Brazila and India clash with EU over seizure of generic drugs

John Zarocostas  GENEVA

Brazil and India clashed with the European Union in the World Trade Organization (WTO) last week because of the detention by Dutch customs authorities of a shipment of a generic drug.

The seizure has renewed concerns from poor nations that rich nations are resorting to harsh enforcement measures and hindering access to cheaper, life saving drugs.

“The decision to impede the transit of a cargo of generic medicines which was not headed for the Dutch market is unacceptable and sets a dangerous precedent,” said Roberto Azevedo, Brazil’s ambassador to the WTO, at a session of the agency’s ruling general council on 3 February. The action that triggered the latest showdown was the detention in December of a 500 kg shipment of losartan potassium, a generic version of the active ingredient for the brand drug Cozaar, developed by Merck and DuPont, which is used to treat hypertension.

Trade diplomats said that Merck is the patent holder under the name Merck, Sharp, and Dohme in the Netherlands. They said that the company filed a request for the shipment to be detained at Amsterdam’s Schiphol airport on 4 December so that they could inspect it for a possible violation of patent rights.

The generic consignment manufactured by the Indian company Dr Reddy’s was in transit and bound for Brazil to be used by the local drug maker EMS.

The drug at the centre of the controversy is not patent protected in Brazil or India.

Eckart Guth, the European Union’s ambassador to the WTO, said that the shipment was detained for 36 days in line with EU and WTO law. He added that the goods, which were not intended for the EU market, “were finally released by the authorities” to the Indian owner on 8 January.

But Ujal Singh Bhatia, India’s ambassador to the WTO, said that detention of this kind may affect trade in drugs and have a “deleterious effect on access to essential drugs.”

Cite this as: BMJ 2009;338:b558

Italian woman at centre of “right to die” case has died

Fabio Turone  MILAN

Eluana Englaro, the 38 year old Italian woman who has been in a persistent vegetative state for the past 17 years, died earlier this week just three days after artificial hydration and nutrition were withdrawn in accordance with a decision by a Milan court.

The case caused an unprecedented institutional conflict in Italy, after the president of the republic, Giorgio Napolitano, refused to sign an emergency decree unanimously approved by the government to prevent her death.

The centre right majority struggled to rush through a new law “to save the life of a woman who could even bear a child and who is in a vegetative state that could change,” the prime minister, Silvio Berlusconi, said in a press conference.

Currently patients in Italy have a right to refuse treatment, but there is no law about advance directives. However, despite the absence of clarity on such directives, a court in Milan gave Beppino Englaro permission to withdraw artificial hydration and nutrition from his daughter because of evidence from several witnesses stating that she had said she would not have wanted to live in a persistent vegetative state. This was the end of a long legal battle that had started in 2000 (BMJ 2008;337:a1893). The decision was strongly opposed by the Catholic hierarchy and by centre right parties, but their legal objections were rejected (BMJ 2008;337:a2099). In November the Supreme Court of Cassation confirmed Ms Englaro’s right to die (BMJ 2008;337:a2630).

The search for a hospital was difficult. Regional health authorities in Lombardy, where the woman was hospitalised, declared that they wouldn’t allow the procedure, and the first clinic that gave its consent later withdrew it after the Ministry of Health threatened to cancel its contract with the national health service (BMJ 2009;338:b323).

On 3 February Ms Englaro was transferred at night—amid demonstrations from prolife activists—to a hospital in the northeastern city of Udine, where many doctors and nurses had joined together to form a medical association to support Eluana’s right to die and to lessen the hospital’s legal risks.

Although the local police and inspectors sent by the health ministry investigated possible violations of the law, the medical team, led by Amato De Monte, head of the anaesthesiology unit at the Santa Maria della Misericordia hospital in Udine, started the gradual withdrawal of food and water.

“The artificial nutrition and hydration were completely withdrawn by Friday [6 February], while a mild sedation was administered, together with the usual nursing care,” said Carlo Alberto Defanti, the neurologist and bioethicist who had been Ms Englaro’s physician since 1994.

An autopsy is planned.

Cite this as: BMJ 2009;338:b574
Daschle nomination as US health tsar fails because of tax problems

Janice Hopkins Tanne  NEW YORK

The former Democratic Senator Tom Daschle withdrew his nomination as secretary of health and human services and as director of the new White House Office of Health Reform on 4 February after criticism of his late payment of income taxes and his industry ties.

