NEWS

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bmj.com
Most patients who stop taking a statin are not intolerant, suggests study

Access to fast track drugs through the cancer drugs fund is cut by half

Ingrid Torjesen LONDON

The number of cancer indications for which patients can have fast track access to drugs not routinely available on the NHS through the cancer drugs fund has been halved by reforms announced by NHS England on 4 April.

NHS England, formerly the NHS Commissioning Board, has drawn up a national list of cancer drugs yet to be assessed by the National Institute for Health and Care Excellence, for which doctors in England can ask for fast track access for their patients. It argues that this will reduce the postcode lottery in access to drugs caused by funding decisions, which were previously made at a regional level through the 10 strategic health authorities.[1]

The national list contains 28 drugs to treat 64 different cancer indications.[2] The charity Macmillan Cancer Support points out that this list has halved the number of cancer indications covered, which previously numbered 129.

Mike Hobday, head of policy and research at Macmillan Cancer Support, said: "It is worrying that the reduced list of cancer drugs that can be funded will restrict access to drugs which were previously routinely available. For rarer cancers, this will be particularly acute."

Doctors will be able to nominate drugs to be considered for inclusion on the list and to make individual funding requests for cancer drugs not listed. Individual funding requests will be considered by four area teams—north of England, Midlands and the East, south of England, and London.

Sean Duffy, national clinical director for cancer at NHS England, said, "Having one consistent method for consideration of overall clinical benefit and funding means that all applications will be assessed by the same criteria. Regional variation of the past is clearly not acceptable for patients."

NHS England has stressed that any patient who had already been approved for funding for a cancer drug not on the national list will still have that drug funded.

The government launched the cancer drugs fund in 2011,[3] worth £200m a year until March 2014, after a £50m trial in October 2010.

Cite this as: *BMJ* 2013;346:f2197

ROCHE

The UK ordered 14.6 million doses of oseltamivir in 2005 to combat avian flu

BMJ OPEN DATA CAMPAIGN

Roche promises Tamiflu trial data to Cochrane researchers

Deborah Cohen BMJ

More than three years after the Cochrane Collaboration first asked Roche for the full clinical study reports for its influenza drug oseltamivir (Tamiflu), the Swiss company has offered the collaboration access to "all 74 Roche sponsored trials."

Don MacLean, life cycle leader for Tamiflu at Roche, emailed the Cochrane researchers on 2 April to propose providing data in a staggered approach over the next few months.

"In line with European Union law, each CSR [clinical study report] will be edited by Roche to ensure patient confidentiality and to protect legitimate commercial interests," he wrote.

A full phase III clinical study report typically consists of 2000 to 3000 pages, and redaction will be a "large undertaking," he added.

The Cochrane group has cautiously welcomed the move, pointing out that Roche has previously promised access to data. MacLean's email follows GlaxoSmithKline's decision to release 30 clinical study reports on its influenza drug zanamivir (Relenza) to the same Cochrane group. The group is concerned, however, that data redaction may make analysis and interpretation impossible.

Sile Lane, director of campaigns at Sense about Science, said that by acknowledging that there were 74 trials and agreeing to publish the results, Roche had recognised that arguments in favour of secrecy no longer held.

"This should be a good moment for them to sign up to the commitment set out at AllTrials for all trials relating to treatments in current use to be registered, and the results reported. It shouldn't have taken the researchers years of persistence and publicity to get [access to] these Tamiflu results. Roche has an opportunity to tell the public and research community that it won't happen like this again," she said.

The announcement comes after years of wrangling for access to what the Cochrane group believes to be the full dataset. Instead of offering access to 74 trials, in December 2009 Roche gave the researchers access to one part of 10 Tamiflu trials (each trial report comes in four to five parts).

Carl Heneghan, one of the Cochrane reviewers, said that when the collaboration asked for more data in 2011, it was told by MacLean that Roche's view was that "you [the Cochrane group] have all the detail you need to undertake a review and so we have decided not to supply any more detailed information."

Heneghan commented: "The very fact that the 74 studies are now being released undermines these original statements: that we had all the detail we needed and that it wasn't necessary and it has become increasingly clear that this is not the case."

