Study finds “troubling differences” across NHS in UK’s nations

Zosia Kmietowicz LONDON
An analysis of the performance of the national health services in the four countries of the United Kingdom has found that England spends less and has fewer staff than the others but delivers more treatment more quickly.

The researchers, from the health charity the Nuffield Trust, say that “troubling differences” exist between the countries in activity, staffing levels, crude productivity, and waiting times. Their study asked whether taxpayers are getting value for money for health services and whether the three devolved health services need to be more accountable.

For the study the researchers examined the performance of the NHS in England, Scotland, Wales, and Northern Ireland across three time points: 1996-7, 2002-3, and 2006-7.

They found that in 2006-7 Scotland had the highest levels of poor health, the highest rates of expenditure, and the highest numbers of hospital doctors, GPs, and nurses per head of population but the lowest rates of crude productivity and inpatient admissions per head.

The study also found that waiting times were worse in Wales and Northern Ireland than in England (Scottish waiting times could not be compared because they were measured differently). By 2006 virtually no patients in England waited more than three months for an outpatient appointment, whereas 44% of patients in Wales and 61% in Northern Ireland waited more than three months.

Jennifer Dixon, director of the Nuffield Trust, said, “Some [differences] will reflect the different policies pursued by each of the four nations since 1999, in particular the greater pressure put on NHS bodies in England to improve performance in a few key areas such as waiting and efficiency, via targets, strong performance management, public reporting of performance by regulators, and financial incentives.”

For the Treasury to hold devolved health services to account in the future, their governments should provide comparative data on performance, the report said.

The analysis is at www.nuffieldtrust.org.uk.
See EDITORIAL, p 164

Doctors struggle to cope with injured after Haitian quake

Peter Moszynski LONDON
As the scale of the devastation in Haiti gradually emerges, with 200 000 people feared dead and one and half million left homeless, healthcare workers are struggling to cope. Not only is this one of the worst natural disasters in recent years, the earthquake wiped out much of the limited infrastructure of one of the world’s poorest countries.

The World Health Organization is coordinating the healthcare sector of the massive international relief operation. WHO’s director general, Margaret Chan, said, “This disaster ranks among the most devastating and logistically challenging in recent history. We are seeing the difficulties that arise when disaster strikes an already disastrous public health situation.

“We have every reason to be concerned about the health of survivors. Many of the problems we try to prevent after a disaster were already present in Haiti.”

These problems include diseases associated with poor water and sanitation systems, low vaccination coverage, widespread malnutrition, outbreaks of infectious diseases, a high prevalence of HIV and tuberculosis, and “erratic delivery of medicines and care.”

Dr Chan described “almost unbelievable damage to infrastructure,” including to many hospitals and healthcare centres. WHO’s immediate priorities are to assess the nature and magnitude of emergency health needs, treat the injured, recover bodies, and set up surveillance of infectious diseases.

Although “offers of help continue to pour in,” she insisted that “aid must closely match urgent health needs and be tightly coordinated.”

An Oxfam spokesman, Ian Bray, said, “It is clear that this is a major catastrophe. Haiti is going to need a great deal of outside help, both now in the immediate aftermath of the disaster and in the long term for reconstruction.”

Médecins Sans Frontières said that all three of its hospitals around the capital were either destroyed or so badly damaged they had to be evacuated. It has set up several emergency surgical facilities under canvas, which have been working around the clock.

The Disasters Emergency Committee has launched a joint charity appeal at www.dec.org.uk.

For the full versions of articles in this section see bmj.com

Cite this as: BMJ 2010;340:c381

See BMJ 2010;340:c331 and c266

The general director of MSF UK described the devastation in Haiti in last week’s BMJ podcast. http://podcasts.bmj.com/bmj/
Out of hours care scrutinised as inquest begins into deaths

Clare Dyer BMJ

A coroner’s inquest into the death of a patient who was given a fatal dose of diamorphine by an agency doctor from Germany on his first shift in the United Kingdom is expected to highlight serious shortcomings in out of hours care provided in primary care.

