

UK NEWS UK should rethink use of Tamiflu while disease is still mild, GP leader says, p 1522

WORLD NEWS Ireland's plan to start colorectal cancer screening will not get government funds, p 1522

bmj.com Three quarters of German intensive care doctors admit to rationing treatment

Angioplasties after myocardial infarction increase in England

Jacqui Wise LONDON

By the end of the year use of primary angioplasty to treat myocardial infarction (MI) will exceed that of thrombolytic treatment for the first time in England, says the eighth report of the myocardial ischaemia national audit project (MINAP).

In October 2008 the Department of Health recommended that primary angioplasty should take over from thrombolytic drugs as first line treatment for myocardial infarction (*BMJ* 2008;337:a2185). The aim is for coverage of 97% of patients by 2011. Primary angioplasty is associated with less mortality and has better longer term outcomes than thrombolysis, provided that the procedure is carried out within three hours of the onset of symptoms.

MINAP collected data from all hospitals and ambulance services in England and Wales that provide care for patients with a suspected heart attack. It found that in England 7351 patients were treated with primary angioplasty in 2008-9, representing 47% of all those receiving treatment (up from 27% in 2007-8). In Wales, 118 patients were treated with primary angioplasty in 2008-9, up from 42 in 2007-8.

Roger Boyle, England's clinical director for heart disease and stroke, said, "Primary angioplasty is the international gold standard of heart attack treatment. We expect still higher numbers of heart attack patients to be treated with primary angioplasty as the NHS continues the roll-out of specialist services this year."

Primary angioplasty is carried out in a catheter laboratory, and ideally the service should be available 24 hours a day, seven days a week and should comprise a cardiologist, nurses, and cardiac technicians, with access to advanced radiological facilities. Only larger hospitals are able to provide this.

The report found that three of 28 English cardiac networks and one of the three Welsh cardiac networks still have very restricted access to primary angioplasty services.

The MINAP report is at www.rcplondon.ac.uk.

Cite this as: *BMJ* 2009;338:b2557



Out of 60 000 safety incidents among children in 2007-8 nearly one in five (17%) were drug related

Watchdog warns of high drug dosage errors among children

Adrian O'Dowd LONDON

Clinicians must improve safety when treating children and young people to avoid what have been high rates of dosage errors, according to the UK patient safety watchdog. The National Patient Safety Agency (NPSA) has raised concerns in a report that outlines ways to improve patient safety in this age group.

As part of its review the agency looked at incidents that occurred between October 2007 and September 2008. It used information from the 910 089 patient safety incidents that had been reported over a year; 60 000 of those incidents involved children.

It also studied direct feedback from children, young people, and their families, and it reviewed studies and policy documents and evidence from doctors, nurses, and professional groups.

A key finding of the report was that there was a high rate of dosing errors in giving drugs, particularly for children younger than 4. Drug incidents were the most commonly reported incident type for children (17%), followed by "treatment/procedure" (13%), and "patient accident" (11%).

The agency found that children under the age of 4 had the second highest percentage of drug incidents of all age groups, and only among people older than 75 were more drug incidents reported. Giving an incorrect dose or strength of drug was the highest reported type of drug incident for children and neonates.

Other findings from the report showed:

- Difficulties associated with recognising the severity of illness in children
- Under-reporting of patient safety incidents in primary care

• Lack of recognition and appropriate management of young people with mental health problems.

The agency has called on clinicians to use existing NPSA tools and to register for the Patient Safety First campaign in England, which was launched last year and aims to change NHS culture to a more safety conscious one, or the 1000 Lives Campaign in Wales, which aims to reduce risks to patients by implementing interventions developed by clinicians (*BMJ* 2009;338:b420).

The report also recommended that hospitals review their local standard operating procedures for drugs management and support training for all healthcare staff in recognising mental health issues in young people.

The report is at www.npsa.nhs.uk.

Cite this as: *BMJ* 2009;338:b2500

IN BRIEF

US continues to bar entry to people with HIV: Paul Thorn, a project director for the Tuberculosis Survival Project and a UK citizen, says he was denied a visa to speak at a conference in the United States because of his HIV status. Earlier in the month 60 Canadians were barred for the same reason when they sought to attend a conference on HIV.

