MPs are urged to end inaction on social care reform

Matthew Limb LONDON
A coalition of experts has called on politicians of all parties to agree urgent reforms of adult social care in England, warning that the current system perpetuates “terrible” abuses.

More than 60 senior figures, including peers, independent advisers, representatives of health and social care organisations, charities, and faith groups, have written to the Daily Telegraph urging “fundamental and lasting reform” of a system that they say harms society, the economy, and the dignity of elderly and disabled people (http://tgr.ph/tIkRRk).

Signatories to the letter include Hamish Meldrum, chairman of the British Medical Association, Brendan Barber, general secretary of the Trades Union Congress, and representatives of the British Red Cross and leading health insurers.

In the letter, published on 3 January, they say that politicians are failing to meet the challenge of supporting increasing numbers of elderly people, “resulting in terrible examples of abuse and neglect in parts of the care system.”

The signatories warn that an estimated 80 000 elderly people are being left without basic care and as a result are “lonely, isolated and at risk.” Others face losing their homes and savings because of soaring care bills, while disabled people are deprived of the support they need to live independently.

The letter says that more and more people are forced to give up work to care for older or disabled relatives and that many of these carers are pushed to “breaking point.” It continues, “Our NHS is also paying the price, as a lack of support leads to avoidable hospital admissions and then keeps older and disabled people in hospital beds because they cannot be cared for at home.”

There is now widespread pressure to reform the funding of adult social care and growing concern that successive governments have failed to honour pledges to tackle the problems.

In 1997, in his first speech as prime minister to the Labour Party conference, Tony Blair said that he did not want to see children grow up “in a country where the only way pensioners can get long term care is by selling their home.”

The current coalition government is expected to produce a white paper on social care by April in response to recommendations from the independent Dilnot commission into the funding of care and support, published in July 2011 (BMJ 2011;343:d4261). Andrew Dilnot, an economist, recommended a new partnership model in which people would pay up to a maximum £35 000 (€42 000; $55 000) towards the cost of their care and be eligible for full state support beyond that.

He has since said that the country’s economic woes should not be an excuse for inaction and argued that it was “nonsense” for anyone to suggest that reform would be too expensive to implement (BMJ 2011;343:d7689, 28 Nov).

The signatories to the Daily Telegraph letter say that reform is a matter of “duty as a nation” and that it is time for politicians to show leadership by seeking agreement.

They write: “With new cross-party talks on the future of care, we are closer than ever to reaching a new consensus. We urge the government and the other party leaders to seize this opportunity for urgent, fundamental and lasting reform.”

Cite this as: BMJ 2012;344:e12

From left: Gary Fitzgerald (Action on Elder Abuse), Jane Ashcroft (Anchor), Jeremy Hughes (Alzheimer’s Society), and Hamish Meldrum (BMA) are among the letter’s signatories

NHS hospitals will be able to raise about half their income from private patients

Ingrid Torjesen LONDON
The number of private patients seen at NHS hospitals is set to increase substantially under the government’s proposed health reforms.

An amendment introduced just before Christmas to the Health and Social Care Bill while it was being debated in the House of Lords will dramatically increase the proportion of income that foundation trusts are allowed to derive from non-NHS work.

A cap was placed on the amount of income foundation trusts are able to raise from non-NHS work when they were created in 2003 because of controversy over the freedoms they would have in deciding how their services were run compared with non-foundation trusts. It is set as the proportion of income they raised from non-NHS sources in 2002–3.

As a result the amount of income foundation trusts can generate from non-NHS work is limited to less than 2% for most hospitals, although some specialist hospitals have caps up to 30%. The amendment would see the cap rise to up to 49%. A spokesperson for the Department of Health said that relaxing the cap would allow foundation trusts to expand the range of services they offered. “This does not represent privatisation of the NHS—it simply gives to foundation hospitals the same freedoms non-foundation hospitals have had for years,” she said.

“Services for NHS patients will be safeguarded because foundation hospitals will still have as their core legal purpose a duty to provide services to them. The amendment we are making provides further reassurance on this duty.”

Mark Britnell, chairman of global health practice at the consultancy KPMG and former director general of commissioning at the Department of Health, said it was essential to allow hospitals to generate extra funds when they had to make efficiency savings to enable them to invest in new facilities and innovate for the benefit of NHS and private patients.

