GP consortia will need first class management support

Adrian O’Dowd

England’s GP commissioning consortia will fail without substantial investment in management and technology that is driven by capable leaders, a study of systems in the United States has warned.

Strong management will be vital when the new GP consortia take charge of most of the NHS budget from 2013, says the report from the health policy think tank the Nuffield Trust.

The report examines the US experience of handing the equivalent of commissioning budgets to doctors over the past 20 years—which has met with mixed success.

Senior researchers from the trust visited four medical groups led by doctors in California. Around 2000 doctor led networks and groups emerged across the US from the mid-1980s. They are contracted by insurance providers to take responsibility for fixed budgets with which to deliver their patients’ care.

Only a small proportion of these groups (around 200) have survived to the current day, after some went bankrupt and others had to merge. They vary in size, representing from 45 000 to more than 600 000 patients.

The Nuffield researchers interviewed senior managers and doctor members of the groups. Their analysis concluded that holding risk bearing budgets could motivate doctors to deliver efficient, high quality, and coordinated care that reduced numbers of avoidable and repeated admissions to hospital.

To be successful, the groups had to ensure that primary and specialist doctors cooperated closely and were able to invest in a range of high quality and innovative services that offered alternatives to hospital care.

The US experience also showed that groups had severely underestimated the importance of high quality professional management support in their early days—such as data and information technology systems, experienced analysts, and other management and financial expertise—and that they now spent around 15-20% of their income on this.

See all BMJ articles about the NHS reforms in England at bmj.com/nhsreforms.

Cite this as: BMJ 2011;342:d337

Cameron defends moving NHS into competitive marketplace

Zosia Kmietowicz

The prime minister, David Cameron, this week defended the government’s controversial reorganisation of the NHS in England, saying that his mission was to bring “the promise of opportunity, fairness, and excellence for all.”

Speaking on 17 January at the Royal Society of Arts, two days ahead of the publication of the Health and Social Care Bill, which will put GPs in charge of 80% of the NHS budget, Mr Cameron said that the country “can’t afford not to modernise” and that the coalition government “has a once in a lifetime opportunity to transform our public services.”

Modernisation meant going further than any previous government had dared, he said, to eliminate entrenched inefficiencies and “opening up the system, being competitive, and cutting out waste and bureaucracy.”

Mr Cameron admitted that job losses in the public sector could not be avoided. However, he defended the need to push through the modernisation programme at a pace that many believe is too fast. “Every year we delay . . . another year our health outcomes lag behind the rest of Europe,” he said.

The reforms, which had been prepared during years in opposition, were a “complete change in the way our public services are run,” said Mr Cameron “from top-down bureaucracy to bottom-up innovation, from closed markets to open systems.” The reforms would see public service professionals being made answerable to people “rather than the government machine.”

On the morning of his speech six unions, including the BMA, wrote a letter to the Times in which they accuse the government of failing to heed warnings that introducing competition on the basis of price will damage healthcare services (BMJ 2011;342:d331).

Mr Cameron said that his plans for public service were ambitious but achievable. “We must champion excellence—and stop the slide against our competitors,” he said. While England’s spending per person on healthcare was similar to that in other countries, people here were more likely to die of cancer or heart disease.

He said that the NHS faced “enormous pressures” from a number of quarters.

“Pretending that there is some easy option of sticking with the status quo and hoping that a little bit of extra money will smooth over the challenges is a complete fiction,” said Mr Cameron.

See all BMJ articles about the NHS reforms in England at bmj.com/nhsreforms.

Cite this as: BMJ 2011;342:d363

Cite this as: BMJ 2011;342:d337

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Government has underestimated shift needed for NHS reforms

Nigel Hawkes LONDON

The UK government’s planned reforms of the NHS in England carry a very high level of risk, says the membership body representing most NHS organisations, the NHS Confederation, in a new report.

The “biggest shake-up of the NHS in its history” will succeed only if a series of demanding conditions is met, it says. The report, which resulted from a meeting of doctors, managers, and NHS experts at Leeds Castle in November, says that a degree of optimism is needed to assume that this will be possible.