Cite this as: *BMJ* 2013;346:f2157

Inquest opens into death of woman who was refused an abortion

JULIEN BEHAL/PA

What we want to know is why there was a systematic breakdown in the care of Savita Halappanavar, said the family's solicitor Gerard O'Donnell

Muiris Houston GALWAY

The first of two reports on the death of pregnant dentist Savita Halappanavar in Ireland in 2012 has found that there was an overemphasis by hospital staff on the welfare of Ms Halappanavar's unviable fetus and an underemphasis on her deteriorating health.

The inquest into Ms Halappanavar's death opened in Galway on 8 April and is scheduled to run for at least one week.

The final draft report says: "The investigating team considers there was an apparent overemphasis on the need not to intervene until the fetal heart stopped, together with an underemphasis on the need to focus an appropriate attention on monitoring for and managing the risk of infection and sepsis in the mother."

Praveen Halappanavar, the husband of Savita who died at University Hospital Galway, is dissatisfied with the report that was delivered to his solicitor, Gerard O'Donnell, last week.

He has instructed O'Donnell and his medical adviser to meet the chairman of the investigating team, Sabaratnam Arulkumaran, to submit their observations, with a view to having these included in the final published report.

O'Donnell has pointed to several key issues arising from the report. It has emerged that, on admission, Ms Halappanavar had an elevated white cell count. O'Donnell and his client have also raised concerns about how adequately her vital signs were monitored, and said that although there was evidence that Ms Halappanavar's condition had deteriorated on the Tuesday evening, this was not acted on until the following afternoon.

"What we want to know is why," said O'Donnell. "Apart from what happened, apart from the observations and recommendations that we know are in the report, we want to know why there was such a systematic breakdown across the board at all levels, from junior to senior positions, in the care of my client's wife.

"It would be one thing if one person forgot to do something, or one person made a mistake that led to her demise. But there was shortfall after shortfall and lack of communication after lack of communication, and she lying in the bed dying.

"We want to ask the chairman, did he ask why all this happened. Or does he have a sense himself that he might share with us, without prejudice."

Ms Halappanavar died on 28 October 2012 from septicaemia from *Escherichia coli* infection, having presented with severe back pain while 17 weeks pregnant on 21 October. A diagnosis of inevitable miscarriage was made, and she was told that the process would be completed within a matter of hours.

Praveen Halappanavar: unhappy with the report

When this did not happen, Mr Halappanavar and his wife requested a termination of pregnancy. However, they were allegedly refused on the basis that the fetal heartbeat was still present, and they were told, "This is a Catholic country."

Cite this as: *BMJ* 2013;346:f2208

NHS medical director defends his decision to pause paediatric heart surgery

Clare Dyer BMJ

Leeds General Infirmary is to resume children's heart surgery from 10 April, after a review team called in to investigate concerns about death rates and staffing levels pronounced it safe.

The surgery, which was stopped on 28 March after a visit from NHS England medical director Bruce Keogh, will restart gradually, beginning with low risk operations, while the review continues to explore other issues about the unit.

The first stage of the review by a multidisciplinary clinical team found that Leeds Teaching Hospitals NHS Trust's data for monitoring surgical results were "uniquely poor, triggering concerns about death rates and gaps in information," NHS England said. It would be asking for "significant improvement to the way the unit monitors the quality of care so it can be compared with similar services."

Keogh told BBC Radio 4's *Today* programme that the unit, for example, omitted to record the weight of the baby operated on in 35% of cases, compared with between 0% and 1.4% in other units.

Leeds was earmarked as one of three children's heart surgery units facing closure in the "Safe and Sustainable" review, aimed at concentrating services in larger, more specialised centres. Campaigners fought a legal battle to try to keep it open, and Keogh's intervention came just a day after a High Court judge quashed the closure decision and ordered the review to redo part of its consultation.

He was criticised by local MPs, who questioned his motives. But Stephen Bolsin, the anaesthetist whose revelations of high death rates in children's cardiac surgery at Bristol Royal Infirmary in the early 1990s sparked a public inquiry, told the *Today* programme on Saturday that politicians "have to be prepared to have the blood of children on their hands" if children died.