Cite this as: BMJ 2011;343:d8338
**UK launches rapid inquiry into the safety of PIP breast implants**

**Adrian O’Dowd LONDON**

The UK government has launched a rapid review into the safety of a particular make of breast implants from France to try to reassure the 40000 women in the country who have the implants. The French government has already announced that it will pay for the 30000 women there who had the implants made by Poly Implant Prosthèse (PIP) to have them removed as a preventive measure (BMJ 2011;343:d8329).

![A French woman is prepared for surgery to remove her PIP silicone breast implants](image)

**Use of community treatment orders for mental health patients rises 29% in a year**

**Adrian O’Dowd LONDON**

The number of people with mental health problems subject to community treatment orders in England has risen by almost a third in the past year, according to the Care Quality Commission.

The commission’s second annual report on the use of the Mental Health Act in England said that the number of people subject to the act was 5% higher than in the previous year—rising from 19947 on 31 March 2010 to 20938 on 31 March 2011.

This was mostly because of the use of community treatment orders, which were introduced in November 2008 as a way of enabling patients who are detained in hospital to be discharged into the community and to receive their treatment there.

The number of people subject to a treatment order at the end of the year grew by 29.1% from 3325 people to 4291 people, even though fewer new orders were started this year.

The report says that this suggests that treatment order powers, once implemented, can last for some time and that the population subject to orders will continue to grow.

The commission is responsible for protecting the interests of people who are subject to the Mental Health Act, by monitoring how mental health services in England (both NHS and independent sector) are using their powers and fulfilling their duties for patients who are detained in hospital or subject to community treatment orders or to guardianship.

In preparing the report, the commission’s mental health act commissioners made 1565 visits and met more than 4700 patients in 2010-11. Monitoring the Mental Health Act in 2010/11 is at http://www.cqc.org.uk.

Cite this as: BMJ 2011;343:d8346

**Individual managers are liable for record discrimination award as well as trust**

**Clare Dyer **

The record £4.5m awarded by an employment tribunal last week to the sacked doctor Eva Michalak (BMJ 2011;343:d8265, 20 Dec) is enforceable not only against the NHS trust that employed her but also against three senior employees who played key roles in the campaign to oust her.

Unusually the Leeds tribunal made Mid Yorkshire NHS Hospitals Trust and each of the three employees—the former medical director, David Dawson, Dr Michalak’s line manager, Colin White, and the human resources director, Dianne Nicholls—“jointly and severally” liable for the full award. All were found guilty of sex and race discrimination against Dr Michalak, 53, who has post-traumatic stress disorder.
One in four hospital patients should be cared for out of hospital

Ingrid Torjesen LONDON

At least a quarter of hospital inpatients should be cared for at home rather than in hospital, the leader of the body that represents NHS managers has said.

Outlining the challenges the NHS will face in the coming year, Mike Farrar, chief executive of the NHS Confederation, the organisation that represents NHS managers, warned that the NHS needed to let go of the “outdated hospital or bust model of care” and to shift resources into community based services, early intervention, and self care.

The confederation believes that at least 25% of patients in hospital beds could be looked after by NHS staff at home. “Hospitals play a vital role, but we do rely on them for some services that could be provided elsewhere. We should be concentrating on reducing hospital stays where this is right for patients, shifting resources into community services, raising standards of general practice, and promoting early intervention and self care.”

Although there was “a value for money argument” for doing this, it was not just about money but about building an NHS fit for the future, and the public needed to be told that or they would lose confidence in the service, Mr Farrar said.

“Care would be better for frail patients who would have fewer crises, shorter hospital stays when they need them, and more time in the comfort and safety of their homes. There would be opportunities to improve safety through consolidation of specialist services. There would be major potential to deliver better value for money and keep the NHS on a sustainable footing.”

Mr Farrar said political and NHS leaders needed to be “honest about the issues, bold about the solutions, and decisive in taking action” to make the case to the public for making the necessary changes to service delivery. This meant providing a vision of how services would be better after the changes rather than focusing exclusively on the closure of some hospital services.

He said changes in how health services were paid for were needed because perverse incentives often meant it did not make financial sense to provide care out of hospital.

The task of shifting public and political opinion on moving more care out of hospital is one of five key challenges for the NHS that Mr Farrar has identified for 2012. The others are increasing efficiency and minimising rises in waiting times during the unprecedented financial pressures; dealing with concerns about the quality of care, particularly of older people; resolving how to fund social care in the long term; and minimising distractions from reconfiguration and implementation of the government’s health reforms.

