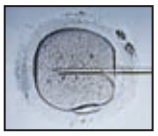

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NHS trust made £300 000 by selling drugs to wholesaler

Jeremy Laurance THE INDEPENDENT

A bizarre twist in the unfolding story of drug shortages in the NHS emerged last week with the disclosure that an NHS trust had sold millions of pounds worth of drugs abroad because it saw an opportunity to make a fast profit.

The Royal Surrey County Hospital NHS Foundation Trust said it had spent £4.6m (€5.2m; $7.1m) over a period of 10 months buying up drugs at the NHS price and selling them to a wholesaler for export, making a profit of £300 000. It later defended its activities on the grounds that trusts had been encouraged to be "entrepreneurial" and continued the practice for six months after warnings from the government that its behaviour was "unacceptable."

Until the trust's activities were exposed it had been thought the export of drugs intended for NHS use was in the hands of a few wholesalers and pharmacists.

Days earlier the health minister Mike O'Brien had condemned the "unscrupulous people" who were "putting profits before people" by selling drugs abroad. He announced an emergency summit on the supply of drugs early next month and said it was unacceptable that patients were having to wait to obtain the drugs they needed.

The issue has been of growing concern to patients and pharmacists for more than a year, as "parallel traders" have taken advantage of the weak pound and strong euro to export drugs for profit. But no one expected that an NHS trust might be involved in the trade.

The Royal Surrey's finance director, Paul Biddle, told the *Health Service Journal*, which uncovered its activities, that the trust had seen an "opportunity to make a margin." He defended the practice on the grounds that the regulator of foundation trusts, Monitor, had "always encouraged trusts to be entrepreneurial."

In a statement the trust vigorously defended its action. It said it had a "history of manufacturing and supplying drugs to other healthcare organisations under licence" and that the drugs supplied recently to a wholesaler were "widely available."

It added: "At no time were drugs supplied which were on the list of drugs in short supply."

Cite this as: *BMJ* 2010;340:c1072

PETER MACDIARMID/GETTY IMAGES

At least nine primary care trusts no longer pay for homoeopathy, found a Channel 4 news programme

MPs say that the NHS should stop funding homoeopathy

Zosia Kmietowicz LONDON

A cross party group of MPs says that the NHS should cease funding homoeopathy, which it says is a placebo treatment and involves deceiving the patient every time it is prescribed.

It is not sufficient to allow a treatment on the NHS just because it offers patients a choice—an argument often cited by the government for homoeopathy being provided by the health service. In their report the MPs claim that "when doctors prescribe placebos, they risk damaging the trust that exists between them and their patients."

The House of Commons Science and Technology Committee looked at whether the government's policies on homoeopathy were based on sound evidence. It found a mismatch between the evidence and policy. Although the government acknowledges that there is no evidence that homoeopathy works beyond a placebo effect, it does not intend to change or review its policy of funding homoeopathy on the NHS, the committee concluded.

MPs found that the explanation given by advocates of homoeopathy that the ultra-dilutions used in remedies can maintain an imprint of substances previously dissolved in them—so called "water memory"—to be "scientifically implausible."

Providing homoeopathy on the NHS gives the remedies "a badge of authority that is unjustified," they said.

Their report says, "Since the NHS Constitution explicitly gives people the right to expect that decisions on the funding of drugs and treatments are made 'following proper consideration of the evidence,' patients may reasonably form the view that homeopathy is an evidence-based treatment."

The MPs have called for the government to look into the ethics of prescribing homoeopathy. They also said that the Medicines and Healthcare Products Regulatory Agency should no longer license homoeopathic products or allow product labels to make medical claims without evidence of effectiveness.

It is estimated that the NHS spends £4m (€4.6m; $6.2m) on homoeopathy every year, although this does not include the maintenance and running costs of the four homoeopathic hospitals in the UK or the £20m spent five years ago on refurbishing the Royal London Homoeopathic Hospital.

