**bmj.com** Sacking of Dr Alain Braillon (left) is setback for French public health, supporters say
**UK news** Primary care trusts are told to tighten regulation of out of hours services, p 332
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# Focus on early years to create fairer society and reduce health inequality, Marmot review says

**Zosia Kmietowicz** LONDON

More public money should be spent on ensuring a high quality of early child development to create a fairer society and reduce health inequalities, an evidence based review has concluded.

Teaching parents the importance of cuddling their babies and talking to young children can help reduce behavioural problems and aid cognitive development, enabling better progress at school, said Michael Marmot, professor of epidemiology and pubic health at University College London, who led the review on tackling health inequalities in England over the next 10 years, commissioned by the government.

JOHN BEHETS

**The human and economic costs of inaction "are simply too high," said Marmot**

Of the six recommendations in his review this is the priority, he said. With better education, people are better able to find their way through modern society, find employment, and have control over their lives, he added.

"The message of our report is that if you can create a fair society then health will improve and health inequalities will get less. Health inequalities are not simply about equal access to health care. All the major aspects of society are key to health and for the distribution of health," Professor Marmot told a press conference to launch his review. "The health and wellbeing of today's children—and those children when they become adults—depend on us having the courage and imagination to do things differently, to put sustainability and wellbeing before a narrow focus on economic growth, and to bring about a more equal and fair society."

He described as "absolutely dramatic" the fact that life expectancy in England has improved by 2.9 years in the past decade in the quarter of the population with the worst health. However, he said that the health of the general population has improved slightly more, meaning that the gap has not narrowed.

His review found that people living in the poorest neighbourhoods in England will, on average, die seven years earlier than people living in the richest neighbourhoods.

All government departments, not just the health sector, need to work towards a fairer society, says the review. And policies should be informed by evidence based interventions.

The review advocates proportional universalism, whereby policies are aimed at all levels of society but work harder for the most deprived.

As well as a focus on early years development and education, the review recommends creating fair employment and good working conditions and strengthening disease prevention.

The government also needs to look at implementing a minimum income for healthy living, said Professor Marmot. Currently people at the poverty level are living on less than what this minimum income would be set at.

***Fair Society, Healthy Lives*** **can be seen at www.marmot-review.org.uk.**

Cite this as: *BMJ* 2010;340:c818

**See EDITORIAL, p 323, FEATURE, p 340, ANALYSIS, p 346**

## NHS cuts mean £400 less per person in England over next four years

**Zosia Kmietowicz** LONDON

The health service in England will have £400 (€455; $620) less on average to spend on every man, woman, and child over the next four years because of cutbacks planned for the NHS, a campaigning group has estimated.

The group, Health Emergency, claims that the savings will be made by cutting staff, reducing numbers of hospital beds, reducing the capacity of emergency departments, slashing GPs' consultation times, and scrapping other primary care services.

It says that seven of the 10 strategic health authorities in England have published plans for cutting a combined total of £15bn from their budgets up to 2014. Similar cuts from the remaining three authorities (North East, Yorkshire and Humber, and East of England) would bring the total to £20bn.

The biggest cut (averaging £673 per head of population) will be in London, followed by the West Midlands (£450 per head).

The NHS chief executive, David Nicholson, set a challenge in 2008 for authorities to make savings of between £15bn and £20bn through increased efficiency from 2011 to 2014 and gave examples of how this could be done (*BMJ* 2009;339:b53055).

Plans set by London's strategic health authority, NHS London, show that health bosses intend to make savings of more than £5bn by axing up to a third of hospital beds, switching emergency and outpatient treatment away from hospitals to health centres and "polyclinics," cutting the length of GP consultation times by a third, and cutting spending on "non-acute" (primary and community care) services by up to two thirds.

Cite this as: *BMJ* 2010;340:c816

## IN BRIEF

**Ice and snow caused 17 000 injuries in one month in Holland:** This winter Dutch hospital emergency departments dealt with around 500 cases a day of people injured through falling on snow or ice. Between 16 December and 15 January 17 000 patients, half aged over 55, were treated. Of these, 16% were admitted to hospital, costing an estimated €38m (£33m; $52m), said the Dutch consumer safety body (www.veiligheid.nl).