Keogh said, "If we have learned anything from public inquiries such as Bristol and Mid Staffordshire, it is that patients were harmed while organisations argued about the veracity of data used to measure clinical results. We would not have been forgiven if a child had died . . . while we sat on our hands."

Cite this as: *BMJ* 2013;346:f2245

Doctors call for Earl Howe to be removed from role in Friends of the RCP

Gareth Iacobucci BMJ

Six fellows of the Royal College of Physicians (RCP) have called for health minister Earl Howe to be removed from his position as chair of the Friends of the Royal College, owing to his prominent role in helping to push through the government's health reforms.

In a letter to RCP president Richard Thompson, the senior clinicians said that Howe was "not a fit person to fulfil this important role," because he had helped introduce controversial legislation opening up the NHS to the marketplace—a policy that they said was "almost universally opposed by members of our college."

The doctors said that Howe's opposition to tobacco display legislation also made him unfit for the role, and urged Thompson to ask him to leave the position.

PETER BYRNE/PA

Earl Howe was criticised for changes to the NHS and opposing public health measures

The letter reads: "Given both his role in the introduction of this legislation, almost universally opposed by members of our college, and his opposition to public health legislation that it is central to the college's goals, we are astonished to discover that Earl Howe is chairman of the Friends of the Royal College.

"His actions, in relation to both the NHS and the tobacco industry, clearly suggest that he is not a fit person to fulfil this important role and we respectfully request that he should be asked by the college to relinquish the position."

The RCP said that the position of chair was always listed in the annual report and accounts for transparency. It confirmed that it had received the letter and would be responding to it fully next week.

A spokeswoman explained: "The Friends of the RCP is an informal advisory group, including past presidents and officers, and figures from finance, industry, and other charities, which plays no role in the governance or management of the RCP but offers advice in areas such as effective fund raising. It meets very infrequently, often annually. The role is not political."

Cite this as: *BMJ* 2013;346:f2239

"Absurd" rules are hampering research into controlled drugs

Krishna Chinthapalli BMJ

All NHS hospitals should be allowed to hold all controlled drugs and use them for clinical research, according to the former chair of the government's Advisory Council on the Misuse of Drugs.

David Nutt, who is now professor of neuropsychopharmacology at Imperial College London and president of the British Neuroscience Association, spoke about barriers to research into illicit drugs, following on from his criticisms last year.[1] At a press briefing on 5 April, ahead of the British Neuroscience Association Festival of Neuroscience on 7-10 April, he said that currently only four hospitals in the UK may hold and administer Schedule 1 controlled drugs.

LYNNE CAMERON/PA

Greg Mulholland, MP (above), has campaigned for the unit. Whistleblower Stephen Bolsin warned against politicians becoming involved

Under the Misuse of Drugs Act 1971 and subsequent regulations, Schedule 1 drugs are presumed to have no therapeutic value, and a special Home Office licence is needed to use them in any research. Such drugs include cannabis, psilocybin, and ecstasy. Nutt alleged that this definition was absurd and restrictive. "To research cannabis, you have to have a special licence. To research heroin, you need no licence at all. No one can conceivably argue that cannabis is more harmful than heroin," he said.

He also cited the example of sativex, a cannabinoid medicine licensed for spasticity in multiple sclerosis. "It should be a Schedule 1 drug, because all cannabis was listed in Schedule 1, but [the Home Office] said that because it's a special formulation of cannabis in a special solution that you spray into your mouth, that exempts it," he said.

"One way forward is to exempt all hospitals from the Schedule 1 licence. All hospitals in this country are exempted from having to hold Schedule 2, 3, and 4 licences." Schedules 2, 3, and 4 are medicinal drugs that are tightly controlled and cannot be lawfully possessed without a prescription. Schedule 2 includes amfetamine, cocaine, and most opioids.

He suggested that Schedule 1 restrictions were hampering clinical research not only into cannabinoid therapy for cancer, pain syndromes, and psychiatric disorders, but also ketamine analogues for depression and mephedrone for substance dependence.

