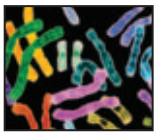

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Cut science funding at your peril, MPs warn chancellor Osborne

Lynn Eaton LONDON

The United Kingdom's coalition government needs to look beyond the short term and start considering the longer term implications of any cuts in science research budgets, warns an influential committee of MPs.

Andrew Miller, Labour MP and chairman of the House of Commons Science and Technology Committee, has criticised chancellor of the exchequer George Osborne's timetable for the proposed spending review in the autumn, which will look at spending cuts across the board, including medical research.

In a letter dated 27 July Mr Miller warns: "The timetable does not sit well with the parliamentary calendar." It requires a response by August, he said, and he expressed surprise that the select committees have not explicitly been asked to "contribute to the exercise."

He draws heavily on a report the committee published in March 2010, under the Labour government, where his predecessor put the case for protecting spending on science and technology.

That report cited a 2008 report from the Academy of Medical Sciences, Wellcome Trust, and Medical Research Council showing that every £1 invested in public or charitable research for cardiovascular disease between 1975 and 1992 had produced a string of benefits that were equivalent to £0.39 a year in perpetuity.

The same report, *Medical Research: What's it Worth?* (www.brunel.ac.uk/385/other/TAP825EconomicBenefitsReportFULLWeb.pdf), showed that every £1 extra spent on public medical research led to an increase in drug industry research and development spending of between £2.20 and £5.10.

"We agree with the former committee that reductions in science investment would be both counterintuitive and counterproductive," wrote Mr Miller.

"Much good progress would be lost, and the size of the reductions to science is unlikely to make a significant dent in the deficit."

He suggests that the model in Canada, where cuts that had to be made in the 1990s were moderate and were speedily reversed once finances allowed, is the least damaging approach.

Cite this as: *BMJ* 2010;341:c4180

SWNS. JOHN STILLWELL/PA. STEVE PARSONS/PA

Caner Salih (top), who raised concerns about practices at the John Radcliffe Hospital, was cleared of any wrongdoing. His senior colleague, Stephen Westaby, had taken annual leave soon after Salih arrived

Poor mentoring is blamed for infant deaths after surgery

Jo Carlowe LONDON

A lack of effective clinical management contributed to infants' deaths at the Oxford Radcliffe Hospitals NHS Trust, a damning review published on 29 July says.

The independent review of paediatric cardiac surgery and clinical governance, chaired by Bill Kirkup, was commissioned by the South Central Strategic Health Authority after four deaths of infants after cardiac surgery between December 2009 and February 2010.

All four cases involved Caner Salih, a newly appointed consultant surgeon, who was left alone soon after his arrival while his senior colleague Stephen Westaby took annual leave.

National data indicated that for the number of patients less than one death would have been expected. However, the review panel found no evidence of poor surgical practice. Mr Salih used up to date methods, but the team at John Radcliffe Hospital was used to different techniques, "some of which have been superseded by the majority of practitioners," said the review.

It was noted that Mr Salih raised concerns about the working practices and the fact that equipment, including ventilators, was old, and yet the trust failed to act on these.

The review found that these factors, along with inadequate supervision, contributed to the clinical risk.

Mr Salih was "telephone" mentored by a senior consultant in London—a practice described by the panel as "a poor substitute for face to face contact." The panel concluded that "different surgical management" may have led to a better outcome.

Its report said, "In Mr Salih's four cases we found no evidence of poor surgical practice, but that he would have benefitted from help or mentoring by a more experienced surgeon . . . We believe that it was an error of judgment for the clinical team to decide that Mr Salih, as a new surgeon working with a team not yet used to his methods, should undertake some of these procedures without assistance from another consultant cardiac surgeon."

In 2000 Stephen Westaby was criticised for not being a team player in a review by the NHS Executive into declining adult cardiac services in Oxford (*BMJ* 200;321:1307).

The review said that paediatric cardiac surgery should remain suspended at the hospital "until or unless the service can safely be expanded."

It also recommended more effective operational planning at the hospital and new clinical governance arrangements.

The review is at www.southcentral.nhs.uk.