Daniel Ubani, 66, a Nigerian born doctor practising in Witten, near Dortmund in Germany, had only three hours’ rest after flying in from Germany and undergoing coaching before beginning his first shift in Cambridgeshire in February 2008.

He was called to the Manea, Cambridgeshire, home of David Gray, 70, who was in pain from kidney stones, and administered 100 mg of diamorphine. Nat Carey, a forensic pathologist, told the inquest: “It is at least 10 times a starting dose that you would give and potentially 20 times.”

Mr Gray’s partner, Lynda Bubb, told the inquest, which opened on 14 January, that Dr Ubani seemed “very tired and not as alert as he could have been.”

Dr Ubani later told Mr Gray’s sons that he was not familiar with diamorphine. His driver, Lesley Dent, said at the inquest that the doctor was looking through the British National Formulary between call-outs.

The inquest at Wisbech coroner’s court will look into the causes of Mr Gray’s death and that of Iris Edwards, 86, another patient seen by Dr Ubani, who died of a heart attack after he failed to send her to hospital.

The system for providing care for evenings and weekends changed when GPs negotiated a new contract in 2004 and primary care trusts took over responsibility for out of hours services in England. Dr Ubani’s services were provided by Take Care Now, a company commissioned by Cambridgeshire primary care trust.

Doctors in the European Union are free to work in other member countries without the stringent checks that apply to other foreign doctors.

The Care Quality Commission, the regulator of health and social care in England, launched an inquiry into Take Care Now last June. Interim findings were that trusts were not consistently monitoring the quality of care, pointing to a possible national problem.

Health minister Mike O’Brien told the BBC’s Newsnight programme: “There are some cases where we need to ensure that the rules are tightened up, and we will. I have got a report which I am ready to publish after we have had this inquest, which shows that there are significant problems with the out of hours service.”

Dr Ubani was suspended from the UK medical register by the General Medical Council but was allowed to go on practising in Germany.

The Crown Prosecution Service attempted to extradite him to face manslaughter charges in the UK. But he was prosecuted instead by the German authorities for causing death by negligence, given a nine month suspended sentence, and ordered to pay £5000 (£4420; $7200).

Government proposes new mandatory code for alcohol industry

Jacqui Wise London

The government has proposed a mandatory code for alcohol retailers in England and Wales that bans “all you can drink” promotions but fail to crack down on the sale of cheap alcohol in supermarkets.

The move has disappointed campaigners, such as the Royal College of Physicians, who have called for a minimum price for a unit of alcohol.

Speaking on Radio 4’s Today programme, Alan Johnson, the home secretary, admitted that the voluntary code for alcohol retailers had failed and that a legally enforceable one was now needed.

After a consultation the government has set out five mandatory conditions to tackle alcohol related crime and disorder. These are:

• A ban on promotions such as “all you can drink for £10” offers, free drinks for women, and speed drinking competitions
• A ban on “dentist chairs,” where alcohol is poured directly into the mouths of customers
• Free tap water to be made available to customers in bars and clubs
• A requirement for bar staff and retailers to demand proof of age of anyone who looks under 18 years old, and
• Small measures of beer, wine, and spirits to be available in all trade premises.

England’s health secretary, Andy Burnham, said, “Public concern about alcohol misuse is growing; it affects people’s health and costs the NHS over £2.5bn every year.”

See Editorial, p 161, Analysis, p 184, Observations, p 187

Cite this as: BMJ 2010;340:c286

Cite this as: BMJ 2010;340:c390

New deal pumps £1m into stem cell research for multiple sclerosis

Geoff Watts London

In a bid to overcome a critical shortage of funds for stem cell research in Britain, the Multiple Sclerosis Society and the UK Stem Cell Foundation have set aside a dedicated pool of research money amounting to £1m (£1.1m; $1.6m).