The federal Department of Health and Human Services is a huge agency that accounts for about one quarter of federal spending.

President Barack Obama has promised to overhaul US health care and had planned a White House office to oversee it, but his plans are now likely to be delayed.

Mr Daschle was widely considered to be highly qualified for the two posts, and his withdrawal left President Obama and his team without a substitute candidate, although many names were mentioned in political gossip columns.

Mr Daschle is an expert on health care and the author of a book on health reform (Critical: What We Can Do About the Health-Care Crisis). He served in the House of Representatives and then the Senate for South Dakota from 1978 to 2004. He was appointed to the influential Senate finance committee and chosen as Democratic minority leader.

In the four years after Mr Daschle left the Senate he was reported to have earned $5m (£3.4m; €3.9m) from Alston and Bird, a law and lobbying firm; Intermedia Advisors, a private equity firm that provided him with a car and driver; and from speeches to groups with interests in the healthcare industry. Mr Daschle did not register as a lobbyist, but provided advice to companies in health care. He also worked at the Center for American Progress, a liberal research and policy institute, the New York Times reported (www.nytimes.com, 12 Dec 2008, “Daschle will lead health care overhaul”).

President Obama announced Mr Daschle’s appointment at a Chicago news conference in December. Mr Daschle knew how to move legislation through the approval process. Furthermore, he was a close associate of Mr Obama and an early supporter in his campaign for the presidency.

The president (then president elect) said that providing health care to more US residents while controlling its growing costs had to be included in the financial recovery programme. “It’s not something we can put off because we are in an emergency,” he added. “No child in America should be receiving her primary care in the emergency room in the middle of the night.”

The expanded programme will be paid for by an increase in the federal cigarette tax from $0.39 to $1.01 per pack.

President Obama said that the bill was “a critical first step” to covering uninsured children and towards providing healthcare insurance for all Americans.

Unlike the existing children’s health insurance programme, states can decide to allow the programme to cover legal immigrant children and legal immigrant pregnant women who have been in the country for less than five years. Previously they had to wait five years for coverage. The new programme will also allow states to provide dental care for children.

Republicans have objected to extending coverage to legal immigrant children, worried that illegal immigrants might get coverage. They are also concerned that families with higher incomes can get coverage for their children instead of buying private health insurance, saying it was a step towards government paid health plans and higher costs for taxpayers.

Cite this as: BMJ 2009;338:b498

Obama signs bill to insure four million more children in US

Janice Hopkins Tanne  NEW YORK

Earlier this week President Barack Obama signed the state children’s health insurance programme bill, to extend healthcare insurance to about four million US children.

Around 10 million children under the age of 18 years currently lack healthcare insurance.

The bill was passed quickly by both the House of Representatives and the Senate after President Obama took office. A commentary published in the New England Journal of Medicine (doi:10.1056/NEJMp0900461) said, “The rapid action underscored Democrats’ intention to reverse or amend many health policies put in place during the Bush administration.”

President George W Bush had twice vetoed previous versions of the bill, saying that it would encourage parents to drop private healthcare insurance and instead join the government programme. He also said it was a step towards socialised medicine (BMJ 2007;335:685, 2007;335:742, 2007;335:749).

The federal and state programme, begun in 1997, covers children whose parents earn too much to qualify for healthcare insurance for poor people provided under the Medicaid programme but not enough to pay for private insurance. Most states cover children whose parents earn up to 200% of the poverty level, currently set at about $35 200 (£24 000; €27 500) for a family of three.

President Obama said that by signing the bill “we fulfil one of the highest responsibilities we have: to ensure the health and wellbeing of our children.”

He said, “It is a responsibility that has only grown more urgent as our economic crisis has deepened, healthcare costs have exploded, and millions of working families are unable to afford health insurance.”

Parents faced “decisions no parent should ever have to make: how long to put off that doctor’s appointment, whether to fill that prescription, whether to let a child play outside, knowing that all it takes is one accident, one injury, to send your family into financial ruin,” he added. “No child in America should be receiving her primary care in the emergency room in the middle of the night.”