**Exposure of children in England to secondhand smoke has fallen:** Exposure to household secondhand smoke among children aged 4-15 years fell by 59% between 1996 and 2006 (*Addiction* 2010;105:543-53). The largest drop was between 2005 and 2006, a time of increased public debate and public information campaigns about secondhand smoke in the lead up to the 2007 implementation of legislation banning smoking in public spaces, the researchers found.

**GMC clears doctors:** A surgeon and an anaesthetist who admitted a series of failures in treating a woman who developed septicaemia and died after an operation to remove a kidney stone have been found fit to practise by the General Medical Council. Consultant urological surgeon John Hines and consultant anaesthetist Paul Timmis had "unblemished" careers, apart from the single episode seven years ago that led to the death of Carmel Bloom, 54, the fitness to practise panel said.

**Complaints against GPs rose by 11% in 2008-9:** Statistics from the NHS Information Centre show that written complaints against NHS GPs and dentists in England rose from 43 942 in 2007-8 to 48 597 in 2008-9. From April 2008 to March 2009 there were 14 866 complaints about clinical care, 11 003 about poor communication or attitude, 7448 about general practices' administration, and 6045 about surgery management.

**Agencies start to tackle primary healthcare needs in Haiti:** Attention in Haiti is moving away from trauma management to the primary health needs of displaced people living in about 250 temporary settlements, United Nations emergency relief officials said. About 91 healthcare facilities are functioning in the affected areas, including 59 in the capital. People are showing signs of mental trauma, and numbers of cases of tetanus and diarrhoea are rising.

Cite this as: *BMJ* 2010;340:c805

# PCTs are told to tighten regulation of out of hours services

**Zosia Kmietowicz** LONDON

The government has introduced a raft of measures to make primary care trusts in England more accountable for the out of hours services they commission, including checking doctors' clinical and language skills, after a review found "totally unacceptable" differences in the way trusts currently implement regulations.

**Daniel Ubani killed a patient**

THE AFRICAN COURIER

Local GPs should be more involved in the putting in place of arrangements for out of hours services and in developing the induction procedures to check that doctors on call are able to provide the care that patients should expect, said the health minister Mike O'Brien at a press conference to launch the review.

Mr O'Brien accepted all 24 recommendations in the review, which he had commissioned from David Colin-Thomé, national clinical director for primary care at the Department of Health, and Steve Field, chairman of council of the Royal College of General Practitioners.

Strategic health authorities are being told to monitor primary care trusts' response to the recommendations, which should be in place by the end of the year, he added.

The GMC has said that it is not acceptable that as the UK regulator it is not allowed to test the language skills and competence of doctors from the European Union as it does with doctors from other parts of the world; a combination of European Union law and domestic legislation (the Medical Act 1983) effectively prohibits this.

For the current review Dr Colin-Thomé and Professor Field visited a number of commissioners and providers of out of hours services. Although they found some good practice, they said that

# Scottish GPs want to be more involved in developing out of hours services

**Bryan Christie** EDINBURGH

Family doctors in Scotland should be much more involved in the planning and development of out of hours services, recommends a report on the future of general practice in Scotland.

Out of hours care is one of six key areas examined in the report, *General Practice in Scotland: The Way Ahead*, produced by the BMA in Scotland. Although reviews have shown that out of hours services in Scotland are of high quality, the report says that accessing the right service still causes uncertainty, anxiety, and frustration among patients. It calls for action to raise the public's awareness and understanding of out of hours services.

In addition, it recommends that the national core standards for out of hours services be reviewed and that consideration be given to developing "unique solutions," particularly in rural and remote areas. All of this activity can be supported by the greater involvement of GPs in planning and development of services, it says.

The report was produced after consultation with the public, professionals' and patients' groups, health charities, and NHS managers on the key

# Doctor who was excluded for raising patient safety concerns is entitled to damages

**Clare Dyer** BMJ

A consultant urologist at a London hospital who was suspended from work for 10 weeks after repeatedly raising concerns about patient safety has won a whistleblowing claim against his hospital trust.

Ramon Niekrash was branded a troublemaker and excluded from Queen Elizabeth Hospital in Woolwich, southeast London, in April 2008 after a series of letters to management about the consequences of cuts to patient services.