The greatest problems lie in the implementation of the reforms and in trying to carry them all out at once and in such a short time, the group concluded. It warns the government that this will be “extraordinarily risky.”

The reforms, to be outlined in more detail in the Health and Social Care Bill, expected to be published on 19 January after the second reading of the Health and Social Care Bill, are ambitious, costly and of accountability for NHS bodies, and create opportunities for new providers of services, including some from the private sector.

The confederation’s report is openly sceptical of the likely effect of GP commissioning, accusing the government of “systematically underestimating” the cultural and behavioural changes required of GPs if it is to work.

Not only will GPs need to retain their role as advocates for patients and their focus on individuals, but they will have to make tricky decisions on rationing care and on reconfiguring services and closing hospitals. But if the effect of the reform is simply for primary care trusts’ commissioning to be carried out by GPs, then the scale of the reform is disproportionate and the results may be unexceptional.

For any chance of success a high level of engagement of GPs will be needed, and consortia will need to be ready to take up their role “very quickly.” The danger is that too much time spent thinking will push implementation closer to the next election; and the political wisdom, says the report, is that it is impossible to undertake major strategic change, particularly involving hospitals, any closer than two years to an election. And the greater the delay, the worse the financial position of the NHS will be.

If it is to be done, “then ‘twere well it were done quickly” is the conclusion, though the report refrains from quoting Macbeth.

The report is also sceptical of the impact of markets. Given the right regulatory framework, adequate information, and intelligent purchasers, markets can drive major improvements in efficiency, responsiveness, and quality, it says. “However, it is much less clear that markets are

Allowing providers to offer cut price services is “potentially disastrous”

Nigel Hawkes LONDON

NHS staff unions have attacked plans to allow “any willing provider” to compete on price for the right to deliver healthcare services.

In a letter to the Times, the BMA, the Royal Colleges of Nursing and Midwives, the unions Unison and Unite, and the Chartered Society of Physiotherapists accuse the government of failing to heed warnings that introducing competition on the basis of price will damage healthcare services.

Their concerns arise from the NHS operating framework, published last month, which revealed that providers would be able to offer services at prices below those set by the NHS in its tariff. The government had already made it clear that any willing provider would be able to bid to provide services, but the framework added the possibility of cut price bids.

The NHS is searching for efficiency savings, so such competition might help achieve them. But the unions see it as a threat to their members. The previous Labour government had declared that NHS bodies would be the first in line to bid for services as “preferred providers.”

The letter says research indicates that price competition in healthcare damages quality. It adds that competition will make it harder for NHS staff to collaborate to create the integrated care pathways that patients want and need and that help to make the service more efficient.

The NHS plan, it says, is ambitious, costly and “extremely risky and potentially disastrous.”

See all BMJ articles about the NHS reforms in England at bmj.com/nhsreforms.

Cite this as: BMJ 2011;342:d331

MPs call for review of PFI schemes to ensure value for money

Adrian O’Dowd LONDON

MPs are calling for all private finance initiative (PFI) hospital schemes to be reviewed to ensure value for money, consider whether alternatives are preferable, and discover whether contracts can be renegotiated.

The government should also be forced to use its “market leverage” to get better value for taxpayers from these schemes, said MPs on the parliamentary public accounts select committee in a report published on 18 January.

Under PFI projects private companies build hospitals and social housing with NHS trusts and local authorities, repaying them typically over 30 years. By April 2009 there were 76 operational PFI hospitals in England.

The committee’s report follows its inquiry that asked the Department of Health and the Department for Communities and Local Government to examine their management of PFI programmes to deliver buildings.

The letting of hospital contracts and
good at solving complex problems such as the configuration of services.”

It worries that trauma, cancer, and emergency medicine—all composites of other services—will suffer because the market signals will determine where individual component services are located, swamping weaker market signals for other services of which they form part.

Accountability is another major concern, with the proposed mechanisms “underpowered,” concludes the report. Mechanisms to ensure quality are also lacking, it says. And it questioned the assumption implicit in the health white paper Equity and Excellence: Liberating the NHS that there is no need to reform and improve primary care.

