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UK government spells out new plan for NHS in England

Nigel Hawkes LONDON

GP commissioning consortiums in England will be obliged to include two lay members, a hospital specialist, and a nurse on their boards, the government has announced. Their name will be changed from GP or GP led consortiums to "clinical commissioning groups," and they will be required to meet in public and publish their minutes.

To avoid conflicts of interest the nurse and specialist cannot be employed by local NHS providers, the government says in its response to the report of the Future Forum, the body it set up to elicit responses to its Health and Social Care Bill in the wake of charges that the bill would destroy the NHS.

While in most respects the government has accepted the forum's recommendations, in this instance it has gone further by insisting on board level representation of other groups.

The forum, chaired by Steve Field, former chairman of the Royal College of General Practitioners, produced a series of recommendations that the government has accepted. These include changes to the role of Monitor, which was charged under the bill with promoting competition. This duty will be removed, and Monitor's role will be restricted to tackling abuses "that demonstrably act against patients' interests."

The government has not committed itself to another recommendation of the forum: that patients should have the right to challenge poor services. It says that it will carry out further work on whether this idea is feasible. But it has accepted the proposal for "clinical senates," groups that will bring together doctors, nurses, and other professionals to give expert advice to the clinical commissioning groups.

The senates will have a formal role in authorising the commissioning groups and advising the national NHS Commissioning Board whether plans are clinically robust. The government denies that this will be a new layer of bureaucracy, saying that the senates (together with the existing clinical networks) will be housed by the NHS Commissioning Board. Health and wellbeing boards will also have the power to object to the establishment of a commissioning group.

In line with forum regulations, the government has agreed to relax the reform timetable, with the blanket deadline for NHS trusts to become foundation trusts by April 2014 lifted. By April 2013 all general practices will be part of a clinical commissioning group or of a "shadow" group—one that is formed but has yet to take on full responsibility. No option exists for practices to opt out of commissioning altogether; but for those that are not ready by April 2013 the NHS Commissioning Board will deputise.

The forum reserved its strongest words for the section of the bill that has caused least controversy, that on education and training. This area needs to be given a lot more thought, the forum concluded. With the abolition of the strategic health authorities, postgraduate deaneries urgently need a home and reassurance of a continuing role. The government accepts this advice, saying that deaneries will continue to oversee training and will have a clear home within the NHS family.

Most of the forum's recommendations neatly split the difference between the health secretary, Andrew Lansley, and his critics.

MARK THOMAS

Most of the recommendations of the forum led by Professor Steve Field (above) have been accepted

See EDITORIAL, p 1323.

Cite this as: *BMJ* 2011;342:d3777

London vaccination summit is a "milestone in global health"

Peter Moszynski LONDON

A conference held in London this week to commit pledges to the Global Alliance for Vaccines and Immunisation (GAVI) far exceeded expectations, organisers said.

Donors committed a total of $4.3bn (£2.6bn; €3bn), exceeding the initial target of $3.7bn, enabling GAVI to "reach more children faster than planned and to accelerate the introduction of new vaccines."

The latest pledges bring GAVI's total available resources for the next five years to $7.6bn, which should see vaccination programmes such as those against rotavirus and pneumococcal infections being rolled out to more countries.

The alliance said that major public and private donors had "achieved a milestone in global health" by committing funding to vaccinate "more than 250 million of the world's poorest children against life-threatening diseases by 2015 and prevent more than four million premature deaths."

GAVI's single largest donor was the United Kingdom, which pledged an additional $1.34bn (making the UK's total contribution $2.45bn), followed closely by the Microsoft founder and philanthropist Bill Gates, who contributed an additional $1bn.

The UK prime minister, David Cameron, who hosted the summit, said on Monday 13 June: "GAVI was one of the very top performers in our root and branch review of the agencies that deliver British aid because it demonstrates tangible results. Britain will play its full part, and our support to GAVI will help vaccinate over 80 million children and save 1.4 million lives. That's one child vaccinated every two seconds for five years."

The UK development secretary, Andrew Mitchell, told the *BMJ* that greater priority needed to be given to the "hardest to reach groups" living in remote areas and countries affected by conflict.

For more see www.gavialliance.org.
See also News, *BMJ* 2011;342:d3721.