Cite this as: *BMJ* 2010;341:c4157

UK ranks eighth out of 13 countries on drug prescribing

J D TALASEK/PHOTOTAKE/ALAMY

The UK was 10th for usage of cancer drugs but 12th for drugs launched in the past five years

Caroline White LONDON

The United Kingdom lags behind several other developed countries in its use of drugs for dementia and cancer but comes out near the top for its use of cardiovascular medicines, says a report.

But no consistent international pattern emerges for all the disease categories assessed, even for those countries at the top of the league table, the findings show.

The report, by Mike Richards, national clinical director for cancer services, was drawn up in response to perceived concerns that UK patients were not getting the same level of access to newer drugs as their peers elsewhere and to the commitment made in the Pharmaceutical Price Regulation Scheme to develop measurable comparisons of new medicines uptake in Europe.

The analysis reviewed drug use per head of the population for seven disease categories that are costly to treat in 10 European countries of varying size, plus Australia, New Zealand, and the United States. The unweighted analysis, which spans the period from April 2008 to March 2009, ranks the UK eighth overall, behind several of its European neighbours—including Spain, France, and Denmark. The US tops the league, and New Zealand comes bottom. The UK earns second place for its use of cardiovascular drugs—thrombolytics for heart attack and cholesterol lowering statins—the latter being prescribed almost three times as much as the international average.

But it scrapes in at 13 for drugs to treat hepatitis C and multiple sclerosis and 11 for antipsychotic and dementia drugs. It manages only 10th place in the rankings for rheumatoid arthritis drugs.

The UK is also at 10th place for cancer drug usage, which the report analyses in more detail, rising to fifth place for hormonal cancer treatments, but dropping to 12th for drugs launched in the past five years.

Bulletin says removal of Mixtard 30 will be costly and disrupt patient care

Nigel Hawkes LONDON

A campaign has been launched against the decision by the Danish drug company Novo Nordisk to withdraw a form of insulin used by 90 000 patients in the United Kingdom.

Mixtard 30, which is a 30:70 mixture of short acting and intermediate acting human insulin, is to be withdrawn from the market at the end of the year. Novo Nordisk's decision, announced in June, caused disquiet among doctors and diabetes charities. Douglas Smallwood, chief executive of Diabetes UK, said that he was "very disappointed" by the announcement and had sought unsuccessfully to have it reversed.

Ike Iheanacho, editor of the *Drug and Therapeutics Bulletin* (a BMJ Group publication), said that the switch would be disruptive to patients and expensive to the NHS. If all 90 000 patients switched to Novo Nordisk's other product, NovoMix 30, prescribing costs would rise by £9m (€11m; $14m) a year in England alone, he said. The costs of reviewing patients and determining the right alternative would be extra.

"There will be both psychological and medical problems," Dr Iheanacho said. Many patients had been taking Mixtard 30 for many years and were successfully stabilised, and achieving the same results with a new product could be tricky. "There is no evidence that the alternatives to Mixtard 30 are any better, so treatment will not be improved by the switch," he said.

The August issue of the *Drug and Therapeutics Bulletin* includes an editorial criticising Novo Nordisk's decision (2010;48:85), and an online petition has been launched.

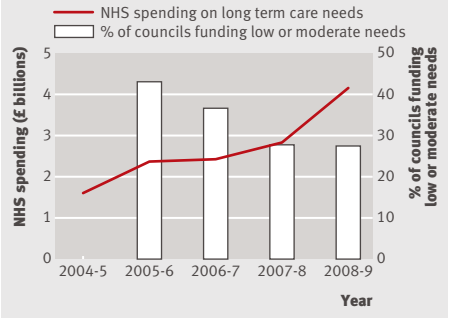
Dr Iheanacho said, "Although not all those forced to switch will choose NovoMix 30, Novo Nordisk has worked out that it will be better off, on balance. But it is not withdrawing Mixtard 30 everywhere. It will still be available in Germany under another name and in the convenient FlexPen dispenser, which has never been available in the UK."

Mixtard 30 was introduced more than 25 years ago. More recent introductions, including NovoMix 30 and Lilly's Humalog, are insulin analogues, in which the amino acid sequence of the insulin has been modified with the aim of improving performance, including both a rapid response and better long term control of glucose concentrations. However, a 2004 Cochrane review showed no benefit in long term control or in reducing episodes of hypoglycaemia.