But London South employment tribunal in Croydon unanimously ruled that he was excluded because of his whistleblowing, entitling him to substantial damages. A separate hearing will decide what damages he should receive for injury to feelings, effects on his health, loss of reputation, and loss of private practice earnings.

Mr Niekrash, 50, who qualified in Australia, warned in his letters that cutting the numbers of specialist nurses and closing the specialist urology ward damaged patient care. He also complained of widespread bullying of staff by managers in cutting costs.

The Queen Elizabeth merged with two other hospitals to form South London Healthcare NHS

there was room for improvement in many areas, and no single organisation provided exceptional commissioning and provision.

Mr O'Brien said that the government was also considering establishing a national database of doctors who have been approved to provide out of hours care to avoid the variation among primary care trusts in vetting doctors.

It was inconsistencies in this vetting procedure that allowed Daniel Ubani, the German doctor who was found at an inquest to have killed a patient unlawfully by giving him 10 times the recommended dose of diamorphine, to be rejected by Leeds primary care trust because he lacked the required language skills, only to be accepted by Cornwall primary care trust to provide out of hours care. Because he was on the list of one trust Dr Ubani was then accepted on the list in Cambridgeshire, where he gave David Gray the fatal dose of diamorphine in February 2008.

***General Practice Out of Hours Services*** **can be seen at www.dh.gov.uk.**

Cite this as: *BMJ* 2010;340:c771

priorities for general practice. The consultation resulted in a focus on access; out of hours services; health inequalities; the balance between primary and secondary care in funding of services; workforce issues; and infrastructure. It was released during the first ever Scottish "general practice week" (8-12 February).

The report says that the response of GPs to the consultation reflected how difficult they find it coping with their workload while preserving what patients value most: the time to talk to their doctor. A common theme running through the report is the challenge of balancing the needs and expectations of patients with the resources available.

**The report is at www.bma.org.uk/sc/healthcare_policy/thewayaheadreport.jsp.**

Cite this as: *BMJ* 2010;340:c796


FRANTZESCO KANGARIS

**Ramon Niekrash outside his hospital, which is now managed by South London Healthcare NHS Trust**

Trust after declaring itself technically insolvent in 2006. Mr Niekrash, who was head of urological cancer from 2002-7, began his letter writing in 2005, copying letters to other consultants.

Cite this as: *BMJ* 2010;340:c739

STEFAN ROUSSEAU/PA

**The study identified a 20% higher in-hospital mortality rate in England compared to the United States**

# Report condemns poor care for trauma patients at night

**Oona Mashta** LONDON

Between 450 and 600 lives could be saved each year in England if care for patients with major injuries was managed more efficiently and effectively, a report from the National Audit Office says.

The study found unacceptable variation in major trauma care from hospital to hospital, which has not significantly improved in the past 20 years despite numerous reports identifying poor practice.

The quality of care depends on where and when people are treated. The study identified a 20% higher in-hospital mortality rate for trauma patients in England compared with the United States. The government said changes are now under way that will transform trauma care.

In England there are at least 20 000 cases of major trauma each year. Of these, about 5400 result in death, and many other patients have permanent disabilities requiring long term care. It costs the NHS between £0.3bn (€0.35bn; $0.5bn) and £0.4bn a year in immediate treatment costs.

Too often patients with severe injuries are taken by ambulance to the nearest casualty department, rather than the hospital with the equipment and expertise to cope with these complex cases, the report found.

Care should be led by consultants experienced in major trauma, but major trauma is most likely to occur at night and at weekends when consultants are not normally in the emergency department. Only one hospital, the John Radcliffe, Oxford, has 24 hour consultant care, seven days a week. The report also criticised delays in access to crucial computed tomography scans as well as surgery and rehabilitation.

Amyas Morse, head of the National Audit Office, said: "Current services for people who suffer major trauma are not good enough. There is unacceptable variation, which means that if you are unlucky enough to have an accident at night or at the weekend, in many areas you are likely to receive worse quality of care and are more likely to die."

Currently 193 hospitals in England provide trauma services, but only 114 (59%) voluntarily submit trauma data for analyses and comparison to the Trauma Audit and Research Network.

The government is now supporting proposals for the introduction of regional trauma networks designed to ensure that patients are delivered safely and rapidly to a specialist hospital where teams of experts, including trauma, orthopaedic, and neurosurgery experts, are on hand to care for patients 24 hours a day, seven days a week.