“It seems strange to tap the talents of leading GPs to rethink the delivery of secondary care while leaving the 80% plus of encounters that most patients experience each day unreformed.” Liberating the NHS: What Might Happen? is at www.nhsconfed.org/publications/reports/pages/liberating-the-nhs.aspx.

See all BMJ articles about the NHS reforms in England at bmj.com/nhsreforms/.

Cite this as: BMJ 2011;342:d360

MPs criticise UK government over poor transition planning

Jacqui Wise

The parliamentary health select committee has criticised the government over its failure to properly plan the transition phase of the health-care reforms outlined in July’s white paper, Equity and Excellence: Liberating the NHS.

The committee’s report into commissioning says that the proposal to abolish primary care trusts (PCTs) in England and transfer commissioning responsibility to GP led consortiums was subject to little prior discussion and had not been foreshadowed in the coalition’s programme.

The report says: “The committee does not believe that this change of policy has yet been sufficiently explained given the costs and uncertainties generated by the process.”

It goes on to say that a successful “surprise” strategy requires clarity and planning, but there seems to have been insufficient detail about methods and structures during the transitional phase. The report states: “The failure to plan for the transition is a particular concern in the current financial context. The Nicholson challenge (to deliver 4% efficiency savings per year) was already a high risk strategy and the White Paper increased the level of risk considerably.”

Since the white paper’s publication last July, 2200 management staff have resigned, which has led to warnings that PCTs are effectively in meltdown. As a consequence, in December 2010 the Department of Health decided that these trusts should form clusters in order to pool capacity and ensure delivery of services during the transition to the new system.

The health select committee said that the development of PCT clusters was a pragmatic response to the current situation. But it recommended that the clusters should be in place by 1 April this year.

At a press briefing the committee’s chairman, Stephen Dorrell, the Conservative MP for Charnwood, said that action to enhance the effectiveness of commissioning was essential for the Nicholson challenge to be met.

Commissioning: Third Report of Session 2010-11 is at www.publications.parliament.uk/.

See all BMJ articles about the NHS reforms in England at bmj.com/nhsreforms.

Cite this as: BMJ 2011;342:d358
IN BRIEF

Single rooms in intensive care halve infection rate: Rates of acquisition of Clostridium difficile, vancomycin resistant enterococcus species, and meticillin resistant Staphylococcus aureus in an intensive care unit fell by 54% (95% confidence interval 29% to 70%) after it was converted from a multi-bed ward to single rooms, shows a study (Archives of Internal Medicine 2011;171:32-8).

Medical aid teams treat those injured in Ivory Coast: Surgical teams from the aid group Médecins Sans Frontières have treated 63 people wounded in clashes that have erupted since early January in Duékoué in western Ivory Coast. The United Nations says that 247 people were reported to have been killed in the country since the beginning of violence sparked by the political crisis.

German universities get €5.5m for research into diseases of ageing: Germany’s health and research ministries have announced funding of €5.5bn (£4.6bn; $7.3bn) over the next four years for research in six “action fields,” focusing on diseases likely to strike Germany’s rapidly ageing population in coming years. Research will be grouped around six university based centres for medical research.

FDA limits amount of paracetamol in pills to reduce liver injury: The US Food and Drug Administration has asked drug manufacturers to limit the amount of paracetamol (acetaminophen in the US) in prescription products to 325 mg per pill, tablet, or other unit. Patients should be told to take no more than 4 g of paracetamol a day. The US has an estimated 1600 cases of acute liver failure every year, paracetamol overdose being the chief cause.

NICE recommends Alzheimer’s patch: The UK National Institute for Health and Clinical Excellence has said that the rivastigmine (Exelon) patch can be used in the NHS to treat Alzheimer’s disease. It is just as cost effective as the pills and is better tolerated and reduces the pill burden for patients, says NICE.

Research centre brings battlefield care to the NHS: The National Institute for Health Research Centre for Surgical Reconstruction and Microbiology was launched at University Hospitals Birmingham NHS Foundation Trust on 18 January. Trauma surgeons and scientists will translate innovations and advances in battlefield medicine into benefits for patients.