Cite this as: *BMJ* 2011;342:d3766

GP groups must learn from US experience, says expert

Nigel Hawkes LONDON

GP led commissioning in England could lead to financial crisis for many consortiums if US experience is ignored, an American expert advises.

Lawrence Casalino says in a report for the healthcare policy think tank the Nuffield Trust that, of 1500 doctor led networks and groups set up in the United States, only a 10th proved successful at managing the financial risks of commissioning.

GPs will need skills to handle risks, says Lawrence Casalino

Many failed, and some went bankrupt, for a mixture of reasons. These included too little focus on the management and infrastructure needed to handle the financial risk; a lack of clinical leadership; resentment among patients that family doctors were acting as gatekeepers to care; an inability to stand up to the tough negotiating stance adopted by hospitals and specialists; and shrinking budgets imposed by insurers.

The US networks, called independent practitioner associations (IPAs), are the closest international parallel to the NHS's GP led commissioning consortiums. Dr Casalino led an IPA for some years. He is now a professor of public health at Weill Cornell Medical College, New York, and spent six weeks examining GP led commissioning in the NHS as a Nuffield Trust scholar.

The associations were seen by many in the early 1990s as the future of US medicine. Instead of being paid per item of service by insurers, doctors in the associations took on contracts that held them accountable for all or part of their patients' care. If they could reduce the cost of that care, the contract would be profitable. If not, they could hit the rocks.

Things went well at first, as there were many opportunities for making savings—reducing time in hospital after giving birth, for example. But with time that became harder, and hospitals responded by merging to create larger organisations with greater prestige that simply refused to cut their prices. Insurers sought to profit from the savings achieved by the associations by reducing the value of their contracts with them.

That left the associations with more risk and less room for manouevre. They were no longer responsible only for service risks but insurance risks, too, which they were not competent to manage.

Dr Casalino's report, published on Monday 13 June, makes 10 suggestions, one of which is not to expect too much too soon. Even with a perfect set of incentives it is likely that most consortiums will take 5-10 years to become highly competent. One major risk is that, left to themselves, consortiums will spend too little on leadership, management, and infrastructure. Generous, ringfenced budgets should be provided to ensure that this doesn't happen, the report says, adding that consortiums will need highly skilled, full time managers and skilled clinical leaders.

Dr Casalino says that if GP consortiums are simply seen as a way of saving money, they will face a strong backlash from doctors and patients. So incentives, and penalties, will need to cover their performance not only on cost but also on quality of care and patients' experience.

"There will be a great many ways to get the new system wrong and very few ways to get it right," Dr Casalino warns.

GP Commissioning in the NHS in England: Ten Suggestions from the United States **is available at www.nuffieldtrust.org.uk.**

Cite this as: *BMJ* 2011;342:d3720

Hospital will continue to offer HIV tests to A&E patients

Caroline White LONDON

A London hospital has begun offering bloodless HIV tests to every adult patient attending its accident and emergency department, in a bid to curb onward transmission of the infection in the capital, where rates are among the highest in the United Kingdom.

Figures from the Health Protection Agency, published at the end of last year, indicate that a quarter (26%) of the estimated 86 500 people infected with HIV in the UK are unaware that they are infected. By 2012 the number of diagnosed and undiagnosed cases in the UK could reach 100 000.

Since the end of January Chelsea and Westminster Hospital has been routinely offering an HIV test to emergency care patients aged between 16 and 67 who are able to be tested. HIV tests are normally routinely offered in the NHS only to pregnant women in antenatal clinics and patients attending sexual health clinics.

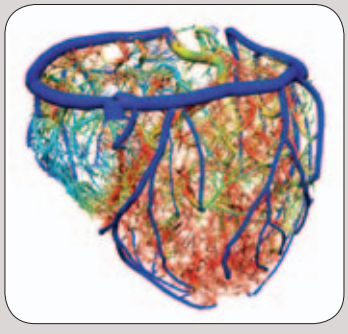
Some 450 emergency care patients have taken the £5 saliva test, which takes less than a minute. At least one person has tested positive. Around 100 000 patients attend the hospital's emergency care department each year.

London's St Mary's Hospital, which sees around 73 000 patients a year in its emergency department, is set to follow suit on 20 June, and Manchester Royal Infirmary began offering routine HIV blood tests in its medical admission units this week.