The National Audit Office therefore recommended interim actions to be taken by September 2011. It calls for primary care trusts and ambulance trusts to introduce triage protocols to determine which emergency departments are best for treating seriously injured patients. Trusts should also develop protocols for the transfer of patients requiring specialist care or surgical procedures not available at the receiving hospital.

The report commends the trauma plans for London, under which care will be concentrated at three major centres. It also praised the work of the Royal London Hospital, which has introduced better coordination between ambulances, the emergency department, and surgery.

***Major Trauma Care in England*** **is at www.nao.org.uk.**

Cite this as: *BMJ* 2010;340:c766

# India will train non-medical rural healthcare providers after

**Ganapati Mudur** NEW DELHI

After a decade of debate the Indian government has signalled its intention to introduce a new medical education programme to train rural healthcare providers for village health centres where doctors are unavailable.

The Medical Council of India, in consultation with the country's health ministry, last week released an outline of an alternative model of medical education that would be open only to students who have completed all their school education in villages. Graduates from the programme would be allowed to practise medicine only in rural areas and would be prohibited from offering services in urban areas.

The proposed four year bachelor of rural health care course will involve lessons in clinical examination, medicine, obstetrics and gynaecology, orthopaedics, paediatrics, surgery, epidemiology, and public health. It would be of shorter duration than the standard undergraduate course in modern medicine, which lasts five and a half years in India.

"We expect graduates from the alternative course to be competent in 60% of the skills possessed by doctors from the standard undergraduate course of modern medicine," said Ved Prakash Mishra, head of the council's academic unit.

The move towards the alternative curriculum comes more than a decade after a panel of medical experts set up by the council had said that India's existing medication education has "utterly failed" to produce doctors who are responsive to the needs of rural communities. The panel had argued in 2000 that the content and delivery of the existing curriculum was preparing doctors exclusively for tertiary care institutions and not for primary care in rural areas.

An ambitious plan launched in 2005 to improve rural health through funding, infrastructure, and medical staff has been hampered by shortages of doctors. Proposals by the government to make rural service mandatory for all medical graduates have remained unimplemented. The health ministry has pledged higher salaries for government doctors in the countryside, but shortages are expected to continue (*BMJ* 2009;339:b2781).

A government task force on medical education estimated three years ago that 74% of India's 760 000 doctors

# Most leading US medical schools lack rules on ghostwriting

**Janice Hopkins Tanne** NEW YORK

A survey of the top 50 US medical schools found that only 13 have policies prohibiting ghostwriting of scientific articles, a new report has found.

Last year the US Institute of Medicine recommended that US academic medical centres prohibit ghostwriting by their teaching staff.

One of the paper's coauthors, Jeffrey Lacasse, from Arizona State University in Phoenix, told the *BMJ*, "This is one of the most pressing problems in evidence based medicine . . . Nobody has ever been sanctioned [for cooperating in ghostwriting]."

The authors wrote, "Even beyond frank misrepresentation of data, commercially driven ghostwritten articles shape the medical literature . . . When a pharmaceutical salesperson hands a clinician an article reprint, the name of the institution on the front page of the reprint serves as a stamp of approval. The article is not viewed as an advertisement, but as scientific research" (*PLoS Medicine* 7(2):e1000230.

"We are not aware of any other academic fields where it is acceptable for professors to allow themselves to be listed as authors on research papers they do not write, or to purposefully conceal the contributions of industry coauthors in order to mislead readers."

Graduate students, they note, would face disciplinary action or even expulsion if they did not write their own papers.

The authors say that ghostwriting might involve a paper written by a drug company or communications company writer that is then presented to an academic for his or her signature or a paper on which a company writer assisted the academic but neither of which discloses the company writer's name or affiliation.

Dr Lacasse and his coauthor, Jonathan Leo, of Lincoln Memorial University in Harrogate, Tennessee, sought information about ghostwriting policies as posted on the websites of the 50 top schools among the 131 medical schools in the United States. They used the 2009 rankings of the magazine *US News & World Report*, which rates schools by the research funding they receive, to determine the top 50 schools.


The authors found that 10 schools explicitly prohibit ghostwriting, though not all define it, while three have authorship criteria that ban ghostwriting in practice.

