NEWS

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Quebec group advocates physician assisted dying

US regulator seeks advice on risks of metal-on-metal hip implants

Deborah Cohen BMJ

The US Food and Drug Administration has said it is seeking expert opinions on the risks and benefits of metal-on-metal hips. The announcement comes in response to a letter from the Wisconsin Democrat senator, Herb Kohl, which highlighted the high failure rates of some of these implants.

The letter cites a recent study in the *Lancet* (2012;379:1199-204), showing an increased failure rate of large diameter metal-on-metal total hip replacements. It also mentions a recent joint *BMJ* and BBC *Newsnight* investigation that found changes in the design of such implants may have contributed to their increased rate of failure (*BMJ* 2012;344:e1410).

Kohl pointed to the damage that failing metal-on-metal hips can cause. "The *British Medical Journal* and BBC *News*[*night*] found that metal-on-metal hips can leach ions into the surrounding tissue, damaging tissue and bone and harming some patients' lymph nodes, spleen, liver, and kidneys," he wrote.

He said this had led the UK regulator, the Medicines and Healthcare Products Regulatory Agency, to recommend that patients with large diameter metal-on-metal total hip replacements have yearly blood tests to check for elevated levels of ions in the blood (*BMJ* 2012;344:e1545). Kohl asked how the devices division of the FDA is using the new information and what other metal-on-metal data it has.

William Maisel, deputy director of science at FDA's Center for Devices and Radiological Health, said, "We are asking outside scientific and medical experts to discuss recent information on these devices so that the agency can continue to make reliable safety recommendations to patients and their healthcare providers."

On 2 April the UK agency advised surgeons to stop using the combination of Mitch TRH cup and heads, made by Finsbury Orthopaedics, and Accolade femoral stems, made by Stryker Orthopaedics, because it has a high revision rate of 10.7% after four years compared with other implants. Surgeons should closely monitor patients with this combination of implants, it says.

Cite this as: *BMJ* 2012;344:e2460

ARINDAM DEY/DEMOTIX/PA

Indian officials cull ducks and chickens in 2011 after a positive report of avian flu near Agartala, Tripura

US board gives green light to publication of bird flu studies

Ingrid Torjesen LONDON

A US government panel has given two journals the go ahead to publish research on transmission of avian flu. It had previously recommended that the journals withhold publication of the studies for fear that public health would be endangered if they fell into the wrong hands (*BMJ* 2011;343:d8333).

In December 2011 the National Science Advisory Board for Biosecurity, which provides recommendations on research publication at the request of the US government, asked the journals *Science* and *Nature* to withhold publication of "methodological and other details" of two studies relating to the potential for human to human transmission of the H5N1 virus via an aerosol because "that could enable replication of the experiments by those who would seek to do harm" (so called dual use research of concern).

It also urged "that language be added to the manuscripts to explain better the goals and potential public health benefits of the research, and to detail the extensive safety and security measures taken to protect laboratory workers and the public."

The authors redrafted the manuscripts, and last week the board agreed that the two papers could be published. The decision to recommend publication of the manuscript by Yoshihiro Kawaoka of the University of Wisconsin in *Nature* was unanimous, and the vote was 12 to 6 in favour of publishing the paper by Ron Fouchier of Erasmus Medical Centre, Rotterdam, in *Science*.

Paul Keim, the board's acting chairman, told a press conference on Monday 2 April that the board had changed its mind on publishing the research for several reasons, including that the redrafted versions were more extensive and stated the potential benefits of the research to public health.

Fouchier said that his paper had been presented as pure scientific research but that *Science* had agreed to give it more space to enable the public health benefits to be explained.

He believes that there was "a misconception" about the potential lethality of the research, which was undertaken in ferrets. "Our first version of the paper was simply about aerosol transmission; it wasn't about virulence and lethality. It was a very scientific paper about aerosol transmission. The whole lethality of the virus we were not incredibly interested in initially, but because of all the controversy and the discussion we knew we had to spell it out."

He said, "Our virus does not kill ferrets when they are infected by aerosol."

Keim said that the current voluntary review process for dual use research was not ideal.