Cite this as: BMJ 2011;343:d8336

and is not expected to be able to work again.

Joint and several liability means that Dr Michalak can choose to enforce the entire award against the trust or against any one of the three named individuals. In practice, successful claimants will choose to proceed against the person or body most likely to be able to pay, in most cases the employer.

This leaves it up to the employer to seek contributions if it wishes from the individuals who are also liable.

A spokesperson for the trust said, “The trust is rightly taking responsibility for mistakes of the past and that includes responsibility for the full compensation award.”

In a BMJ Group blog (http://blogs.bmj.com) on the case, Chris Cox, director of legal services at the Royal College of Nursing, said the case was a “welcome reminder to all staff working in the health service that if you harass, bully, or otherwise treat to their detriment fellow employees on the proscribed grounds, then you may face a very hefty financial bill for your actions, as well as potentially disciplinary action by your employer and even by your professional regulatory body.”

Cite this as: BMJ 2011;343:d8293

More care at home would be better value for money

NHS must stop talking about integrated care and deliver it as a priority

Nigel Hawkes LONDON

A clarion call for the NHS in England to stop talking about integrated care and start delivering it has been issued by the health think tanks the King’s Fund and the Nuffield Trust.

Just as cutting waiting times was the target for the last decade, providing seamless, patient centred care for frail elderly patients and for people with chronic conditions should be the priority for the next 10 years, a new report by the two organisations says. Such care should become “a real and pressing priority” for commissioners and providers and be delivered at pace and scale, they say, and space should be created in the risk averse NHS for true innovation to flourish.

The prize would be an NHS that is able to deliver the right care to the right patients at the right time and in the right place, improving outcomes while reducing numbers of acute admissions. Nobody questions the objective, the report says, but delivering it has eluded healthcare systems everywhere, not just the NHS.

A major question that remains unanswered is how to measure success. The report says that measuring the experiences of patients and carers should be given “urgent priority” but it has few suggestions about how to do this.

Integrating care is not about integrating organisations and imposing a national system, the report admits. Managers and commissioners fail to innovate, because they fear such actions would not be acceptable to higher authorities.

The report says that this might change if integrated care was the new priority and if local organisations had enough freedom. But several things stand in the way: traditional divisions between primary and secondary care, and health and social care; a payment system that rewards acute sector activity; no shared electronic patient record; and weak commissioning.

Other barriers are the emphasis on choice and competition and regulations that focus on the quality of individual parts of the system and rather than on how well the system performs as a whole. Performance in the NHS in England is measured by three outcomes frameworks—there should be one, the report says.

It calls for “the crafting of a powerful narrative at both a national and a local level” about how services could and should be delivered. It also says that integrated care is about efficiency as well as quality.

Integrated Care for Patients and Populations: Improving Outcomes by Working Together is at www.kingsfund.org.uk

Cite this as: BMJ 2011;343:d8344
Boehringer promoted off-label drug to patients, finds watchdog

Zosia Kmietowicz LONDON

A watchdog has ruled that the drug company Boehringer Ingelheim breached five clauses of the UK drug industry’s code of practice when it promoted the anticoagulant dabigatran (which it markets as Pradaxa) outside its licensed indications to members of the public.

The company brought discredit on and reduced confidence in the drug industry, failed to maintain high standards, advertised a prescription only drug to the public, and encouraged members of the public to ask their doctor to prescribe the drug, said the Prescription Medicines Code of Practice Authority in its ruling, which was made in July but published in November. The authority regulates the advertising code of the UK’s drug company representative body, the Association of the British Pharmaceutical Industry.

A GP complained to the authority about articles that appeared in the Daily Mail, the Daily Telegraph, and the Daily Express on 5 April 2011 referring to the use of dabigatran to prevent strokes. The articles contained exaggerated claims about dabigatran, said the GP, and these were traced to a press release issued by a media agency on behalf of Boehringer Ingelheim. The articles also included quotations from UK experts and representatives of patients’ groups that were likely to have been facilitated by the company.

Dabigatran is an orally active direct thrombin inhibitor that, at the time the articles were published, was licensed only for the prevention of venous thromboembolism after hip or knee replacement surgery. However, the company had applied to the European Medicines Agency to extend the licence to prevent stroke and systemic embolism in patients with atrial fibrillation, and this extension was granted on 18 August.