Announcing the plan on Thursday 14 January, Doug Brown, biomedical research manager for the MS Society, said that the new partnership in this field would “pump prime and speed stem cell research.”

To mark the creation of the fund the London Regenerative Medicine Network chose the same day to hold a meeting at which two prominent stem cell researchers outlined their views on future research into multiple sclerosis.

Robin Franklin of the Medical Research Council’s Centre for Stem Cell Biology and Regenerative Medicine in Cambridge said that some of the studies currently preoccupying cancer researchers may also turn out to be helpful in understanding and even treating multiple sclerosis.

The central nervous system, he said, has the stem cells needed to generate new oligodendrocytes, the cells responsible for myelin formation. “The frustrating thing about multiple sclerosis is that although this process does occur naturally, it doesn’t occur very efficiently. But it means we’re pushing on a door that’s already slightly ajar, not trying to stimulate something which doesn’t normally happen.”

It is now vital to understand the mechanism by which the brain itself makes extra oligodendrocytes in response to need, Professor Franklin said. “In the last 18 months we’ve made some pretty spectacular progress, some of which has yet to be published.” His own group, working with another at the University of California in San Francisco, has identified a pathway that prevents the brain’s own stem cells from giving rise to new myelinating cells. “A drug which inhibits this process should allow the production of these cells,” he said.

In seeking to understand this and other related pathways, researchers...
London faces serious financial problems and cuts of £5bn

Adrian O'Dowd

Doctors’ leaders have warned that London is facing the most severe healthcare financial problems of anywhere in England, as NHS budget cuts will bite hardest in the capital.

The BMA published a report this week warning that London is heading towards “a major financial and organisational crisis” that will mean the closure or downgrading of hospital services.

Real term cuts of £5bn (£5.7bn; $8.2bn) to primary care trusts’ funding by 2017 are now being envisaged, says the report, which was commissioned by the BMA and written by John Lister, information director at the campaigning organisation London Health Emergency.

In preparing the report Mr Lister looked at board papers and other published material from primary care trusts in London and found that the brunt of the cuts made in the anticipated freeze on NHS budgets from 2011 will fall on London.

This is unfair, argues the report, as London faces unique challenges. Almost 15% of England’s population live there, but it could face a much higher share of the expected cutbacks. Also, London has a higher proportion of patients with mental health problems than other English regions.

The capital also has rising patient activity and a number of what the report describes as “very expensive” private finance initiative hospital schemes.

The report says: “London’s health services are headed towards a major financial and organisational crisis. The apparently calm exterior in many areas reflects either a delayed reaction to problems or a delayed recognition of the scale of the problems that have to be faced . . . in the stormy financial period ahead.”

London’s strategic health authority, NHS London, has made several proposals, says the report, including:

• Reducing the number of people going to hospital emergency departments by 60% and the number of outpatients by 55%
• Diverting millions of patients to (yet to be built) “poly-systems” or clinics, which would cut as much as £1.1bn from hospital budgets
• Reducing staffing of non-acute services by 66%
• Cutting by a third the duration of GP appointments, and
• Trimming London’s hospital network by downgrading many district general hospitals to lesser local hospitals and leaving a handful of major acute hospitals.

The study says that although NHS London has been proactive in preparing for the tough financial times ahead, it has been less than transparent in its plans. It adds that the strategic authority had refused requests made under the Freedom of Information Act to release a confidential report drawn up for it by the US consultancy McKinsey on the scale of the problem and how to deal with the cutbacks.

The chairman of the BMA’s London regional council, Kevin O’Kane, said, “While we recognise that there are problems with healthcare delivery in London, we are extremely worried that plans to cut services are being kept secret. “We are calling for full disclosure of the proposals so that there can be a public debate. This is vital so that Londoners can have their say about local cuts and take a wider view of what is happening to the NHS.”