Dutch complementary medicine practitioners must refer seriously ill patients: Dutch doctors who practise complementary medicine must refer patients with life threatening illnesses to mainstream care, after a court ruling on the complementary treatment of the actress Sylvia Millecam, who died from untreated breast cancer. Two doctors were found guilty of “deliberately prejudicing” her health care, resulting in “severe physical harm” (*BMJ* 2008;336:853).

Meat eaters have higher risk of some cancers: Vegetarians and people who eat fish but not meat may have a lower incidence of some cancers, concludes a study of 61 566 British men and women (*British Journal of Cancer* doi:10.1038/sj.bjc.6605098). The study, with an average follow-up of 12.2 years, found that (in comparison with meat eaters) vegetarians had a relative risk of stomach cancer of 0.4 (0.2 to 0.8), and of bladder cancer 0.5 (0.3 to 0.9). Among fish eaters the relative risk of ovarian cancer was 0.4 (0.2 to 0.8).

Device firm paid \$0.8m to surgical adviser: Medtronic, which makes bone graft devices, paid nearly \$0.8m (£0.5m; €0.6m) over the past three years to one of its advisers, a surgeon. The surgeon, Timothy Kuklo, who reported favourably on one of its devices, was accused by the US army of having fabricated the results of his study of the use of the device to treat blast injuries in soldiers in Iraq, which appeared in the *Journal of Bone and Joint Surgery* (*BMJ* 2009;338:b2026). The journal has retracted the article.

BMJ's impact factor doubles in eight years: The impact factor of the *BMJ* for 2008 was 12.83, more than twice the 2000 figure of 5.33. The impact factor, which is calculated by Thomson Reuters (taking over this role from the Institute for Scientific Information, now incorporated into Thomson Reuters), is a measure of how often a journal's “average article” is cited in a particular year.

Cite this as: *BMJ* 2009;338:b2543



Website captures people's experiences of clinical trials

Zosia Kmietowicz LONDON

The reasons why some people choose to take part in clinical trials and what they make of the experience have been captured on a new section of Healthtalkonline, the website run by the charity DIPEx (www.healthtalkonline.org).

Over 40 people from a wide range of backgrounds across the United Kingdom were interviewed and filmed for the new section, which can be found on the website under the heading “Medical research.” They talk about how they were approached about taking part in a trial; what information they needed; their feelings about being randomised; practical issues such as appointments, tests, and monitoring; and their feelings about the end of the trial. The interviews also include people who chose not to take part in or withdrew from a trial.

Commenting at the website's launch, David Weatherall, emeritus regius professor of medicine at the University of Oxford, said that professional staff who run clinical trials need to be trained so that they have a better understanding of what it's like to take part



Use words of one syllable when explaining trials, said one patient

and how best to provide information and care during and after the trial.

Louise Locock, deputy research director at DIPEx, who headed the project, said, “Clinical trials are a vital part of improving health care through the development of new treatments. This research provides much needed information on how people react to participation in trials, what their experiences of trials have been, and how they view the management of such

trials, including aftercare.

“The project also provides an online resource at Healthtalkonline for people considering participation in clinical trials to share in the experiences of others.”

In one of the interviews on the website Pam, aged 70, says, “We are very, very worried about our conditions. Please answer all our questions. Some of them may seem stupid to you, sometimes we may not take on board everything you say to us . . . You've got to give us confidence in the trial and explain it all in words of one syllable.”

Cite this as: *BMJ* 2009;338:b2545

UK should rethink use of Tamiflu while disease

Adrian O'Dowd LONDON

The United Kingdom may need to rethink its strategy on use of the antiviral drug oseltamivir (Tamiflu) to treat swine flu, a BMA official has said, as the UK's number of cases is rising faster than in most of the rest of the world.

The number of confirmed cases of A/H1N1 infection rose by 1021 between last Thursday and Monday to a total of 2773 (as the *BMJ* went to press), says the Health Protection Agency. This was the third biggest jump around the world, which now has 52 427 confirmed cases, the World Health Organization reported, including 231 deaths. In Mexico, where the first major outbreak occurred, no new cases were reported over the weekend.