Cite this as: BMJ 2011;342:d336

UK government faces court challenge over medical abortion

Clare Dyer BMJ

The United Kingdom’s largest independent abortion provider is mounting a High Court challenge to make it possible for women to complete early stage abortions at home.

BPAS, formerly known as the British Pregnancy Advisory Service, is asking the court to rule that the 1967 Abortion Act allows women to take the second dose of tablets for an early medical abortion at home.

The act says that any treatment for the termination of pregnancy has to be carried out at a hospital or clinic. Early medical abortion, available in the first nine weeks of pregnancy, requires women to take two sets of treatment, mifepristone and misoprostol, 24 to 48 hours apart. Currently in the UK this means two visits to a hospital or clinic.

BPAS is seeking a declaration that a correct interpretation of the act would allow the second part of the treatment, misoprostol, to be administered at home, provided that it had been prescribed and issued at a hospital or clinic. But the Department of Health for England is opposing the application, to be heard on 28 January.

BPAS points out that in other countries, including the United States, France, and Sweden, the second drug is issued to women on their first visit with instructions on how to take it at home. This eliminates women’s anxiety that they will have cramping and bleeding on the way home, it argues.

The House of Commons science and technology committee reported in 2007 that there was “no evidence relating to safety, effectiveness or patient acceptability” to support the current practice of requiring two visits.

BPAS’s chief executive, Ann Furedi, said, “We are asking for a court declaration that, in early medical abortion, treatment should be defined as the prescribing and issuing of the necessary drugs but not necessarily administration. This would be a definition in keeping with almost every other area of medical practice. The first medication would still be taken in the clinic, but the second could be taken at home, just as it is in other countries.”

Cite this as: BMJ 2011;342:d264

Regulator drops cases on homoeopathic malaria prophylaxis

Susan Mayor LONDON

The General Pharmaceutical Council of Great Britain has closed cases against pharmacies that offer people homoeopathic remedies to protect them against malaria, after the pharmacists took “remedial action.” The council made no changes to the pharmacists’ registration to practice, however.

The cases were brought after a joint investigation in 2006 by Sense About Science, a charity that promotes evidence based science, and the BBC television programme Newsnight. The investigation showed that the first 10 homoeopathic clinics and pharmacies selected from an internet search recommended homoeopathic pills containing no proved active ingredients to a researcher who said she was travelling to countries where malaria is endemic.

Last week the General Pharmaceutical Council, the regulator of pharmacists, said in a statement that it had carried out a detailed investigation of the complaints.

“In all three cases remedial action was taken,” the council said. After considering whether the individual pharmacists’ fitness for registration was impaired the council said that it “did not believe that pursuing these particular cases further would establish or clarify any significant points of generally principle.” It added that the cases are now closed and refused to comment further when invited to do so.

Tracey Brown, managing director of Sense About Science, warned, “The General Pharmaceutical Council’s decision not to take any action against pharmacies who have been offering travellers homoeopathic alternatives to antimalarial medicine, after four years of delay, is downright shabby and irresponsible.”

See PERSONAL VIEW p 232.

Cite this as: BMJ 2011;342:d338

Ainsworths, London, provided homoeopathic pills to a researcher who was going to a malaria area
Fall in US abortion rate stalls after 17 years, report finds

Janice Hopkins Tanne  NEW YORK

Numbers of abortions in the United States, which have been falling since 1981, rose slightly from 19.4 per 1000 women aged 15 to 44 in 2005 to 19.6 in 2008, the non-profit Guttmacher Institute has reported.

The 2008 rate was well below the peak of 29.3 abortions per 1000 women in 1981, but the steady decline in the US rate “appears to have stalled,” the report says. The study was unable to verify claims that the recession has stalled,” the report says. The study was unable to verify claims that the recession has led to a higher number of abortions, because, it says, “the small increase in abortion incidence began before the recession,” which started in late 2007.

The US has one of the highest abortion rates in the developed world, said Lawrence Finer, associate director for domestic research at the institute.

The US Centers for Disease Control and Prevention had previously reported that the number and rate of abortions rose by 3% between 2005 and 2006.