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Cite this as: BMJ 2009;338:b498
Tom Daschle speaks to the press after withdrawing his nomination

However, Mr Daschle had tax problems as well as connections with the healthcare industry. He quickly paid about $140 000 in taxes on the car and driver service provided by the equity firm, but withdrew his nomination.

Cite this as: BMJ 2009;338:b551

see OBSERVATIONS, p 382

Italian doctors can report illegal immigrants to police, new law says

**Fabio Turone MILAN**

A law that will allow health professionals to report to the authorities any patient whom they suspect of being an illegal immigrant has been proposed by the Italian centre right government led by Silvio Berlusconi.

Until now health professionals have been barred from reporting patients to the police, except in well defined cases in which evidence indicates a direct involvement in a crime.

But the “security package” approved last week by the Italian Senate, despite widespread criticism, overturns the previous ban, stating that doctors are free to report those they suspect may be living illegally in the country.

“It’s the end of professional confidentiality,” said Costas Moschoschoritis, director general of the charity Médecins Sans Frontières in Italy.

The measure was sponsored in particular by the Lega Nord (Northern League), whose representatives have led many xenophobic campaigns in recent years and who are now pushing to introduce a specific new law to punish those illegaly entering the country.

“I think the national health service must engage in opposing illegal immigration,” the undersecretary of health, Francesca Martini, told the press after the Senate vote. “This is my opinion, then the doctors will be free to decide for themselves.”

She added, “This will not weaken the mandate of the health service, as medical treatment will still be guaranteed for all.”

Many medical societies, trade unions, and other groups have protested against the new measure. “This rule goes against medical ethics and the basic principles of public health,” said Amedeo Bianco, president of the National Federation of the Medical Orders.

Giacomo Milillo, secretary of the National Federation of General Practitioners, had similar objections. “For fear of being denounced and expelled from the country, clandestine immigrants might prefer to stay away from hospitals and practices,” he said. This might increase the risk of outbreaks of infectious disease, he added.

After doctors made several calls to be allowed to register their conscientious objection to the law, the government made it clear that doctors would not be obliged to report suspected illegal immigrants but would simply be allowed to do so. Critics replied that this would make no difference, because even the possibility of being reported might deter many people from seeking care.

Gynaecologists and paediatricians were also worried about the health of women and children. “This will put children especially at risk,” the Italian Pediatrics Society said in a statement. It invited members not to report patients.

The presidents of the Italian Society of Gynaecology and Obstetrics and the Association of Hospital Gynaecologists and Obstetricians also took a strong position against the proposed law. “We will not denounce patients,” said Giorgio Vittori and Giovanni Monni in a joint statement.

Cite this as: BMJ 2009;338:b548

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**Israeli shells killed three daughters of Palestinian doctor**

**Judy Siegel-Itzkovich JERUSALEM**

The Israel Defense Forces has admitted that shells from one of its tanks unintentionally killed three daughters and a niece of the Palestinian gynaecologist Izzeldin Abuelaish, who was at home in the Gaza Strip on 16 January (BMJ 2009;338:b213).

Dr Abuelaish, who has worked for years conducting research at Israel’s Sheba Medical Centre and at Soroka University Medical Centre while continuing to live in Gaza, said on Israeli television that he accepted the findings of the investigation.

According to the report, which was approved by the military’s chief of general staff and head of the southern command, two tank shells hit Dr Abuelaish’s home.

Israeli military forces came under fire from a building next to the doctor’s home and returned fire. Soldiers said that they saw “suspicious figures” on the upper floors of the house and suspected that they were coordinating the mortar and sniper fire for Hamas.

They shot at the building, where three of Dr Abuelaish’s daughters and a niece were staying. A son and another daughter and the doctor’s brother were wounded.

Zeev Rotstein, director general of Sheba Hospital, said that Dr Abuelaish had a good reputation among Israelis.

Cite this as: BMJ 2009;338:b523

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An Italian carabiniere watches as more than 200 illegal immigrants from north Africa arrive in Sicily
IN BRIEF

Painkiller blamed for children’s deaths in Nigeria: The National Agency for Food and Drug Administration and Control in Nigeria has announced that 84 children have died and a further 27 have fallen ill since November after taking a pain relief syrup called My Pikin. It discovered in November that the product contained the chemical diethylene glycol, an industrial solvent found in antifreeze that is sometimes used as a cheap alternative to glycerin.