Novo Nordisk said that the use of Mixtard 30 had steadily fallen and that eight in 10 new diabetes patients in the UK are now given a prescription of an insulin analogue. Its managing director in the UK and Ireland, Viggo Birch, said that the company's long term strategy was improvement, and to achieve that older products had to be withdrawn.

Cite this as: *BMJ* 2010;341:c4210

NHS SPENDING ON LONG TERM CARE NEEDS



Source: *Careless: funding long-term care for the elderly*. Policy Exchange

Report wants pooled funding to meet older people's care costs

Andrew Cole LONDON

The new commission into the funding of social care in England should consider merging NHS and local authority spending on care for elderly people to keep costs in check, says a report from the right of centre think tank Policy Exchange.

The report points out that the NHS is already responsible for a quarter of the estimated £16.17bn (€19.3bn; $25bn) of public spending on long term care and that its contribution is set to rise substantially as cuts take effect in local government.

"It would be naive to think that reducing spending on the means-tested long term care system will not result in cost shifting to the NHS where unit costs are typically 30% higher," the report notes.

It proposes that NHS and local authorities'

Australia, which ranks fifth overall, comes 12th for its use of cancer drugs, whereas the US only manages eighth position. Germany, which comes 11th overall, occupies third place for cancer drugs.

The report found that the causes of the variations "appear to be complex."

Professor Richards cautioned against jumping to conclusions about quality of care. "There is no right or wrong level of usage," he said, adding that it was up to clinicians to decide on appropriate levels. "You can't take the simplistic view," he warned.

But the government used the report's findings to back its announcement of a £50m fund, available from October, to enable patients to access cancer drugs more easily, including those currently deemed too expensive or used off label.

The intention is to extend the fund to £200m (€240m; $313m), pending the outcome of the comprehensive spending review later this year.

The report is at www.dh.gov.uk.

Cite this as: *BMJ* 2010;341:c4128

social care budgets should be merged and controlled by the NHS in future.

The problem with the current system—where funding is split between two different departments—was that the two services were interdependent, said coauthor Henry Featherstone, head of the Health and Social Care Unit at Policy Exchange.

"If you ringfence one and squeeze the other, what do you think is going to happen?" he asked. NHS spending on long term care had risen dramatically since local authorities tightened their eligibility criteria, he said.

The report says the commission should choose between three models of funding for long term care. These are a partnership model where the state provides 50% of funding and then part matches individuals' contributions thereafter; the social insurance approach used elsewhere in Europe; and a "hybrid" model where the state funds a basic level of care that must then be topped up by individuals.

But it urges the commission to reject out of hand the idea of a National Care Service, funded entirely by the taxpayer. It calculates that, if informal carer costs are taken into account, this would cost £106bn a year—the equivalent of another NHS.

It also casts doubt on the Department of Health's assumptions that the costs of care will rise by as much as 50% in the next 15 years as the population ages. It says a number of international studies suggest that most elderly people are living longer without severe disability.

***Careless: Funding Long-Term Care for the Elderly* is available at www.policyexchange.org.uk/.**

Cite this as: *BMJ* 2010;341:c4121

Working time directive puts lives at risk, surgeons claim

Lynn Eaton LONDON

Patients are less safe than they were a year ago, before the introduction of the 48 hour limit on the average working week in the United Kingdom, say respondents to a survey by the Royal College of Surgeons.

However, the BMA, which has fought for the limit on doctors' working week, is contesting some of the survey's claims, citing a report from the now extinct Postgraduate Medical Education Training Board, which states that medical errors linked to overwork are more likely in posts that are not compliant with the directive.

The board's report, which was based on responses to the training surveys in 2008-9, before the full 48 hour limit came into operation, showed that trainees who attributed their errors to overwork were in posts that overall were less compliant with the directive (among those who attributed their errors to overwork 64% of posts complied with the directive over a 26 week period, whereas among those who didn't attribute their error to overwork 77% complied).

Bill McMillan, head of medical pay and workforce at NHS Employers, said he was surprised that the college's survey showed the NHS was less safe for patients.

"We are not aware of any evidence that suggests that the new legislation specifically has led to an increase in errors," he said.

The college's survey was issued to coincide with the first anniversary of the 48 hour average week, which began on 1 August 2009.

