NEWS

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Israeli forces attack medical facilities in Gaza and destroy brand new hospital

Watchdog rules advert that attacked plain packaging was misleading

Adrian O'Dowd LONDON

The Advertising Standards Authority has ruled against a large tobacco firm over an advertisement that it ran last year about standardised packaging of tobacco products.

The authority issued a ruling[1] on 30 July that an advertisement run by Gallaher, the UK trading company of Japan Tobacco International, which opposed the introduction of standardised packaging of tobacco products, was misleading and must not be published again.

Anti-tobacco campaigners and charities welcomed the ruling, saying that the advertisement in question was part of a campaign that was "one of the most blatantly dishonest in recent UK advertising history." Gallaher, however, said that it disagreed strongly with the authority's decision and had submitted a formal request to Hayden Phillips, the independent reviewer of the authority's adjudications, for the decision to be reconsidered.

The company ran a series of six advertisements as part of a £2m campaign launched in 2012 against standardised tobacco packaging. All six have now been ruled misleading.

The advertisement involved in this week's ruling, which ran in April 2013, included a reproduction of an email from the UK Department of Health to the Australian Department of Health and Ageing. The email featured text from a civil servant inquiring about the evidence on standard packaging in Australia and mentioned the UK government's plan to introduce such packaging. The text said, "As I'm sure you are aware, one of the difficulties regarding this is that nobody has done this and therefore there isn't any hard evidence to show that it works." In the Gallaher advertisement, the words "there isn't any hard evidence to show that it works" were highlighted, followed by the words "WE COULDN'T HAVE PUT IT BETTER OURSELVES."

In its ruling, the authority said that the advertisement did not make clear its claim that no evidence existed to support the introduction of plain packaging in 2011 or that it was not referring to the present time. The advertisement was "likely to mislead and should not be published again," said the authority.

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Two doctors die from Ebola and lives of others are under threat

Ingrid Torjesen LONDON

The risks to doctors caring for patients in the outbreak of Ebola virus disease in west Africa became increasingly apparent this week when it was confirmed that a second doctor had died from the virus in a month and at least two others were infected.

The World Medical Association has warned that poor care practices were putting doctors' lives at risk in what has become the world's worst recorded outbreak of the disease. Reports have also emerged that doctors and officials trying to get to some villages in affected areas have been threatened by frightened local people doing all they can to keep outsiders and potential carriers of the virus out. Some communities are blaming aid agencies for spreading the virus and turning to traditional medicine rather than sending people with suspected cases to official Ebola clinics.[1]

The present outbreak began in Guinea in February and spread to neighbouring Liberia and Sierra Leone. As at 23 July at least 1200 people were believed to have been infected, 672 of whom had died, show figures from the World Health Organization.

Last weekend Samuel Brisbane, a Liberian doctor, died from the disease. Brisbane, who had once been a medical adviser to the former Liberian president, Charles Taylor, worked at the country's largest hospital, the John F Kennedy Memorial Medical Center in the capital, Monrovia. His death came just days after it was announced that Sheik Umar Khan, a leading Ebola doctor in Sierra Leone, had been infected. In early July Samuel Mutoro, a senior doctor from Uganda, died after treating infected patients in Liberia.

A US doctor working with Ebola patients in Liberia has also tested positive for the disease. Kent Brantly, a family doctor from Texas was working as medical director at an Ebola case management centre run by Samaritan's Purse, a Christian charity. He recognised his own symptoms and confined himself to an isolation ward. Another US citizen working at the same centre with Brantly has also been infected.

The World Medical Association has warned that the working conditions of many health professionals, especially junior doctors, caring for patients with Ebola virus disease are inadequate. Nivio Moreira, who chairs the association's Junior Doctors Network, said, "We are appalled by reports that many junior doctors are not provided with protective equipment essential for dealing with such a deadly disease.

"We are also concerned about reports of unsupervised junior staff in the current Ebola outbreak, which needs high level of expertise to support the junior staff."

Margaret Mungherea, the association's president, said, "Governments have a responsibility to ensure that health workers are trained and provided with a safe workplace and protective gear."

The virus kills up to 90% of those infected, but the chance of survival is higher if patients are treated early.

A spokeswoman for Médecins Sans Frontières said that around 70% of patients who had been treated in the organisation's isolation wards since March had survived.