Relief agency suspends activities in Pakistan: Médecins Sans Frontières has suspended its activities in Swat district, northwestern Pakistan, after the deaths of two workers on 1 February. Riaz Ahmad and Nisar Ali, aged 24 and 27, had gone to rescue people injured in a military operation when their ambulance came under fire. The government is fighting insurgents in the area.

Human papillomavirus vaccine for developing world: The Global Alliance for Vaccines and Immunization will make the human papillomavirus vaccine against cervical cancer available to girls in developing nations if it can close a funding gap of $4bn (£2.7bn; €3.1bn). Most deaths from cervical cancer occur among women in poor nations. Large scale procurement means that the alliance can deliver the vaccine for $8.25 a girl, compared with the several hundred dollars it costs in the developed world.

Shorter working week reduces safety incidents: A rota that complies with the 48 hour European Working Time Directive coupled with efforts to improve sleep may improve patient safety, a study at a UK hospital has found (Quarterly Journal of Medicine 2009 Jan 27, doi:10.1093/qjmed/hcp004). During a total of 4782 patient days involving 481 admissions, 32.7 fewer medical errors occurred during the intervention than during the traditional rota (27.6 v 41.0 per 1000 patient days, P=0.006).

Saturated fat campaign launched in the UK: The UK Food Standards Agency (www.food.gov.uk) has launched a campaign on the health risks of eating too much saturated fat. People in the United Kingdom eat on average 20% more saturated fat than the recommended maximum. The agency recommends that people eat less cheese and choose low fat milk. Children older than 2 should switch from full fat milk.

NEWS

NICE recommends kidney cancer drug it previously rejected on cost grounds

Susan Mayor LONDON

The UK Food Standards Agency (NICE) is recommending the use of sunitinib as a first line treatment for advanced kidney cancer, in draft guidance issued this week. The guidance comes after NICE applied new arrangements for assessing the cost effectiveness of drugs for people who are terminally ill, overturning its previous ruling that the drug did not offer the NHS value for money.

The latest draft guidance recommends sunitinib, an oral tyrosine kinase inhibitor, as a first line treatment option in advanced or metastatic renal cell carcinoma in patients who are suitable for immunotherapy and who are fit enough.

However, the guidance does not recommend the use of three other drugs—bevacizumab, sorafenib, and temsirolimus—for first line treatment for these patients. Further more, the two drugs that are also licensed for second line treatment, sorafenib and sunitinib, are not recommended by NICE for second line treatment.

The previous draft of the guidance acknowledged that sunitinib was a clinically effective treatment but considered that it did not offer a cost effective use of NHS resources, costing more than NICE’s threshold of £20 000 to £30 000 per quality adjusted life year (QALY) (BMJ 2008;337:a1262).

NICE has recently introduced new arrangements for taking into account the added value that society puts on treatments that extend life. These state that treatments with demonstrable benefits in terms of survival can be recommended for patients who are not expected to live more than 24 months, even if the incremental cost effectiveness ratio exceeds the current limit of £30 000 per QALY gained (BMJ 2009;338:b3).

On the basis of this cost analysis, and taking into account a pricing scheme proposed by sunitinib’s manufacturer that provides the first cycle of the treatment free to the NHS, NICE’s independent advisory committee concluded that sunitinib does represent a cost effective use of NHS resources when used as a first line treatment for advanced or metastatic renal cell carcinoma.

The draft appraisals are available at www.nice.org.uk/guidance/index.jsp?action=folder&o=43118.

Cite this as: BMJ 2009;338:b499

Panel set up so providers can appeal against

Nicholas Timmins FINANCIAL TIMES

A new body has been created to preside over the fair use of competition in primary care in England.

The Co-operation and Competition Panel is a court of appeal for healthcare providers that believe a primary care trust has not put services out to tender when it should have done or has not run the tendering process fairly. It began operations at the end of January with the formal job description “to support the delivery to patients and taxpayers of the benefits of competition.”

Private healthcare providers, the voluntary sector, GPs, NHS organisations, and others can appeal to the panel if a complaint about unfair competition is not resolved either locally by the primary care trust or subsequently by its strategic health authority.