Both London hospitals are part of a trial looking at whether uptake is influenced by the healthcare professional who offers the test. At Chelsea and Westminster, where acceptance currently runs at 75%, all tests are offered by doctors; at St Mary's nurses will offer the test.

A spokesman for Chelsea and Westminster Hospital said that it would continue routine testing once the trial funds had run out and that it planned

Winning hearts



Matthew Limb LONDON

This computer simulation of coronary perfusion was judged best image in a competition devised by the British Heart Foundation to show how research scientists are using imaging and video technology in different ways to fight heart disease.

It shows a model of the coronary circulation and how it deforms during the contraction cycle. The vessel colour shows the pressure exerted on the vessels by contraction of the heart. The winning image was submitted by Professor Nic Smith, of King's College London and the University of Oxford, providing an insight into one of 1200 science projects funded by the British Heart Foundation.

Cite this as: *BMJ* 2011;342:d3757

UK sues Servier over alleged blocking of generic substitute

Clare Dyer BMJ

The UK government is suing the French drug company Servier for £220m (€246m; $360m) for allegedly blocking generic versions of its angiotensin converting enzyme inhibitor perindopril entering the UK market between 2001 and 2007.

The Department of Health, along with all the strategic health authorities and primary care

to extend it to other high risk areas, such as acute oncology and medical admissions. Tuberculosis clinics were also being considered, he said.

The trial follows a pilot study in 2009 when more than 2000 emergency care patients had an HIV test. Four new diagnoses were made, and two further cases were identified through contact tracing.

Ann Sullivan, a consultant physician at Chelsea and Westminster Hospital, told the *BMJ*: "That prevalence is about right for this area, which is about seven diagnosed cases per 1000 people. In order for this test to be cost effective we need to diagnose one per 1000."

She added: "Infection rates among those not in high risk groups have been increasing. Two of the four newly diagnosed cases did not have typical risk factors, so they would have been missed."

Figures from the Health Protection Agency show that in London, overall, 5.24 in every 1000 people had a diagnosed HIV infection in 2009. The number of people in London with HIV acquired in the UK has doubled in the past 10 years. Other UK hotspots include Brighton and Hove, with 7.57 per 1000 people, and Manchester, with 5.22 per 1000.

National guidelines published in 2008 by the British HIV Association, the British Association for Sexual Health and HIV, and the British Infection Society recommend extending routine HIV testing to all patients registering with a GP or being admitted to hospital in areas where the HIV rate is more than two in 1000 among 15-59 year olds.

Keith Radcliffe, president of the British Association for Sexual Health and HIV, said, "Treatment costs are approximately double for people diagnosed with late HIV infection, and early treatment dramatically reduces the risks of sexual transmission, so the public health benefits of routine HIV testing are clear for all to see.

"We hope that this initiative encourages all clinicians working in high prevalence areas across the country to recognise that increased HIV testing saves lives, is cost effective, and reduces the burden of HIV on our society."

Cite this as: *BMJ* 2011;342:d3705

PETER MACDIARMID/PA

The UK government's new strategy is designed to prevent incidents, such as the bombing in Tavistock Square, Bloomsbury, in July 2005 (above), that are caused by terrorists who live in the UK

Doctors will be asked to help identify people at risk of becoming terrorists

Clare Dyer BMJ

Doctors and other health professionals are to be asked to help identify people who are at risk of being drawn into violent extremism as a part of an updated strategy to combat terrorism unveiled by the UK home secretary, Theresa May.

The document outlining the revised "Prevent" strategy says that the Department of Health will need to ensure that the "crucial relationship of trust and confidence between patient and clinician" is balanced with the healthcare worker's duty to protect the wider public safety.

But the BMA said it had not been consulted and the move would put doctors "in an impossible position." A spokeswoman said: "Ethically and legally doctors already know when they need to breach confidentiality. There has to be a reason in the public interest—the patient is going to harm themselves or others. It's not their job to keep a watching brief on patients and try to predict what's going to happen in the future."

The document argues that acting to prevent terrorism is akin to taking action to prevent child abuse or domestic violence and suggests that people with mental health problems may be more easily drawn into terrorism.

It cites the cases of two Muslim converts, Nicky Reilly, who has Asperger's syndrome and was convicted of trying to blow up a shopping centre in Exeter, and Andrew Ibrahim, a former drug addict who was jailed for making a bomb at his flat in Bristol.