***Evidence Check 2: Homeopathy* is at www.parliament.uk.**

Cite this as: *BMJ* 2010;340:c1091

bmj.com poll Should homoeopathy be available on the NHS? Vote at bmj.com/#polldaddy-head

IN BRIEF

Wakefield resigns from autism centre he founded in Texas: Andrew Wakefield, the British gastroenterologist who sparked a worldwide scare over the measles, mumps, and rubella vaccine, has resigned from Thoughtful House, the autism centre he founded in Austin, Texas. The move follows a ruling by the UK General Medical Council that he acted dishonestly and irresponsibly over a 1998 research paper in the *Lancet*, which the journal recently retracted (*BMJ* 2010;340:c696).

Drug firm drops libel action against professor: GE Healthcare has dropped a libel action it started at London's High Court against Henrik Thomsen, professor of radiology at the University of Copenhagen, after comments he made at an Oxford conference suggesting a link between the company's injectable contrast agent gadodiamide (Omniscan) and the rare debilitating disease nephrogenic systemic fibrosis (*BMJ* 2009;339:b5615). The company said it accepted that his concerns were expressed in good faith.

Focus cancer resources where biggest cuts in mortality can be made: The total cost of cancer in England is £18.3bn a year and is set to rise to £24.7bn in the next decade, says a new report from the think tank Policy Exchange. The new figure includes healthcare costs, costs to patients and families, and losses in productivity. The group calls on governments to adopt the best practices from high performing countries and focus resources where the largest cuts in mortality can be achieved.

Falls services fall short in satisfaction ratings: Although most (76%) of the 1000 people questioned in a postal survey about their experiences of local falls prevention services in England, Wales, the Channel Islands, and Northern Ireland reported a positive experience, the remainder were not satisfied (www.rcplondon.ac.uk). Most complaints related to communication. Many patients also thought that exercise programmes were too infrequent and too short.

Iran agrees to improve access to health care: Iran has rejected calls from several nations, including the UK, to allow independent UN human rights experts to conduct an investigation into allegations that some people arrested since the 12 June elections have been tortured and killed while in detention. However, during a review by the UN human Rights Council Iran agreed to some recommendations, including to continue to improve access to health care in the country.

Cite this as: *BMJ* 2010;340:c1093

Private firm will win bid to operate entire NHS hospital

Adrian O'Dowd MARGATE

An NHS district general hospital will be run by a private organisation for the first time after the decision by a fellow NHS body to drop out of a bidding process.

Hinchingbrooke Health Care NHS Trust in Huntingdonshire is the first NHS trust to invite potential partners from within and outside the NHS to apply for a franchise to operate the hospital. The only remaining NHS organisation that was bidding to manage the hospital—Cambridge University Hospitals NHS Foundation Trust—withdrew from the bidding, saying that the costs were too high.

Unions are worried about the development and fear that it is a "dangerous experiment" that goes against recent comments from the Department of Health and health secretary Andy Burnham that the NHS should be the "preferred provider" of services.

The trust, which has an accumulated deficit of £38.9m ($60m; €44m) as of March 2009, is keen to proceed with the bidding process that now involves five private organisations—Care UK (Partnership Health Group Limited); Circle Health; Interhealth Canada (UK) Ltd; Ramsay Health Care UK; and Serco Health.

Five private firms are bidding to run Hinchingbrooke Health Care NHS Trust

The process to find the right partner involves several phases, and a winner is expected to be chosen later this year. The contract insists that the successful company taking over management of the hospital will have to keep maternity and emergency services open, and staff at the trust will continue to be employed by the NHS, which will also retain hospital assets.

Mark Millar, chief executive at Hinchingbrooke Trust, said: "This process brings a huge opportunity for the hospital, patients and staff alike.

"Through discussions with interested parties we're seeing exactly the added benefits that these proposals might bring. We are still absolutely clear that, whatever happens, the staff and buildings will remain protected within the NHS."

Dr Stephen Dunn, director of strategy at NHS East of England, told the *BMJ*: "The staff at the trust have been very engaged with this whole process and sit on our stakeholder panel. They have known about the plans going back to 2008.

Courts are being used "to litigate a scientific debate," counsel claims

Clare Dyer BMJ

The science writer Simon Singh's right to free expression was infringed when he was required to "prove the unprovable," his counsel, Adrienne Page QC, told three of the most senior judges in England and Wales this week.