The panel said that the press release did not mention the risk of major haemorrhage with dabigatran or any other side effects, making the information provided unbalanced. It also expressed concern about the very positive statements in the “Notes to Editors” section of the press release, which described Pradaxa as “leading the way in new oral anticoagulants/direct thrombin inhibitors . . . targeting a high unmet medical need” and queried whether this reflected the evidence fairly.

Overall the panel judged that the content of the press release and the material for spokespeople would encourage members of the public to ask for a prescription only drug and found Boehringer Ingelheim in breach of five clauses of the code of practice.

Cite this as: BMJ 2011;343:d8251

US healthcare executives top list of highest paid

Janice Hopkins Tanne NEW YORK

Healthcare and pharmaceutical executives were four of the top 10 best paid executives in the United States in 2010, according to a report by GMI, an independent research firm that surveyed more than 2600 companies.

Pay for chief executives increased by 27% in 2010, the firm said. No bankers were on the top 10 list. Home pay, the amount executives pay tax on, included annual compensation, increases in pension plans, profits from exercising stock options, and some other benefits, GMI said.

Several of the executives retired during 2010. Despite their high pay, in several cases the share prices of these chief executives’ companies declined during their time in office.

John Hammergren, chief executive of the drug distributor McKesson Corp, was the top earner, with total remuneration of $145 266 971 (£94 340 000; €112 730 000). According to GMI, he exercised 3.3 million stock options for a profit of $112m. In addition his retirement benefits grew by $13.5m. His also received $1.6m in severance pay. If he were to be fired, he would receive $469m in severance pay.

Second highest in pay was Joel Gemunder, chief executive of Omnicare, a geriatric pharmaceutical care company that serves nearly half a million residents in more than 5500 long term care facilities in 37 states. He earned $98 283 242 when he retired in 2010. That sum included cash severance pay of $16m. Fifth highest paid boss was Thomas Ryan, head of the CVS Caremark pharmacy chain. He received $68 079 823, which included a $28m profit on his options.

By comparison, the pay of top hospital executives seems small. Herbert Pardes, who is retiring as head of New York-Presbyterian Hospital, the city’s largest hospital, earned $1.7m in salary, plus a $1.9m bonus and $64 686 in other compensation.

Cite this as: BMJ 2011;343:d8330

IN BRIEF

Judges rule out new inquest into death of David Kelly

A retired orthopaedic surgeon, David Halpin, has lost a High Court challenge to a decision by the attorney general for England and Wales, Dominic Grieve, not to ask the court to order a new inquest into the death of the UK government scientist David Kelly. The Hutton inquiry concluded that Dr Kelly killed himself after being revealed as the source of a BBC report that the UK government had exaggerated the case for the Iraq war, but a group of doctors disputes the suicide finding.

Experimental cancer trials network gets extra funding

The UK’s Experimental Cancer Medicine Centres network has been awarded £35m (€42m; $55m) funding for the next five years across its 18 centres. Two existing centres, those at Barts and the London and in Edinburgh, were awarded joint grants to team up with newly created centres at Brighton and Dundee, broadening the scope of the network and expanding patients’ access to experimental new treatments.

Public health programmes for poor US children get almost $300m

The US government has awarded $296.5m (£190m; €230m) in bonus payments to 23 states for enrolment targets under the Medicaid programme for poor people and adopt special programme for children in public health programmes.

Blood donors may stay at home because of Olympics and extra bank holidays

The London Olympics and extra bank holidays to celebrate the Queen’s jubilee could severely affect blood donation levels this year, NHS Blood and Transplant has warned. In 2011 extra bank holidays around Easter and the royal wedding week resulted in thousands fewer donations.

Spain sees 600 000 smokers quit after smoking ban

In the first year after Spain introduced its ban on smoking in public places, 569 million fewer cigarette packages were sold and 600 000 smokers quit, says the National Committee to Prevent Smoking.

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Cite this as: BMJ 2012;343:e2

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Cite this as: BMJ 2012;343:e2
Minimum safe staffing levels may be set for emergency departments and elderly care wards

**Ingrid Torjesen**  
London

The public inquiry into the high number of deaths at Mid Staffordshire NHS Foundation Trust is expected to recommend that minimum staffing ratios be set for total numbers and the skills mix of doctors and nurses in accident and emergency and elderly care wards in England to ensure the safety of care.