It does not mention the case of Bilal Abdullah, a junior doctor born in Britain who was jailed for driving a burning Jeep into Glasgow airport. But it says: "We also know that people connected to the healthcare sector have taken part in terrorist acts in the past."

The move to involve healthcare workers is part of a revised strategy to try to tackle home grown terrorism, focusing particularly on the health services, schools, universities, and prisons.

***Prevent Strategy* is at www.homeoffice.gov.uk/publications/counter-terrorism/prevent/prevent-strategy/prevent-strategy-review?view=Binary.**

Cite this as: *BMJ* 2011;342:d3627

trusts in England, has launched a High Court action to reclaim the money they say that the NHS in England had to pay for more expensive drugs.

Servier's patent on the drug, used to treat hypertension and heart disease, ran out in 2001, after which, the government says, other companies should have been allowed to market generic versions. But it accuses Servier of using patent litigation to keep generic manufacturers out and in one case paying an unnamed manufacturer £5m not to enter the market.

In July 2009 the European Commission launched an antitrust investigation of Servier and a number of generic makers, which is still ongoing, over "agreements which may have the object or effect of hindering entry on to the market of generic perindopril."

The ongoing investigation followed the report of an 18 month investigation by the commission into the drug industry that highlighted the use of litigation and settlements with generic companies that had led to delays in the entry of generic drugs on the market (*BMJ* 2009;339:b2843).

As its patent neared expiry Servier took out a number of secondary patents, claiming protection for the drug in different forms or with different processes of manufacture. The Canadian company Apotex launched a generic version in the United Kingdom in 2006, but Servier gained a High Court injunction stopping sales.

The High Court ruled in 2007 that the patent was invalid, and Servier was ordered in 2008 to pay Apotex £17.5m in damages.

Cite this as: *BMJ* 2011;342:d3645

ANTOINE ANTONIOL/BLOOMBERG VIA GETTY IMAGES

UK government is suing the French company Servier (above) for £220m

IN BRIEF

EU urges more action to rid Europe of measles and rubella: European Union health ministers have urged national authorities to step up vaccination programmes to eradicate measles and rubella in the 27 member bloc by 2015. They identified "marginalised people and Roma" as undervaccinated groups and called for information campaigns explaining the benefits of vaccination. On 13 June the European Commission pledged a further €10m (£8.8m; $14.3m) to the Global Alliance for Vaccines and Immunisation.

Portugal introduces annual appraisal of doctors: Doctors working in the Portuguese national health service will be required to undergo annual appraisal from 2012. The appraisal will include an assessment of individual objectives and competences, including professional attitude, communication skills, professional development, and research.

Record number of countries seek aid for vaccines: A record 50 eligible countries have applied for vaccine funding from the Global Alliance for Vaccines and Immunisation during the organisation's latest application round, nearly double the previous record in 2007, when 27 countries asked for help.

UK charities call for review of all antipsychotic prescriptions for dementia: The Dementia Action Alliance is calling for all people with dementia who are taking antipsychotics to have a clinical review from their doctor by 31 March 2012 to ensure that their prescription is appropriate and adheres to best practice guidelines. The alliance, made up of more than 40 organisations, says that about two thirds of prescriptions for antipsychotics are inappropriate.

Method of recruitment to smoking helpline makes no difference in quit rates: Telephone counselling services for smokers trying to quit are just as likely to help people give up smoking whether smokers are recruited by referral from a doctor, direct mail, or phone calls or through passive methods such as posters or television advertisements, a study has found (*Journal of the National Cancer Institute* doi:10.1093/jnci/djr230). Such quitlines had a positive effect on prolonged and continuous abstinence after 6-9 months and after 12-18 months, regardless of recruitment method.

Cite this as: *BMJ* 2011;342:d3701

Germany legislates to boost organ transplant numbers

Annette Tuffs HEIDELBERG

The German government has passed a new law instructing hospitals to support organ donation and to report details of all potential deceased donors to the national organ procurement agency.

The law, which aims to improve the way transplantation is organised, strengthens the responsibilities of the procurement agency, the German Organ Transplantation Foundation (Deutsche Stiftung Organtransplantation).

Hospitals will have to employ at least one full time transplant official who identifies potential donors, maintains contact with the foundation, supervises hospital staff with respect to transplantation, and takes care of relatives of donors.

