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English schools close as confirmed flu cases rise

Adrian O'Dowd LONDON

A mass public information campaign starts in the United Kingdom this week as leaflets on how to stop the spread of swine flu begin to arrive in every home.

The number of confirmed cases of the A/H1N1 virus in the UK had risen to 28 by Tuesday, as the *BMJ* went to press, and another 331 patients are being tested, the Health Protection Agency has said.

Twenty one countries around the world are now affected, the World Health Organization has said, with 1124 cases of confirmed swine flu and 26 deaths—25 in Mexico and one in the United States. Mexico still has the highest number of laboratory confirmed cases, at 590, followed by the US, with 286 cases.

Five schools in the UK—three in London, one in Devon, and one in south Gloucestershire—have now closed after some of their pupils became ill. At one of the affected schools, Alleyn's School in Dulwich, southeast London, around 1200 pupils and staff will be offered the antiviral oseltamivir (Tamiflu).

Five pupils tested positive for the virus; and after advice from the Health Protection Agency the school decided to close for one week.

The UK's first human to human transmission of the virus was confirmed in Scotland last week in a man from the Forth Valley area who had been in contact with a couple that had been on honeymoon in Mexico and were the first confirmed cases in the UK.

Alan Johnson, the health secretary, said that the UK was doing well in its efforts to contain the virus, but in an interview with *The Andrew Marr Show* on BBC One he said



ROMEO RANOCO/REUTERS

The Scottish government is sending 1.45 million surgical facemasks to England to help with its shortfall

that he expected another bout of infections later in the year.

“Our evidence from all previous pandemics is that you get two phases,” he said. “You get a first wave that is often very mild, and then you get a much more serious wave that comes along in the autumn and the winter.”

The Scottish government has announced that it is sending 1.45 million surgical facemasks to help boost low stocks in England and Wales, mostly intended for use by health professionals.

The supply will come from Scotland's current stockpile of 9.3 million masks. The rest of the UK, however, has a shortfall. The

Department of Health has ordered more which will start to be delivered next month.

A spokesman for the health department in England said, “The arrangements in place across the United Kingdom are continuing to ensure that we are well placed to deal with this new infection.”

The countries with confirmed cases (but no deaths) are Austria, Canada, China (and Hong Kong), Costa Rica, Colombia, Denmark, El Salvador, France, Germany, Ireland, Israel, Italy, Netherlands, New Zealand, Portugal, Republic of Korea, Spain, Switzerland, and the United Kingdom.

Cite this as: *BMJ* 2009;338:b1857

Staff shortages persist at troubled Mid Staffordshire trust

Adrian O'Dowd LONDON

Shortages of surgeons and nurses are still a problem at the Mid Staffordshire NHS Foundation Trust, despite a highly critical report into care there that insisted staffing levels be increased.

The trust was criticised for severe failings in a report published by the former regulator, the Healthcare

Commission, in March (*BMJ* 2009;338:b1141).

The government and Monitor, the regulator of foundation trusts, jointly commissioned reports into what lessons could be learnt, one from George Alberti, national clinical director for urgent and emergency care, into the current standard of care there, and one from David

Colin-Thomé, national director for primary care.

These newly published reports have concluded that although there have been improvements in the past year—such as the trust investing £3.8m (€4.3m; \$5.6m) in new staff, recruitment, and training and more consultant cover in the emergency department, middle grade doctors,

and nurses—further action was required.

Professor Alberti's report says, “There are highly committed, acute surgeons working at the trust but too few in each of the surgical specialties.” The medical wards also had too few qualified nurses.

The two reports are at www.dh.gov.uk.

Cite this as: *BMJ* 2009;338:b1833

IN BRIEF

Taiwan is no longer excluded from World Health Assembly:

The World Medical Association has lauded the decision by Margaret Chan, head of the World Health Organization, to invite Taiwan to participate in this year's World Health Assembly. Otmar Kloiber, the association's secretary general, said: "At a time when the world is facing a possible flu pandemic, Taiwan's continued exclusion would have posed a real risk to public health."

Europe backs embryo screening:

The European parliament has adopted an amendment recommending that member states encourage efforts to avoid rare hereditary diseases through genetic counselling of carrier parents and, where appropriate and not banned by national laws, through preimplantation genetic diagnosis and selection of healthy embryos.