Dr Singh is appealing against preliminary rulings in a libel action brought against him by the British Chiropractic Association over a comment piece he wrote in the *Guardian* newspaper. The case has become a cause celebre for free speech campaigners, who say that it illustrates the chilling effect of the libel laws on scientific debate (*BMJ* 2009;339:b5393; 2010;340:c339).

Because the Court of Appeal's eventual ruling is expected to set an important precedent, the appeal was heard by a particularly eminent panel that included the lord chief justice, Lord Judge, and the master of the rolls, Lord Neuberger. The third judge, Lord Justice Sedley, one of the most experienced in the appeal court, once dubbed a GP's evidence in a vaccine case "junk science" (*BMJ* 2007;335:416-7).

Dr Simon Singh questioned claims by chiropractors

DAVE PENMAN/REX

Dr Singh's article argued that there was no evidence for the claims made by the British Chiropractic Association that childhood ailments such as asthma or colic could be treated by spinal manipulation. He described the claims as "bogus" and criticised the association for "happily promoting" them.

The association sued him for libel, claiming that he was accusing them of knowingly peddling bogus treatments. He denies that he intended any such meaning.

Last May in the High Court Mr Justice Eady ruled that Mr Singh's article did carry the meaning the association asserted. He also held that the statement was one of fact, rather than

"Staff are both very well informed of what is going on, and nobody locally sees this as privatisation. This is not about privatisation. Staff and assets will remain in the NHS and they do not see it as the thin end of the wedge. Locally, Unison is clear of that fact.

"The staff are all pretty clear that there is a £40m debt that hangs over Hinchingbrooke and that debt issue needs to be resolved. They understand that we have gone through all the options and this is the best way of ensuring that Hinchingbrooke remains open and remains sustainable and viable going forward.

Dr Dunn emphasised that all of the companies bidding had provided elective surgery to NHS patients in treatment centres.

Unison, the public sector union, condemned the plans to hand over the running of Hinchingbrooke Hospital to a private company. Karen Jennings, Unison head of health, said: "Hinchingbrooke Hospital does have debts, but they are no worse than many other trust's. The new hospital management has made inroads into tackling the deficits, making this whole outsourcing process an unnecessary costly and dangerous experiment. What experience do these private companies have of running a district general hospital?

"The government should step in and make sure that the NHS is truly the preferred provider and let Hinchingbrooke stay NHS run."

Details can be seen at www.eoe.nhs.uk.

Cite this as: *BMJ* 2010;340:c1060

comment, depriving Mr Singh of the defence of fair comment.

Ms Page said the courts were being used at great expense "to litigate a scientific debate" between Mr Singh and the chiropractors.

She said that the defence of justification—that the statement was true—would inevitably be struck out unless Mr Singh could identify in his pleadings the individuals who were responsible for placing the claims on the association's website and whose state of mind could properly be attributed to the association. But this would place an "impossible burden" on him, because he knew nothing about the individuals in the association and their state of mind.

Ms Page said attribution of motive and state of mind were generally treated as comment in modern cases rather than a statement of fact, generally because they were unprovable.

It was an interference with the right of free speech in article 10 of the European Convention on Human Rights to require an author "to prove the truth of something which is not capable of proof," she added.

Cite this as: *BMJ* 2010;340:c1120

New figures show glaring discrepancies in GPs' funding

MARK THOMAS

Anger at the awarding of a contract for three practices in Camden to a private company led an activist to demand data under the Freedom of Information Act. The figures show big variations

Nigel Hawkes LONDON

Figures released by a London primary care trust, as a result of a request made under the Freedom of Information Act, show huge differences in funding between general practices.

The highest paid practices in Camden, north London, earn more than twice as much per patient as the lowest paid, with the figure for the base contract per patient ranging from as low as £57.72 (€65; $90) to as high as £145.34.

The wide range in practices' incomes is not a complete surprise, said Laurence Buckman, chairman of the BMA's General Practitioners Committee, as anonymised figures published by a committee representing the UK health departments, NHS Employers, and the BMA have shown "enormous" discrepancies between practices in all primary care trusts. But this is believed to be the first time that the amounts paid to named practices have been disclosed.

The figures emerged as a result of a Freedom of Information request made to NHS Camden primary care trust in June 2008 by Peter Roderick, a lawyer and environmental activist who was a patient at a local practice, the Camden Road surgery. He was angered by the trust's decision to award the contract for the practice to UnitedHealth, a private healthcare company (*BMJ* 2008;336:412-3) and sought details of how much the company was being paid.