Cite this as: *BMJ* 2012;344:e2512

UK Biobank opens its data vaults to researchers

Geoff Watts LONDON

After more than a decade of planning and preparation, UK Biobank is ready for its first customers. From accumulated capital now amounting to 20 terabytes of stored data it will be dispensing anonymised biomedical information on its 500 000 volunteers to any researcher anywhere who can use it to advance the understanding of human health and disease.

Recruited over a period of four years, each Biobank participant has undergone measurements of height, weight, blood pressure, body fat, and much else, supplied details of medical history and lifestyle, and had tests of sight, hearing, and fitness. They have also donated samples of urine, saliva, and blood for genetic testing.

The self selected half million include 26 000 people with diabetes, 11 000 who have had heart attacks, and 50 000 with joint disorders.

WELLCOME LIBRARY, LONDON

The 500 000 bar coded samples of urine, saliva, and blood are stored in an archive freezer

Describing what makes the study special, chief executive and principal investigator Rory Collins first highlighted the importance of size—this study ranking as the biggest of its kind. "But in addition to being big it's remarkably detailed," he said. "We can characterise participants' diseases in exquisite detail."

The study is also prospective. "We can then look to see whether there are factors, be they lifestyle, genetic, or other things, that determine their likelihood of getting a disease. Identifying causes will allow novel ways of treatment and prevention," said Collins.

Biobank, he said, is offering a unique combination of breadth and depth.

Speaking of access to these data, Collins emphasised that there is no requirement for researchers to collaborate with Biobank on their projects. "It's a resource for them to use at the cost of pulling out the data," he said. The one condition is that users of the data publish their findings. However, although it would be desirable for the research to be published in an open access journal, this was not mandatory, said a spokesman.

In the meantime Biobank is continuing to collect new information. "We are about to send out to participants accelerometers," Collins said. "These will be worn for a week to measure their activity, rather than merely questioning them about it." There are also plans to perform magnetic resonance imaging on the brains, hearts, and bodies of 100 000 of the study participants.

Wendy Ewart, deputy chief executive of the Medical Research Council, applauded Biobank's funders for their prescience in putting up the money required for the study. "To have invested in the long term and at this scale for something that wasn't going to yield results for five years or beyond took courage," she said.

Describing the project as "a remarkable venture," Biobank's board chairman, Mike Rawlins said, "It's an amazing example of the altruism of ordinary people. Half a million members of the general public have put themselves out . . . for no personal return whatsoever."

Cite this as: *BMJ* 2012;344:e2459

Half of clinical commissioning groups have GPs with conflicts of interest

Matthew Limb LONDON

An analysis of clinical commissioning groups showing the financial links many GP board members have with non-NHS providers has raised fresh fears over potential conflicts of interest.

The False Economy research group, which is funded by the Trades Union Congress, examined 50 clinical commissioning groups.

It identified 22 groups whose boards have a substantial proportion of GPs with an external financial interest in a private company or other non-NHS provider.

Concerns have been raised that once they are put in charge of NHS budgets doctors who have a stake in other companies that provide healthcare might be able to profit from commissioning their own services.

A spokesman for False Economy said the government had not resolved such complications and so would create confusion among patients and ensure doubt would be cast on the motives behind some GPs' commissioning decisions.

The spokesman told the *BMJ*, "The government has given no thought whatsoever to this situation. Clinical commissioning groups have been left on their own to clear up the mess."

False Economy has highlighted that many GP board members on 10 of the clinical commissioning groups have links with Virgin Care companies, which provide services to the NHS including urgent care, physiotherapy, psychological therapies, and screening.

The report lists eight GPs on Barnet Clinical Commissioning Group as shareholders in Barndoc Healthcare Limited, "the profit-making company that is owned by local GPs and holds the out-of-hours contract in Barnet."

False Economy says seven of the 11 board members on South Worcestershire Clinical Commissioning Group are shareholders in Elgar Healthcare, which runs a walk-in health centre contracted to Worcestershire Primary Care Trust. When the clinical commissioning group takes over the primary care trust's duties, the group will have to decide whether to extend the contract.