Sebelius is to head US health department:

The US Senate has confirmed Kathleen Sebelius, former Kansas governor, as secretary of the Department of Health and Human Services. Ms Sebelius will oversee the Centers for Disease Control and Prevention and be a leader in the Obama administration's new programme for universal health insurance. One of her first decisions was to order 13 million courses of flu treatment.

Study finds no link between statins and cancer:

Statins do not increase or decrease the risk of cancer, a large Finnish study has concluded (*International Journal of Cancer* doi:10.1002/ijc.24536). It looked at everyone in Finland who bought at least one statin prescription between 1996 and 2005. The average follow-up was 8.8 years.

Commission will investigate provider of out of hours care:

The Care Quality Commission is to investigate Take Care Now, a company providing out of hours cover for GPs, after Daniel Ubani, a German doctor, killed a patient on his first UK shift with a fatal dose of diamorphine. Dr Ubani, who qualified and practised in Germany, gave 100 mg of the drug to David Gray, who had kidney stones and renal colic and had sought pain relief.

Cite this as: *BMJ* 2009;338:b1839

NICE launches portal for professionals to access evidence

Helen Mooney LONDON

A new service that will allow people throughout the health and social care sectors to access a range of clinical and non-clinical evidence has been launched by the National Institute for Health and Clinical Excellence.

NHS Evidence will help users to identify the best evidence by "sorting, sifting, and prioritising a range of information and awarding an accreditation mark to the most reliable and trustworthy sources of guidance."

Originally announced in Ara Darzi's NHS next stage review, *High Quality for All*, last year, the service will try to help NHS professionals navigate the current maze of evidence and best practice available (*BMJ* 2008;337:a642).

All information submitted for accreditation will be assessed by an independent advisory committee, and those producing guidance must show they meet a predefined set of criteria that show that their product has been developed using rigorous processes.

The information will be brought together in one central portal, and topic areas will include clinical, commissioning, drugs and

technology, public health, social care, and education.

Users will be able to browse evidence using "topic trees," upload and share their own content, such as local service models and policies, and customise the service.

Health minister Lord Darzi said, "In my strategy for the future of the NHS I made clear that if quality was to become the organising principle for the NHS, its staff and patients must have a way to access the latest authoritative clinical and non-clinical evidence and best practice.

"NHS Evidence will ensure that whatever you do within the NHS you will always have access to the best information you need to deliver the highest quality care to your patients."

The chief operating officer for NHS Evidence, Gillian Leng, said, "This is just the first stage in the development of an impartial service that will provide the most comprehensive source of relevant and trustworthy information about clinical, non-clinical evidence, and best practice, at the touch of a button.

"It's good news that users, including patients, will be able to find the information they need and know that it comes from a credible source—this will ultimately help improve efficiency and ensure all patients receive the best available care."

Cite this as: *BMJ* 2009;338:b1828

Global aid agencies boost support to



Mexicans queue outside a mobile clinic set up to provide rapid tests for A/H1N1 influenza

John Zarocostas GENEVA

International agencies, spearheaded by the World Health Organization, are scaling up their support to low and middle income nations, including Mexico, to help them respond to the possible threat of an A/H1N1 flu pandemic.

All the poorest countries "with the greatest needs," are being targeted, said Mike Ryan, WHO's director for global alert and response. He said that the agency has begun to dispatch 2.4 million doses of antiviral drugs to 72 countries, including Mexico,



Rheumatoid arthritis patients should be referred more swiftly

Roger Dobson ABERGAVENNY

Patients with rheumatoid arthritis should be referred to a specialist rheumatology clinic as soon as the condition is first suspected, says a new UK consensus statement on the treatment of early disease.

Patients should be started on effective treatment as soon as possible, and dedicated early assessment services should be developed, it says (*Rheumatology* doi:10.1093/rheumatology/kep073).

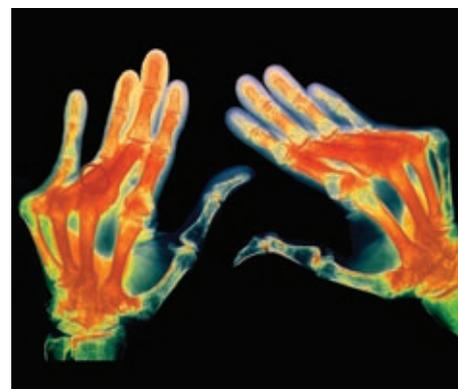
The authors wrote: "The consensus group stressed that all healthcare professionals should refer patients to a specialist rheumatology clinic when they first suspect rheumatoid arthritis or undifferentiated inflammatory polyarthritis.