Cite this as: BMJ 2010;340:c393

are probably not starting from scratch. “A lot of the pathways that seem to be important for regeneration in multiple sclerosis are also pathways that have already been identified in tumour biology,” said Professor Franklin.

The drug industry is already trying to develop anticancer drugs that intervene in these pathways. These drugs may turn out to be relevant to the control of multiple sclerosis.

Work of the kind described by Professor Franklin would not necessarily require the transplantation of new cellular material. Where such transplants are needed, researchers will have to decide which type of stem cell would be most effective. The choices, said Gianvito Martino of the Vita-Salute San Raffaele University in Milan, include haemopoietic cells from bone marrow and neural stem cells.

Such cells from bone marrow have already been given to more than 600 patients with multiple sclerosis around the world, with some encouraging results, especially among the most severely affected individuals. Neural stem cells, by contrast, have so far been used only in animal studies. But the evidence would seem to justify the consideration of phase I trials in humans.

Questioned about the possibly damaging effects on the development of stem cell therapy through their controversial use by ill qualified practitioners, both experts expressed disquiet. Cases such as that of Robert Trossel, currently appearing before the UK General Medical Council for the alleged illegitimate use of stem cell therapy (BMJ 2010;340:c197, 13 Jan), were, said Professor Franklin, “not helpful.” Professor Martino agreed, deploring the largely unregulated state of this branch of medicine.

Cite this as: BMJ 2010;340:c292

Some patients given haemopoietic cells from bone marrow have had encouraging results.
IN BRIEF

UK gives £20m to thalidomide victims: The government has apologised to the current 466 UK victims of the drug thalidomide and confirmed that it is giving £20m (£23m; $33m) to support their health needs. The drug, which was given to expectant mothers from 1958, was withdrawn in 1961 after it was found to cause limb and other deformities. Many people affected by it cannot work and need adapted homes and cars.

New York targets salt consumption: New York city’s health department is being supported by the American Heart Association, national organisations, and some food manufacturers in a campaign to reduce the salt content of packaged and restaurant food by 25% over the next five years. These two food sources represent about 80% of the salt in Americans’ diets.

Former chief medical officer has died: Donald Acheson, who was the UK’s chief medical officer from 1983 to 1991, died on 10 January aged 83. Sir Donald, who had an epidemiological background, is credited with the successful AIDS policy that saw the introduction of needle exchanges for drug users and safer sex campaigns. He also authored a report on health inequalities in 1998 in which he recommended banning smoking in public places.

New Jersey legalises marijuana for medical use: New Jersey has become the 14th US state to approve the medical use of marijuana for people with serious chronic illnesses such as cancer, AIDS, and multiple sclerosis. The drug will be available within about nine months through state dispensaries and will be strictly regulated, like opiate drugs. New Jersey is one of the few east coast states to legalise such use.

FDA warns drug companies about misleading statements: The US Food and Drug Administration has warned Amylin Pharmaceuticals, Eli Lilly, Bayer, and Cephalon about statements by their representatives, including promotion of unapproved uses of drugs. The drugs involved are the diabetes treatment exenatide, the antipsychotic duloxetine, the levonorgestrel intrauterine contraceptive device, and the leukaemia treatment bendamustine. The FDA warned the companies to cease false or misleading advertisements.

Cite this as: BMJ 2010;340:c330

Trial begins in Kansas of man who killed abortion doctor

Janice Hopkins Tanne NEW YORK

The trial of Scott Roeder for murder began in Wichita, Kansas, last week. Although he pleaded not guilty, Mr Roeder has publicly admitted killing George Tiller, one of the few US doctors who provided late term abortions, in May 2009.

The trial had been expected to be about premeditated first degree murder. However, Judge Warren Wilbert has allowed Mr Roeder’s lawyers to plead that he killed Dr Tiller in “voluntary manslaughter” to protect fetuses. Under Kansas law voluntary manslaughter is a killing committed in “an unreasonable but honest belief that circumstances existed that justified deadly force.”