The new measure, an amendment to the transplant law required by European Union rules, was passed on 6 June 2011.

Currently about 5000 transplantations take place each year in Germany, but the number of patients on the waiting list has risen to more than 12 000.

There were calls for the new law to go further. The former foreign minister the Social Democrat Franz-Walter Steinmeier, who donated a kidney to his wife, had cross party support for a proposal that all German citizens should declare their wishes concerning organ donation when they apply for identity cards, driving licences, and health insurance cards (*BMJ* 2011;342:d660).

At the moment relatives are asked to make the decision regarding organ removal if a donor card cannot be found. A recent opinion poll showed that 70% of the population are in favour of Mr Steinmeier's proposal.

However, experts, including the head of the German Organ Transplantation Foundation, Günter Kirste, believe that improving the way organisations work can also boost the number of organs available for transplantation.

He said, "It is not so important whether relatives or the deceased patient is taking the decision about organ donation but that potential donors are reported at all."

In an interview with the television station Deutsche Welle, Professor Kirste was critical of hospitals that failed to employ enough doctors in intensive care units and to define their role in relation to organ donation.

Cite this as: *BMJ* 2011;342:d3739

Loss of trials from UK must end, NHS body says

Matthew Limb LONDON

The European Commission must produce clearer, simpler regulations on clinical trials to prevent the United Kingdom health services losing out to other countries in hosting studies and making new treatments available to patients, says the NHS Confederation, the body that represents most NHS organisations in England.

Opportunities for patients in the UK to take part in clinical trials and for clinicians to gain expertise in new drugs is being hampered because of "bureaucratic" European Union rules, says the confederation.

The UK's involvement in global clinical trials has "dropped dramatically" since the European Union's Clinical Trials Directive (2001/20/EC) was introduced in the UK in 2004.

The European Commission is consulting on revisions to the directive, which was brought in to promote good clinical practice and harmonise clinical trial activity across the EU.

The NHS Confederation, in its submission to the commission's consultation, says that by 2008 the UK was involved in just 2% of global drugs trials, down from 6% in 2004.

The NHS Confederation cites figures from the Department of Health for England on the number of mid-stage, late stage, and post-approval clinical trials that test potential treatments in humans to see whether they should be approved for wider use in the general population. It says that the number fell from 728 in 2008 to 470 in 2009, "the lowest level in the past decade."

Elisabetta Zanon, who heads the NHS Confederation's European Office, said that interpretation of the European guidance varied in different countries and that the process for submitting a request for authorisation of a clinical trial was too slow and bureaucratic.

She said, "The rules as they stand are not clear enough. They do not provide NHS organisations with enough clarity about what processes they do and do not need to follow . . . As a result the UK's involvement in the global development of new medicines and technologies has stalled."

The confederation's European Office argues for a more streamlined and risk based approach to regulation. A single submission of applications for clinical trials would reduce bureaucracy.

bmj.com Editorial: Regulation and governance of clinical research in the UK (*BMJ* 2011;342:d238).

Cite this as: *BMJ* 2011;342:d3665

WILL & DENI MCINTYRE/SPL

All German hospitals will have to have at least one full time transplant official who identifies donors

Pfizer launches virtual clinical trial that uses "apps"

Bob Roehr WASHINGTON, DC

The giant drug company Pfizer is conducting a "virtual" clinical trial that relies solely on electronic rather than face to face encounters between researchers and participants. It announced the trial on 7 June at a conference on clinical trials held on the Bethesda, Maryland, campus of the US National Institutes of Health.

Freda Lewis-Hall, Pfizer's chief medical officer, said that the company is trying to reduce barriers to participation in clinical trials; to offer a consistently strong experience that does not vary by location; and potentially to save money in conducting trials in the future, if the concept proves viable.

Surveys of patients show that the time and effort needed to visit a trial site even within the same city, often many times on a fixed schedule, can make them less willing to participate in a study. Patients are more willing to make the effort if they face a life threatening condition and treatment options are limited but not as willing when the situation is less dire.

The study is using an already approved drug for bladder control in what Dr Lewis-Hall called an operation study to test concepts and tools. The results will be compared with those of already completed studies.

Web based and mobile phone applications ("apps") are being used to manage recruitment, enrolment, and data reporting. Blood tests can be scheduled electronically either at a neighbourhood clinic or by appointment with a visiting nurse. The treatment drug is shipped directly to the patient. Help from doctors is available 24 hours a day, seven days a week by phone from a central location.