The panel is charged with providing advice on the application of EU law on procurement and competition, in line with the Department of Health’s guidance on competition and cooperation.

Since last year primary care trusts have come under pressure to separate out their provider arms so that they are, at the least, at an arm’s length distance from the trust. Were all such services to be put out to tender, the health department says, they would create a £10bn (£11.4bn; $15bn) a year market.

However, primary care trusts are under no general requirement to invite bids to run such services—or the hospital care that pri-
Evidence lacking for memory clinics to tackle dementia

Rebecca Coombes LONDON

Critics have questioned the ethics of carrying out screening for dementia, part of the work proposed for a new network of memory clinics in England and Wales, when evidence of the effectiveness of current drugs for the disease is limited.

Iain Chalmers, editor of the James Lind Library and formerly of the Cochrane Collaboration, speaking at a Lancet conference in London last week, said that he was sceptical about the clinics.

“People ask why NICE [the National Institute for Health and Clinical Excellence] is limiting access to Alzheimer’s drugs. Well, the costs are rising very fast and they are not fantastically good. We are going to all have these memory clinics but what do we do when we diagnose someone?” he said. “I heard one expert say: ‘The cupboard is bare.’ Cholinesterase inhibitors cost £70m [€80m; $100m] a year. You could have at least 700 extra elderly care doctors instead.”

Cholinesterase inhibitors are the main drugs used for Alzheimer’s disease in the United Kingdom. NICE has ruled that these drugs are not cost effective for the early stages of Alzheimer’s disease and should be used only for patients with the moderate stages of the disease.

A government strategy announced last week worth £150m over two years included plans to establish memory services staffed by specialists to provide early diagnosis and treatment (www.dh.gov.uk/dementia). Early treatment would allow people with dementia to “treatment and intervention that can help them live well with the condition,” said the Department of Health.

But Catherine Duggan, associate director for clinical pharmacy specialist services, East and South East England Specialist Services NHS, agreed that it was important to manage patients’ expectations of the new memory clinics.

“It’s very hard to assess the effect of drugs for Alzheimer’s disease. They are more difficult to assess than, for example, how we manage primary and secondary prevention for cardiovascular disease, whereby we can assess patient outcomes and compare with population data to achieve a positive outcome. However, we do need to use drugs in patient populations to inform the evidence base,” she said.

“While there is a need for the NHS to be seen to provide services and treatments for patients, we also need a rational way to manage expectations alongside innovative drug use. We could start to screen for Alzheimer’s, but if the back-up services or drug options aren’t available, or if the evidence for drug use is limited, one could question the ethics of rising expectations and providing screening.”

See the Clinical Reviews on Alzheimer’s disease (doi:10.1136/bmj.b158) and dementia (doi:10.1136/bmj.b75).

unfair competition

primary care trusts commission. But primary care trusts have been told that where a “new or significantly changed” service is needed, they will have to provide a public explanation if they do not tender the service. It is this process that the panel will oversee.

The panel has no legal standing and will merely offer advice. This has led Andrew Lansley, the Conservative’s health spokesman, to argue that it “lacks the clout” to be effective.

But the secretary of state for health and Monitor, the regulator of NHS foundation trusts, will generally be expected to follow its advice, as will primary care trusts and strategic health authorities.

GPs are urged to raise awareness of inequalities

Andrew Moscrop LONDON

Changes in the pay scheme for GPs over the next 18 months will mean more money for GPs in areas of poor health and less money for those in better off areas, GPs were told last week at a conference in London.

However, the pay package itself cannot reduce the social causes of health inequalities, the GPs were told.

“More than 80 GPs from around the country gathered in London for a conference to mark the launch by the Royal College of General Practitioners of a booklet, Addressing Health Inequalities: A Guide for General Practitioners, which provides practical advice to GPs on reducing health inequalities.

Steve Field, the college’s chairman of council, welcomed the imminent change to the quality and outcomes framework (QOF) that will result in more money for GPs caring for patients in deprived communities but said that GPs also needed to “become more vocal and put the issue [of health inequalities] on the political agenda.”

Participants discussed issues such as providing quality health care to people with learning difficulties, and putting the issue of health inequality on the undergraduate curriculum.