Johnny Marshall is a GP who chairs Buckinghamshire based United Commissioning and is also a shareholder—along with five GP board colleagues—in Vale Health, which provides services to the NHS. He told the *BMJ* that clinical commissioning groups would need to develop strong governance arrangements over the next 12 months as they began to take on shadow status from 1 April 2012.

He said, "It is vitally important that we don't find ourselves with either the perception or reality that clinical commissioning decisions are unduly influenced by any financial interests. Interests have to be declared."

Cite this as: *BMJ* 2012;344:e2431

NHS regulator may not be fit to register GP practices, MPs warn

Adrian O'Dowd LONDON

MPs have raised fears that the NHS's main regulator, the Care Quality Commission (CQC), might be unfit to register all 10 000 GP practices later this year.

MPs heavily criticise the commission for failing to be an effective regulator with serious questions raised over its governance, leadership, and culture.

As the independent regulator of health and adult social care in England, the commission, which was formed in 2009 from the merger of three previous regulators, regulates more than 21 000 care providers against 16 quality and safety standards.

MARTIN RIEDL/SPL

Proper funding will lessen unacceptable variations in paediatric diabetes care, said Anna Morton

Payments are to rise sixfold for teams that deliver good diabetes care for children

Zosia Kmietowicz LONDON

Paediatric teams whose care of children and teenagers with diabetes meets 13 standards set out by the NHS in England will qualify for extra funding under a new agreement. Teams that are unable to achieve the standards by April 2013 risk having their funding withdrawn.

The best practice tariff for paediatric diabetes has been developed by leading paediatric doctors, nurses, and commissioners together with NHS Diabetes, a national organisation working to improve the quality of care for people with diabetes. It spells out 13 standards that paediatric teams need to provide to qualify for annual payments of £3189 for each patient aged 18 years or under. Under the current Payment by Results system, diabetes services are paid £120 per visit, up to four visits a year.

Tabitha Randell, clinical lead for NHS Diabetes and a consultant in paediatric endocrinology and diabetes at Nottingham University Hospitals NHS Trust, said that the new tariff will mean that services get the payment only if they achieve all the standards for 90% of children attending the clinic. This will help them focus on getting children to make all their appointments, unlike the previous system, which paid clinics each time children attended the clinic.

She added, "We hope the changes to the financial levers will lead to an improvement in the care and outcomes for children and young people with diabetes. This should then result in a reduction in costs to the service, in levels of emergency hospital admissions among children with type 1 diabetes, and in the incidence of life changing yet often preventable complications associated with the condition."

Randell said that three quarters of services in England are ready to meet the standards, as they have known about them since last year. The remainder have still got some progress to make.

The standards say that a team should have a minimum of a doctor, a nurse, and a dietitian with specific training in paediatric diabetes. All children with diabetes should have at least four appointments a year with the doctor and team and at least eight additional contacts, such as phone calls, emails, and school visits.

All the children should have their glycated haemoglobin checked at least four times a year, and clinics must have policies in place to tackle poor diabetes control and on what to do if children persistently fail to attend.

Other standards detail services for children with a new diagnosis of diabetes, access to psychological services, and 24 hour access to advice on the emergency management of diabetes for families and other health professionals.

Teams are also expected to take part in the national paediatric diabetes audit, regularly attend their local paediatric diabetes network meetings, and have a clear policy for transition of patients to adult services.

Anna Morton, director of NHS Diabetes, said, "Outcomes for children with diabetes in this country compare poorly with the rest of Europe. We will show that with a proper funding mechanism providers can improve, and unacceptable variations in care can be addressed."

Best Practice Tariff for Paediatric Diabetes **is at http://bit.ly/Hn3S7K.**

Cite this as: *BMJ* 2012;344:e2481

Its role in ensuring quality standards had not been fulfilled effectively, and it had not achieved the right balance between registration and inspection, said MPs.

In February, the commission's chief executive, Cynthia Bower, resigned after a series of damning reports on its performance (*BMJ* 2012;344:e1396).