In a written statement submitted to the inquiry’s chairman before Christmas, the counsel to the inquiry, Tom Kark QC, said “that consideration should be given to the production of model staffing guidelines for certain types of wards and departments against which the Care Quality Commission should assess the acceptability of staffing.”

Mr Kark pointed out that the real dangers in accident and emergency services at Mid Staffordshire were understaffing, inadequate training, and poor governance. And he questioned why external scrutiny of waiting times in the department had been considered more appropriate than the number of emergency medicine consultants per emergency admission.

Poor care has been shown to be related to numbers of suitably qualified staff. Brian Jarman, director of the Dr Foster Unit at Imperial College London, told the inquiry that hospitals with poor staff ratios had higher hospital standardised mortality ratios. Hospitals with a lower ratio had significantly more doctors per bed, he said, while hospitals with a higher proportion of staff grade doctors than senior staff had a higher ratio.

Christine Beasley, chief nursing officer for the NHS, said that ensuring that hospitals meet minimum staffing levels might form part of a revamped regulatory system. “As we look at the new [care] system and regulatory system, we could pick up some of this and make it a much stronger requirement of registration of organisations,” she said.

However, the Care Quality Commission told the inquiry it does not want regulatory standards for staffing levels because there would be a “risk of creating false assurances about the quality of care.” Cynthia Bower, chief executive of the commission, said that any guidance would need considerable flexibility to enable managers to deploy staff according to the volume of work.

Mr Kark said: “It is too easy to blame the wider complexities for a failure to grapple this issue… The argument that this could lead to the closure of certain departments in certain circumstances, for instance an A&E [accident and emergency] department which has insufficient consultant cover at night or weekends, is fallacious, first because guidelines are merely that and one-off failure to comply would be unlikely to attract disproportionate attention from the regulator.”

He added: “Those departments which cannot comply in the long term must be assumed to be providing an unsafe level of care and should accordingly be closed.”

**Cite this as:** BMJ 2012;344:d8353

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European lobby groups call for “revolving door” between drug regulators and industry to be closed

**Nigel Hawkes**  
London

The European Commission has been urged to review procedures at the European Medicines Agency (EMA) and the staff regulations that govern the conduct of EU officials, after claims that a former executive director of EMA arranged to become a consultant to the drug industry while still employed by the agency.

Thomas Lönngren, who ran Europe’s drug regulatory agency for 10 years before stepping down at the end of 2010, has already been told by the EMA that he should not provide product related advice to drug companies nor take managerial, executive, or consultative positions in the industry for a period of two years.

But the Alliance for Lobbying Transparency and Ethics Regulation, Formindep, and Health Action International wrote an open letter last month to John Dalli, the European commissioner for health and consumer policy, saying that the evidence about Mr Lönngren’s activities demands revisions and tightening of the regulations. The evidence consists of documents from the UK companies registry Companies House showing that a new company, Pharma Executive Consulting, was established on 2 November 2010 and that Mr Lönngren became a director of it on 10 November, while still employed by EMA. In a letter to EMA dated 28 December 2010 Mr Lönngren first disclosed his intention to become a consultant to the drug industry, and in later disclosures he said this would include a contract with NDA, a consultancy group that describes itself as Europe’s leading regulatory affairs consultancy.

In March 2011 an EMA inquiry into Mr Lönngren’s activities reported that they did not represent a conflict of interest so long as he did not take management, executive, or consultative positions in the industry and that his consultancy services did not include advising on matters that fell “within the remit and the area of responsibilities” of the EMA.

In a letter to the committee from his lawyers, Mr Lönngren said that he would be advising NDA on health technology assessment and would not be involved in regulatory issues.

The activist groups are far from satisfied by these assurances. “The possibility that a former regulator may use his insider knowledge to advise pharmaceutical companies is worrying,” the letter stated. The letter calls on Mr Dalli to revise and strengthen the “revolving door” rules within the regulations that govern European Commission employees.

**Cite this as:** BMJ 2011;343:d8335
MSF reconsiders operations in Somalia after two die in fatal attack

Peter Moszynski LONDON

The murder of two senior staff members in Mogadishu last week has led the international medical aid organisation Médecins Sans Frontières (MSF) to reconsider whether it can continue working in the violence prone and famine affected country.

On 29 December a disgruntled former employee entered the charity’s Somalia headquarters with a gun and opened fire, killing the country director immediately and mortally wounding a senior doctor.

