories are bed nets (whether untreated, insecticide treated, or long lasting insecticidal nets); antimalarial drugs; rapid diagnostic test kits; insecticides for indoor residual spraying; and pumps for indoor spraying. Within categories countries may impose taxes and tariffs on some types of product but not others.

Of the 47 African nations for which M-TAP has collected tariff data 29 have removed all import duties on antimalarial drugs, 23 have removed them on rapid diagnostic tests, 20 have removed them on long lasting insecticidal nets, 16 have removed them on compression spray pumps for indoor residual spraying, and 15 have removed all tariffs on insecticides for indoor spraying.

Detailed information on the current status of tariffs in 76 countries is available at www.m-tap.org.

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tumour stage and measuring prostate specific antigen (PSA) concentrations.

The study measured CCP levels in two groups of men with prostate cancer: 366 US patients who had undergone surgery to remove the prostate and 337 UK men with cancer that was not judged to require immediate treatment.

Tissue samples were taken from the prostate during surgery or from biopsy samples used to diagnose the disease. Samples were then tested for levels of 31 different genes involved in cell cycle progression. Levels were expressed as a CCP score in which a one unit change in the score corresponded to a doubling in the level of gene expression.

In men who had undergone radical prostatectomy a high CCP score was predictive of recurrence of prostate cancer as determined by PSA concentrations, with nearly a doubling of risk for a doubling of gene expression (hazard ratio 1.9 (95% confidence interval 1.5 to 2.3)). The CCP score was also predictive of death after disease progression (hazard ratio 3 (1.7 to 5.3)).

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Germany plans law to limit hospital rooms to two beds or offer a discount

Annette Tuffs HEIDELBERG

German patients who have to share a hospital room with more than one other patient should be offered a discount as a way to improve the quality of care, an MP has suggested in a new draft bill.

Jens Spahn, a health spokesman for the Christian Democrats, the major partner in Germany's ruling coalition, also proposes that the law on the quality of care should include a target maximum waiting time of three weeks to see a GP or a non-hospital specialist and that health insurance companies should be involved in managing doctors' appointments.

Currently patients have to pay €10 (£8.4; $13.5) a day out of their own pocket for a hospital bed; the remaining costs are covered by the state health insurance companies.

Rooms with more than two beds don't help to improve recovery, for psychological and hygiene reasons, said Mr Spahn. His ideas are supported by the federal health minister, Philipp Rösler, of the liberal Free Democrat Party, the other main party in the ruling coalition. He said that two bedded rooms should become the standard.

But doctors and hospitals opposed the ideas as unrealistic and not in the interests of patients. Georg Baum, spokesman for the German Hospital Society, said that a third of all hospital beds in Germany would have to be closed if rooms with more than two beds were no longer allowed.

The opposition Social Democrats welcomed the two bedded room policy and presented their own controversial draft of a law to improve patient care. Under their proposals GPs and non-hospital specialists with practices would be fined up to €25 000 if their patients have to wait for more than five working days for an appointment.

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