They propose an amnesty during which faculty members who have participated in ghostwriting could own up.

They suggest that from the academic year 2010-11 medical schools adopt this authorship policy: "All listed authors on a publication must meet the authorship criteria set by the International Committee of Medical Journal Editors.

"Making minor revisions to a manuscript does not qualify as authorship. Participating in the creation of ghost-authored manuscripts is not permitted. A ghost author is defined as someone who makes substantial contributions to writing a publication but is not listed as an author. All individuals who have made a substantial contribution to the manuscript must be listed as authors. Accurately reporting authorship is essential for maintaining research integrity, and violating any of these rules is considered research misconduct akin to plagiarism or falsification of data."

Cite this as: *BMJ* 2010;340:c799

# doctors drop their opposition

SIPRA DAS/THE INDIA TODAY GROUP/GETTY IMAGES

**About 10% of India's primary health centres function without doctors**

serve 28% of the population in urban India. India's 300 medical colleges produce about 34 000 doctors each year, but nearly 25 000 enter postgraduate programmes or leave the country.

"Even doctors with rural roots refuse to go back to their villages," said Ketan Desai, the council's president.

About 2500 of India's 23 450 primary health centres function without doctors, according to figures from the National Rural Health Mission. The health ministry has announced plans to deploy the graduates from the new alternative course to primary health centres and to 146 000 village health subcentres.

Sections of India's medical community have in the past opposed proposals for an alternative medical education programme, arguing that this would be tantamount to introducing differential standards of care for the country's urban and rural populations (*BMJ* 2007;334:12).

The Indian Medical Association issued a memorandum last month declaring that the alternative programme would "produce substandard, half baked doctors" who would provide, at best, compromised care to rural people. Some doctors have approached Delhi High Court to oppose the move to introduce the new course.

But the association seemed to have altered its stand this week after the Medical Council of India made it clear that graduates from the new programme would have to practise exclusively in rural areas for at least five years after graduation.

Discord over how the proposal will be implemented persists, however. Some doctors and public health specialists are arguing that each state should be allowed to tailor its own rural health education programme.

Cite this as: *BMJ* 2010;340:c817

# Psychiatrists aim to redefine female sexual dysfunction

**Ray Moynihan** BYRON BAY

The definitions of female sexual dysfunction and its disorders of desire, arousal, orgasm, and pain are facing a major overhaul as part of the current revision of the influential *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

A working group for the American Psychiatric Association, which produces the manual, has proposed new definitions that give greater acknowledgment to the relationship context of women's sexual difficulties and new criteria to raise the threshold for diagnosis.

Describing current criteria for "hypoactive sexual desire disorder" as being "highly problematic," a member of the working group, Lori Brotto, a psychologist and assistant professor at the University of British Columbia, wrote that a woman's lack of sexual desire may sometimes be a "normal reaction to a problematic context and therefore should not be pathologized" (*Archives of Sexual Behavior*, doi:10.1007/s10508-009-9543-1)

Writing in the same journal, another working group member, Cynthia Graham, of the Isis Education Centre, Warneford Hospital, Oxford, stated that in order "to avoid pathologizing normal variation in sexual experiences" women's mild and passing sexual problems should not be regarded as symptoms of a medical dysfunction (doi:10.1007/s10508-009-9535-1).

The group has proposed abandoning the two existing disorders of desire and arousal and merging them into a new entity potentially labelled "sexual arousability disorder." Under its proposals, symptoms may have to be of a certain severity and to present for more than six months before a woman qualifies for a diagnosis.

It is unclear how the proposal to move away from the label "hypoactive sexual desire disorder" will affect drug companies—including Boehringer Ingelheim—that are currently testing products to treat the condition. Boehringer Ingelheim recently released abstracts suggesting that its drug flibanserin could offer woman an extra 0.7 "satisfying sexual events" per month, over and above the effects of a placebo.

For more than a decade some researchers have claimed that the condition called female sexual dysfunction affects 43% of women, though others believe the true prevalence is far less.

Cite this as: *BMJ* 2010;340:c830

# Stem cell scientists call for open process for reviewing research

**Susan Mayor** LONDON

Leading stem cell researchers have expressed concern that some reviewers may be hampering publication of high quality research in the field and are calling for a more open process of review to prevent this.