The Guttmacher Institute also said that a “disturbing increase” in harassment of abortion clinics had been seen. Almost nine in 10 abortion clinics (89%) reported anti-abortion harassment in 2008, a rise from 82% in 2000.

Its report said, “Harassment was particularly common among providers of all sizes in the Midwest and South. Picketing was the most common form of harassment (reported by 55% of providers), followed by picketing combined with blocking patient access to facilities (21%).”

Nearly 20% of the largest facilities reported a bomb threat. For the first time the report included information on internet harassment: 3% of abortion providers said that protesters had posted pictures of patients on the internet.

Access to an abortion provider can be difficult, the institute said in this its 15th annual survey. Only 35% of women of reproductive age live in a county that has an abortion provider. About 87% of US counties don’t have an abortion provider, and some women may lack the time or resources to travel to one.

The institute notes that its state by state report indicates where the abortion was performed, not where the woman lived. Wyoming reported the lowest rate of abortions, less than one per 1000 women—only 70 abortions in 2005. However, about 1100 Wyoming women obtained abortions in 2005, almost all of them outside the state.

The highest abortion rates in 2008 were in northeastern states, followed by the West, the South, and the Midwest. Abortion services were concentrated in cities. The number of abortion providers rose slightly from 2005 to 2008, from 1787 to 1793. Most abortions (70%) were provided in independent, specialised clinics.


Cite this as: BMJ 2011;342:d315

Illinois governor hesitates over abolishing death penalty

Janice Hopkins Tanne  NEW YORK

The Illinois House of Representatives and Senate have voted to repeal the state’s death penalty, but the state’s newly elected governor, Pat Quinn, a Democrat, has not yet signed the bill into law.

Governor Quinn said on 12 January that he would follow his conscience in deciding whether to sign. He has 60 days to decide. During his election campaign he supported the death penalty but said he would maintain the state’s current moratorium on executions.

If he signs the bill Illinois will become the 16th state to outlaw executions.

Two men, Kevin Fox and Jerry Hobbs, who were wrongly accused of murdering their children but cleared by DNA evidence, appealed to Governor Quinn to sign the bill.

Five men who were exonerated for their crimes while on Illinois’ death row asked for a meeting with Governor Quinn to ask him to sign the bill.

Illinois has had a moratorium on the death penalty since 2000, when the then governor, George Ryan, a Republican, imposed it and removed 171 people from death row. He commuted most sentences to life in prison and freed four inmates whose guilt was in question.

Twenty death penalty cases have been overturned in Illinois since 1977. In some cases evidence has shown that the accused weren’t guilty. In other cases trials were found to be unfair, or confessions had been coerced by the police.

In Texas the Dallas Morning News has called for a moratorium on executions in the state. Since 1976 Texas has executed by far the highest number of prisoners in the United States—a total of 464. The editorial in the newspaper said, “Unnerving evidence of miscarriage of justice is all around us. The state leads the nation in DNA exonerations . . . It’s clear Texas law-enforcement officials and courts have gotten it terribly wrong at times, so much so that a moratorium is just as appropriate in Texas today as it was in Illinois in 2000.”

The Innocence Project, which supports an end to executions, said, “Our work has proven that innocent people are sentenced to die.”

Cite this as: BMJ 2011;342:d323

Jerry Hobbs spent five years in jail after being wrongfully accused in 2005 of murdering two girls
Reluctance to donate is particularly widespread among Spain’s immigrant population.

Organ donors and transplantations fall in Spain, the leading country in both

**María de Lago** MADRID

The number of organ donors and transplantations fell last year in Spain, the country that leads the ranking in both and whose transplantations model was recently adopted by the EU.

The decline—which signals a break in the increase seen in recent years—was caused largely by a sharp reduction in deaths from traffic incidents. Improved management of cerebral infarctions and a small increase in the refusal rate to donate organs among families whose relative has died have also contributed to the fall. The reluctance to donate is particularly widespread among the immigrant population.