The college's president, John Black, who supports the reintroduction of a 65 hour week, recently told members he had received a memo from Andrew Lansley, England's health secretary, which he believes signalled a willingness to opt out of the working time directive completely. (See http://careers.bmj.com/careers/advice/view-article.html?id=20001148.) Mr Lansley has also told Sir John that releasing junior doctors from the directive was "a very high priority."

Of the 8000 members of the Royal College of Surgeons working in the UK, 980 answered the latest survey. Eighty per cent of consultant surgeons and 66% of surgical trainees said that care of patients had deteriorated since the directive came into effect; 72% of consultants and 59% of trainees who responded to a similar survey in October 2009 said that care had deteriorated.

Two thirds of trainee respondents believed that they now spent less time in training—up from 41% of respondents in 2009. And the percentage who reported inadequate handovers rose from 37% of consultants in October 2009 to 41% now and from 29% of trainees to 37% now.

"Surgeons at all levels are telling us that not only is patient safety worse than it was before the directive, but their work and home lives are poorer for it," said Sir John, who admitted that the survey gave only anecdotal evidence.

Asked to illustrate cases where patient safety had been compromised, he cited an example from a hospital in the West Midlands where an inexperienced locum was brought in to do an operation because of a gap in the rota. The locum removed the 8 year old girl's ovary rather than her appendix. The college was unable to supply any further specific incidents where safety was known to have been compromised.

A summary of results are at www.rcseng.ac.uk/news/docs/rcs_ewtd_survey_results_jul_2010.pdf.

Cite this as: *BMJ* 2010;341:c4212

Surgeons are still willing to work a 65 hour week, says their royal college president, John Black

IN BRIEF

England consults on improving autism care: The Department of Health in England has launched a consultation on how to improve care services for adults with autism. The 12 week consultation process is seeking views from people with autism, their families, and wider society on issues such as diagnosis, training of staff, assessing needs, and local leadership in provision of NHS and social care services (www.dh.gov.uk/en/Consultations/Liveconsultations/DH_118058).

Most Scottish patients rate GPs' care highly: The care provided by GPs in Scotland has been rated good or excellent by 90% of people who took part in a survey of just under 190 000 adult general practice patients. The survey, published by the Scottish government, found that 81% of patients rated the overall arrangements to see a doctor as good or excellent.

90% of patients rate care as good or excellent

Americans from southern states are more likely to be uninsured: New US census data show that the northeastern state of Massachusetts has the lowest percentage of uninsured people under age 65, about 7.8%. Southern states had the highest numbers of uninsured people: nearly 27% in Texas and New Mexico and 24.2% in Florida. The figures do not show the effects of job losses resulting from the recession since 2007.

UK figures show rise in injuries on train and tube: The annual number of injuries to passengers using the UK railways and tube networks is rising, show figures for 2009-10. Just over 4200 incidents were reported in 2009, a rise of 8.4% from the 2008 figure. The rise was caused mainly by passengers falling on stairs and escalators, says the Office of Rail Regulation (www.rail-reg.gov.uk/upload/pdf/HealthSafetyReport2010.pdf).

Australian antivaccination website has misleading information: The Australian Health Care Complaints Commission has ruled that the website of the Australian Vaccination Network, a non-profit organisation, contains information that is incorrect and misleading. The site quotes selectively from research to suggest that vaccination may be dangerous, the commission found during its investigation of two complaints. It ruled that the network should add information making it clear that its purpose is to provide information against vaccination.

Cite this as: *BMJ* 2010;341:c4197

Scottish NHS should not be exempt from budget cuts

Bryan Christie EDINBURGH

The NHS in Scotland should not be given special protection against cutbacks in public expenditure, an independent budget review set up by the Scottish government has concluded.

The review, which was asked to identify options for savings, also says that free, universal services such as eye tests and personal and nursing care, and plans to abolish prescription charges, "may no longer be affordable."

It proposes that up to 60 000 jobs be cut from the total public sector workforce in Scotland by 2014-15 and that public sector pay be frozen for two years, in line with plans for England and Wales already announced by the UK government. Where possible, these job reductions should take place by natural wastage. The report also supports a review of public sector pensions.

The recommendations have been made in response to what the report describes as the "most challenging public spending environment since the Second World War." It estimates that it may take 15 years for public spending in Scotland to return, in real terms, to 2009-10 levels.