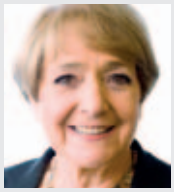
Between September of this year and April 2013 the commission will carry out what the MPs' report describes as a "major challenge" in registering 10 000 GP practices, and the committee said it was unconvinced the regulator was up to the task.

Registration will be decided primarily on the information provided by the GPs themselves. GP practices will have to declare whether they are meeting the essential standards, an approach that carries risks, says the report.

Margaret Hodge, Labour MP for Barking and committee chair, said: "We are far from convinced that the CQC is up to the major challenge of registering and assessing 10 000 GP practices this year. Registration will now be decided on the basis of information from GPs themselves, and there is a risk that the CQC will simply become a postbox."

The Department of Health had underestimated the scale of the task it set in requiring the commission to merge three bodies while taking on an expanded role with a smaller budget than its predecessors, said MPs. Only recently has it begun to take action to help the commission, which had been struggling for some time.

This had contributed to the commission's problems, such as the fact that it did not act quickly enough on vital issues, for example information from whistleblowers. Nor had it dealt with problems effectively. "We have serious concerns about the commission's governance, leadership, and culture," says the report.



Margaret Hodge: registration will become a postbox

Commission inspectors were responsible for large and varied portfolios of providers, but inspectors did not have enough support to develop the requisite skills and experience. It had made a mistake when it decided to close the dedicated whistleblowing line that one of its predecessors had used because whistleblowers were a crucial source of intelligence in helping to monitor quality of care.

The Care Quality Commission: Regulating the Quality and Safety of Health and Adult Social Care**, is at www.parliament.uk.**

Cite this as: *BMJ* 2012;344:e2425

IN BRIEF

Men are at greater risk of sudden heart death: Nearly two thirds of deaths from sudden arrhythmic syndrome occur in men, with an average age of 33 years, shows a national audit of 317 cases recorded in the United Kingdom since July 2008 (www.ic.nhs.uk/ncasp/sads). Just over a sixth (17%) died during some form of exertion. More hospitals need to take part in the audit, says the report.

Canada faces shortage of generic drugs: The president of the Canadian Medical Association has described the 80% fall in stocks of generic injectable drugs in Canada as a "desperate situation." The manufacturer of generic drugs Sandoz Canada slowed production after receiving a letter from the US Food and Drug Administration in November 2011 about manufacturing standards and after a plant fire in Quebec in March.

Man is guilty of importing and using anaesthetics for circumcisions: A man who was not registered to practise as a doctor in the UK has been given a suspended sentence of six months for administering prescription lidocaine while conducting circumcisions on two young boys. Moeenuddin Langah, who is said to be registered as a doctor in Pakistan, strapped the boys to a table and unlawfully injected them with anaesthetic imported from India before using unsterilised surgical tools. One boy was left with pain and swelling and had to undergo surgery after the operation.

NICE issues new quality standards on lung cancer: New quality standards for care of people with lung cancer from the National Institute for Health and Clinical Excellence (www.nice.org.uk) say that there should be public awareness campaigns about the signs of lung cancer and that people presenting with one or more symptoms indicating lung cancer should be referred within a week for radiography or to a chest physician.

Dutch groups challenge law that allows smoking in small cafes: A legal challenge to the Dutch government's policy of allowing smoking in small cafes has been launched by the antismoking lobby group Clean Air Nederland, backed by the Dutch Cancer Society and Heart Foundation and an asthma charity. They argue that the government is not fulfilling its treaty obligations under the World Health Organization's framework convention on tobacco control requiring signatories to actively discourage smoking.

Cite this as: *BMJ* 2012;344:e2474

Drug firms in Europe do not have to declare their lobbying activities

Michael Day MILAN

The drug industry's lobbying power in Europe dwarfs that of opposing campaign groups and is largely hidden thanks to lax rules that allow drug companies to conceal how much they spend on attempts to influence European Union policy, a new report claims.

The report, produced by the charities Corporate Europe Observatory and Health Action International Europe, says that the industry is known to spend more than €40m (£33m; $53m) a year in attempts to influence decision making in the EU. It says that nearly half of this sum is spent by drug manufacturers on their own in-house lobbyists.