The study has begun in California and will roll out to nine other US states when necessary permissions have been obtained.

Dr Lewis-Hall said that studies that involve patients' self reports are especially amenable to a virtual method. "And this is a disease that is managed primarily by the patients within their own environment. So we thought it was a good therapeutic area [to test the concept]," she said.

An adviser to the study, Craig Lipset, said it will be interesting to see whether the diary-like apps for self reporting, the automatic reminders built into the system, and the freedom to take part at any hour of the day or night rather than at the convenience of the researcher will result in data entries that are closer to real time and hence more accurate than responses that are based more on distant recall.

See FEATURE, p 1338.

Cite this as: *BMJ* 2011;342:d3722

Research into treatments for mental illness is under threat

Jacqui Wise LONDON

Scientists have called for urgent action after the abrupt withdrawal by drug companies from research into treatments for brain disorders.

In the past year a number of drug companies, including GlaxoSmithKline and AstraZeneca, have pulled out of neuroscience research in Europe because they see it as economically unviable. Furthermore, levels of European Union research funding into mental disorders and diseases of the brain have been low in comparison with private sector funding.

A report from the European College of Neuropsychopharmacology, published this week, makes a number of recommendations.

It calls for the regulatory process to be reviewed to encourage more and better trials in psychiatry and for incentives to be offered to drug companies, such as extending the life of patents on new drugs for brain disorders. It is also setting up a "medicine chest" for data from industry studies about research compounds that companies are no longer working to develop.

The report, published in *European Neuropsychopharmacology* (www.ecnp.eu/publications/reports/report-summit2011.aspx), follows a summit in March attended by representatives from academia, governments, the drug industry, regulatory agencies, and patients' organisations.

David Nutt, co-organiser of the summit and professor in neuropsychopharmacology at Imperial College London, said, "Developing drugs for brain disorders takes much longer than for other drugs—on average, 13 years—and is therefore more expensive. "There are also higher failure rates, often later in the development cycle."

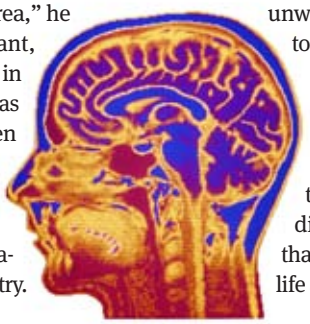
Professor Nutt said another problem was that licensing barriers for psychiatric drugs are disproportionately high. "Many companies are deciding it's too difficult to work in this area," he said. Only one new antidepressant, agomelatine, has been licensed in Europe in the past 10 years, whereas 10 new antiepileptics have been licensed. The report says that this is because placebo controlled clinical trials of monotherapy continue to be required for registration of most new drugs in psychiatry.

And whereas new drugs for epilepsy are commonly accepted as add-on treatments, these are not encouraged in depression. In addition, the European Medicines Agency has increased its demands concerning studies involving children and adolescents, making it difficult to fulfil requirements for some rare disorders.

Professor Nutt said that more basic neuroscience research was needed. "Neuroscience is a complex discipline. We are still nowhere near understanding the fundamental targets for drugs."

The report says that another challenge is the persistence of prejudice against mental illness. In particular, there is suspicion of drug treatments for mental illness, leading to a greater unwillingness by healthcare systems to pay for them.

Guy Goodwin, a summit co-organiser and president elect of the European College of Neuropsychopharmacology, said that the cost burden of psychiatric disorders is very high. But he said that drugs that improve the quality of life are often undervalued in comparison with those that increase the quantity of life.



MEHAU KULYK/SPL

"Many companies are deciding it's too difficult to work in this area"

Cite this as: *BMJ* 2011;342:d3747

Peer review must stay as guarantee of quality of scientific research, academics tell MPs

Adrian O'Dowd LONDON

The quality of scientific and medical research can be guaranteed only by the continued use of peer review by journals, research leaders have told an inquiry by MPs.

Peer review, although not a perfect system, was the best option available, MPs on the parliamentary science and technology select committee heard on 8 June as part of their inquiry into peer review (*BMJ* 2011;342:d3046).