The penalty for a conviction on voluntary manslaughter could be five years in prison, whereas a life sentence could be imposed for a murder conviction.

Judge Wilbert said that the trial is about murder, not abortion. However, groups on both sides of the abortion debate have highlighted abortion issues and expressed concern about the effect of the trial.

Last week the Associated Press news agency reported that Judge Wilbert is a practising Roman Catholic who once sought endorsement by an anti-abortion group. However, the Associated Press report said, “Wilbert, 57, is considered by many in the legal community to be a fair judge. No one can seem to point to an instance in which he injected his religious beliefs into a case.”

Women’s rights and abortion rights activists said that the judge’s ruling allowing a voluntary manslaughter defence increased the danger for them. “We think the potential now for even more mischief and more attacks on pro-choice politics is very, very evident. The other side is going to attack on every front. They’re just emboldened,” said Nancy Keenan, president of NARAL (National Association for the Repeal of Abortion Laws) Pro-Choice America, in the Washington Post.

In the New York Times national anti-abortion groups said that murder was anathema to them, but some anti-abortion activists have praised Mr Roeder, with one calling him a hero.

Dr Tiller was killed while serving as an usher in his church in Wichita, a small Kansas city that has been a centre of abortion disputes in the United States. Dr Tiller’s clinic was attacked several times, and he was shot in both arms several years ago. Protesters surrounded the clinic at a legally prescribed distance. After Dr Tiller’s murder the clinic was closed.

Cite this as: BMJ 2009;338:b2237.

Healthcare providers sometimes take part in torture and ill treatment, report alleges

Peter Moszynski LONDON

Healthcare workers in medical facilities, juvenile detention centres, orphanages, drug treatment centres, and other institutions are sometimes forced to withhold care or engage in treatment that intentionally or negligently inflicts severe pain or suffering for no legitimate medical purpose, Human Rights Watch claims.

In its annual World Report for 2010 the group summarises major trends in human rights issues worldwide, and this year has a section documenting healthcare providers’ alleged complicity in torture or in cruel, inhuman, or degrading treatment in countries throughout the world. The cases it highlights include:

• Government physicians conducting forcible anal examinations of men suspected of engaging in homosexual activity in Egypt, and forcible vaginal examinations to assess virginity in Libya and Jordan

• Lay midwives practising female genital mutilation in Iraqi Kurdistan, while government physicians there promote the practice and dispute negative health consequences

• Staff at drug treatment centres in China and Cambodia denying care for drug users in withdrawal and subjecting individuals who depend on drugs to forced labour or exercise instead of providing evidence based treatment, and

• Physicians in Nicaragua denying women lifesaving abortions, resulting in preventable deaths.

The report maintains that in each of these cases the healthcare providers’ conduct amounted to cruel, inhuman, or degrading treatment because they “unjustifiably or deliberately caused severe mental or physical suffering.”

Joe Amon, health and human rights director at Human Rights Watch, said, “Ethical guidelines and international human rights law expressly condemn health providers’ involvement in torture or ill treatment. Yet providers engage in a wide range of abuses in the name of medical treatment, often because they are following abusive government health policies.”
Indonesian doctors are told to prescribe more generic drugs to reduce escalating health costs

Ben Bland | JAKARTA
Government doctors in Indonesia will soon be required to prescribe generic drugs where possible in a bid to drive down the spiralling costs of providing health care in the world’s fourth most populous nation.

Officials from the health ministry said that doctors working in state hospitals and clinics would be able to prescribe more expensive branded drugs only if no generic equivalents were available.

Although a decree requiring doctors to use generics was implemented in 1989 it has never been properly enforced. Many doctors, who are paid less than many other civil servants, have continued to prescribe branded drugs because of the kickbacks they receive from drug salespeople.

The health minister, Endang Rahayu Sedyaniingsih, who took up office in October, said that she was determined to stop this practice and that she was finalising a new ministerial decree to ensure that the use of generics becomes widespread.