Dissatisfied with the response, he appealed to the UK information commissioner, who ruled against the trust's argument that the information was commercially sensitive.

Faced with the ruling, the Camden trust decided to publish details of not just the five practices named in the request but all its 39 general practices, including the total per patient.

The data throw light on the "haves" and "have nots" among Camden's general practices. The table published on NHS Camden's website (www.camden.nhs.uk/what-funding-does-your-gp-surgery-get-from-us.htm) divides payments into four columns: base contract, enhanced services, Quality and Outcome Framework (QOF) payments, and total funding. Funding for improvements to premises and education are excluded.

From the number of patients registered at each practice it is simple to work out funding per patient. The lowest funded practice, St Phillips, is a special case because it is the practice that serves the London School of Economics. The second lowest figure of base contract per patient is that for the practice of Dr Alan Grasse in West End Lane, London NW6, at £57.72. The highest is Holborn Medical, which gets £145.34 per patient. The mean for all 39 practices listed is £89.38 per patient.

The *BMJ* asked NHS Camden whether there was any explanation for such a wide variation, but at the time of writing the trust had not replied. There are many possibilities. Practices may work under general medical services (GMS) or personal medical services (PMS) contracts, which can make a big difference. The terms of the contracts may differ for entirely legitimate reasons.

But Paddy Glackin, medical director of the Londonwide Local Medical Committees, suggested that the figures represent historical anomalies "locked in" by the 2004 GP contract. "It's down to all sorts of accidents of history," Dr Glackin said. "Some practices were favoured in the past; some new practices were well looked after, some weren't. It's often down to quirks."

Cite this as: *BMJ* 2010;340:c1071

US doctors are lax in treating hypertension, report says

Bob Roehr WASHINGTON, DC

A new report by the US Institute of Medicine calls hypertension a "neglected disease." The institute recommends a range of public health interventions to reduce its prevalence.

"Although hypertension is relatively easy to prevent, simple to diagnose, and relatively inexpensive to treat, it remains the second leading cause of death among Americans," said David Fleming, who led the study committee that wrote the report. He is director of public health for Seattle and King County, Washington.

Hypertension is the most common primary diagnosis in the United States, affecting about 73 million adults (one in three). Despite annual spending of $73bn (£47bn; €54bn) on related health care, high blood pressure accounts for one in six deaths of adults. Over the decade 1995 to 2005 that death rate increased by 25%.

"Millions of Americans continue to develop, live with, and die from hypertension because we are failing to translate our public health and clinical knowledge into effective prevention, treatment and control programs," says the report.

It points out the meagre grant portfolio of the Centers for Disease Control and Prevention (CDC), which in 2009 was just $54m, spread across the entire spectrum of heart disease and stroke prevention.

It criticises the CDC's cardiovascular disease prevention programme for focusing more on medical care than population based interventions. It calls the programme "dramatically underfunded" relative to the disease burden and the potential for prevention.

Given the reality of limited fiscal resources, the report calls for shifting funding to a population based approach that emphasises reducing weight and sodium intake, increasing potassium intake, improving diet, and increasing physical activity.

Non-adherence is a major factor explaining the continuing high prevalence of hypertension, it says. Physicians bear responsibility for not following guidelines for screening, counselling, and prescribing of drugs; this is particularly important because 86% of people with uncontrolled hypertension have health insurance and visit their doctors, one study cited by the committee found. The report recommends research into why guidelines are not being followed.

FDA restricts use of erythropoiesis stimulating drugs in cancer patients

Janice Hopkins Tanne
NEW YORK

The US Food and Drug Administration and a manufacturer of erythropoiesis stimulating agents have announced a new safety plan for use of these drugs in patients with cancer.

DR P MARAZZI/SPL

Health staff giving ESAs must join Amgen's risk evaluation programme

Studies found that when the drugs were used in patients with cancer they caused tumours to grow faster and led to earlier deaths in some patients (*Clinical Cancer Research* 2008;14:3242; *CMAJ* 2009;180:e62-71). In April 2008 the FDA required the manufacturer, Amgen, to establish a risk management programme for these drugs.