By contrast, campaign groups active on issues concerning medicines in the EU spend just €3.4m between them a year. "With the immense disparity between the affluence of public interest groups and the industrial lobby, it becomes even more difficult to level the policy playing field," said Katrina Perehudoff, Europe project officer for Health Action International.

But the study indicates that, with many drug firms failing to declare their EU lobbying activities on the official register, adherence to which is voluntary, the real amount spent by the industry might be as high as €91m a year.

This sum, the researchers note, would be similar to the industry's spending in the United States, where lobbying costs must be declared. In the US the pharmaceutical manufacturing sector last year spent about €86m on lobbying.

Olivier Hoedeman, of the Corporate Europe Observatory, said, "There is an urgent need to strengthen the EU's lobby transparency register and make it mandatory for lobbies to sign up and ensure that the information disclosed is reliable."

Drug industry lobbying has been linked to the EU's decision to enhance data protection that may have delayed the marketing of cheaper generic drugs. One such accusation appeared in the *Journal of Health Politics, Policy and Law* in 2009 (34:979-1010).

Other reports have implicated the industry

Journals demand that Japanese university verifies the authenticity of 193 papers by anaesthetist

Ingrid Torjesen LONDON

The editors in chief of the world's leading anaesthetics journals have offered Tokyo's Toho University an ultimatum: vouch for the integrity of all research conducted by the anaesthetist Yoshitaka Fujii or the journals will retract his research papers.

The letter asks the university to verify the authenticity of 193 papers. The university has until 30 June to respond with a timeline for assessing the papers. It has been asked to confirm that each study occurred as represented in the relevant paper and that appropriate ethical approval was obtained. It has also been asked to examine the original research data and verify that they are authentic.


Yoshitaka Fujii has already retracted eight papers

Toho University has already undertaken an investigation to look at the credibility of nine papers published by Fujii. The investigation, which began in September 2011, found that although the research had purportedly been conducted at Ushiku Aiwa General Hospital, only one clinical study by Fujii was officially recorded at the hospital and the other eight had been conducted without any ethics committee approval (*BMJ* 2012;344:e2019).

The university said in a statement that Fujii admitted that the clinical studies had taken place without ethics committee approval. He subsequently sent letters of retraction to the four journals that published the eight affected articles and was dismissed from Toho University on 29 February after a disciplinary hearing.

Last month Steve Yentis, editor in chief of *Anaesthesia*, told the *BMJ* that he expected that further papers would have to be retracted. He added that the investigating committee had not implied that the studies were fabricated but had left it unclear "as to whether these studies took place at all or whether they took place but without approval."

A paper in *Anaesthesia* on 8 March analysed 168 papers by Fujii and found "extremely aberrant data distribution."

Cite this as: *BMJ* 2012;344:e2490

lobby in EU member states' response to H1N1 influenza, specifically in the huge amount spent on insufficiently tested vaccines.

In June 2010 a report by the Social, Health and Family Affairs Committee of the Parliamentary Assembly of the Council of Europe said that the handling of the H1N1 pandemic by EU agencies led to a "waste of large sums of public money, and unjustified scares and fears about the health risks faced by the European public" (*BMJ* 2010;340:c3033).

Richard Bergström, director general of the European Federation of Pharmaceutical Industries and Associations, told the *BMJ* that his organisation and its members supported "full transparency of lobbying activities," despite the new claims that many members failed to declare lobbying activity.

He added: "I can spend all my time seeing people that invite me to see them. EFPIA is asked for its views and very often for data and analysis. You can call that lobbying—I would not. I do not deny that we also proactively try to influence policy making. That is our job, as is it for all other stakeholders in a democracy."

Divide & Conquer: A Look behind the Scenes of the EU Pharmaceutical Industry Lobby **is at http://haieurope.org/wp-content/uploads/2012/03/28-March-2012-DivideConquer.pdf.**

Cite this as: *BMJ* 2012;344:e2465

Working with pharma will not harm clinical decisions

Clare Dyer BMJ

Doctors are being urged not to be "tempted to accept the negative myths about cooperating with industry" in a new guide to promote collaboration between healthcare organisations and the drug industry to improve care of patients in the United Kingdom.