“We will fight the promotion of drugs through doctors, as well as the promotion of baby milk,” she told a briefing organised by the Jakarta Foreign Correspondents’ Club on 15 January.

She added that although this new rule would be implemented only in state clinics, she planned to expand the regulation at a later date so that it would apply to doctors working in Indonesia’s fast growing private health sector.

The minister emphasised that this time the government was determined to fight back against the corruption that blights the health sector and many other aspects of life in Indonesia.

“We will ask health officials to sign an integrity pact and will set up a new centre to monitor government health employees,” she explained. “We have also established a 24 hour telephone complaint line, and we will open our ears and listen to any complaints.”

The government, which was returned to power in July with a large popular mandate, has increased the health budget for this year to 21 trillion rupiah (£1.4bn; €1.6bn; $2.3bn) from 17 trillion rupiah last year.

Although there have been calls for medical societies to educate their members about the ethical and legal responsibility of physicians and other healthcare professionals in regard to the detention and interrogation of political detainees and suspected terrorists, Dr Amon said that less attention has been given to the everyday abuse that can occur even in hospital settings.


Cite this as: BMJ 2010;340:c329

European Commission investigates drug firms over illegal sweeteners to protect patents

Rory Watson | BRUSSELS
The European Commission is stepping up pressure on drug companies it suspects of using illegal sweetener deals to protect their patents and prevent generic drugs from entering the market.

Just three weeks before she is due to stand down as the European Union competition commissioner, Neelie Kroes has asked several European companies to supply her staff with copies of their patent settlement agreements.

The commission did not divulge the identities of the companies. But several confirmed they had been asked to provide documentation of all agreements with generic drug producers concluded between 1 July 2008 and 31 December 2009. These included AstraZeneca, GlaxoSmithKline, Sanofi-Aventis, Novartis, and Roche.

A spokeswoman for GlaxoSmithKline said, “We have received a request from the EU commission, as part of their ongoing monitoring, for information regarding interactions with generic manufacturers. We will be providing the commission with all relevant information.”

Announcing the initiative on 12 January, Mrs Kroes said, “Patent settlements are an area of concern, not least if there are situations where an originator company pays off a generic competitor in return for delayed market entry. We need to monitor this type of agreement in order to better understand why, by whom, and under which conditions they are concluded.”

Mrs Kroes has consistently attacked anti-competitive commercial behaviour, particularly cartels, during her five year stint in Brussels and has fined companies millions of euros for using illegal practices that prevent their rivals and the public from benefiting from greater choice and competition.

The initiative followed publication in July of the results of a highly critical Commission inquiry into the drug industry. This concluded there were shortcomings in the sector and showed that, on average, the public had to wait over seven months after a patent had expired before less expensive generic products went on sale.

Cite this as: BMJ 2010;340:c268
New EU health chief questions plan to let drug industry communicate directly with patients

Rory Watson BRUSSELS
John Dalli, a former Maltese economy and social affairs minister, will have more influence over public health policy than any of his predecessors when he takes up his post as the European Union’s health commissioner next month.

In a move that underlines the increasing importance of health issues on the European agenda, his five year mandate, which is due to start on 1 February, will include responsibility for drafting all pharmaceutical legislation. The previous health commissioner, Markos Kyriaziou and Androulla Vassiliou, had argued unsuccessfully for this area to be transferred from the European Commission’s enterprise and industry directorate general, to their own bailiwick.

Now the commission’s president, José Manuel Barroso, has agreed to the transfer. A deciding factor was the Lisbon Treaty, which came into force at the beginning of December and updates the European Union’s rulebook. It includes pharmaceuticals and medical devices under the health policy heading.

The transfer has been generally welcomed by consumers. But the European Federation of Pharmaceutical Industries and Associations has given a measured response to the change. It said that the industry had a dual role of meeting patients’ needs and contributing to Europe’s economic wellbeing.