The FDA said that such a programme was needed to ensure that the drugs' benefits "outweigh the risks of shortened overall survival and/or increased tumour progression or recurrence as identified in clinical studies in patients with breast, non-small cell lung, head and neck, lymphoid and cervical cancers."

The drugs are epoetin alfa (marketed in the United States as Procrit and Epogen) and darbepoetin alfa (marketed as Aranesp), by Amgen and Centocor Ortho Biotech Products, part of Johnson and Johnson. The drugs stimulate bone marrow to produce more red cells. They are used to treat anaemia related to chemotherapy in patients with cancer.

The drugs are also used to treat anaemia in patients undergoing dialysis, people with chronic renal failure, and some other patients, but the risk management programme applies only to their use in patients with cancer.

The new risk evaluation and mitigation strategy requires health professionals to give patients receiving the drugs a guide on how to use the drugs safely.

If health professionals are giving the drugs to patients with cancer they must also participate in Amgen's "assisting providers and cancer patients with risk information for the safe use of ESAs [erythropoiesis stimulating agents]" (APPRISE) programme, a part of the risk evaluation programme. Amgen must make sure health professionals maintain active enrolment in the APPRISE programme, complete a training module on how to use these drugs in cancer patients, and discuss with patients the risks, benefits, and FDA approved uses of the drugs before patients begin treatment. They must also get a written acknowledgement of the discussion from the patient.

Cite this as: *BMJ* 2010;340:c1050

GSK hid heart risks

Janice Hopkins Tanne NEW YORK

The US Senate's Finance Committee has claimed that GlaxoSmithKline (GSK) knew that "there were possible cardiac risks associated with Avandia" (rosiglitazone) for several years before a 2007 study in the *New England Journal of Medicine* showed a link between the drug and heart attacks.

The committee released a 342 page report on Saturday 20 February. It said the company should have warned patients and the Food and Drug Administration. "Instead," the report says, "GSK executives attempted to intimidate independent physicians, focused on strategies to minimize or misrepresent findings that Avandia may increase cardiovascular risk, and sought ways to downplay findings that a competing drug might reduce cardiovascular risk." It says that another drug, pioglitazone (Actos), might pose less risk to patients.

Rosiglitazone helps control blood sugar concentrations by increasing sensitivity to insulin.

The 2007 study, a meta-analysis by Steven Nissen and Kathy Wolski of the Cleveland Clinic (*New England Journal of Medicine* 2007;356:2457-71), concluded: "Rosiglitazone was associated with a significant increase in the risk of myocardial infarction and with an increase in the risk of death from cardiovascular causes that had borderline significance."

Patients often don't make recommended lifestyle changes or take drugs as prescribed. The built environment and limited recreational opportunities can inhibit physical activity.

Financial considerations can also be a factor as to why people on low incomes do not adhere to antihypertensive treatment. The report suggests that insurers, including the federal Medicare and Medicaid programmes, reduce or eliminate copayments for antihypertensive drugs. Drug companies should simplify and expand their patient assistance programmes, it says.

Black and Hispanic people are disproportionately affected by hypertension. The report says that programmes should work to reduce these disparities.

It is estimated that if Americans consumed less salt and ate more vegetables, fruits, and lean protein the prevalence of hypertension might fall by as much as 22%.

Reducing daily salt intake from 3400 mg to the currently advised maximum of 2300 mg could bring down the number of people with high blood pressure by about 11.1 million and save an estimated $18bn in healthcare costs each year.

The report recommends broad public education campaigns, particularly at the community level, to reduce the prevalence of hypertension in the US.

A Population-Based Policy and System Change Approach to Prevent and Control Hypertension **can be found at www.iom.edu/reducehypertension.**

Cite this as: *BMJ* 2010;340:c1074

# of diabetes drug, claims committee

Besides its report released on Saturday, the committee sent an accompanying statement and a 92 page document to the FDA commissioner, Margaret Hamburg. It described its investigation and findings and asked the FDA what it would do to protect patients in an ongoing clinical trial with rosiglitazone.

In an online press release GSK has criticised the Senate committee's report and rejected its conclusions. It said the report's conclusions about the safety of rosiglitazone were "based on analyses that are not consistent with the rigorous scientific evidence supporting the safety of the drug."