It finds "no overwhelming rationale" for ringfencing the NHS budget to protect it from the cutbacks and expresses concern at the burden this would place on non-protected services.

The review has also identified the NHS distinction award—additional pay to recognise "exceptional" contributions by NHS consultants (*BMJ* 2010;340:c151)—as a potential area for savings. It says that the cost of the scheme "appears significantly out of line with all other public sector non-consolidated pay/bonus arrangements." It recommends that the Scottish government raise concern over the scheme with the Fair Pay Review that has been set up by the UK government.

The review's findings produced a strong reaction from the BMA in Scotland. Its chairman, Brian Keighley, said, "I absolutely agree with the review that developing a longer term strategic view of public services is required. However, public sector workers should not bear the responsibility for the failings of the banking system, and the NHS must not pay the price of poor financial management by governments."

Dr Keighley defended the distinction award scheme and said that the NHS pension scheme had recently been reviewed.

He said, "This report makes some serious recommendations that we must warn against. We recognise that the UK is entering a period where a degree of pay restraint will be required, but the BMA will continue to argue for fair reward for our members. Public sector workers are already facing a two year pay freeze and cannot be expected to continue to pay the price for the mistakes of others. This all comes on top of four years of no funding increase for general practice. Eventually something has to give, and essential frontline services will suffer."

The review proposals will now be considered by Scottish ministers as they plan how to reduce the Scottish budget.

The *Report of Scotland's Independent Budget Review Panel* is at www.scotland.gov.uk/Resource/Doc/919/0102410.pdf.

Cite this as: *BMJ* 2010;341:c4160

US doctors are urged to support women to have vaginal delivery after a prior caesarean

Bob Roehr WASHINGTON, DC

Doctors in the United States have emphasised the safety of vaginal delivery for women who have had one or two previous caesarean sections in an attempt to "swing the pendulum back to fewer caesareans and a more reasonable VBAC [vaginal birth after caesarean] rate."

In new guidelines the American College of Obstetricians and Gynecologists says that no woman who wishes to have a vaginal delivery should be forced to undergo a repeat caesarean section (*Obstetrics & Gynecology* 2010;116:450-63). If a doctor is uncomfortable with a woman's request during her prenatal care to have a vaginal delivery she should be referred to another doctor or centre, they say.

Richard Waldman, president of the college, said that the current rate of caesarean sections was unacceptably high and that doctors needed "to work collaboratively with patients and colleagues, hospitals, and insurers" to bring down the rate of second caesareans.

He said the new guidelines "emphasise the need for thorough counselling of benefits and risks, shared patient-doctor decision making, and the importance of patient autonomy."

GIACOMO PIROZZI/PANOS

As many as 215 million women in the developing world do not have access to modern family planning

UK aid policy for women's health to focus on family planning, says minister

Peter Moszynski LONDON

The UK government is to put family planning at the heart of its approach to women's health in the developing world, the international development secretary, Andrew Mitchell, has said.

The new approach will see a "significant increase" in the availability of family planning and a new focus on maternal and newborn health, accompanied by a "wide ranging" consultation exercise. Initial responses from development agencies have been largely positive, although there is concern that the focus on newborns will be at the expense of health care for under 5s.

Mr Mitchell's department estimates there are currently 215 million women in the developing world who would like to delay or avoid their next pregnancy but do not have access to modern family planning methods. It estimates that increasing access could prevent up to 30% of all maternal deaths and 20% of newborn deaths.

The new strategy highlights family planning, adolescent fertility, unsafe abortion, antenatal care, and skilled care at delivery. The department says that the failure to deal with these issues "contributes to up to 1000 women dying needlessly in pregnancy and childbirth every day."

Mr Mitchell said, "It is clear why reproductive and maternal health is the most off-track of all the millennium development goals. The international community has failed to assist millions of women by ignoring the complexities of why at least a third of a million women in the world's poorest countries die during pregnancy and childbirth each year. For too long we've been trying to tackle the issue with one hand tied behind our backs."

He said his department will now have "an unprecedented focus on family planning, which will be hard-wired into all our country programmes."

Claire Seaward, Oxfam's Healthcare For All campaign manager, told the *BMJ*, "Women in poor countries must be given choices and control over their reproductive rights. A third of maternal deaths could actually be avoided if women had access to family planning, and it's great to see priority being given to this long-neglected issue.