GPs in the UK may now be starting to deal with the problem differently, said Peter Holden, the BMA's lead on pandemic flu and a negotiator for the association's General Practitioners Committee. “It is a major

problem,” Dr Holden said, “and it's something we are addressing at the moment.

“The HPA [Health Protection Agency] is now operating at capacity, and GPs are still trying to run normal services and deal with this. The best way to describe it is that the weather forecast for the UK is good, but in certain places there are tropical thunderstorms.

“It's becoming very labour intensive, and we feel quite strongly that this has got to be looked at. You don't want to overreact, but just because a given alert level hasn't been declared doesn't mean that some practices are not absolutely swamped.”

Dr Holden said the sheer number of possible cases meant a risk GPs might start prescribing Tamiflu over the phone rather than sending someone to swab the patient and test them before prescribing the drug. “That in itself has its own problems. That would be a very quick way of blowing your

UK sees rise in people donating a kidney to unknown recipients

Susan Mayor LONDON

The number of living donors who volunteer to donate a kidney to someone whom they do not know has increased by 50% in the past year, according to UK figures.

The Human Tissue Authority (HTA), the UK watchdog that licenses the storage and use of human tissue for treatment and research, reports that the number of people who were approved to donate a kidney to someone they do not know rose from 10 in 2007-8 to 15 in 2008-9.

“Although numbers are small, we found the increase in the number of altruistic donors interesting and unexpected,” said Vicki Chapman, director of policy and strategy with the Human Tissue Authority. “When the legislation was drafted, we were expecting very small numbers indeed. The rapid increase was surprising but shows there is a future for this type of donation.” She noted that most people who volunteer for altruistic kidney donation have personal experience of someone needing an organ donation or are aware of the need for donated organs through working in medicine.

The authority has enabled a more flexible approach to who can donate an organ to whom, since being established in 2006.



APHOTO/SPL

Since May 2007 there have been 22 altruistic kidney donor transplantations in the UK

This has enabled a growing number of people to benefit from a living donor transplant, including from recipients they have not met, termed non-directed altruistic donation. The first altruistic donor was approved in May 2007 and since then 22 altruistic donor transplantations have gone ahead.

Although most organs used in transplantation are donated from people who have died, the Human Tissue Authority approved 1023 living donations in 2008-9, compared with 971 in 2007-8. There were 6599 people

in the United Kingdom waiting for a kidney transplant on 12 June 2009.

The authority is responsible for approving all transplantations involving living people, after an independent assessment process. The process ensures that the donor and recipient are thoroughly assessed and understand what is involved in giving and receiving an organ and that the risks have been properly explained.

Peter Rowe, consultant nephrologist at Plymouth Hospitals NHS Trust, where three altruistic kidney transplantations have been performed, said, “It would have been difficult for a living person to donate an organ altruistically before the HTA code of practice was published, but now we have a robust regulatory framework to work to.”

The independent assessment process makes sure that the donor understands the risks involved, he explained, adding, “We only carry out this type of procedure if we are sure it is as safe as possible for the donor.”

In altruistic organ donation, the donor contacts their local transplant centre. If they are assessed as a suitable donor, their details are put forward into a national allocation scheme and matched to a suitable recipient. The donor and the recipient remain anonymous throughout the process.

Latest figures show that 6931 people were on the UK transplant list to receive a kidney. See www.hta.gov.uk.

Cite this as: *BMJ* 2009;338:b2503

is mild, GP leader says

supplies of Tamiflu—and how do you know the person is telling the truth? It’s a very real risk.

“Professional logic would dictate that it is probably time for a review of our Tamiflu strategy. It might be that we shouldn’t issue it while the flu is mild. The whole purpose of putting people on Tamiflu was to reduce the hospitalisation rate, and that isn’t a big issue at the moment.”

Only one person in the UK has died from the virus: a 38 year old woman who died in Paisley this month after giving birth prematurely (*BMJ* 2009;338:b2470, 16 Jun).