The country director, 53 year old Philippe Havet, was an experienced emergency coordinator from Belgium who had worked with MSF since 2000 in many countries, including Angola, the Democratic Republic of the Congo, Indonesia, Lebanon, Sierra Leone, and South Africa. The doctor was Andrias Karel Keiluhu, better known as “Kace,” who was 44 years old and had worked with MSF since 1998 in his native Indonesia and in Ethiopia, Thailand, and Somalia.

The charity said in a statement: “We will sorely miss Philippe and Kace; their energy, humour, and commitment. Our heartfelt sympathy goes out to their loved ones.”

An MSF director, Christopher Stokes, told the BMJ: “We believe the shooting was a result of the non-renewal of the individual’s contract, a decision taken with clear support from the community, as he was suspected of theft.”

He emphasised that “this was an act of violence by an individual, not related to any politics. Somalia is a lawless environment and every man has a gun.”

The charity has worked in Somalia continuously since 1991 and currently operates 13 projects in the country, including medical activities related to the ongoing emergency, vaccination campaigns, and nutritional interventions. It also helps Somali refugees in camps in Dadaab, Kenya, and Dolo Ado, Ethiopia.

This was the second serious incident to affect the charity in recent months. Last October two Spanish employees were abducted from Dadaab refugee camp on the Kenyan border. Blanca Thiebaut, aged 30, from Madrid, and Montserrat Serra, aged 40, from Girona, are still missing. It is believed that they are being held by militants inside Somalia (BMJ 2011;343:d6729, 17 Oct).

Mr Stokes said that MSF was now “faced with a terrible dilemma.” There are “incredible rates of malnutrition in Mogadishu,” he said, along with cholera cases and direct victims of the fighting.

“Somalia is probably one of the hardest environments for aid to be delivered effectively, and at the same time the level of need is the highest.

“Our medical teams wish to maintain lifesaving activities in Mogadishu and elsewhere in Somalia but must now review levels of exposure and risk. The people of Somalia are the victims of this violence as much as MSF is. Abandoning them is the last option for us.”

The charity is also currently extremely concerned for the welfare of 156 Sudanese staff members in South Sudan’s Pibor county, who fled into the bush last week when Pibor hospital and two clinics in neighbouring villages were attacked by a marauding tribal militia.

Cite this as: BMJ 2012;344:e19

Hanover bans e-cigarette use in civic offices amid calls for better safety data

Ned Stafford HAMBURG

Health authorities in Germany are warning of potential risks to health from electronic cigarettes (e-cigarettes), with a top official at the German Cancer Research Centre in Heidelberg calling it one of the major new health issues currently facing Germany and the rest of Europe.

Martina Pötschke-Langer, head of the centre’s cancer prevention unit, told the BMJ that e-cigarettes usually contain nicotine and other potentially harmful substances. But unlike medical products that contain nicotine, such as chewing gum and patches used to help cigarette smokers quit, which can be bought only in pharmacies, e-cigarettes are unregulated and can be sold over the internet or in tobacco kiosks and other shops. Current information on the health effects of e-cigarettes is dangerously meagre for a product already on the market, she said, adding that research efforts need to be greatly intensified to provide a foundation on which to base regulatory decisions.

“E-cigarettes are one of the most burning health issues at the moment because dozens of companies are trying to develop the nicotine market outside of pharmacies in Germany and other European Union countries,” said Dr Pötschke-Langer, who is also head of the World Health Organization’s Collaborating Centre for Tobacco Control in Heidelberg.

E-cigarettes contain a replaceable cartridge of propylene glycol or glycerin based liquid solution with nicotine. When the user inhales, the device heats the liquid solution to produce a smoke free vapour. E-cigarettes are being marketed for use in places where smoking is not allowed, and as an aid to quitting.

An increase in the popularity of e-cigarettes in Germany and their widening availability is setting off alarm bells among German health authorities, and several regional and federal officials in recent weeks have issued warnings about the potential risks to health. In the last week of December the city of Hanover banned their use by civil servants in city offices and city vehicles. The city is considering extending the ban to restaurants and other enclosed public areas pending studies to determine the potential effects of passive smoking of e-cigarettes.

Hanover based its decision in part on a warning about the health risks of e-cigarettes issued on 19 December by the Federal Centre for Health Education in Cologne (www.bzga.de/presse/presearchiv/?jaHR=2011&nummer=716).

Cite this as: BMJ 2012;344:e3