"But this cannot be at the expense of strengthening overall public health systems. The UK government must also address the chronic shortage of midwives and other health workers in poor countries and ensure that health care is free, so women are no longer paying with their lives."

Simon Wright, head of health at Save the Children, told the *BMJ* that the proposed government strategy focuses on mothers and newborns up to 28 days old "but excludes the millions of children who die after the first month of life."

He said that of the almost nine million children who die before the age of 5 each year, 55% of them are older than one month. He added, "This means the deaths of nearly five million children are outside the focus of the government's new plan.

"The UK government is departing from globally agreed guidelines which clearly state that maternal, newborn, and child heath must be tackled together," he said. "Integrated health services improve efficiency, are more user friendly, and reduce the costs of travelling multiple times and places."

Cite this as: *BMJ* 2010;341:c4135

The college says that, in line with past recommendations, most women with one previous caesarean delivery with a low-transverse incision are candidates for vaginal delivery and should be counselled and offered a trial of labour.

Jeffrey Ecker, from Massachusetts General Hospital in Boston and immediate past vice chairman of the college's committee on obstetrics practice bulletins, who co-wrote the guidelines, said, "The college guidelines now clearly say that women with two previous low-transverse caesarean incisions, women carrying twins, and women with an unknown type of uterine scar are considered appropriate candidates for a TOLAC [trial of labour after caesarean]."

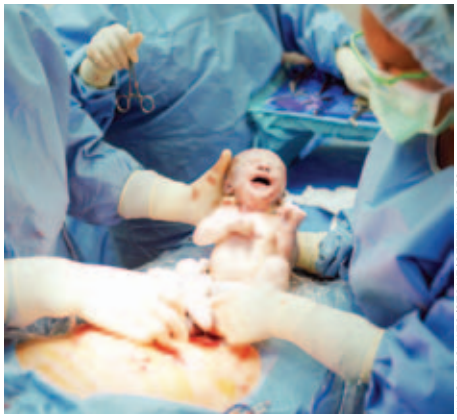
Between 60% and 80% of women who have previously had a caesarean section will have a successful vaginal delivery, says the college.

The guidelines say that doctors should discuss vaginal delivery early in a second pregnancy so that plans can be made well in advance to accommodate a woman's wishes.

While it is safest to have a trial of vaginal delivery in hospitals where staff can provide emergency caesarean sections, hospitals that do not have the right personnel on site can still offer vaginal delivery by having processes in place to get staff in place quickly, they say.

In 2007 nearly a third (31%) of all births in the US were by caesarean section. The rate of subsequent vaginal delivery among women who had a first delivery by caesarean section was about 5% in 1985, 28% in 1996, and 8.5% in 2006.

Cite this as: *BMJ* 2010;341:c4167



LUCA TROVATO/STONE/GETTY IMAGES

In 2007 nearly a third (31%) of all births in the US were by caesarean section: the rate of second caesareans was 91.5% in 2006

ADREES LATIF/REUTERS

Agencies act to avert "public health catastrophe" after floods in Pakistan

Peter Moszynski LONDON

Relief teams responding to Pakistan's worst flooding in generations are being hampered by massive infrastructural damage that has left the worst hit areas unreachable except by air.

Health workers are warning of the risk of waterborne diseases as continuing monsoon rains threaten to cause further damage downstream.

Millions of people have been affected, and 1500 people have already died as a result of floods, local news agencies report. One of the worst hit areas is the province of Khyber Pakhtunkhwa (formerly the North West Frontier Province). This area has seen hundreds of thousands of people displaced by a recent Pakistan army campaign against suspected Taliban insurgents.

Meanwhile the World Health Organization has reported an increasing number of cases of diarrhoeal diseases. Seventeen mobile health teams are providing health services in different parts of Peshawar, capital of Khyber Pakhtunkhwa.

The UN Office for the Coordination of Humanitarian Affairs said that search and rescue operations were the most urgent need, and a spokesman added: "In addition, requests were also made for boats to facilitate access, rescue, and assessment efforts. In terms of relief assistance, the authorities at provincial as well as national level requested support in emergency shelter, food (mainly ready to eat food), health, and sanitation."