Nicola Sturgeon, Scotland’s health secretary, called on the Westminster government to pay the cost of providing everyone in Scotland with swine flu vaccinations when one becomes available. But Jim Murphy, the UK’s Scottish secretary, disagreed, saying Scotland did not need special treatment.

Cite this as: *BMJ* 2009;338:b2565

Doctor in Baby P case claims unfair dismissal

Clare Dyer *BMJ*

The paediatrician who was sacked after failing to spot that Baby P had a broken back and eight fractured ribs two days before he died has launched a claim of unfair dismissal against her former employers, Great Ormond Street Hospital for Children NHS Trust.

Sabah Al-Zayyat is taking her case to an employment tribunal, which has the power to award up to £66 200 (£79 000; \$109 000) if she succeeds in her claim.

The severely abused 17 month old boy, now known as Baby Peter, was taken to see Dr Al-Zayyat by his mother two days before he died in August 2007 (*BMJ* 2008;337:a2845). But although she noticed bruises she failed to carry out a full examination, because he was “miserable and cranky,” she said.



Dr Al-Zayyat could receive £66 000

Dr Al-Zayyat, 52, who qualified in Pakistan and worked in Saudi Arabia before coming to Britain, was employed by the Great Ormond Street trust on a rolling six month contract to provide paediatric services at St Ann’s Hospital in Tottenham, north London.

She is expected to argue that she was not told—as she should have been—that there were any

child protection concerns about the boy.

A spokesman for the trust confirmed that it had received notice of Dr Al-Zayyat’s legal action.

He added, “The trust will vigorously defend its position.”

Dr Al-Zayyat has been suspended from practice by the General Medical Council pending a possible fitness to practise hearing.

Cite this as: *BMJ* 2009;338:b2540

SOLO SYNDICATION

Obama asks AMA to support his healthcare reform package

Janice Hopkins Tanne NEW YORK

Addressing a meeting of the American Medical Association's policy making House of Delegates in Chicago on 15 June, President Barack Obama has asked for the association's support for his healthcare reform initiative.

The AMA, which represents about a quarter of doctors in the United States, expressed support and said it would evaluate all proposals for reform in the light of six principles: expanded coverage, improved quality, reform of government programmes, reduction of costs, greater focus on wellness and prevention, and reform of payment and delivery. An AMA spokeswoman said that the association was waiting to see what plans emerged from Congress.

In his speech President Obama said, "The status quo is unsustainable." He said that the US is spending about 50% more on health care per person than the next most costly nation, yet "the quality of our care is often lower, and we aren't any healthier." He added: "In fact, citizens in some countries that spend less than we do are actually living longer than we do."

The president called for reform of the US healthcare system and for healthcare insurance coverage to be provided for 46 million uninsured Americans. He also called for healthcare costs to be reduced and electronic medical records to be implemented. He asked doctors to return to being healers—the reason they entered the profession—not "bean counters" for insurance companies.

He called for changes in reimbursements to doctors, so that they are paid for the quality of care rather than the number of tests they do. And he said that medical students should be encouraged to go into primary care rather than specialties and that primary care doctors should be rewarded better.

President Obama also called for better quality medical information to be provided to doctors and patients. "Identifying what works is not about dictating what kind of care should be provided," he said. "It's about providing patients and doctors with the information they need to make the best medical decisions."

However, unlike the Clinton administra-

tion 16 years ago, which submitted a highly detailed programme that failed, President Obama has not spelt out a programme. He has left that to Congress. Several proposed bills are working their way through the legislative process. At least three approaches have been presented in the House of Representatives and the Senate. The plans will be argued over during the summer, and legislation will be proposed for a vote in the early autumn.

The suggestions call for all Americans to have healthcare insurance, for employers to be required to provide healthcare insurance or contribute to a fund to help people buy it, and for people who don't have insurance through their jobs to be able to buy it with the aid of subsidies or tax benefits. A controversial "public option" healthcare insurance plan would be offered as an alternative for people who can't get insurance through their jobs or buy it from a company.