It said the report selectively picked information from documents "which mischaracterizes GlaxoSmithKline's comprehensive efforts to research Avandia and communicate those findings to regulators, physicians, and patients."

The company further said, "Contrary to the assertions in the report, and consistent with the FDA-approved labeling, the scientific evidence simply does not establish that Avandia increases cardiovascular ischemic risk or causes myocardial ischemic events."

It said that the FDA had considered assertions by the FDA staff member David Graham that rosiglitazone increased the risk of heart attacks and should be withdrawn. However, GSK said, the FDA followed the recommendation of an independent advisory committee and decided that the drug should remain available.

The FDA said it had told healthcare professionals and patients that it was reviewing primary data from a large study published last year (*Lancet* 2009;373:2125-35) and other studies. When the review is completed it will present the data at a public meeting in July 2010."

The report is at www.finance.senate.gov.

Cite this as: *BMJ* 2010;340:c1107

The FDA is reviewing primary data and will present its findings in July 2010

Patient advocate calls for register of medical errors in Germany

Ned Stafford HAMBURG

The German government's commissioner for patients has called for the establishment of a federal register listing "doctors' mistakes," a suggestion strongly rejected by the German Medical Association as unnecessary while at the same time criticised by some campaigners for patients' rights as inadequate.

Wolfgang Zöller, a Bundestag member serving as patient commissioner in the German health ministry, proposed the register in an interview in the daily *Hannoversche Allgemeine Zeitung* (15 Feb, p 2), saying that Germany needs a "new culture" for dealing with doctors' errors to reduce their number.

He suggested setting up a malpractice register, which initially would not identify doctors suspected of malpractice. Establishment of the register could be inserted into a proposed law on patients' rights now under discussion by the government, he said.

Spokespeople for the German health ministry have attempted to downplay the suggestion, saying in the German press that the register had not yet been discussed within Chancellor Angela Merkel's governing coalition.

Jörg-Dietrich Hoppe, president of the German Medical Association, responded: "We don't need a compulsory register of mistakes in treatment but, instead, sensible working conditions for doctors, then many mistakes could be avoided."

Dr Hoppe added that the association's goal has been and still is a "mistake avoidance culture" in which doctors can discuss their errors without fear and learn from their mistakes.

He noted that a system of expert committees and arbitration services established throughout Germany by state medical associations in 1975 to deal with medical liability malpractice had performed well. About 90% of the expert committees' decisions are accepted by both parties, thus avoiding lawsuits, he added. In 2008 about 11 000 patients filed complaints to the system.

But Frank Lepold, manager at the German Patient Protection Alliance's office in the state of North Rhine-Westphalia, said that although a nationwide register as proposed by Mr Zöller would be an improvement over the current situation, it did not go far enough. "For us, it doesn't seem to be enough. It would only be a first step toward better patient protection," he said.

The German Medical Association's statement is at www.baek.de/page.asp?his=3.71.7962.8025.8057.

Cite this as: *BMJ* 2010;340:c1084

Few US medical schools and centres disclose industry ties

Janice Hopkins Tanne NEW YORK

Few of the leading medical schools and hospitals in the United States tell the public about their academic members' ties to the drug and device industry, although more institutions now require members to disclose this information to them, say the American Medical Student Association and the Association of American Medical Colleges.

Prominent academic physicians who have not told their institutions about lucrative consulting arrangements with drug and device companies have been headline news in recent years in the US (*BMJ* 2009;338:a3188; 2009;339:b2725).

The trend is towards greater disclosure, said Kim Cunningham, a spokesperson for the American Medical Students Association. The association has compiled a scorecard of US medical schools' disclosure practices (www.amsascorecard.org). First published in June 2009, the scorecard is updated as new information comes in.

Only seven medical schools have received the highest grade for disclosing past and present industry ties on a publicly available website or disclosing such associations to patients when the relationship might be a conflict of interest.

US medical schools, medical centres, and hospitals use their websites to help patients to find a doctor. Most post the biographies of their doctors but very few include information about doctors' relationships with drug and device companies.