Their concerns echo those expressed in a letter sent last summer to the editors of science journals by 10 stem cell researchers from around the world. The letter claimed that "papers that are scientifically flawed or comprise only modest technical increments often attract undue profile. At the same time publication of truly original findings may be delayed or rejected" (http://eurostemcell.org/commentanalysis/peer-review).

The letter followed a major conference, the EuroSyStem/European Molecular Biology Organisation Conference on Advances in Stem Cell Research, at which researchers shared their frustration at sometimes receiving what they considered to be "unreasonable or obstructive reviews." To improve the situation, they proposed that when a paper is published, the reviews, response to reviews, and associated editorial correspondence could be provided as supplementary information, while preserving anonymity of the referees.

SPL

**Some reviewers asked for "unnecessary experiments"**

Speaking to the BBC about the issue this week, Austin Smith, director of the Wellcome Trust Centre for Stem Cell Research at the University of Cambridge, and one of the letter authors, and Robin Lovell-Badge, who was speaking in a personal capacity and not in his role as head of the division of stem cell biology and developmental genetics at the National Institute for Medical Research, said that the issue has not been resolved.

They said they were finding "increasingly that some reviewers were sending back negative comments or asking for unnecessary experiments to be carried out for spurious reasons." They felt that this might be being done "to delay or stop publication of research findings so that the reviewers or their close colleagues can publish first."

"It's hard to believe except you know it's happened to you that papers have been held up for months and months by reviewers asking for experiments that are not fair or relevant," Professor Smith told the BBC.

Cite this as: *BMJ* 2010;340:c719

# US health spending rises to 17% of GDP as economy contracts

**Bob Roehr** WASHINGTON, DC

Spending on health care in the United States rose to $2.5 trillion (£1.6 trillion; €1.8 trillion) in 2009, experts at the government's Center for Medicare and Medicaid Services have estimated.

That is a rise of 5.7% over the amount spent in 2008. Spending on health care in the US now constitutes 17.3% of the gross domestic product (GDP), up from 16.2% in 2008.

It is the largest percentage increase in health spending in the five decades that records have been kept. The analysis attributes much of the increase to the economic recession that struck the US in 2009, resulting in contraction of the economy and therefore of GDP, but some was due to an actual rise in spending.

The rate of increase in health spending should ease as the economy recovers. "For the next several years growth [in health spending as a percentage of GDP] will be relatively flat as the economy recovers," said Christopher Truffer, an analyst at the centre and lead author of the report, which appeared in *Health Affairs* (doi:10.1377/hlthaff.2009.1074).

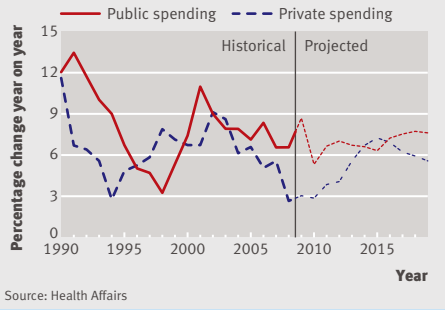
Spending on physician and clinical services was the biggest factor in the annual increase (this spending rose by 6.3% in 2009, compared with a 5% increase in 2008), due in part to care associated with the H1N1 flu epidemic. Hospitalisation was the next leading factor (5.9% in 2009; 4.5% in 2008).

While prescription drug costs showed the greatest change from the previous year (5.2% in 2009; 2% in 2008), the 2009 rate of increase was less than that for the other major factors.

Consumers' out of pocket expenses in 2009 increased at a slower rate than in the previous year (2.1% in 2009; 2.8% in 2008) to $283.5bn. Some of that could be attributed to continuing enrolment in the Medicare Part D prescription drug programme for elderly people (*BMJ* 2010;340:c81), but economic uncertainty also led some people to defer or not purchase recommended services.

The analysis projects that health spending will continue to outpace the rest of the economy for the next decade. It is predicted to constitute 19.3% of GDP by 2019. The report does not foresee any of the proposed health reform plans as having an important effect in reining in this growth.