The public option is a sticking point. Insurance companies complain that the proposals

would undercut them, leading people to choose the public plan and run healthcare insurance companies out of business. A CBS News and *New York Times* poll showed that 72% of Americans support a government sponsored healthcare plan that would compete with private insurance (www.nytimes.com, 20 Jun, "In poll, wide support for government-run health").

Existing publicly funded plans, such as Medicare for elderly people and Medicaid for poor people, spend far less on administration than private healthcare insurance plans do. Furthermore, public plans do not need to return profits to shareholders.

US doctors are worried that the proposed plans will cut their reimbursement rates and that the proposed organisation to evaluate best practices, along the lines of the UK National Institute for Health and Clinical Excellence, will dictate what they do. "Socialised medicine" and "rationing" are the terms commonly heard on conservative talk show programmes, together with "waiting lines." A video and transcript of President Obama's speech is available at www.ama-assn.org.

Cite this as: *BMJ* 2009;338:b2541



Obama told doctors to be healers not "bean counters"

German agency asks Pfizer to disclose all reboxetine data

Ned Stafford HAMBURG

An independent scientific institute that conducts healthcare research and evaluations mainly on behalf of Germany's public health insurance regulator has accused the drug giant Pfizer of "concealing" research data on its depression treatment reboxetine.

The Institute for Quality and Efficiency in Health Care, which is based in Cologne and known in Germany as IQWiG, contends that Pfizer has refused to provide a complete list of all published and unpublished trials of reboxetine, which was approved in 1997 in Germany and marketed by Pfizer as Edronax.

If the institute says it is unable to assess the benefit of the drug because of lack of data, it is likely that health insurance companies in Germany may refuse to reimburse its cost.

"Deception through concealment is no trivial offence," said the institute's director, Peter Sawicki. "By concealing study data, the manufacturer is depriving patients and doctors of the opportunity to make an informed decision on different therapy options."

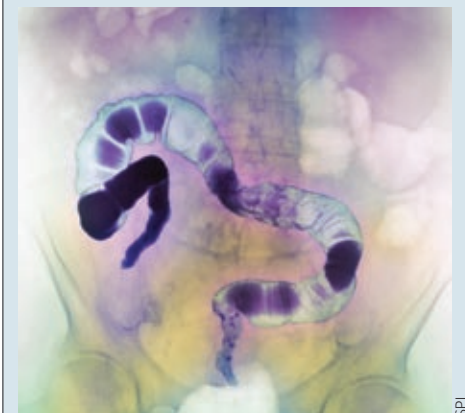
In a preliminary report issued on 10 June IQWiG ruled that reboxetine had "no proof of benefit." It said that reboxetine was tested on about 4600 patients, but the institute only had access to data on 1600 patients. "If the unpublished data are not included, there is a high risk of incorrectly estimating the benefit and harm of this agent," it said.

See Editorial, *BMJ* 2009;338:a3182.

For more information see www.iqwig.de.

Cite this as: *BMJ* 2009;338:b2521

Ireland's plan to start



Screening is expected to reduce deaths from colorectal cancer by a third in Ireland



PETER PARKS/AFP/GETTY IMAGES

Cyclists pass the national Olympic stadium in Beijing, a city noted for its high levels of pollution

Long term exposure to air pollution decreases life expectancy, report says

Susan Mayor LONDON

Long term exposure to air pollutants is associated with increased mortality, warns a major UK report published this week, which has also defined the most useful measure of air pollution in developing strategies to reduce adverse effects on health.

The new report follows up a 2001 review that looked at the long term effects of exposure to air pollutants on health, itself based on two major US studies. That review said that a causal relationship with mortality was “more likely than not” and that the studies’ findings were applicable in the UK.

Research in the field has progressed rapidly since its earlier review, so the Committee on

the Medical Effects of Air Pollutants—an expert committee that advises the UK government—decided it needed to review the latest evidence, including a European cohort study.

“We are left with little doubt that long-term exposure to air pollutants has an effect on mortality and thus decreases life expectancy,” the committee warns in its report, and it explains that the new evidence has strengthened the association, particularly with particulates.

After reviewing a first draft of the report Michael Krzyzanowski, regional adviser on air quality to the World Health Organization and health head of the European Centre for Environment and Health, Bonn, said, “The estimates of burden of disease, based on the

conclusions from this evidence, indicate very significant public health impacts and have important policy implications.”