The committee's chairman, Andrew Miller, Labour MP for Ellesmere Port and Neston, said that the research charity the Wellcome Trust had highlighted in its written evidence to the committee a "common criticism" that the peer review system could sometimes be slow and limit the emergence of new ideas that challenged established norms. Mr Miller asked the witnesses for their opinion.

Rick Rylance, chairman elect of Research Councils UK, giving evidence, said, "[Winston] Churchill once said that democracy was the worst system in the world apart from all the others, and I kind of think the same a little about peer review.

"Peer review is absolutely crucial, but it carries limitations of one kind or another in that it can slow down things, the volume of workload is increasing, and so on. But nonetheless we need to remain committed to the principle of doing peer review, because in the end it is always the first and last resort of quality."

Rick Rylance: "Peer review carries limitations"

Mark Walport, director of the Wellcome Trust, also giving evidence, said, "To be clear, what we said in our submission was what other commonly raised criticisms are . . . We didn't actually say we agreed with that criticism. The issue is that peer review or expert review is as good as the people who do it. It has to be used wisely. The challenge is not whether peer review is an essential aspect of scholarship—because there is no alternative to having experts looking at things and making judgements."

Their fellow witness David Sweeney, director for research, innovation, and skills at the Higher Education Funding Council for England, said, "We think there is a risk there, but we also look at the many experiments that are going on with social networking and modern technological constructs, and we hope that the broad view that is taken of those will mitigate the risks which the Wellcome Trust identified."

MPs asked whether the growing number of online repository journals such as *PLoS One* (*Public Library of Science One*) were technically sound. *PLoS One* is an online, open access journal for the communication of all peer reviewed scientific and medical research.

"It is entirely sound," replied Sir Mark. "It's a well peer reviewed journal, but it does not limit its publication to those papers that are seen to be stunning advances in new knowledge."

MPs asked government witnesses who appeared before them later in the session whether peer review was fundamental to the formation of government policy.

John Beddington, the government's chief scientific adviser, said, "The answer to that question is that science and evidence are clearly fundamental to government policy, and peer review is a fundamental part of science evidence. The process of science involves peer review and I believe properly so."

The *BMJ*'s editor in chief, Fiona Godlee, and deputy editor Trish Groves talk about the BMJ Group's evidence to the parliamentary inquiry into peer review in a podcast at http://podcasts.bmj.com (13 May).

Cite this as: *BMJ* 2011;342:d3656

More than half of child labourers work in hazardous conditions

John Zarocostas GENEVA

Millions of child labourers worldwide, especially those engaged in hazardous work, face grave health risks that have been systematically under-reported, says a study.

Children are more likely to be killed or injured at work than adults, says the report by the International Labour Organization (ILO), launched on 1 June at its annual ministerial conference. Children are at risk of health problems ranging from lung damage and cancers to premature arthritis through exposure to extreme toxic chemicals, harsh settings, and repetitive tasks.

The ILO's director general, Juan Somavia, called for joint action by governments, employers, and workers to protect children. "Tackling work that jeopardises the safety, health, or morals of children must be a common and urgent priority," he said.

The report highlights the high proportion of children still involved in hazardous work: about 115 million of the world's estimated 215 million child labourers. In 2008, the year with the latest global figures, an estimated 62.4 million children aged 15-17 and 52.8 million aged 5-14 years were in hazardous work, the ILO said.

"Every minute of every day a child is injured or made ill because of hazardous work," Constance Thomas, director of the ILO's programme on the elimination of child labour, told the *BMJ*. Ms Thomas said that preliminary findings from a new 22 country study by the programme, to be published in a separate report in a few months' time, all show much greater rates of injury, illness, and death among children than among adults.

She said that in developed and developing countries, from the United States and the European Union to Chile, Brazil, and the Philippines, "trends are all going in the same direction," with children's rates of injury, illness, and death twice those of adults.

The ILO's study on hazardous work analysed the extent of the problem in seven sectors: crop

M CROZET/ILO

Child workers like this girl in La Paz, Bolivia, are at high risk of injury

Firm sues doctor after he reports slimming product to regulator

Melissa Sweet SYDNEY

An Australian doctor and campaigner for the ethical marketing of medical treatments, Ken Harvey, is facing an $A800 000 (£520 000; €590 000; $845 000) defamation suit relating to a complaint he lodged with regulatory authorities about a complementary weight loss product called SensaSlim.