"Currently, rheumatologists in the UK are referred patients from primary care after an interval of 6-10 months after symptom onset."

The authors say it is now accepted that an early start to treatment offers the opportunity to improve clinical and other outcomes but add that the time to first treatment with a disease modifying antirheumatic drug is still not optimal in the United Kingdom.

The consensus statement includes four core principles and three key clinical practice recommendations for best practice in the management of a disease that, the authors say, affects 420 000 people in England and Wales, two thirds of whom develop symptoms before the age of 60. Underpinning the four core principles is the idea that minimising the cumulative effects of inflammation improves signs and symptoms of disease, increases functional performance and health related quality of life, and reduces the risk of joint damage and non-articular complications. The four principles are:

- Patients should be detected and referred at first suspicion, even if the differential diagnosis is uncertain. Rheumatology departments should also provide rapid access to a diagnostic and prognostic service.
- The disease should be treated immediately. The report says that optimising outcomes requires that effective treatment be started ideally within three months of the onset of symptoms.



ZEPHYRUS/PL

Minimising the cumulative effects of inflammation improves functional performance, report says

- Because tight control of inflammation improves outcomes, assessment should be frequent.
- Treatments should be tailored to each patient. The report says, "Optimising therapy means balancing the risks and benefits of the various treatment options to meet the achievable goals for each patient."

The three key clinical practice recommendations are to increase awareness of the illness among the public and professionals; create systems that ensure early diagnosis and treatment; and titrate treatment regularly, depending on disease activity.

Cite this as: *BMJ* 2009;338:b1831

poorer nations to fight flu threat

from stocks donated by the drug company Roche in 2005 and 2006.

He said the most vulnerable people will be given courses of the treatment as part of the agency's rapid containment strategy and that WHO plans to supplement its regional stockpiles as a contingency measure.

Margaret Chan, WHO's director general, is in contact with manufacturers and major donors and international financial institutions to ensure that enough funds are earmarked to help poor nations buy antiviral drugs, diagnostic equipment, and other supplies and that adequate supplies are available.

Dr Ryan said that a pandemic is imminent. Keiji Fukuda, WHO's assistant director general for health security, told reporters that the situation remained "pretty fluid" and emphasised that the situation was still changing. WHO is urging countries not to drop their guard.

The secretary general of the United Nations, Ban Ki-moon, said on Monday: "We should avoid a false sense of security . . . In the face of uncertainty we must be vigilant."

Meanwhile the World Bank has decided to help Mexico fight the spread of the virus with \$205m (£135m; €155) in rapidly disbursed funds. Its president, Robert Zoellick, said, "Our first, second, and third focus is on people's health and lives."

World Bank officials said that \$25.6m had already been redirected from an ongoing health project in Mexico to allow the country to buy drugs immediately and to boost its flu testing capacity. The bank is also reviewing its country lending portfolios to see whether it can boost pandemic flu preparedness.

The International Federation of Red Cross and Red Crescent Societies said that more than 130 of its national societies have started responding or are preparing to respond to the threat of a pandemic. Measures include stepping up national awareness campaigns and surveillance of cases, federation officials said.

It said it is supporting the Mexican Red Cross in its campaign, which includes delivering and distributing 20 000 personal protection kits for healthcare professionals.

Cite this as: *BMJ* 2009;338:b1856

European flu toll reaches 107 confirmed cases

Rory Watson BRUSSELS

By the morning of Tuesday 5 May, when the *BMJ* went to press, 107 confirmed and 10 probable cases of A/H1N1 flu had been reported in the European Union, said the Stockholm based European Centre for Disease Prevention and Control (ECDC).

In the previous 24 hours the number of confirmed cases had risen by 28 as more infected patients were discovered in Spain (13), the United Kingdom (nine), France (two), Italy (two), Portugal (one), and Germany (one).

The ECDC and the European Commission have produced two short standard information sheets advising the public on measures to take to reduce the risk of acquiring or transmitting the flu.

These emphasise the need to avoid close contact with sick people and explain the benefits of washing hands frequently.

Cite this as: *BMJ* 2009;338:b1859

Polyclinics could be focus of care for offenders with mental health problems, report says

Lynn Eaton LONDON

Polyclinics could become the focal point for healthcare services for people in England with a mental illness who have offended or are at risk of doing so, says a new report on mental health services for prisoners.