The committee recommends $PM_{2.5}$ (the mass per cubic metre of particles passing through the inlet of a size selective sampler with a transmission efficiency of 50% at an aerodynamic diameter of 2.5 micrometres) as the best measure of particulate air pollution for quantitative assessment of the effects of interventions. Particles less than 2.5 micrometres in diameter are small enough to be deposited in the alveoli, particularly in high risk groups such as children and sick people.

The committee found that the relative risk of mortality from all causes rose by 6% with a 10 microgram per cubic metre increase in $PM_{2.5}$. With the same increase in particulate matter, the risk of cardiopulmonary mortality rose by 9% and of lung cancer mortality by 8%.

Evidence for the possible effects of long term exposure to the common air pollutant gases—sulphur dioxide, nitrogen dioxide, and ozone—was less clear than that for particulate air pollution.

“In none of these cases [gases] have we been persuaded that the evidence base is yet sufficiently strong to warrant quantification,” the committee reported. “The problem is one of inadequate evidence rather than evidence for there being no effects. Better evidence might well lead us to change our views in this area.”

The committee is now working on a further report looking at the effects of exposure to air pollutants on morbidity.

Long-Term Exposure to Air Pollution: Effect on Mortality (Final Report) is at www.advisorybodies.doh.gov.uk/comeap/finallongtermeffectsmort2009.htm.

Cite this as: *BMJ* 2009;338:b2532

colorectal cancer screening will not get extra government funding

Muiris Houston GALWAY

A national colorectal cancer screening programme for people in Ireland aged 55 to 74 years has been recommended by two expert reports published last week. However, the Irish health minister, Mary Harney, has failed to commit additional funding for the project, instead asking experts to come up with “innovative ways” of introducing the programme “within existing resources.”

The primary screening test recommended by experts from the National Cancer Screening Service

and the one found to be most cost effective by the Health Information and Quality Authority is the faecal immunochemical test, designed to detect blood in the stool. A test kit would be posted every two years to people eligible for screening.

The faecal immunochemical test is more selective for blood originating from the colon and rectum than the older faecal occult blood test. It does not require dietary and drug restrictions and is expected to reduce the number of false positive results.

Patricia Harrington, of the Health

Information and Quality Authority, predicted that the recommended programme “would result in a 14.7% reduction in the incidence and 36% reduction in mortality from colorectal cancer,” while the National Cancer Screening Service has said that an additional 11 000 colonoscopies would need to be carried out.

Although acknowledging that the United Kingdom and other countries use the faecal occult blood test, consultant gastroenterologist Colm O’Morain, of Trinity College Dublin, said he had no doubt that the faecal immunochemical test was better

because it offered greater specificity and sensitivity.

Ms Harney said that colorectal cancer killed more than 900 people in Ireland every year. She said, “The expert reports confirm that a properly organised screening programme would have huge public health benefits, and I want to find innovative ways of putting that in place.”

The report from the National Cancer Screening Service, *Recommendations for a Colorectal Screening Programme in Ireland*, is at www.cancerscreening.ie.

Cite this as: *BMJ* 2009;338:b2551

Fighting for women: a group of professionals will consider how to spot



At 71 some doctors might be thinking about retirement. Not so George Alberti, former president of the Royal College of Physicians and newly appointed champion on violence against women. **Geoff Watts** talks to him

Sir George Alberti: "Some people will say I'm a weird choice"

Geoff Watts LONDON

"A sort of Geordie lad," one longstanding colleague described him. "And a man who doesn't mince his words—occasionally to his disadvantage."

While it might be difficult to be on the receiving end of such straight talking, these qualities have served the Geordie George in question, Professor George Alberti, amply: he has held professorial chairs, led national and international bodies, been president of the Royal College of Physicians, and been crowned as a medical tsar. And, at 71, the long march continues with his recent appointment to lead a task force on violence against women.