Nutt went on to talk about other barriers to his own research. Last year, he injected psilocybin, the hallucinogenic ingredient in magic mushrooms, into healthy volunteers and found an improvement in mood. "We noted that in some of our normal volunteers that they felt better for a period of weeks afterwards. There is a vast literature out on the internet of people self medicating and some of it is quite compelling," he said.

His team at Imperial College has Medical Research Council funding and ethical approval for a clinical trial of psilocybin for people with depression. However, he said that Home Office and EU regulations would delay his trial for at least a year and add hundreds of thousands of pounds in costs because any pharmaceutical company seeking to produce psilocybin must apply for an "unnecessary" special licence and then comply with "arcane and disruptive" EU standards on good manufacturing practice.

Nutt also criticised the government in 2009 when he was chair of the Advisory Council on the Misuse of Drugs and was subsequently dismissed from his post. At the time, he said that alcohol and tobacco caused more harm than cannabis and opposed the government's stricter classification of cannabis.[2]

Cite this as: *BMJ* 2013;346:f2210

MARTIN BOND/ALAMY

Research into psilocybin from magic mushrooms is being delayed because of EU rules

IN BRIEF

New funding sought to transform major diseases: The Global Fund to Fight AIDS, Tuberculosis, and Malaria has set a goal of raising $15bn (£9.8bn) for activities between 2014 and 2016. Added to an estimated $61bn from implementing countries and other sources, the money would provide 87% of the global resources needed to fight these three diseases. The funding would treat 17 million patients with tuberculosis, prevent a million new cases of HIV each year, treat 10 million more patients with HIV, and prevent millions of new cases of malaria.

Commissioners asked to improve health of people with learning disabilities: Clinical commissioning groups are being encouraged to sign up to a charter developed by the charity Mencap, together with the Royal College of GPs and others, to deal with health inequalities among people with learning disabilities in England (www.mencap.org.uk/CCGcharter). The pledges include ensuring that staff receive learning disability awareness training and offering annual health checks to people with a learning disability.

Dramatic increase in deaths from liver disease in Canada: Over the past eight years, the death rate from liver disease has risen by nearly 30%.[1] On 2 April, the Canadian Liver Foundation and medical experts across Canada called for a national liver disease strategy to reduce deaths from viral hepatitis, alcoholic liver disease, fatty liver disease, and liver cancer.

Potential savings to United Kingdom from more exercise is £7bn: If each adult in the UK did 12 minutes more exercise each day, the country could save £7bn in NHS treatment costs, welfare, and loss of earnings, said a report by the healthcare charity Nuffield Health and the London School of Economics. People who do not exercise have almost 80000 more hospital inpatient visits a year, it said. Currently, 70% of adults do not meet the target of 150 minutes of exercise a week.[2]

Solomon Islands struggle to manage dengue fever outbreak: An outbreak of dengue fever in the Solomon Islands has killed three people and infected at least 1700 others since an outbreak began in February, health authorities have said. Australia and New Zealand are sending a team of nine doctors, nurses, and public health experts to manage the situation with more on standby if needed.

Cite this as: *BMJ* 2013;346:f2224

Campaigners step up fight to "kill off" regulations governing commissioning

Gareth Iacobucci BMJ

Opponents of controversial regulations that will require large sections of the NHS to be tendered to the open marketplace have stepped up their fight to "kill off" the proposals, ahead of a crunch parliamentary debate and vote later this month.

The regulations, which critics say will lead to widespread privatisation and fragmentation of the NHS, will be subject to a debate and vote in the House of Lords[1] on 24 April, following a "fatal motion" laid down by Philip Hunt, deputy leader of the opposition in the House of Lords.

Ahead of the key debate, the website Open Democracy has published 15 testimonies[2] from a mix of leading doctors, campaigners, and academics, outlining why the legislation should be blocked.

The Department of Health has already been forced to redraft the regulations,[3] published under section 75 of the Health and Social Care Act, following pressure from general practitioners (GPs), royal colleges, and politicians.