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AHMED JALLANZO/EPA/ALAMY

Liberian health workers protect themselves from infection as they prepare to dispose of the body of a woman who died of Ebola disease

IN BRIEF

Paracetamol is no better than placebo for low back pain: A study of 1652 people with acute low back pain who received as much as four weeks of treatment with paracetamol or placebo found that those on paracetamol recovered no more quickly than those on placebo.[1] Paracetamol did not improve pain levels, function, sleep, or quality of life, the study showed.

Bill for the right to die at home: Norman Warner, a backbench Labour peer and a former health minister, has introduced a private member's bill in the House of Lords to give people the right to choose to die at home. The bill enables people to ask their GP to register in their medical records that they wish to die at home, or the place they regard as home, and gives the health secretary the power to produce regulations to achieve this.

Diageo advertisement for rum is banned: The drinks company Diageo has been told by the Advertising Standards Authority that its social media advertisement for Captain Morgan rum breaches responsible advertising regulations and must be removed. The advertisement shows Captain Morgan raising a glass alongside text stating, "Wednesday. I'm declaring war on midweek boredom." The complaint focused on the suggestion that alcohol could overcome boredom, contrary to the advertising rules.

Bumping fists is more hygienic than a handshake: Bumping fists may be a more hygienic greeting than shaking hands, a study at Aberystwyth University has found.[2] Using rubber gloves and a thick layer of *E coli,* scientists exchanged handshakes, high fives, and fist bumps, and results showed that the transfer of bacteria was highest during a handshake. Germ transfer was reduced by more than half in the high five and by 90% when bumping fists.

Agency is cleared to continue policy of antibiotics in animal feed: A federal appeal court ruling has allowed the US Food and Drug Administration to continue its policy of allowing antibiotic use in animal feed. The ruling overturned a lawsuit filed by five watchdog organisations to force the FDA to tackle antibiotic use for non-sick livestock. The US Centers for Disease Control and Prevention issued a warning in 2013 about rising antibiotic resistance.

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DAVID K HOFFMAN/ALAMY

A&Es appear to be missing targets because they have exhausted potential productivity fixes

Longer A&E waits are inevitable as services hit capacity, report warns

Nigel Hawkes LONDON

Most reasons given for the declining performance of emergency departments in England's hospitals are wrong, or at best explain only part of the problem, a new analysis from the Health Foundation and the Nuffield Trust has found.[1]

Soaring attendances, ageing patients with complex problems, poor access to GP services, and winter weather are usually blamed for hospitals missing the four hour accident and emergency (A&E) target. But the new report found that attendances at major A&E units, where long waits are likely to be more serious, had increased only in line with population growth; the "soaring" figures were accounted for by emergency units dealing with less critical cases.

The proportion of older people attending A&E departments has increased, but this accounted for only 11% of the decline in performance against the target, while cold winter weather in 2012-13 accounted for only 19% of the decline. The study found no evidence of any increase in patients with more than one long term condition or of poor access to GP services associated with achieving the four hour target—although this was associated with increased A&E attendances.

The report found that the key element was occupancy—that is, the number of patients in an A&E department at any given time. While attendances rose by only 3% from 2010-11 to 2012-13, occupancy rose by 8%. And higher occupancy, or crowding, is associated with longer waiting times, a greater chance of missed targets, and poorer quality of care.

So, the report has found that A&E departments have become busier at a rate that cannot be wholly accounted for by additional patients coming in. One possibility is that slowly rising attendances over the past decade have been accommodated by improved use of existing capacity but that this has reached a ceiling. Over the same period capacity declined slightly, but demand was met by better productivity. If this explanation is true, the reason for missed targets is that A&E departments have run out of productivity fixes; they have no other ways to improve their performance.

If capacity had risen in line with attendances from 2003-04 to 2012-13, the NHS in England would have gained an additional 25 major A&E units. That gives an idea of the scale of the productivity gains, as well as the possible investment needed if increasing capacity is seen as the only way to maintain existing targets.

Given the squeeze on cash and the difficulties of recruiting A&E staff, such an investment boom seems unlikely. The alternatives are to reduce demand, although there is little evidence that any interventions can do so in the timescale needed; or to divert patients to community or minor A&E services, although experience has shown that such units simply tap into new demand that would not otherwise have entered the system at all. A much simpler possibility would be to abandon the four hour target, the report noted. It said that the choice, therefore, was between options that were unaffordable, unachievable, or unpalatable.

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End "perverse" payment system that penalises emergency departments, says college

Zosia Kmietowicz THE BMJ

Two bodies that represent the interests of patients who need emergency care have called for an end to what they have called the "perverse" incentives that penalise hospital emergency departments that host "front end" primary care teams.