Sohail Altaf, Khyber Pakhtunkhwa's senior medical officer, said, "To avert the looming threat of spread of waterborne diseases, especially cholera, we have dispatched dozens of mobile medical teams in the affected districts."

A spokesman for the International Federation of the Red Cross said, "Entire settlements of mud-brick houses are reported to have been swept away, major bridges have collapsed, and some major provincial cities have been totally cut off after road and rail links were severed.

The widespread disruption to the country's communications network has meant that reaching the worst hit areas of the country is extremely difficult."

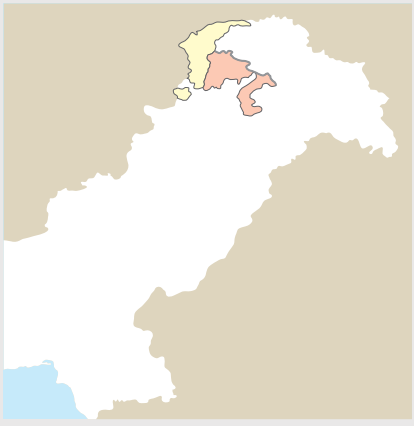
Benoit de Gryse, head of mission at Médecins Sans Frontières, said, "It is still too soon to gauge the scale of this unprecedented disaster," but he said that the charity was concerned that millions of people lacked safe drinking water.

The medical aid agency Merlin, which has been in Khyber Pakhtunkhwa for the past two years, has brought in three mobile helicopter teams to the worst hit areas.

The United Kingdom has announced a £5m (€6m; $8m) grant for water and sanitation equipment to be channelled through Unicef, in addition to other funding.

Cite this as: *BMJ* 2010;341:c4205

DISTRICTS AFFECTED BY FLOODS IN PAKISTAN



Source: *WHO country office, Pakistan*

Janice Hopkins Tanne NEW YORK

The American Medical Association, together with almost all US state medical societies, has written to major US health insurance companies criticising their methods for rating doctors. They say the ratings lack transparency and are inaccurate.

The medical organisations sent a letter to 47 of the largest US health insurance companies on 16 July saying that their ratings of doctors were "opaque" and "inaccurate" and too often based on cost rather than quality of care provided (www.ama-assn.org/ama1/pub/upload/mm/368/rand-letter.pdf).

They have called on insurers to submit their physician cost profiling programmes for re-evaluation and external review "by unbiased, qualified experts" to improve quality.

US insurance plans and employers have begun classifying doctors in two or three tiers on the basis of the cost of caring for a patient with a given condition (low, average, or high cost). Patients who see low cost doctors pay less out of their own pocket than if they see a high cost doctor.

The association's letter refers to a recent series of studies by the research organisation the Rand Corporation, which found that in some specialties doctors were wrongly classified by insurance companies up to two thirds of the time and that one quarter of all doctors overall were misclassified.

The letter says, "Physicians' reputations are being unfairly tarnished using unscientific methodologies and calculations. Some physicians have even been placed in three different efficiency tiers by three different insurers based on calculations using the same data." It adds, "inaccurate reports and erroneous physician" ratings, which have been used to try to control healthcare spending, "not only have the potential to harm patients and physicians, but they divert scarce resources from meaningful efforts to help physicians evaluate and address unwarranted variation in health care delivery."

The letter says that the insurance companies rate doctors "without regard to the quality of the services provided" and that studies "all conclude that quality or cost ratings for individual physicians are unreliable."

The American Medical Association said that it and other medical associations had been working to identify problems with and find alternatives to the ratings. The letter says, "[We] cannot support

Doctors who train overseas perform as well as US colleagues

Bob Roehr WASHINGTON, DC

Doctors in the United States who trained overseas performed as well as those who trained in the US, says a new study that looked at length of stay in hospital and mortality from congestive heart failure or acute myocardial infarction in Pennsylvania (*Health Affairs* 2010;29:8).

The retrospective observational analysis examined 244 153 hospital records coded for heart failure and acute myocardial infarction from 2003 to 2006. It categorised the 6113 attending physicians according to whether they trained at a medical school in the US (71%), were Americans who trained overseas (7%), or were foreign born doctors who trained outside the US (23%).