Among the institutions that do reveal ties to industry, the doctor's biography may say that he or she has received more than $5000 (£3200; €3700) in consulting or speaking fees from a list of companies, or it may say that the doctor has consulted for a list of companies.

The American Association of Medical Colleges has called for greater disclosure of conflicts of interest.

In 2008 Arthur Rubenstein, dean of the University of Pennsylvania's school of medicine, announced that the institution would begin posting on the internet information about faculty members' paid "extramural activities" because "it is the right thing to do."

The Hospital for Special Surgery in New York, an internationally known centre for orthopaedics, has required information about doctors' ties to the industry for about 15 years and began posting the information in July 2009.

The Cleveland Clinic in Ohio tells patients whether a doctor received $5000 or more from industry. Stanford University in California has similar information for patients on its website.

Cite this as: *BMJ* 2010;340:c1075

BMJ GROUP AWARDS ✪ BMJ GROUP AWARDS ✪ BMJ GROUP AWAR

BMJ Group Awards: Secondary Care Team of the Year category

Doctors behaving imaginatively

Tony Delamothe *BMJ*

The judges for the BMJ Group Award for the secondary care team of the year were looking for UK teams that had produced measurable improvements in outcomes that mattered to patients. Evidence of team work was given high priority; and, with a nod to the current economic climate, we encouraged entries implemented within the organisation's existing resources.

Altogether we received 26 entries, from which the judges shortlisted four. Many great sounding initiatives didn't make the cut because they lacked robust data on patient outcomes. Of the shortlisted entries two came from distant edges of the country, while two came from metropolitan London.

The Emergency Medical Retrieval Service (EMRS), which is based at the Glasgow City Heliport, has transformed the care and transfer of seriously ill and injured patients in remote and rural parts of Scotland. Two dozen healthcare facilities in such areas receive emergency patients without onsite emergency physicians or intensive care units.

The initiative began in 2004 with 10 consultants delivering a 24 hour seven day advisory service for seven remote hospitals on a voluntary basis. In 2008 the EMRS was established as a government funded pilot to provide training and support to rural clinicians as well as rapid access to a critical care consultant who could assist with onsite assessment, resuscitation, and stabilisation before initiating air transfer to definitive care in an urban hospital.

About two thirds of calls are medical emergencies and a third are for major trauma. The mean time from referral call to arrival of patient in a definitive care centre is 3.75 hours. While the predicted mortality among these patients was 25%, as calculated by the acute physiological and chronic health evaluation (APACHE), observed mortality was 17%. The service is saving an estimated 24 lives each year on the west coast of Scotland.

Patients of the diabetic retinopathy team at the Royal Cornwall Hospital, Truro, may be surprised to receive invitations directing them not to the hospital but to a mobile clinic opposite television chef Rick Stein's café on Padstow quay or by a veterinary practice near Newquay. Thanks to a new, self contained eye screening unit patients no longer have to trek miles for their annual appointment: retinal photography can now be performed in the remotest village. The service sees more than 23 000 patients each year in 70 locations, referring 500 patients to three district general hospitals for treatment. Easier access has increased patients' take-up of the service by over 30%.

Identifying patients with sight threatening retinopathy has been only the first part of the process. Much attention has also been given to getting timely expert surgical and medical input in what is a team effort, involving ophthalmologists and diabetologists. To accommodate urgent appointments the system of booking and managing clinics has been streamlined. A recent external quality assurance by the English National Screening Committee highly commended the service for its innovation.

The heart attack and stroke

Pressure mounts for Dutch MPs to hold "time to die" debate

Tony Sheldon UTRECHT

The Dutch parliament is under mounting pressure to debate legalising assisted suicide for older people who are not dying but feel their life is over. A group of prominent senior figures in Dutch society has raised 85 000 signatures in 10 days—exceeding the 40 000 needed to trigger a parliamentary debate under a "citizens' initiative" law.

The group, called Of One's Own Free Will (Uit Vrije Wil), seeks to "legalise help with dying for older people who regard their life as complete, at their explicit request and under conditions of carefulness and verifiability." The group includes former health minister Hedy d'Ancona, former European commissioner Frits Bolkestein, and professor in neurobiology at Amsterdam University, Dick Swaab (www.uitvrijewil.nu).