The number of organ donors in Spain dropped from 34.4 per million inhabitants in 2009 to 32 million in 2010, while the total number of registered donors fell from 1606 in 2009 and 1502 in 2010, reports the Spanish National Transplant Organisation. This reduction is the largest seen in the past 20 years.

The number of transplantations carried out in Spain also fell noticeably last year to 3773, down from 4028 in 2009 (6% less) and 3945 in 2008. In addition, the average age of donors increased by two years to 56.5 compared with 2009.

The health general secretary, José Martínez Olmos, said Spain “continues with its 19 years of uninterrupted leadership in donations and transplants” and “still has the highest figures of donations in the world, well above European Union and US average rates (18.3 and 25.2 donors per million inhabitants, respectively).”

The main reason for the drop in donations is “the diminution of brain deaths occurring in the ICU [intensive care unit],” explained Mr Martínez Olmos.

The number of donors from traffic incidents fell from 249 in 2005 to 85 in 2010. In 2009 traffic victims made up 8.3% of all donors in Spain, but last year they accounted for just 5.7%.

Deaths from cerebral infarctions or haemorrhages also decreased, and the refusal rate for organ donation among relatives slightly increased in 2010 and reached 18%, according to preliminary data of the transplant organisation. The contribution of immigrants to the total donations is stuck at the 2006 levels; they provided 9.3% of all donations although they make up at least 12.3% of Spanish population.

Although Mr Martínez Olmos said that the Ministry of Health “is not worried by the decrease in the number of donors,” he admitted that it is “busy looking for solutions.”

One possible solution involves trying to increase the number of living donors and cardiac dead donors, both of which reached their highest levels in 2010. Last year there were 240 kidney transplants from living donors in Spain and 130 cardiac dead donors.

The Ministry of Health also plans to encourage donations among immigrants and is promoting good Samaritan or altruistic living donations to unknown recipients.


Cite this as: BMJ 2011;341:d242

Welsh Assembly considers opt-out scheme for organ donation

**Roger Dobson** ABERGAvenNY

Wales has moved a step closer to being the first part of the United Kingdom to introduce an opt-out scheme for organ donation.

A proposed legislative competence order (a form of secondary legislation) relating to organ and tissue donation has been laid before the Welsh Assembly. The aim of the order is to transfer specific powers from the UK parliament to the assembly in relation to consent to organ donation. It would allow Welsh ministers to introduce a system of presumed consent to organ donation. Edwina Hart, the assembly’s minister for health, said, “We would do that in order to increase the number of potential organs available for transplantation.

“...by two years to 56.5 compared with 2009.

That aim is supported by a number of clinical bodies, including the British Medical Association and the Royal College of Nursing, and charities such as the British Heart Foundation and Kidney Wales Foundation.”

She told the assembly that the UK government had expressed a number of concerns, including the practicality of having a different system in Wales from that in England and the implications for human rights.

“I will obviously look at these issues ... but I do not think that it is something that I could comment on. I simply provide that as the information that we have now received,” said Ms Hart.

It is not usual for a proposed order to be introduced ahead of the UK government’s confirmation that it accepts it. But Ms Hart said that if the assembly had waited for confirmation time restraints meant that assembly members would have had no proper opportunity to scrutinise the order. As well as being approved by the assembly, a legislative competence order must be approved by the UK parliament. Having been subject to prelegislative scrutiny, a draft order is formally laid before the assembly, which then votes on it.

Joyce Robins, co-director of Patient Concern,
Transplantations fall in Israel as new law takes effect

Tamara Traubmann TEL AVIV
The number of patients in Israel who die while waiting for a transplant rose last year, and the number of transplantations fell by 20%, the annual report of the Ministry of Health’s National Transplant and Organ Donation Centre has said.

As a result the shortage of organs has become more acute. Rafi Biar, chairman of the centre’s steering committee and director of the Rambam Medical Centre in Haifa, said that the main cause of the decrease is a new law that changed the protocol for defining “brain death” after discussions with the Chief Rabbinate.

According to Jewish law death can be determined only after cardiopulmonary failure, and until recently the Chief Rabbinate had prohibited organ donation, as it did not recognise brain stem death. However, in 2008 the Israeli parliament passed a law that defines “brain respiratory” death as an indication of death for all legal purposes and also outlined the procedure that should be carried out to ensure that death had occurred. The law was formulated in cooperation with the Chief Rabbinate.