The guidance is supported by organisations representing the industry and by healthcare bodies including the BMA, the Academy of Medical Royal Colleges, and the royal colleges of GPs, physicians, and psychiatrists. The Department of Health for England, the NHS Confederation, and the governments of Scotland and Wales also back the guide, which is aimed at achieving better cooperation with the industry for the benefit of patients at a time of budgetary constraint.

The guidelines, which come from the Ethical Standards in Health and Life Sciences Group, say, "Undertaken appropriately, working with industry will not harm objectivity of clinical decision-making and should not be perceived negatively by peers."

The guidance is at http://bit.ly/H9Y3eo.

Cite this as: *BMJ* 2012;344:e2489

US court hears arguments against Obama's health reform act

Janice Hopkins Tanne NEW YORK

The US Supreme Court took an unusual six hours over three days to hear arguments challenging Barack Obama's health reform act, passed two years ago (*BMJ* 2010;340:1635), while crowds outside protested for and against the law.

The court is expected to issue its ruling in late June, in the midst of the US presidential campaign. It may have a major effect on the positions of Obama and his likely Republican opponent, the former Massachusetts governor Mitt Romney.

In Massachusetts in 2006 Romney championed a mandatory health insurance plan that was the model for Obama's health reform act. Romney's plan provides health insurance for almost all Massachusetts residents. However, in his campaign for the Republican nomination he has worked hard to distance himself from his Massachusetts plan.

The nine Supreme Court justices are thought to be divided, with more leaning to the conservative side. But with one or two "swing votes," the ultimate decision is hard to predict.

The court considered three main issues. On the first day, Monday, it considered an old law that said that a person could not file a lawsuit challenging a tax until the person had paid the tax. In the case of the health reform act that would not occur until 2015. Experienced court observers said that they did not think the court would use this opportunity to postpone a decision until after this year's presidential election in November.

On the second day the court considered the key issue, the "individual mandate." This requires every US citizen to get health insurance, either through their job or to purchase it in the private market. Assistance is available for people on low incomes; and purchasers can choose from different plans in "exchanges."

On the final day the court heard arguments about the extension of Medicaid, the health insurance scheme for people in poverty or on low incomes. Medicaid is funded jointly by the federal government and the states. The health reform requires states to include many more people in Medicaid, but the federal government will pay almost all the increased costs. Several justices asked why there were objections to this generous provision.

The individual mandate relies on the "commerce clause" of the US Constitution, which gives Congress the right to regulate interstate commerce, such as health insurance from companies that operate in several states. The government argued that people who do not purchase health insurance nevertheless engage in commerce because sooner or later they need healthcare. When they cannot pay, the cost of their care is spread among insured people and taxpayers.

The government argued that two of the law's requirements would not work without the individual mandate: the requirements that insurance companies cover all people regardless of their health problems and that people with health problems not be charged more. Without a large pool comprising younger, healthier people as well as older, sicker people, health insurance would not work. Healthier people would not buy insurance until they needed it, leading to higher premiums, and fewer insured people.

Cite this as: *BMJ* 2012;344:e2463

CAROLYN KASTER/AP/PA

Protesters with a copy of the US constitution at the Supreme Court last week

Canadian trainees are not covered by new guidance on pelvic examinations

Barbara Kermode-Scott HALIFAX, CANADA

Recently updated Canadian guidelines concerning patient consent for pelvic examinations undertaken during anaesthesia contain a "major flaw" because they do not specifically mention trainees, say health law experts.

In 2010, the Society of Obstetricians and Gynaecologists of Canada and the Association of Academic Professionals in Obstetrics and Gynaecology of Canada released an updated policy statement regarding pelvic examinations performed on women under anaesthesia. Unlike the previous 2006 guideline that applied to "medical trainees" (explicitly including students and residents), the updated statement for the most part applies only to "medical students," point out legal analysts at Dalhousie University in Nova Scotia. This leads to "the unfortunate paradox of some women now being less protected against examinations they did not consent to," they say in the *Canadian Medical Association Journal* (doi:10.1503/cmaj.110725).