A "complete" life, it suggests, could be one in which physical decline has resulted in inescapable loss of personal dignity or one of complete dependence on others. But the Dutch Medical Association rejects the initiative, claiming it meddles

team at Royal Free Hospital, London, provides the first fully integrated, direct access heart attack and stroke centre in the United Kingdom. Recognising the clinical synergies between acute "heart attack" and "brain attack," the hospital's departments of cardiology and neurology integrated their primary angioplasty and stroke thrombolysis services. Patients are given direct access to the service, bypassing the accident and emergency department. The pathway is triggered by the London Ambulance Service, which alerts the hospital's switchboard via a dedicated hotline.

A key component in service integration has been a multiskilled "receiving team," trained to assess and manage both heart attacks and strokes. After treatment, patients are transferred to an integrated heart attack and stroke unit, with guaranteed ringfenced beds.

For stroke, the median door to needle time is 49 minutes, and for heart attack the median door to balloon time is 46 minutes. These times put the Royal Free among the top performing stroke and heart attack services in the country. The team attributes its success to excellent multidisciplinary working between the hospital's departments of cardiology, neurology, and radiology along with the London Ambulance Service's close collaboration.

The 56 Dean Street clinic is an outpost of Chelsea and Westminster Hospital NHS Foundation Trust in the heart of Soho, London. It counts 50 gay venues within a 500 m radius and is therefore close to major reservoirs of undiagnosed HIV infection.

Audits of new HIV diagnoses show that a significant number of individuals present late with advanced disease, often with considerable morbidity and mortality. Reducing the proportion of undiagnosed HIV infection has been identified as a priority by England's national strategy for sexual health and HIV.

In surveys of men attending gay bars, clubs, and saunas in central London, 11% tested positive for HIV, half of whose infection was previously undiagnosed. To address this, 56 Dean Street developed a walk-in, rapid testing service for HIV, which guarantees HIV test results within the hour. The service operates for eight hours a day, six days a week.

In the first six months 200 new cases of HIV infection were diagnosed, a number similar to that for the previous 12 months. Patient approval is high, and the number of patients is rising as awareness of the new service grows.

The five judges—Michael Burke, medical director at the North West London Hospitals NHS Trust; Bernard Crump, chief executive officer of the NHS Institute for Innovation and Improvement; Jonathan Fielden, a member of the BMA council and fellow of the Department of Health's National Leadership Council; Neil Douglas, professor of respiratory and sleep medicine at the University of Edinburgh; and Andrew Vallance-Owen, group medical director of BUPA—have a tough job ahead of them in choosing the ultimate winner.

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From top: staff at 56 Dean Street, London; screening at Royal Cornwall Hospital, Truro; Dr Andrew Cadamy from the EMRS, Glasgow; and the Royal Free Hospital, London

JOHN NORMAN/ALAMY

Assisted suicide for people with "a complete life" would be restricted to those over 70

with careful legislation and practice surrounding euthanasia and assisted suicide.

Discussion in the Netherlands on a "suicide pill" for older people dates back to 1991 and a newspaper article by former Supreme Court judge, Huib Drion (*BMJ* 2004;328:1204).

Recent jurisprudence has stated that it is illegal to actively guide or direct a person to commit suicide. An exception is made for doctors who assist suicide under euthanasia laws. But a Supreme Court judgment in 2002 ruled that the patient must have a medically classifiable condition. Existential suffering is excluded.

The Free Will group argues its proposal is based on a fundamental principle of "self determination" that is "rooted in Dutch culture." Any decision must not be impulsive but taken freely by a competent person, be well considered, authentic, consistent, and understandable. The law would be restricted to helping Dutch nationals older than 70 years.

Help would be offered by trained "care providers," who would ensure that the suicide adheres to legal criteria and is carried out with expertise, care, and is verifiable. An independent second opinion would be needed, and the carer would ensure the drugs are taken and then report to a coroner.

Although a professional carer is needed to obtain the prescription drugs required, this could be a spiritual figure, psychologist, or palliative care nurse. "Helping elderly people die who are not terminally ill falls outside the professional domain of a doctor," the group state.

The Dutch Medical Association fears that the initiative creates a second way to ending life. Patients judged not to meet the legal requirements for euthanasia or assisted suicide will simply bypass their doctor.

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