The College of Emergency Medicine and Urgent Health UK, the federation of social enterprises that provide unscheduled primary care, have said that the NHS tariff system is stifling innovation in this area. They said that the way the tariff was set for emergency care meant that emergency departments were a drain on hospital finances and that hospitals had to subsidise these services by doing more elective work.

A college spokesman said that this financial drain made co-location with primary care teams more of a challenge, because there was less money for innovation. "The challenge here is to get the tariff to fairly recognise the work under-

GP commissioners underspend on mental health, claims Labour

Adrian O'Dowd LONDON

The Labour Party has criticised commissioning GPs in England for underfunding mental health services in their areas. Representatives of commissioning groups, however, have said that many of the groups have made mental health a priority and are trying to ensure it has equal consideration with physical health needs.

Labour's shadow public health minister, Luciana Berger, released figures on 25 July received from 142 of England's 211 clinical commissioning groups (a 67% response rate) after a freedom of information request. The figures show that commissioning groups spent an average of 10% of their annual budget on mental health services in 2013-14, despite research showing it accounts for 23% of the burden of disease.

Labour said the figures showed that even parts of the country where high numbers of patients had a known mental health condition spent below the 10% average. Spending on mental health varied from Surrey Heath Clinical Commissioning Group's £7m, 6.6% of its total budget, to £62m in West London, or 18%.

Despite official figures from Public Health England showing that Merton CCG in southwest London had the highest proportion of its population with a common mental health disorder (31%),[1] it spent just short of the national average on mental health services last year, said Labour. Similarly, NHS Northern, Eastern And Western Devon CCG, allocated only 6.7% of its budget to mental health, despite an above average proportion of the local population needing such treatment.

Berger said, "Mental health should be treated no differently to physical health. But vulnerable people face this alarming postcode lottery. People with mental illness shouldn't have to expect different standards of care simply because of where they live."

Simon Wessely, president of the Royal College of Psychiatrists, said, "Although many CCGs are certainly getting it right, there are those who need to urgently reconsider whether they are giving mental health parity of esteem with physical health," he said.

JONATHAN GOLDBERG/REX

Mental health accounts for 23% of disease burden but gets just 10% of the funds, says Luciana Berger

Phil Moore, chair of the mental health commissioners network at NHS Clinical Commissioners, the representative body for CCGs, told *The BMJ*, "Many CCGs have made mental health a priority commissioning area and are working hard to address the historical issues around levels and variation of spend. It is not simply how much is spent compared with the burden of mental health illness but equally about how effectively the money is spent."

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Surgery for menorrhagia varies widely in England and Wales, audit finds

Anna Sayburn LONDON

An audit of hospital care for women with heavy menstrual bleeding found wide variation in treatment, with 60% of women having surgery in some trusts compared with 20% in others.[1]

The audit was carried out from 2010 to 2014 in NHS hospitals in England and Wales. It covered referral patterns, protocols for management, and what happened in practice and an audit of patient reported outcomes of 8000 women.[2] Both exercises were repeated a year later.

The study found improvements between the first and second organisational audit, although only half of NHS hospitals had written protocols or care pathways. The audit of patient reported outcomes found a high level of satisfaction with treatment: 90% of women rated their care as good, very good, or excellent. Most women said that their quality of life had improved significantly one year after their first appointment.

Women who underwent surgery were most likely to have seen a big improvement in quality of life. On a scale of 1 to 100, women who had surgery rated their quality of life at 80 one year after the first appointment, while those who had no treatment in secondary care rated it at 65 and those who had drug treatment or had an intrauterine system fitted rated it at 67.

Women from non-white ethnic minority groups were 25% less likely than white women to have had surgery and a third more likely to have had no hospital treatment. They also reported less improvement in symptoms or quality of life, with an average score of 58 out of 100 after a year, compared with 72 for white women.

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taken across the piece and remove the cross subsidisation," he said.

The system for recording activity in emergency departments was also unduly complex, said the college, with the consequence that much data went unrecorded.

The "marginal tariff," under which hospitals are paid only 30% of the payment rate for emergency admissions above expected activity,[1] also meant that hospitals were not properly remunerated for emergency admissions even though the population is ageing and demand is rising, said the college.

Clifford Mann: progress is stifled

The organisations are writing jointly to the chief executive of Monitor, David Bennett, its chief financial officer, Paul Baumann, and the chief inspector of general practice at the Care Quality Commission, Steve Field, calling for the tariffs to be changed.