Canada's resident doctors need to be covered by a policy statement regarding pelvic examinations for training purposes with the same requirements that the updated statement establishes for medical students, emphasise the coauthors Elaine Gibson, associate director of Dalhousie's Health Law Institute, and Jocelyn Downie, Canada research chair in health law and policy.

They argue that either the policy statement by Canada's two obstetrics and gynaecology associations needs to be revised to include junior doctors receiving training or that a new statement specific to trainees needs to be drafted.

Cite this as: *BMJ* 2012;344:e2426

MPs back guidance on assisted suicide in rare Commons debate

Clare Dyer BMJ

The House of Commons has thrown its overwhelming support behind guidelines on assisted suicide from the director of public prosecutions, in the first full debate on assisted dying to take place on the floor of the UK's elected chamber since 1970.

DOMINIC LIPINSKI/PA

An attempt to put guidance on assisted dying from DPP Keir Starmer QC on the statute books was withdrawn

MPs taking part in the debate, which was allowed by the Commons backbench business committee, also backed the further development of specialist palliative care and hospice provision. But an amendment calling for the director of public prosecutions' guidelines to be put on a statutory footing was withdrawn after it was widely opposed, with some MPs characterising it as a "Trojan horse" for moves to legalise assisted suicide.

The Conservative MP Richard Ottaway proposed a motion calling on the House to welcome the guidelines issued by the director of public prosecutions, Keir Starmer, in February 2010 (*BMJ* 2010;340;c1167). These outline the factors that would influence a decision to prosecute or refrain from prosecuting someone who helped another person commit suicide.

The guidelines make it clear that a relative or friend who helps a loved one to die from compassionate motives is unlikely to be prosecuted, while doctors and other healthcare professionals face a greater risk of prosecution. Some 31 cases are thought to have been referred to the director of public prosecutions since the guidelines were issued, but no prosecutions have been brought.

But some MPs took advantage of the debate to go further and put on record their opposition to, or support for, the legalisation of assisted suicide or voluntary euthanasia. Some spoke of their own experiences or those of their constituents.

The Labour MP Paul Blomfield said his emotions were "still a bit raw" after his 87 year old father, who was terminally ill with lung cancer, had taken his life last July. "I am sure that what drove him to end his life when he did was the fear that if he did not act while he could he would lose the opportunity to act at all.

"If the law had made it possible, he could, and I am sure he would, have shared his plans. He would have been able to say goodbye and to die with his family around him and not alone in a carbon monoxide filled garage. He and many more like him deserved better."

The Conservative MP Guy Opperman told of his own collapse in the central lobby of the Houses of Parliament and diagnosis with a meningioma. He had been told he faced the risk of death, paralysis, loss of speech or sight before undergoing surgery and fortunately had been left without any deficit, but "it made me think about what might have been."

He urged the House "to address the issue that dare not speak its name, which is that we need to consult properly about assisted suicide." In the longer term, he said, "the matter will not go away."

Cite this as: *BMJ* 2012;344:e2424

Cancer treatment with patients in mind

Zosia Kmietowicz LONDON

"Living with cancer and living to your full potential," "not letting cancer treatments interfere too much with your quality of life," and making "the patient's journey as pleasant as possible," are how Kirit Ardeshna described the ambitions of the new University College Hospital Macmillan Cancer Centre, which opened its doors in London this week.

The £100m development, to which Macmillan Cancer Support has contributed £10m and the Teenage Cancer Trust £2.6m, is the realisation of a long term dream, said Robert Naylor, chief executive of University College Hospital. "Ten years ago we visited the Memorial Sloan-Kettering Cancer Center in the US and were impressed by the way they treated cancer: out of hospital wherever possible, and a service that was designed around the needs of the patient, not the other way around. We were left with the question, why can't we do that here? Now, the cancer centre gives us the opportunity to do this and so much more."

Cite this as: *BMJ* 2012;344:e2492