Geordie lad he may be, but it's not exactly in the genes. The Albertis (not, as I'd wrongly assumed, a product of Italian ancestry) are

actually German Jewish by origin; the name, for reasons that remain obscure, was picked by a great grandmother. Nor was the choice of medicine a familial one. "It was the influence of our local GP when I was 6 and had decided that driving a dustbin van was not going to bring in a great deal of money, although it would be a lot of fun." The Royal Grammar School in Newcastle took Alberti to Oxford and thence to a career in diabetes medicine.

His first chair was in chemical pathology at Southampton, which is where Professor Desmond Johnston—now of Imperial College London but then a senior house officer in need of a research project—first met him. "A delightful colleague, very supportive to his staff," says Johnston. And, as a supervisor, attentive.

Alberti's main contribution to medicine, Johnston adds, was work that he'd been doing at Oxford shortly before the move to Southampton. This featured the use of low dose insulin in the treatment of ketoacidosis, an approach that remains substantially unaltered.

The year 1978 saw Alberti returning to Newcastle, first to take a chair in clinical biochemistry and later one in medicine. It was the last five years of his tenure in this second role that coincided with his period as president of the Royal College of Physicians. He took on the job hoping to make the college, among other things, more relevant to people living outside London.

"We improved its political influence with the government," says Alberti. "What I also hope we did was introduce more plain speaking rather than talking in southern [English] gentrified riddles."

But did he bring changes to the royal college? Johnston is not sure, pointing out that bodies of this kind have a huge inertia. Michael Rawlins, chairman of the National Institute for Health and Clinical Excellence and professor of clinical pharmacology at Newcastle when Alberti joined the university, said he did. "I think he shook it up. He was able to sweep out some of the cobwebs for Carol [Carol Black, successor to Alberti as president of the college] to continue the work."

Doctors call for the head of the World Medical Association to quit as a "matter of priority"

Zosia Kmiotowicz LONDON

More than 700 doctors from around the world have called for the Israeli president of the World Medical Association to step down, calling him "unfit for office" and claiming that he has turned a blind eye to the "institutionalised involvement of doctors" in torture in Israel.

In a letter they say that the appointment of Yoram Blachar, president of the Israeli Medical Association since 1995, as president of the World Medical Association last November is "a matter of grave concern." The signatories, who include professors and doctors from 43 countries, say that the appointment "makes a mockery of the principles on which the WMA was founded in 1947, which was a response to egregious abuses by Germany and Japan in World War Two."



Blachar: president of the WMA since November 2008

The letter, addressed to Edward Hill, chairman of the World Medical Association's council, and to the council body, was sent by the lead signatory, Alan Meyers, assistant professor of paediatrics at Boston University, on 21 May. It lists numerous reports that have highlighted the use of torture by doctors in Israel and occasions when the Israeli Medical Association has failed to respond to the charges. Professor Meyers had not received a response by the time the *BMJ* went to press on 23 June.

In 1996 a report from Amnesty International concluded that Israeli doctors working with security services "formed part of a system in which detainees are tortured, ill treated, and humiliated in ways that place prison medical practice in conflict with medical ethics." At the time Dr Blachar "took no action," says the letter. It adds that Dr Blachar had justi-

fied, in a letter to the *Lancet* in 1997, the use in Israel of "moderate physical pressure" (*Lancet* 1997;350:1247).

However, a World Medical Association spokesman said that this statement was not Dr Blachar's opinion but a reference to Israeli guidelines and that it has been widely misquoted. The spokesman said, "Dr Blachar did not then endorse the use of torture and has not done so since. Indeed he has repeatedly supported WMA policy statements and documents that condemn all use of torture, whether by physicians or others."

In correspondence in the *BMJ* Dr Blachar has several times denounced the use of torture by Israeli doctors. In 2003 he wrote, "I repeat, for the hundredth time, that the IMA [Israeli Medical Association] and I as its president oppose torture in any form" (*BMJ* 2003;327:1107).

Professor Meyers said that "moderate physical pressure" is how the Israeli

early signs of abuse

On relinquishing his presidency in 2002 Alberti was appointed national director for emergency access: a medical tsar. This was not entirely alien territory, because he'd been one of the coauthors of the NHS Plan, and while at the college he'd tried to repopularise acute medicine as a proper specialty.