The long awaited report by the Labour peer Keith Bradley was commissioned by the government in 2007 to look into whether people in the prison system with mental health problems or learning disabilities could be diverted to other services and how court liaison services could be improved. In fact Lord Bradley's final report is far wider ranging than this. Speaking at the launch of his report he said, "It became clear to me it was otherwise going to be a huge missed opportunity."

Among his recommendations Lord

Bradley calls for better provision of primary care so that people with a mental illness or learning difficulty can get the sort of support—such as cognitive behavioural therapy—that might help reduce the risk of them offending in the first place.

And he wants more training for GPs so that they can recognise patients whose mental health puts them at a high risk of offending.

"I'm not criticising GPs," he told the *BMJ*. But because of the demands on their time, he said, they were not always in a position to recognise that a patient may have problems. "What I am asking the government to do is develop a range of primary care services that the GP can refer them to."

Polyclinics could offer the opportunity to provide GPs and other support services under one roof, he said, acknowledging

that many traditional general practices may not be eager to have offenders with such problems on their lists.

His report calls for a national network of criminal justice mental health teams to divert people from the criminal justice system to more appropriate services.

It also recommends better commissioning of psychiatric reports on people facing court hearings to remove the current lengthy delays in getting the reports to court.

Lord Bradley also wants the NHS to take over commissioning of health services for people in police custody. These are currently commissioned by each police force.

Lord Bradley's report is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694.

Cite this as: *BMJ* 2009;338:b1841

Darzi opens first of London's polyclinics

Oona Mashta LONDON

Health minister Ara Darzi last week officially opened one of the first seven polyclinics planned for the capital, at Loxford in Redbridge.

The polyclinics will offer services seven days a week from 8 am to 8 pm, together with services normally provided at hospitals such as outpatient appointments, minor surgery, blood tests, and x ray imaging.

The six other polyclinics in London will be located in Hammersmith (at Hammersmith Hospital), Harrow, Hounslow, Lambeth, Tower Hamlets, and Waltham Forest.

A London-wide consultation on developing new major trauma and stroke services is under way. NHS Healthcare for London is canvassing doctors' views. To complete a questionnaire online or find out more visit www.healthcareforlondon.nhs.uk.

Cite this as: *BMJ* 2009;338:b1836



Clinic doctors Jasvinder Chana and Chidi Okorie pose with health minister Lord Darzi

Health minister Ara Darzi pushes innovation in the NHS

Jacqui Wise LONDON

Doctors have been challenged to come up with innovations to tackle some of the health challenges that the population faces.

A £220m (€250m; \$330) pot will be available to England's 10 strategic health authorities to encourage innovation within the NHS. Each authority will receive £2m this year and £5m in each of the following four years as dedicated regional innovation funds.

England's strategic health authorities have a legal duty to promote innovation and support the spread of innovative technologies and solutions throughout the health services. This is part of new measures set out in the health bill currently before parliament.

Strategic health authorities will decide locally how to use the money to support innovation. The funds will focus largely on promoting innovations in healthcare delivery, health improvement, and patient engagement rather than the development of new drugs or devices. Teams of NHS staff, general practices, primary care trusts, or any type of NHS organisation can bid for the new regional innovation funds.

In addition, £20m over five years has been set aside for innovation challenge prizes to reward breakthroughs in the biggest

healthcare challenges, from childhood obesity to the treatment of dementia. These challenges will be set annually by an expert panel headed by John Bell, president of the Academy of Medical Sciences. The panel will finalise the challenges over the summer and they will be announced this autumn. The prizes, worth up to £1m each, will reward those ideas that can be copied and diffused quickly across the NHS.

Announcing the initiative in London this week, the health minister Ara Darzi said that the issue of innovation was one close to his heart. The move follows his strategy *High Quality Care for All* in June 2008, which said that the NHS must become more pioneering and a place in which innovation is supported and allowed to flourish (*BMJ* 2008;337:a642).

Lord Darzi told the *BMJ*, "In the past 50 years 40% of all innovations have come from within the UK. We have the brain power, but we need to be better at putting these good ideas into action."

He added, "We want to reward innovation. For example, Dr John Charnley designed the low friction hip replacement, which was a fantastic invention that was never rewarded." Lord Darzi gave another example of an innovative idea—a commode that had been designed in Sheffield to specifically help patients disabled by stroke.