Australian Skeptics, a group that presses for sensible scientific views (www.skeptics.com.au), has launched a campaign to raise funds to support Dr Harvey, a retired academic with an honorary appointment at La Trobe University, Melbourne, in what it calls a "SLAPP" (strategic lawsuit against public participation).

"To use legal action to stop his complaint in its tracks is similar to the sort of action that the British Chiropractic Association used against Dr Simon Singh in the UK," said Tim Mendham, executive officer of Australian Skeptics, referring to the association's libel action against the writer Simon Singh after he accused it of "happily promoting bogus treatments" (*BMJ* 2010;340:c2086).

The Australian Therapeutic Goods Administration's complaints resolution panel has received a number of complaints about the product, including some from Dr Harvey, but under the Therapeutic Goods Regulations these cannot be considered while legal action is under way.

Dr Harvey said the case highlighted several regulatory failures by the Therapeutic Goods Administration.

Documentation seen by the *BMJ* shows that on 10 March the administration's complaints resolution panel upheld an anonymous complaint against the marketing of SensaSlim, but this determination was withdrawn after the company said that its response to the complaint had not been taken into account.

A spokeswoman for the administration said that it had not failed to take appropriate regulatory action in relation to SensaSlim. She said that SensaSlim is a listed low risk medicine, meaning that it has been evaluated for quality and safety but that, unlike in the case of high risk prescription drugs, the administration provides no assurance that the product is effective. She added that it was an important part of the regulatory system that the authority observe procedural fairness.

An in-house legal counsel for SensaSlim Australia, Terry Harrison, denied that the company was trying to stop Dr Harvey or other critics speaking out. "It's not an action to stop the complaints process. It's nothing to do with gagging him, as he's trying to spin it," he told the *BMJ*.

The case against Dr Harvey is due for mention in the New South Wales Supreme Court on Tuesday 14 June, as the *BMJ* went to press.

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agriculture, fishing, domestic services, manufacturing, mining, and quarrying.

In crop agriculture children are loading and carrying heavy loads, which can cause joint and bone deformities, lacerations, and back and muscle injury, it says. The handling of toxic agrochemicals can potentially cause dermatitis, liver damage, neurological disorders, cancers, and reproductive health disorders,

The study concludes that there is "a need to strengthen workplace safety and health, and to put in place specific safeguards for adolescents between the minimum age of employment and the age of 18.

It says work related illnesses are systematically under-reported. ***Children in Hazardous Work*** **is at www.ilo.org.**

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HASAN JAMALI/AP/PA

Shiite muslims call for political prisoners to be freed during a sermon in Diraz, Bahrain, 10 June

Bahraini doctors deny anti-state activities at military trial

Sophie Arie LONDON

Some 20 doctors have appeared in court in Bahrain, denying charges of anti-state activities during pro-democracy protests that began in February.

They were accused of taking over and controlling the Salmaniya medical complex, the capital Manama's main state hospital; using violence in a government building (the hospital); kidnapping and imprisoning people in the hospital.

The prosecution said that automatic weapons and ammunition were discovered in Salmaniya Hospital. The military seized control of the hospital after imposing martial law in March and arrested staff members, saying that the medical complex had become an opposition coordination centre (*BMJ* 2011;342:d2928, 10 May).

The government official Abdul-Aziz bin Mubarak al-Khalifa also accused the medical professionals, most of whom are Shiite, of refusing to treat Sunnis.

Some 70% of Bahrainis are Shiite, and the Shia led protests have been calling for greater freedom and equal rights under the Sunni ruling family.

In all, 23 doctors and 24 nurses, many of whom worked at Salmaniya Hospital, face trial. They entered pleas of not guilty on Monday 13 June; their lawyers and relatives say they are being targeted simply for treating injured protesters. Human rights observers were also at the trial.

One doctor at the trial reportedly attempted to tell the judge that his confession had been extracted under torture but was cut short.

The human rights charity Amnesty International has gathered reports from relatives who say that the accused have been tortured and forced to sign confession documents while blindfolded.

Defence lawyers asked for civilian doctors to examine their clients, and the trial was adjourned until 20 June. Bahraini officials say that any cases of abuse will be investigated and prosecuted.

A BMJ Group blog from a Shia doctor in Bahrain is at http://blogs.bmj.com (14 Jun).

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