"The intention was really to tackle the four hour waiting time," he says. "But it was rapidly obvious that this wasn't just an A&E [accident and emergency] issue. It was a problem right through from primary care to coming out of the hospital."

He thinks he's helped. "But no one makes more than a few millimetres of difference in this sort of megalithic system.

Alberti's latest venture into tackling the issue of violence against women and girls will try to find ways in which the NHS can offer practical help. The violence in question ranges from bullying in schools to genital mutilation. Alberti has already had some exposure to the problem through the number of women subjected to violence who end up in emergency departments.

"Some people, I'm sure, will say I'm a weird choice," he says. "But I have a certain amount of independence and no particular axe to grind on the subject."

Cite this as: *BMJ* 2009;338:b2468

government described its practice regarding Palestinian prisoners in its custody until September 1999, when the Israeli Supreme Court declared all forms of physical coercion to be illegal. "However, that has apparently not signalled an end to the abuse of prisoners," he said.

In 2007 a report by the Israeli human rights organisation B'Tselem into the interrogation methods used against 73 detainees claimed that the Israeli security forces "routinely included mental and physical ill treatment," Professor Meyers said.

He said, "The main aspects of the interrogation regime were severance of the detainee from the outside world, use of incarceration conditions as a means of psychological pressure and to physically weaken the detainee, binding the detainee in a painful position, degradation, and threats.

"Any physician who wilfully uses his or her professional skills to inflict suffering should be barred from medical practice by our profession, regardless of their criminal culpability."

Dr Blachar did not respond to a request from the *BMJ* for a response to the letter.

Cite this as: *BMJ* 2009;338:b2556

AIDS epidemic among young people in South Africa shows signs of slowing

Pat Sidley JOHANNESBURG

South Africa's AIDS epidemic, in which 5.2 million people are HIV positive, seems to be slowing, with indications that young people especially are changing their behaviour to reduce their risk of contracting the disease.

The prevalence of the disease in South Africans has remained fairly constant at about 10.6% of the population. However, findings of a national survey show that in children between the ages of 2 and 14 the prevalence of HIV has dropped from 5.6% to 2.5% between 2002 and 2008.

On receiving the report, the health minister, Aaron Motsoaledi, said with audible relief, "There is light at the end of the tunnel."

The latest data were collected by the Human Sciences Research Council, a state owned but independently run research organisation, in its third national population based survey. Previous surveys were conducted in 2002 and 2005.

The survey used household questionnaires and sampling methods to look at prevalence and behaviour that affects the risk of contracting HIV. It also sought to find out how much was understood about AIDS and prevention and what type of media (aside from news media) informed this. The current report focuses on teenagers and will be followed by other reports drawn from the data.

The survey found that in youths aged 15 to 24 the prevalence of HIV dropped from 10.3% in 2005 to 8.7% in 2008.

The proportion of young people in this age

group who reported using a condom in their last sexual encounter increased substantially, from 57% in 2002 to 87% in 2008 among men and from 46% to 73% among women.

The group at most risk of getting HIV was African women aged between 20 and 34, with 32.7% of this group found to be HIV positive. African men aged between 25 and 49 had an HIV prevalence of 23.7%.

In the 2005 survey, nearly one in five (18.5%) women aged 15 to 19 had partners more than five years older than themselves, exposing themselves to the greater risk

associated with the higher prevalence of HIV in men in this age group. This increased to 27.6% of 15-19 year old women in 2008.

The country's new president, Jacob Zuma, elected on 22 April, has already announced that several programmes related to fighting the AIDS epidemic would be intensified, including reaching more people with antiretroviral treatment and ensuring better prevention of the disease to halve the rate of new infections.

The period of the three surveys was marked by the then president Thabo Mbeki's denialist views, which doubted that HIV caused AIDS and was carried through to policy by the then health minister, Manto Tshabalala-Msimang. The findings in the survey tend to support the view that many people in the country formed misconceptions about the transmission of the virus.

The report is at www.hsrc.ac.za.

Cite this as: *BMJ* 2009;338:b2485



Awareness campaigns are thought to have contributed to the fall in HIV prevalence