But opponents of the plans maintain that the changes have not dealt with their fundamental concerns,[4] after legal advice obtained by campaigning group 38 Degrees[5] concluded that clinical commissioning groups would still be required to put all services out to tender, unless there is only one provider available to provide the service.

The BMA's general practitioners committee has also passed a vote demanding the withdrawal of the legislation,[6] while the House of Lords Secondary Legislation Scrutiny Committee has accused ministers of allowing "insufficient time" for proper scrutiny of the revised regulations.

The reactions published by Open Democracy include a passage from Hunt, who wrote: "The public will never forgive the governing parties for undermining one of the nation's most popular services. Let's hope that enough Tory and particularly Lib Dem peers understand their wider responsibility and support my motion to kill off the regulations."

Patients with prostate cancer and BRCA2 mutations need aggressive treatment

Ingrid Torjesen LONDON

Men diagnosed as having prostate cancer need to be treated quickly and aggressively with surgery or radiotherapy rather than put under active surveillance if they have inherited the BRCA2 mutation, a study has found.

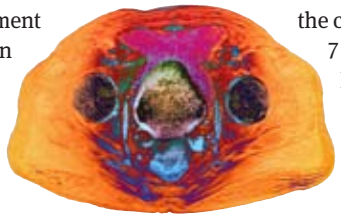
The study, published in the *Journal of Clinical Oncology* on 8 April,[1] found that prostate cancers spread more quickly and were more often fatal in men who had the BRCA2 mutation. Current NHS guidelines for prostate cancer recommend that men with localised prostate cancer should be placed under active surveillance unless their cancer is high risk.[2]

According to the study authors, their findings indicate that men with the faulty BRCA2 gene should be regarded as higher risk and offered immediate radical treatment (surgery or radiotherapy) even if their tumour is localised, because their cancer is more aggressive.

In the largest study so far to compare prostate cancer in patients with and without BRCA mutations, researchers from the Institute of Cancer Research and the Royal Marsden NHS Foundation Trust, both in London, examined the medical records of 61 carriers of the BRCA2 mutation, 18 carriers of the BRCA1 mutation, and 1940 non-carriers.

They found that men with BRCA1 or BRCA2 mutations were more likely to have been diagnosed as having advanced stage prostate cancers (stage 3 or 4) than non-carriers (37% *v* 28%, P=0.003). Men with BRCA mutations were also twice as likely to be diagnosed as having cancer that had already spread than non-carriers (18% *v* 9%, P=0.005). Prognosis was also poorer for carriers of the BRCA mutations.

Of men whose cancer was confined to the prostate at diagnosis, BRCA1 or BRCA2 mutation carriers were over three times more likely than non-carriers to have progression of the cancer within five years (23% *v* 7%; P<0.001). Patients with BRCA2 mutations also died significantly more quickly after diagnosis than non-carriers—living a median of 6.5 years (95% confidence interval 3.4 to 9.6) compared with 12.9 years for non-carriers (P<0.001).



An enlarged prostate (centre) from cancer: some men are at higher risk even if their tumour is localised, said the authors

ZEPHYR/SPL

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Also responding was Clare Gerada, chair of the Royal College of GPs, who wrote: "The new reforms, of which these regulations are a key part, remove the legal framework for a universal, publicly provided, publicly managed, publicly planned, democratically accountable health service."

John Ashton, president-elect, Faculty of Public Health, added: "Despite government denials, expert legal opinion is that the regulations, even as revised, will make it obligatory for the new market structures, the CCGs [clinical commissioning groups], to put all services including NHS hospitals out to tender in the marketplace."

Kambiz Boomla, a GP in East London, said that the regulations are likely to be "the birth of lawyer led commissioning."

Cite this as: *BMJ* 2013;346:f2168

ASADOUR GUZELIAN

Doctors Clive Peedell and David Wilson of the National Health Action Party ran from outside the headquarters of NHS England in Leeds to Sheffield on Saturday, disguised as prime minister David Cameron and deputy prime minister Nick Clegg, dressed as a poodle, to publicise this month's changes to the NHS, which they say will dismantle it and lead to increased privatisation

Psychiatrists win unfair dismissal case after being made to do out of hours work

Clare Dyer BMJ

Three consultant child psychiatrists with child care responsibilities have won an unfair dismissal case against the NHS trust that took over their services from a previous provider and tried to make them do out of hours on-call work.