Mr Dalli was careful to strike a similar tone when cross examined by MEPs for three hours on 14 January on his suitability for the health post. He confirmed that he would place the interests of patients first but insisted that this did not exclude a strong commitment to the future competitiveness of the drug industry.

Mr Dalli has said he will press ahead with two relatively non-controversial pharmaceutical proposals already on the table: stepping up measures against counterfeit drugs and improving pharmacovigilance.

But he expressed strong concerns about controversial plans to allow drug companies to communicate directly with the public by allowing companies, under certain conditions, to publish information on their products in the media.

“We will reassess the package on information making the evidence matter

BMJ Group Awards: Getting Research into Practice category

Karen Pettersen
BMJ EVIDENCE CENTRE
Considerable time and effort are invested in randomised controlled trials and long term prospective observational studies to assess the benefits and harms of interventions. However, it is not enough simply to publish high quality research: the challenge is to ensure that clinicians act on the research findings.

The BMJ Group’s Getting Research into Practice award celebrates successful initiatives to introduce evidence based improvements in health care that have been completed in the previous two years.

Our shortlist, chosen from 127 submissions, represents the best in an impressive field: those projects and initiatives with a strong evidence base—both in terms of the rigour of the original research they aimed to implement and in the approach taken to achieve change in practice—and those that have a clear and long term impact on outcomes that matter to patients.

While on sabbatical in Dubai in 2006 Ebenezer Ellen Benjamin, professor of nursing in Vellore, southern India, noted that episiotomy was routinely performed on a wide range of women (64%) in Al Wasl hospital and that, despite this high rate of episiotomy, 0.2% of women still developed third and fourth degree tears.

With a view to changing practice and reducing numbers of episiotomies, Professor Benjamin recruited a multidisciplinary team of midwives, nurses, and medical staff to a project that used a PDCA (“plan, do, check, act”) systematic quality improvement model. In an in-service session the current evidence for giving episiotomy was presented. In-house guidelines were formulated that were based on World Health Organization recommendations; and adherence by staff members was monitored closely, with support and further training offered to any practitioners not following the guidelines. The episiotomy rate was successfully brought down to below 20% within six to eight months, with no increase in the incidence of third and fourth degree tears.

The Sexual Health and HIV Evidence into Practice (SHHEP) group is a collaboration between UK, African, and Asian research organisations that has capitalised on the evidence generated by randomised controlled trials and social science research to influence government policy on sexual health and HIV in developing countries.

One of the group’s successes involved advocating research findings to change the law in Ghana so that survivors of gender based and sexual violence are no longer forced to pay for their own medical tests to prove assault in court.

It has also influenced changes in policy and practice in several countries, including Brazil and Ghana, leading to the introduction of an easy to use and inexpensive, point of care dipstick test to screen pregnant women for syphilis and thus to reduce infant mortality.

The essence of the project is to share learning. The group has formulated a range of targeted mechanisms to communicate health research to different audiences and spearhead change.

BMJ Group Awards: Getting Research into Practice category

Making the evidence matter

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and bring more patient perspective to the proposal,” he said, adding that the reassessment would include stronger demarcation between information and advertising. “You do not want a situation where people in a vulnerable position can be coerced to purchase a product that may not be good for them,” he said.

Pharmaceutical policy is not the only extension of powers that the commission’s public health directorate general, known as DG SANCO, will receive when the changes take effect on 1 February. DG SANCO will also take over responsibility from the enterprise and industry directorate general for the operations of the London based European Medicines Agency.

In reality the change is more administrative than substantive, as both directorates already have a seat on the agency’s board, an arrangement that will continue. However, in future it is DG SANCO that will take the lead in the commission’s relations with the agency. These include budgetary issues, a review of its activities, and, in the near future, the search for a new director.

Mr Dalli confirmed that he would continue to champion legislation allowing patients to receive reimbursable medical treatment in another EU country. The proposal was blocked by Spain. He plans an early meeting with the Spanish health minister.