Cite this as: BMJ 2009;338:b544
Men whose semen samples thawed can sue trust, say judges

Clare Dyer BMJ

Six cancer patients whose frozen semen thawed because of failings by a hospital trust have been given the go ahead by the Court of Appeal to claim compensation, in a judgment that breaks new legal ground.

The six had their semen frozen and stored at Southmead Hospital in Bristol in case their fertility was damaged by chemotherapy. The samples thawed in June 2003 when the amount of liquid nitrogen in the storage tanks fell below the required level.

Three appeal court judges headed by the lord chief justice overturned a ruling by a county court judge that negligence claims brought by the six against North Bristol NHS Trust for mental distress and psychiatric injury could not go ahead because the semen was not the property of the men or part of their bodies.

Negligence claims arise from personal injury or damage to property; and the trust, while admitting that it should have topped up the tanks manually when the automatic system failed, denied liability, on the basis that the semen was not the men’s property.

But Igor Judge, the lord chief justice, said that “developments in medical science now require a reanalysis of the common law’s treatment of and approach to the issue of ownership of parts or products of a living human body.”

Lord Judge said that the men’s appeals raised “interesting questions about the application of common law principles to the ever expanding frontiers of medical science.” They raised a “novel question” about the ability to sue over damage to bodily substances—in this case semen samples that the men had produced for their possible later use and that the trust had promised meanwhile to freeze and to store.

Lord Judge, together with the master of the rolls, Anthony Clarke, and the law lord Nicholas Wilson ruled that the men’s semen was their property.

“Unlike products of the body which are removed from it with a view to their being abandoned, such as cut hair, clipped nails, excised tissue, and amputated limbs, the sperm was ejaculated with a view to its being kept,” said Lord Judge.

“In our judgment, for the purposes of their claims in negligence, the men had ownership of the sperm which they ejaculated. By their bodies, they alone generated and ejaculated the sperm. The sole object of their ejaculation of the sperm was that, in certain events, it might later be used for their benefit.”

The ruling opens the way for the men to claim damages for psychiatric injury or mental distress if they can show that it was caused by the trust’s negligence and was a foreseeable result of it. The judges sent the case back to the county court, although the claims may now be settled out of court.

The judges noted that the compensation in the case of the six men was likely to be “relatively small.” Three had recovered their natural fertility, the sample given by the fourth was unlikely to have resulted in a conception, the fifth had since died, and the sixth, whose fertility was still uncertain, had not suffered a psychiatric injury but only mental distress.

Cite this as: BMJ 2009;338:b501

BMJ readers vote for doctors who have made a difference

Deborah Cohen BMJ

More than 1300 people took part in the first week of voting for the BMJ Group’s lifetime achievement award, after the shortlist was announced on 31 January (BMJ 2009;338:b325). The 10 candidates had been chosen on the basis of who had made a unique and substantial contribution to improving health care.

The BMJ spoke to 10 of the people who had either nominated or were supporting one of the shortlisted candidates.

Four people nominated Patrick Bradley, a professor and head and neck oncological surgeon at Nottingham University Hospitals NHS Trust. One colleague, Nick Jones from the Department of Otorhinolaryngology at the same trust, suggests “there is nothing that he has not done or contributed to.”

Nominating Andrew Lister, director of the Cancer Research UK medical oncology unit at Barts and the London, is James Malpas, emeritus professor of medical oncology at the same institution. He believes Professor Lister is a worthy recipient of a lifetime achievement award because he is “approaching the end of a long and distinguished career in a particularly exacting area of medicine.”

Championing Judith Mackay, senior adviser to the World Lung Foundation and noted anti-tobacco campaigner in Asia based in Hong Kong, is her husband, John Mackay, a hospital doctor. Judith Mackay gave up salaried work to campaign for tobacco control, and according to her husband it’s “her ability to energise people globally and inspire a new generation of skilled and dedicated advocates” that makes her worthy of an award.

Graham Shaw, chief executive of the charity DiPEx, which runs the website www.healthtalkonline.org, is supporting Ann McPherson’s nomination, who cofounded the charity. Dr McPherson is an Oxford based GP, lecturer, writer, and broadcaster, who, Mr Shaw says, “has consistently and with great devotion pushed patients’ needs.”
Measles cases in England and Wales rise sharply in 2008

Lynn Eaton  LONDON
The number of measles cases in England and Wales rose by a third last year, the latest figures show.