Avinoam Reches of Hadassah Medical Centre, Jerusalem, participated in the discussions. He said, “Under the previous protocol brain death was primarily diagnosed through clinical tests. In the protocol required by the new law, on the other hand, death should be confirmed by use of equipment. This new procedure cannot always be carried out.” The new law also obliges doctors to notify the family before they can embark on the process of diagnosing brain stem death.

Cite this as: BMJ/2011;342:d332

Rabbi says brain stem death is not enough for organ donation

Jacqui Wise LONDON
The United Kingdom’s chief rabbi, Jonathan Sacks, has issued an edict that carrying donor cards is unacceptable and that the current organ donor system is incompatible with Jewish law.

The ruling comes after years of debate among rabbincial authorities over the definition of death and when an organ may be removed for transplant purposes. The new statement from the chief rabbi and his rabbinical court, the London Beth Din, says that organs may be removed for transplantation only at the point of cardiorespiratory failure, rather than at brain stem death.

The latest figures for 2010 show that 66% of donations came from donors after brain death and 34% from donors after cardiovascular death, NHS Blood and Transplant said.

The BMA warned that the edict may reduce the number of donations. Three people die every day in the UK because of the shortage of organs for transplantation. An association spokesman said, “Organ donation and transplantation is a huge success story, and it will be a tragedy if the number of organs available started going down and fewer lives could be saved.” The BMA said it is a matter of urgency that the chief rabbi meet with organ donation experts to discuss the issue.

Lord Sacks’s statement said that a living person may donate an organ, such as a kidney, to save someone else’s life providing that the donor does not put his or her own life at major risk. Jewish law also permits donation after death as long as the organ is needed for immediate transplantation. However, the statement says: “Live people (irrespective of how close to death) may not donate organs to save another person’s life if in doing so it will hasten their own demise.”

The statement says: “There is a view that brain stem death is an acceptable Halachic (following Jewish law) criterion in the determination of death. However, it is the considered opinion of the London Beth Din that in Halacha cardiorespiratory death is definitive.”

The chief rabbi’s office says that it is already in consultation with the UK medical profession about the possibility of devising a method whereby the number of organs donated by Jews can be increased in accordance with Halacha. It wants Jews to be able to register directly with the NHS national organ donor registry with the clear provision that a Halachic authority is contacted if and when donation is anticipated and for the donation to be carried out within Halachic rules.

The chief rabbi said, “At this point, however, since the national registry system is not set up to accommodate Halachic requirements, donor cards (even those purporting to be Halachic) are unacceptable.”

James Neuberger, associate medical director for NHS Blood and Transplant, said that it would welcome the opportunity to discuss this important issue with the chief rabbi. “NHSBT respects the views of all religions and has received public support from all the major faiths in the UK towards organ donation. It is a very personal choice, and anyone with questions around how their religion reflects the donation of organs is urged to discuss it with their local faith leader,” he said.

“Organ donation only occurs after someone has died, whether it is by cardiac or brain stem death, and individual donors’ wishes are always at the centre of discussions with their relatives.”

He added: “We do not record donors’ religions on the organ donor register (ODR), but anyone in favour of donation or joining the ODR should inform their relatives of any beliefs they hold that reflect their religion so that this can be taken into consideration at the time donation is being discussed.”

Cite this as: BMJ/2011;342:d275

which promotes choice for patients, said, “Edwina Hart had been all ready to forge ahead to allow Wales to bring in a system of presumed consent. Her plans may have been spiked by worries from the attorney general [for England and Wales] that such a system might not be legal or may have human rights implications. She was undeterred by the report from her own health committee, which advised against such legislation—as did our organ donation taskforce and the House of Lords’ EU committee.

“so called presumed consent is actually pretend consent. It is dishonest. As our law points out, the absence of refusal is not evidence of consent. Nothing alienates patients, their carers, and relatives more than feeling taken for granted.”

Cite this as: BMJ/2011;342:d273