**ANNUAL GROWTH IN US SPENDING ON HEALTH CARE (PRIVATE AND PUBLIC SECTOR)**




Source: Health Affairs

One trend is for public spending to grow faster than private spending. Health spending by the private sector is at a historically low level, said Dr Truffer. This is because of the poor economy, with people losing their jobs and therefore their associated employment based health insurance, and applying instead for public health insurance programmes and direct services.

He does not expect that economic recovery will bring a return of private spending to recent levels. Over the longer term, he said, retiring "baby boomers" will swell the ranks of those eligible for Medicare, the health programme for elderly people.

Cite this as: *BMJ* 2010;340:c772

BMJ GROUP AWARDS ✪ BMJ GROUP AWARDS ✪ BMJ GROUP AWARDS ✪ BMJ GROUP AWARDS ✪ BMJ GROU

BMJ Group Awards: Corporate Social Responsibility category

# Fighting for the environment, the young, and the isolated

**Zosia Kmietowicz** LONDON

The four teams, out of 30 nominated, that made the shortlist for the BMJ Group award for corporate social responsibility each bring a different but strong case for the prize.

Two of those shortlisted chose to tackle perhaps the most pressing issue the world has ever faced by taking action to limit their organisation's impact on the environment.

Users of health services provided by Southern Health in Melbourne, which operates across 40 sites, including six major hospitals, might not realise it, but the water with which they flush the toilet is captured from dialysis reverse osmosis equipment. They might also not notice that the air conditioning at the various sites is very finely tuned, never running too hot or too cold. But they do know that they have to switch off lights and computers when not in use and use the recycling bins whenever possible.

These and other efforts have resulted in an estimated saving of 35 million litres of water a year, 2 544 402 kWh of electricity and 1390 tonnes (22%) of waste away from landfill by the health provider. Champions of the environmental project called Our Healthcare, Our Environment, which has been running since 2006, estimate their initiatives have saved the health authority $A83 000 (£46 000; €52 700; $US73 000) on the basis of 2006-7 prices.

The other environmental champion on the shortlist is the Greening Initiative at St Michael's Hospital, in Toronto, Canada. Since 1992, when the hospital implemented one of the first programmes in a healthcare facility to divert food waste from landfill, work by the initiative has led to projects to save energy, recycle waste, and reduce water consumption. One project, which led to the replacement of 15 leaking traps and the implementation of a heat recovery system, prevented the loss of 2.8 million pounds of steam annually.

It is estimated that the heat recovery project saves the hospital $C1.5 million (£900 000; €1m; $US1.4m) in utility bills every year. But the initiative also has had other benefits. It has created a sense of ownership and pride among staff that is recognised throughout the hospital, said Eduarda Calado, who coordinates the initiative.

The other shortlisted teams in this category have also shown important aspects of corporate social responsibility. The Healthcare Careers and Skills Academy from the University Hospital of North Staffordshire NHS Trust is an innovative careers advice service for the trust's own staff and for young people, students, and unemployed people in the area who are interested in a career in the health service.

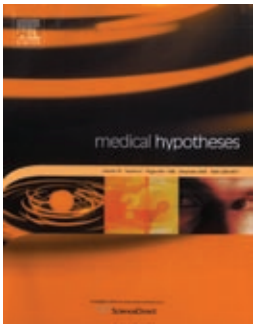
The trust has seen more than 1000 people in the local community since it opened its doors in May 2008. As well as offering careers advice to staff at the trust the team does outreach work at job centres in the area. It also works with charities, such as the Richmond Trust and Landau, whose clients have learning disabilities and mental impairments, and is a lead partner for the Young Apprenticeship in Health

# Will advent of peer review emasculate hypothetical oddities?

**Geoff Watts** LONDON

With postal deliveries comprising mainly junk mail, the monthly arrival of the journal *Medical Hypotheses* is a treat. But for how long? If a group set up to advise the journal's publishers have their way, what makes it so distinctive may in due course wither. The group, which includes medical editors and others with an interest in editorial affairs, is advising Elsevier that the editorial decisions currently made by one man, Bruce Charlton, should be overseen (and often, no doubt, over-ridden) by peer reviewers. Subject to the constraints of an unfamiliar orthodoxy, the bright and sometimes highly coloured plumage of *Medical Hypotheses* would surely suffer a fade to grey.