Victoria Laakkonen, Sarah Taylor, and Mary Cole won their case in the Southampton employment tribunal in July 2012 and have now had their victory upheld by the employment appeal tribunal, whose judgments set precedents for other cases.

The three women had been working part time for Salisbury Health Care NHS Trust under contracts with an express term that they were not required to do out of hours work. Oxford Health NHS Foundation Trust successfully tendered to provide child and adolescent psychiatric services for three areas, including Salisbury, and became the psychiatrists' employers from April 2010.

The contract awarded to the Oxford trust required it to provide emergency and crisis care 24 hours a day, 365 days a year, and Oxford wanted all 11 consultants in the bigger area to undertake on-call duties. The women would not agree to the change in their conditions.

After carrying out a consultation, which the Southampton tribunal found was "insincere, not genuine and pre-determined," the Oxford trust served the women with three months' notice of dismissal, coupled with an offer of re-engagement on the same terms as before, except that it included a requirement to do out of hours work.

The women accepted the offer under protest and continued to work for the Oxford trust but launched a claim for unfair dismissal, supported by the BMA.

The psychiatrists' change of employer from the Salisbury trust to the Oxford trust was covered by TUPE (the Transfer of Undertakings (Protection of Employment) Regulations 2006), which gives employees the legal right to transfer to the new employer on their existing terms and conditions of employment.

The Oxford trust argued that some exceptions allowed by the regulations applied, but the Southampton tribunal held that they did not, and the appeal tribunal agreed that the dismissals were unfair.

The Southampton tribunal made an order for the psychiatrists to be reinstated on the pre-transfer terms, including the exemption from out of hours duties. It also awarded compensation for unfair dismissal, but this was set aside by the appeal tribunal.

Cite this as: *BMJ* 2013;346:f2234

Social research company threatens CHC with libel suit for its criticism

Clare Dyer BMJ

A community health council (CHC) in Wales and its volunteer chair and vice chair have been threatened with a libel action over a report it sent to the Welsh government about a consultation on proposed changes to local NHS services.

Opinion Research Services (ORS), which was commissioned by Hywel Dda health board to work on the "Your Health Your Future" consultation, has sent a solicitor's letter threatening to sue Hwyel Dda CHC, its chair, and vice chair, unless they remove allegedly defamatory statements, apologise, and pay legal costs.

Under CHC regulations for Wales, councils have the right to refer proposals they believe not to be in the interests of the health service in their district to the Welsh ministers for a final decision. The CHC used its powers to refer plans to downgrade services, including closing a hospital accident and emergency department, to the then health minister Lesley Griffiths.

Morgan LaRoche, solicitor for ORS, has accused the council of making "an attack on ORS's good faith" in the 25 page referral document and of making statements that were "not only false but seriously damaging to the reputation of ORS." Its letter alleges that the CHC's injury to its client's reputation was "deliberate or reckless 'collateral damage'" in the council's attack on the health board.

The solicitors demanded that the CHC, its chair Tony Wales, and vice chair Gabrielle Heathcote agree to remove the allegedly defamatory comments from the document, publish an apology, and pay legal costs.

"If these requirements are not met, the CHC ought to be in no doubt whatsoever that ORS will commence legal proceedings," added the letter, which asked for its demands to be met by 11 April. The CHC has taken the report down from its website.

"Members of CHCs in Wales are volunteers who give up their time to help the community," said Azeem Majeed, head of the department of primary care and public health at Imperial College London.

Cite this as: *BMJ* 2013;346:f2189

ANTHONY DEVLIN/PA

Hywell Dda CHC referred changes to health minister Lesley Griffiths (above)

CHINAFOTOPRESS/GETTY IMAGES

Pigs were suspected to be a source of infection because 16 000 were dumped in the Huangpu river, one of the main drinking water sources for Shanghai. But tests on the carcasses proved negative

Outbreak of H7N9 avian flu kills seven and infects 23 in China

Jane Parry HONG KONG

The outbreak of H7N9 avian influenza in eastern China had killed seven people and infected 23, including 12 severely, by 8 April.