There were 1348 confirmed cases of measles in 2008 compared with 990 in 2007, says the Health Protection Agency. The London region had the largest number of cases (662), followed by the North West (180). The South West (38) and Wales (39) had the fewest.

“The majority of these cases could have been prevented as most were in children who were not fully protected with MMR [the combined vaccine against measles, mumps, and rubella],” said Mary Ramsay, an immunisation expert at the agency.

But now that fears about the MMR vaccine, which began with Andrew Wakefield's paper in the Lancet in 1998, have been quashed, parents have begun to accept the triple vaccine, she said.

“We are glad to see that public confidence in the MMR vaccine is now high, with more than eight out of 10 children receiving one dose of MMR by their second birthday. However, children who weren't vaccinated many years ago are still at real risk. Measles should not be taken lightly as you can never tell who will go on to develop the more serious complications of pneumonia and encephalitis,” said Dr Ramsay.

She added that parents could still vaccinate a child who missed out initially.

The uptake of the MMR vaccine between July and September last year, for children aged up to 2, was 84.5%. The proportion of children immunised with both doses of MMR by their 5th birthday was 77.9%. Although most cases of measles were in children, almost one in five (252) were in adults.

Speaking on BBC Radio 4’s Today programme, David Salisbury, head of immunisation at the Department of Health, said he accepted that the overall number of cases was low. But he added, “We shouldn’t be having 1300 cases; we should be having no cases.”

He said that there was one death last year and added that the French press had recently reported the death of a 12 year old girl there from measles.

The statistics for England and Wales come as researchers in Germany, which had an outbreak of 614 measles cases in the city of Duisburg in 2006, found that at least 80% of these cases were in unvaccinated children.

In their paper for the World Health Organization Bulletin, the researchers say that the main reasons for the outbreak were that parents either forgot to take their children to be vaccinated or rejected the vaccine, for various reasons including the mistaken belief that it was dangerous (2009;87:108-15). Two of the children died of encephalitis, and 95 were admitted to hospital.

The researchers state that stringent measures to control measles are needed to eliminate the disease from Europe. The United States was declared free from endemic measles transmission in 2002, but Europe has had large outbreaks in the Ukraine (>44 000 notified cases in 2005-6), Switzerland (>1400 cases in 2006-8), and Austria (>200 cases in 2008).

In August 2008 England’s chief medical officer gave GPs additional funding to identify children who had not yet received their measles vaccine and to offer a catch-up vaccine.

For details of the catch-up programme see www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_086837.

Cite this as: BMJ 2009;338:b533

Another shortlisted cancer specialist is Jillian Mann, a paediatric oncologist in Birmingham, who is being championed by Ian Booth, a paediatrician at Birmingham Children’s Hospital. Professor Mann has made “a towering contribution” to the health and welfare of children with cancer.

Supporting Michael Rawlins, chairman of the National Institute for Health and Clinical Excellence (NICE) is former Times health editor, Nigel Hawkes. “Sir Michael Rawlins has created an organisation recognised around the world,” Mr Hawkes says.

Tomas Berl, professor of medicine at University of Colorado in Denver, is backing Robert Schrier, professor of medicine at the same institution.

Dr Schrier has advanced the understanding of renal physiology and has stimulated “worldwide interest in the biomedical science community,” Professor Berl says.

Nominating Moises Selman, director of research at the National Institute of Respiratory Diseases in Mexico, is his colleague Mary Carmen Navarro. She cited his extensive contribution to the “complex field of interstitial lung diseases.” Ms Navarro said that Dr Selman’s contribution had been carried out in conditions closer to developing countries rather than developed ones.

Prashanth Srinivas, a doctor at the Karuna Trust, a charity dedicated to providing primary health care for people in rural India, is championing Hanumappa Sudarshan, founder of the trust and a public health activist. Commenting on why Dr Sudarshan should win the lifetime achievement award, Dr Srinivas says he is someone who “has dedicated his life to the service of rural and tribal people in India.”

John Dark, director of cardiopulmonary transplantation at the Freeman Hospital in Newcastle, is supporting Magdi Yacoub, professor of cardiothoracic surgery at Imperial College, London, who is one of the world’s most eminent surgeons.

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