Bruce Charlton—who combines his role as editor with those of reader in evolutionary psychiatry at Newcastle University and what he calls a "virtual professorship" at the University of Buckingham—has been in charge at *Medical Hypotheses* for some seven years. The journal was founded in 1975 by David Horrobin, another Newcastle doctor whose unconventional career was backed by a capacity for controversial and unorthodox thinking. Horrobin started it as a forum for new ideas because he believed that, compared with other sciences, medicine was short on good theorising with which to underpin its experimental work. He also saw the peer review process as intrinsically biased against any new idea, let alone a revolutionary one. Although peer review might be appropriate for assessing experimental work, this didn't necessarily make it equally suitable for judging theoretical speculation, he thought.




**Editorial decisions may be overseen by peer reviewers**

Charlton became a member of the *Medical Hypotheses* advisory board in the late 1990s and took over as editor after Horrobin's death in 2003. "I think he'd sized me up and decided I would be the person to take over. When he realised he was going to die he began giving me briefings, even on the ward while he was receiving chemo." Charlton clearly feels the weight of his inheritance; he talks not only of his own fears for the journal's future, but how his deceased mentor would have felt about the proposed changes.

What prompted Elsevier to set about a rethink of its journal was Charlton's intention to publish two papers which, so Elsevier claim, undermine the current understanding of AIDS. One of them, by the Stanford virologist Peter Duesberg, certainly tries to do this. He uses the instance of South Africa to argue against the HIV virus as the cause of the disease. One might suggest that Duesberg is a tiresome man and that Charlton's intention to give him more space in which to argue his already familiar case was ill conceived. But is this sufficient reason to revamp the entire basis of the journal's editorial selection procedure?

Even odder is the case of the other banned paper. Submitted by a group based in Florence it seems not to deny the viral origin of HIV, but to tease the Italian health authorities for the incompetence of their bureaucracy and procedures by suggesting that those authorities themselves behave as if they are "AIDS deniers."

The future of *Medical Hypotheses* remains, for the moment, in limbo. The journal is currently profitable, with a good impact factor, and a board that includes many worthy and several celebrated academics. If Elsevier does follow its advisory group's recommendations it may lose some or all of the above—to say nothing of its editor.

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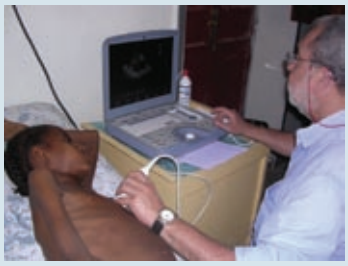


**From left: Milena project, Ethiopia; Healthcare Careers and Skills Academy, Staffordshire; Southern Health, Melbourne; logo for St Michael's Hospital, Canada**

and Social Care for young people aged between 14 and 19 years.

The team offers help with writing CVs, filling out job applications, and understanding the range of careers opportunities in the NHS. To date the academy has guided 55 people to jobs within the trust and 178, including 35 young people, have completed work experience placements.

The final project is the most far flung. Run by a team of heart surgeons at the University of L'Aquila in Italy, the Milena project is subtitled "A heart for Ethiopia." The team has taken its corporate social responsibility to Africa where it has developed a project that provides heart surgery services to the people of the city of Mekele in northern Ethiopia.

Milena refers to an Italian woman of Ethiopian origin who died prematurely at the age of 26 from a congenital heart condition. Mekele was chosen as the project's base after consultation with Ethiopia's health ministry because it lacked a freely accessible cardiac screening service. It is isolated and has few local resources, so anyone in the area who needs surgery has to make a 48 hour bus journey first to Addis Ababa and then a plane trip to Salam Hospital in Khartoum. This is all paid for by the charity.

The team from L'Aquila visits the area five times a year and has to date treated 3000 patients, 60 of them with open heart surgery. The project also runs an orphanage in Mekele providing basic care, psychological support, and education to orphaned and abandoned children. The Italian team also helps to train people locally and has developed the cardiology training curriculum for medical students at Mekele university.

Now it is over to the judges: Jane Fiona Cumming, co-founder and director of Article 13 Ltd, strategic advisers on risk associated with business responsibility; Janet Sidaway, director of CSR Consulting, a consultancy specialising in developing and assessing corporate social responsibility policies and practices; and Olivia Roberts, senior research officer in the International Department of the British Medical Association.

The award is sponsored by Healthcare Locums.

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