The challenges could be set for non-clinical as well as clinical advances.

Cite this as: *BMJ* 2009;338:b1825

Doctors do pull their weight in changing NHS, debate decides



CHRIS RENTON

Deborah Cohen *BMJ*

Doctors were cleared of the charge of neglecting to lead change in the health service at a debate in London organised jointly by the *BMJ* and the King's Fund last week.

When the debate opened, a

majority of 63% were in favour of the motion "This house believes doctors are neglecting their duty to lead health service change," but that faction had shrunk to 49% by the close of proceedings.

Speaking for the motion were

Alan Maynard, professor of health economics at York University (second left), and James Mountford, a consultant at McKinsey (third left). Arguing against were Mark Goldman, a doctor and chief executive of the Heart of England NHS Trust (second

right), and James Cave, a GP (far right). The debate was chaired by *BMJ* editor Dr Fiona Godlee (centre). To listen to a podcast of the debate and read the arguments visit www.bmj.com/campaigns/leadership/index.dtl. Cite this as: *BMJ* 2009;338:b1844

Lung cancer treatment in UK lags behind other countries

Susan Mayor LONDON

The quality of lung cancer treatment in the United Kingdom varies between different hospitals and lags behind that in other western European countries, according to an audit published this week.

The third National Lung Cancer Audit, published by the NHS Information Centre and the Royal College of Physicians, shows an overall improvement in the quality of care being given by hospitals in the UK compared with previous years (figure). But it finds that some hospitals are failing to offer acceptable standards of practice in key aspects of care, including diagnosis and treatment.

Tim Straughan, chief executive of the NHS Information Centre, said, "While there have been overall improvements in care since the previous audit in 2006, there's still a wide variation between hospitals which cannot be explained on the basis of differing patient profiles alone."

The audit assessed the management of more than 26 000 patients with lung cancer first seen in 2007, including more than 75% of the expected incident cases for the audit period.

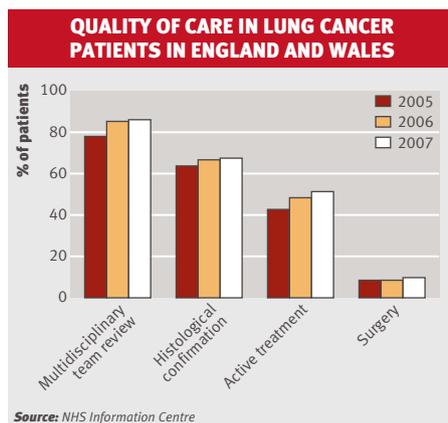
Results show that the best performing trusts deliver treatment that compares with anything available internationally. However, care and outcomes for the UK overall are below those reported by other western European countries.

The overall proportion of lung cancer

patients receiving any active anticancer treatment remains low, at 51%, but has increased from 43% in 2005. This figure compares with a treatment rate of 75% in Italy, the report notes (*Thorax* 2006;61:232-9).

It found considerable variation in the proportion of UK patients receiving any form of treatment for their lung cancer, ranging from one third in the worst performing hospitals to 75% in the best performing.

Only 10% of patients had surgery, the main curative treatment for lung cancer, although this has increased from 9% in previous years. Resection rates quoted from other countries included 25% from Italy, 20% from the Netherlands (*European Respiratory Journal* 1996;9:7-10), and 17.5% from Sweden (*Lung Cancer* 2009;63:16-22).



Patients treated at the highest performing trusts in the UK were over four times more likely to undergo surgery than those in the poorest performing hospitals, with rates ranging from fewer than 5% to more than 25%.

Mike Richards, the national cancer director, said, "Low resection rates may represent late presentation to hospital and/or poor access to surgery. In either case these low rates merit investigation."

Histological confirmation of cancer diagnosis was made in 68% of patients but varied from fewer than 20% to more than 85%. Based on the performance of trusts in previous years, a histological confirmation rate of at least 75% is considered a reasonable benchmark for acceptable practice, the report states.

Nearly nine in every 10 patients (87%) included in the audit were reviewed by a multidisciplinary team, compared with 78% in 2005.

Professor Richards said, "The quality of care being delivered to patients appears to be improving. But, there is still a large scope for improvement."

"Trusts need to look carefully at the areas where their performance varies with national averages ... and address the underlying causes," recommended Mr Straughan.