The study found that "patients of non-US citizen international graduates had the lowest mortality levels, and patients of US-citizen international graduates had the highest." The death rate among patients treated by foreign trained doctors was 9% lower than that among patients treated by doctors trained in the US and 16% lower than that among patients treated by American doctors who trained overseas; only the second difference was significant.

Graduates of US medical schools discharged patients more quickly than the other doctors, while patients of US doctors trained overseas had the longest hospital stays. A correlation between length of time since graduating and increased mortality among patients was consistent across all three categories of training.

Cite this as: *BMJ* 2010;341:c4158

payer programs designed to steer patients to certain physicians and practices based on inaccurate physician ratings or primarily on physician cost of care profiles without regard to the quality of the services provided."

Karen Ignani, head of America's Health Insurance Plans, which represents the health insurance industry, defended insurers' practices and said that she had "concerns" about the methods used in the Rand studies.

In a letter to the American Medical Association she wrote, "Specifically, health plans base their assessments both on quality and cost as opposed to these analyses which focused solely on costs. Quality, which includes patient satisfaction, is the most important factor used to create value-based networks for patients. Unfortunately, this research didn't take this into account."

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Avandia adviser may be probed for possible conflicts of interest

Janice Hopkins Tanne NEW YORK

The US Food and Drug Administration has asked its parent department to investigate possible conflicts of interest relating to one of the members of the panel that recently recommended further restrictions on the drug rosiglitazone (marketed as Avandia), manufactured by GlaxoSmithKline (GSK) and used to control type 2 diabetes (*BMJ* 2010;341:c3862, 16 Jul).

After an internal review of disclosure forms the FDA asked the Office of the Inspector General of the Department of Health and Human Services to investigate disclosure or non-disclosure of conflicts of interest by the panel member David Capuzzi.

David Capuzzi is said to have defended rosiglitazone

The *Wall Street Journal* reported that Dr Capuzzi was one of three panel members who voted to keep rosiglitazone on the market with no additional warnings and said that he defended the drug. The drug lowers blood sugar concentrations in patients with type 2 diabetes, but there are questions about whether it increases the risk of cardiovascular disease.

An FDA spokeswoman said that all committee members should report current and previous relations with the sponsor of a product. She said that members "are required to report all current financial interests and those held within the previous 12 months that could be affected by the discussion and outcomes of the meeting, or that would present appearance issues, to the best of their knowledge. These include financial interests with the sponsor of a product that is the subject of the advisory committee meeting."

Failure to disclose financial interests to the FDA before participating in an FDA advisory committee meeting is illegal, she said. "We issued no waivers for the Avandia meeting. This means that among the members that participated, all were cleared for conflicts of interest based on the confidential financial disclosure they provided to FDA," added the spokeswoman.

Dr Capuzzi is professor of medicine at Thomas Jefferson University in Philadelphia. Several news organisations reported that Dr Capuzzi had been a member of GSK's speakers' bureau, speaking about a different drug, Lovaza, and also once about Avandia. Lovaza contains omega 3 fatty acids and is used to lower cholesterol concentrations.

A GSK spokeswoman told the *BMJ*: "Prior to the second quarter of 2009, Dr Capuzzi was a speaker to healthcare professionals on behalf of GSK . . . Our records indicate that in 2008 and the years before that, Dr Capuzzi spoke on behalf of GSK several times and was compensated approximately $8000 [£5000; €6000] for his time."

She said that Dr Capuzzi participated in one advisory board for Avandia as a consultant before 2008 and that he was compensated $750 for his time as a consultant. He was not contracted to speak on Avandia for the company, she said.

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New anatomical light is shed on old masterpiece

Michael Day MILAN

The Italian Renaissance genius Michelangelo included a view of God's brain in his monumental work on the ceiling of the Vatican's Sistine Chapel, a new study suggests.

The claims may explain unusual—and much debated—abnormalities on one of the frescoes.

For years art experts have discussed the odd, lumpy bits on God's neck in the part of the painting known as "Separation of Light from Darkness."

The anomalies are strange, says Rafael Tamargo, a neurosurgeon at the Johns Hopkins University School of Medicine, Baltimore, because "Michelangelo definitely knew how to depict necks—he knew anatomy so well." He soon realised that the unusual features in the neck strongly resembled a brainstem (*Neurosurgery* 2010;66:851).

Cite this as: *BMJ* 2010;341:c4178