Clifford Mann, president of the College of Emergency Medicine, said, "The co-location of primary care services with emergency departments is part of the solution to deal with the growing numbers of patients who are presenting to A&E [accident and emergency departments]. Progress is being hampered by financial barriers in the system which can and should be removed. This is just one area of a tariff system that penalises emergency departments. The tariff system needs reform. The college, in our document, has been promoting change in the tariff system over the past year."

Simon Abrams, chair of Urgent Health UK, said, "It is vital that the tariff system is reformed in order to resolve this concerning issue and ease the pressure on A&E departments. We are keen to, in partnership with the College of Emergency Medicine, offer our continued assistance to health leaders and regulators to ensure progress is made as soon as possible."

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Charles Alessi
Change through motivation

PETER LOCKE

CHARLES ALESSI, a GP in southwest London who is 60 this year, is chairman of the National Association of Primary Care and one of the godfathers of GP led commissioning. As a defender of the selective role of competition in the NHS—the alternative, he says, is "equitable mediocrity and stagnation"—he has been a robust and energetic standard bearer, always willing to argue the case. He is a senior adviser to Public Health England and interim chairman of NHS Clinical Commissioners, the membership organisation for clinical commissioning groups.

What was the worst mistake in your career?

"Thinking that I could achieve change purely through argument and conviction. Change is about having the critical mass to get traction, and it's also about finding the sweet spot that motivates even the recalcitrant to consider altering their behaviour"

What was your earliest ambition?
To make things happen. I have always been one to think through how things could be better and have then taken it upon myself to help make the required changes.

Who has been your biggest inspiration?
My father. He was a GP, and he taught me that to achieve change you had to motivate people, and this was how I tried to manage my clinical practice.

What was the worst mistake in your career?
Thinking that I could achieve change purely through argument and conviction. You need more. Change is about having the critical mass to get traction, and it's also about finding the sweet spot that motivates even the recalcitrant to consider altering their behaviour.

What was your best career move?
Becoming a GP and working in the community.

If you were given £1m what would you spend it on?
On a damn good holiday, and a party to celebrate all that we have achieved in primary care.

Where are or were you happiest?
I am happiest now. Actually feeling that we can make a difference together, and seeing change unfold, is very powerful.

Who is the person you would most like to thank, and why?
The ward clerk in the hospital where I was a houseman. Jess was extraordinary; she genuinely cared for the people on the ward. She taught me that patients were more than the substrate for diseases.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
Both Bevan and Lansley have been notable in different ways: Bevan for his vision and Lansley for his intimate and detailed knowledge of the system. The worst? The whole succession of people who thought that healthcare and the NHS were all about hospitals, and that primary care was at best a distraction and at worst an irritation.

To whom would you most like to apologise?
To all the patients I didn't help as much as I would have liked to, and to those for whom I wasn't there when they needed help—and there were many.

What single unheralded change has made the most difference in your field in your lifetime?
Discovering that it is indeed possible to change our relationship with patients to one of genuine partnership. In primary care that partnership is very deep, and it lasts for decades. This is really what makes British primary care what it is—the envy of the world.

Do you believe in doctor assisted suicide?
I worry. The options are a free for all, or such an over-regulated service that most people would lose the will to live—only this time it would be the doctors who were contemplating suicide.

What book should every doctor read?
2030: The Future of Medicine, by Richard Barker. It really is a glimpse into the day after tomorrow.

What poem, song, or passage of prose would you like mourners at your funeral to hear?
I love all opera, especially Wagner's. Hence I suppose that the end of act 3 of *Die Walküre*, when Brünnhilde is put into suspended animation, would be just right.

What is your guiltiest pleasure?
My yearly trip to Bayreuth, Germany, where I immerse myself for a week in Wagner's operas.

If you could be invisible for a day what would you do?
Spend it with the editors of the BBC's *Today* programme.

What is your most treasured possession?
A book I have read many times—*The Yogi and the Commissar* by Arthur Koestler, a writer and philosopher in the 1930s. He described two ways of influencing people: one using a commissar, who whips people into submission; and the other using a yogi, who finds ways for people to make the right decision.

What personal ambition do you still have?
To achieve more change and help the NHS in its journey from dealing with structures to dealing with people.

Summarise your personality in three words
Passion. Fun. Passion.

Where does alcohol fit into your life?
There is a U-shaped association between alcohol and dementia prevention, so when I do take my single glass of wine I make damn sure it's a good glass of claret.

What is your pet hate?
Not achieving, and seeing the (healthcare) system concentrate on pseudo assurance that tells you very little about the systems you're trying to assess.

What would be on the menu for your last supper?
Good sourdough bread and a risotto with truffles.

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