The report is at www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/audit-reports/lung-cancer.

Cite this as: *BMJ* 2009;338:b1830

US Institute of Medicine report calls for an end to firms' drug and device promotion to doctors

Bob Roehr WASHINGTON, DC

Product promotion among doctors by drug companies and medical device manufacturers should be virtually eliminated, and remaining research and educational ties should become completely transparent, a new report from the US Institute of Medicine recommends.

The institute's president, Harvey Fineberg, said that the report "sets a new standard for comprehensiveness" across the spectrum of activity—from research and treatment guidelines to education and training of healthcare professionals and regular clinical practice.

He said he was particularly pleased that the report focuses on "prevention and anticipation, as opposed simply to responding after the fact to these problems."

Bernard Lo, a medical ethicist at the University of California, San Francisco, chaired the committee that wrote the report. He said that conflicts of interest are "a vital issue that goes to the heart of patient trust." The recom-

mendations "reinforce and advance" those made by more than a dozen other groups over the past few years.

Dr Lo said that the US government should require drug companies "to report through a public website all payments they make to physicians, researchers, and medical organizations. Such a public record will deter inappropriate relationships and undue industry influence." Reporting should be standardised, with uniform categories and formats.

The report calls on all doctors to decline gifts from the industry (including meals), refuse to participate in activities and publications where content is controlled by the industry, and limit use of drug samples.

The report acknowledges that policies on conflicts of interest "typically focus on financial gain because it is relatively more objective, fungible, and quantifiable. Financial gain can therefore be more effectively and fairly regulated than other secondary interests."

Creation of practice guidelines should not

be funded by the industry, and professionals with conflicts of interest should be excluded from writing those guidelines, or at least movement should be made in that direction, the report says. But as Dr Lo acknowledged, "The reality is that there is not enough public funding for practice guideline development," in the US, unlike in the UK.

Eric Campbell, from Massachusetts General Hospital, added that it was difficult to learn from other industries about how to manage such conflicts because "medicine is unique in the extent to which relationships between physicians, researchers, and drug companies are ubiquitous."

He said that disclosure was paramount, "because you can't manage what you don't know about."

See Observations, p 1103

Conflicts of Interest in Medical Research, Education, and Practice can be bought at http://books.nap.edu/catalog.php?record_id=12598.

Cite this as: *BMJ* 2009;338:b1852

Hanumappa Sudarshan: the quiet reformer who has set up

Hanumappa Sudarshan is battling on two fronts in India: for rural health facilities and against corruption. He tells **Rebecca Coombes** that he would have been murdered by now if he was living in the more political northern areas of the country



A girl from the Soliga tribe attends a school established by Dr Sudarshan

Rebecca Coombes LONDON

Hanumappa Sudarshan has spent his career working on the fringes of Indian society, among tribal and rural people. In 1979, as an idealistic young doctor, he went to work with the Soliga tribal people in Karnataka, southeast India, initially discovering it impossible to find patients because local people distrusted him and kept their distance.

In a country with severe inequalities in health care, where poor patients mostly have to pay for their own health care, Dr Sudarshan has, over the course of 30 years, established free comprehensive health services to some of its most impoverished people. His public-private partnership model for primary health care has now spread to several other states.

Today, his influence is felt well beyond the remote Biligirirangan hills where he started to practise. This is partly down to his ability to establish primary health care in

difficult and geographically remote areas, demonstrated by the fact that the Karuna Trust, established by Dr Sudarshan, today provides services to about 600 000 rural poor people. But his name is also associated with cleaning up corruption in the Indian healthcare sector and exposing quackery, a role that involves taking on powerful figures and organisations.

Dr Sudarshan's international reputation was bolstered last month when he was voted runner-up for the lifetime achievement award at the inaugural BMJ Group Awards. When he was in London to receive his accolade, Dr Sudarshan explained to the *BMJ* how he had challenged social inequalities from an early age.

Two episodes inspired him to become a doctor, the death of his father, in pain and without medical help when he was 12, and reading Albert Schweitzer's autobiography *Aus Meinem Leben und Denken (Out of My Life and Thought)*. He



STROBEL/STRINGER/GETTY IMAGES

Dr Binayak Sen waves from a police van as he is taken to court in Raipur last year

Indian doctor starts his third year in prison

Ganapati Mudur NEW DELHI

An Indian doctor whose achievements in community health have been recognised by the international medical world and whose personal sacrifices have been cited by academics in medical schools across India will complete two years in prison on 14 May this year.