See OBSERVATIONS, p 188.
Cite this as: BMJ 2010;340:c353

Doctors sign petition for head of German NICE to remain in post
Annette Tuffs HEIDELBERG
About 600 German doctors have signed a petition in support of Peter Sawicki, whose role as head of the country’s healthcare quality and efficiency body is in jeopardy.

Dr Sawicki has been director of the Institute for Quality and Efficiency in Health Care (IQWiG), Germany’s equivalent of the UK National Institute for Health and Clinical Excellence, since it was established in September 2004. But his contract runs out in August 2010 and may not be renewed by the country’s new health minister. A decision was due to be made on Wednesday 20 January, after the BMJ went to press.

In an earlier letter to the new German government several members of the Christian Democratic party, which forms the ruling coalition together with the liberal Free Democratic party, have demanded a change of direction in the policy and leadership of the institute to make it more acceptable to the drug industry. Furthermore, health experts in the Free Democratic party have emphasised that Germany’s standing as a manufacturing and business centre for the drug industry means that the country should extend more friendly terms to drug companies.

In the past the institute has issued recommendations questioning the advantages of short acting insulin analogues for late onset (type 2) diabetes that were heavily criticised by the industry and others (BMJ 2006;332:874). Recently its questioning of the effectiveness of the drug memantine for patients with Alzheimer’s disease was harshly received by some neurologists.

Criticism of the institute has been accompanied by personal attacks on Dr Sawicki, who has been accused of irregularities in claiming expenses and in commissioning external consultants. The accusations are currently being investigated.

Dr Sawicki said that in principle he was willing to continue in his job for a second period of six years. The institute is funded by the health insurance companies, but the health minister can veto decisions such as the choice of its head.

The letter to the health minister, signed by 600 doctors, says that the work of Dr Sawicki and the institute was essential to medical practice and had helped to strengthen the international reputation of evidence based medicine in Germany.

Cite this as: BMJ 2010;340:c318

CORRECTION We made a mistake in two of the shortlists of candidates for the BMJ Group Awards (BMJ 2009;339:b6599). Firstly, in the Junior Doctor category an editorial error resulted in our publishing only four names, whereas in fact there are nine candidates. The complete list of candidates for this category is Yannick Bejot (neurology, France), Vivian Ewel (neurosurgery, UK), Cristian Gragnaniello (neurosurgery, Italy), Philip Hyde (paediatrics, UK), Richard Lyon (emergency medicine, UK), Douglas Noble (public health, UK), Philip Smith (gastroenterology, UK), Oliver Warren (surgery, UK), and Evan Wood (internal medicine, Canada).

Secondly, in the Excellence in Medical Education category we said that the first two schemes (those of the London Deanery and the King’s Health Partners) constituted a joint nomination, whereas in fact they are separate nominations and will be considered separately for the award.

Cite this as: BMJ 2010;340:c305

The Alzheimer’s drug memantine

The model’s effectiveness was confirmed cessation for six months. In a randomised controlled trial of 800 smokers, $100 (£60; €70) was paid for confirmed abstinence: cessation by biochemical test: $100 (£60; €70) was paid for confirmed cessation for six months after enrolment into the study, and a further $400 was paid for confirmed abstinence for an additional six months. The trial convinced General Electric to implement this approach for all its 152 000 employees in the US in 2010.

So, that’s our shortlist. The judges for this year’s award are Peter Rothwell (winner of last year’s award for Outstanding Achievement in Evidence Based Health Care), Angela Coulter (an independent healthcare analyst and consultant), and Peter Brindle (a part-time GP who also acts as the lead on research for three primary care trusts).

The Getting Research into Practice category is sponsored by NHS Evidence (www.evidence.nhs.uk). For more about the BMJ Group Awards go to http://groupawards.bmj.com/.

Cite this as: BMJ 2010;340:c305