Ten cases occurred in Shanghai and the remainder in three nearby provinces of Anhui, Zhejiang, and Jiangsu. One 4 year old boy in Shanghai, who was confirmed as a patient on 4 April, has since shown signs of recovering, according to a blog post on 7 April by Wu Fan, director of the Shanghai Municipal Center for Disease Control and Prevention.

There was no evidence of human to human transmission, according to Liang Wannian, director of the H7N9 influenza prevention and control office under the National Health and Family Planning Commission, speaking at a press conference in Beijing on 8 April. He told reporters that 621 close contacts of infected patients had been monitored, and none had shown signs of infection.

In addition to genetic sequencing data of the virus samples from three patients made available online by the Chinese health authorities to international researchers, the first virus sample has been shared with World Health Organization affiliated laboratories, Liang said. "We have maintained close cooperation with WHO in clinical research and epidemiology. We will boost cooperation regarding the study of the virus, including its pathological condition, infection rate, and recovery rate," state media quoted him as saying.

"No doubt the Chinese have been keeping people informed and it's also reassuring that the animal health side is coming out with information on the virus in poultry markets," said Malik Peiris, clinical virologist specialising in emerging virus disease at the animal-human interface at the University of Hong Kong's Li Ka Shing Faculty of Medicine. "There's been quite a significant number of cases, and the virus is able to cause substantial severity and mortality. I don't think there's any less cause for concern than there was [when the first cases were announced] in early April," he said.

Sales of live poultry have been suspended in Shanghai, and a cull of birds in markets where the virus has been detected has been ordered. Poultry sales in Nanjing (Jiangsu province) and Hangzhou (Zhejiang province) have also been suspended.

The Hong Kong government will begin testing live poultry imports from China on 11 April, and at the time of going to press, nine people who had travelled to the affected region had been tested for the virus on their return to Hong Kong. An outbreak of H5N1 avian influenza in 1997 killed six people in Hong Kong.

Cite this as: *BMJ* 2013;346:f2222

Healthcare professionals received £40m from drug companies last year

Gareth Iacobucci BMJ

Drug companies paid around £40m (€47m; $61m) to doctors, nurses, and other healthcare professionals in the United Kingdom in 2012 in honorariums and other fees, according to estimates from the Association of the British Pharmaceutical Industry (ABPI).

The disclosure came as the pharmaceutical industry began publishing aggregate totals of payments made to doctors and other healthcare professionals as part of a drive to improve transparency.

The payments included sponsorship for NHS staff to attend medical education events, training and development, fees for speaking engagements related to clinical practice, and participation in advisory boards.

The disclosure follows agreement by ABPI members in 2011 to amend the association's code of practice.[1] That agreement will also require ABPI member companies to disclose the number of health professionals they have worked with who have received payments.

The industry has committed itself to disclosing certain payments made to healthcare professionals at an individual level across Europe by 2016, for payments made in 2015 onwards. The association said that the move would help satisfy "the high expectations of stakeholders for increased transparency."

A consultation[2] on how individual disclosures could be achieved is currently being carried out with all parties by the Ethical Standards in Health and Life Sciences Group, a partnership between industry, royal colleges, and professional organisations. Publication of aggregate figures represented "a first, important step" in the process, the ABPI said.

Stephen Whitehead, ABPI chief executive, said: "Working closely with healthcare professionals has helped the industry to consult with, and listen to, clinical expertise and develop medicines which are in the best interest of patients.

"Full transparency about these relationships is right and appropriate and we have taken the lead to make this a reality. By publishing these figures, [the] industry's aim is to ensure these vital relationships are open and transparent."

He added: "These figures also show another way in which the pharmaceutical industry adds value to the NHS by supporting training and development and medical education. This support is particularly important at a time when NHS budgets are under increasing pressure."

Cite this as: *BMJ* 2013;346:f2201