On Monday 4 May India's Supreme Court asked the central Indian state of Chhattisgarh to respond within two weeks to a petition

for bail from Binayak Sen, a paediatrician and civil rights activist, who was arrested in 2007 after an allegation that he had carried letters for armed Maoist rebels. Dr Sen has asserted that the allegation is false, and the charge against him remains unproved, despite numerous hearings in a lower court in Raipur, the state's capital.

The campaign seeking Dr Sen's release has steadily grown. Doctors, civil rights groups

in India and abroad, academics, public health activists, and legal experts have individually and jointly decried his incarceration and repeatedly urged his release. Last year a group of 22 Nobel laureates wrote to the federal and state governments asking that Dr Sen be freed while the judicial process proceeds, to enable him to continue his "important medical work" (*BMJ* 2008;336:1155).

Dr Sen's supporters view the Supreme Court's decision to admit his petition for bail as a "positive development." Dr Sen, who was given a diagnosis of angina in prison earlier this year, hopes to be treated at the college where he trained, the Christian Medical College in Vellore, Tamil Nadu.

His supporters believe he was arrested because he had helped expose human rights violations such as torture and extrajudicial killings supported by the state.

"His incarceration is politically motivated," said Sudha Bharadwaj, a member of the Chhattisgarh unit of the People's Union for Civil Liberties, India's oldest human rights organisation. Each Monday since mid-March this year this group and others have staged peaceful protests close to the jail in Raipur where Dr Sen is held.

Cite this as: *BMJ* 2009;338:b1864

health services for 600 000 people

was inspired by Ghandi and Swami Vivekananda, the Hindu spiritual leader, to serve the poor. After medical school, he didn't join the brain drain to work in the United Kingdom or the United States, like many of his peers, but was drawn to use his education to work among the Soliga tribe.

Despite many years of isolation, news of Dr Sudarshan's "magic medicine" gradually spread, and tribal and non-tribal people came for treatment. Thirty years later, the Vivekananda Girijana Kalyana Kendra, the organisation founded by Dr Sudarshan for tribal people, has a 20 bed tribal hospital with a laboratory, x ray equipment, and an operating theatre.

National health programmes for the management of tuberculosis, epilepsy, blindness control, mental health, dental health, and community care are all embedded in the locality. There is also a mobile medical unit, sickle cell anaemia

research and screening work, and training programmes for health workers and house surgeons.

Dr Sudarshan set up Karuna Trust in 1986 to provide rural primary health care, not just for tribal people. Its initial aim was to eliminate leprosy, which was successful, but it is also concerned with local people's mental health. "The people who suffered from symptoms of mental illness had no access to help as the nearest hospital was 100 km away," he says.

Dr Sudarshan's integrity and humility were cited by many supporters as the reason they voted for him in the *BMJ* Group Awards. It's interesting to see he has the grit and stubbornness also to pursue anticorruption work. He admits that if he were based in the more political north, he might have been "bumped off" by now.

As a government appointed ombudsman to reduce corruption in health care, Dr Sudarshan

was shocked at how healthcare business was carried out. A 2005 report by Transparency International India put health as the second most corrupt sector in the country, second only to the police. "Everyone is involved, doctors, nurses. I feel that it is an illness," he says.

"I used to talk about eradication. Now we say it must be controlled. If you go into hospital you have to pay a bribe to be admitted; if you go into labour you have to pay a bribe to be transported to the operating theatre or you can be delayed. Corruption is rife from birth to death. In medical education we are not taught to be sensitive to corruption."

A big problem is corruption in drugs procurement, where companies give generous kickbacks for purchase of spurious or



Dr Sudarshan with *BMJ* news editor Annabel Ferriman at the awards ceremony in April

substandard drugs at excess prices. Dr Sudarshan refers to one intravenous fluids scam, where suppliers who were offering goods that were 50% cheaper than existing ones were bypassed by purchasers in favour of a company providing bribes.

He has driven some reforms through, including transparency on websites for electronic procurement. "Part of the problem is that most of the institutions are managed by doctors, who are very bad at managing. Hospitals need full time managers," he says.

What pains him is waste of already stretched resources. "We [health care in India] spend only 1% of gross domestic product on health care. But there is no point increasing budget when it is leaking through corruption."

Cite this as: *BMJ* 2009;338:b1794