LETTERS

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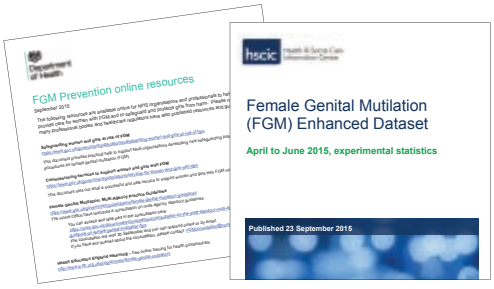

FGM ENHANCED DATA COLLECTION

Mandatory submission of patient data to third parties: FGM now, what next?

The government has done much to tackle female genital mutilation (FGM),[1-3] but the planned rollout of FGM Enhanced Data Collection across the NHS in October 2015 is ill considered. All healthcare professionals will be legally obliged to submit highly sensitive, patient identifiable information on every woman with FGM attending the NHS for whatever reason. A woeful consultation preceded the ministerial direction, which also says patient consent is not needed. While stating that confidential data will not be released to third parties (such as police, Crown Prosecution Service), the reassurance is inadequate and not future proofed.[4-6] The legal responsibility for communicating that this information will be collected, where it will be sent, and what may happen to it is devolved to frontline clinicians.[7 8] The push to implement an electronic infrastructure and opt-out that is not fit for purpose will bring already compromised patient confidence closer to breaking point.[9 10] The initiative has no evidence of benefit, wastes precious clinical time, and will profoundly damage trust in health professionals who will either collude or ignore the imperative.

Correspondence with the minister of public health and civil servants remains unanswered. The Department of Health seems wilfully unaware of the wider ramifications of breaching confidentiality and the impact on the human and healthcare rights of already disadvantaged women and their families. Rather than tackling FGM, this measure is likely to be counterproductive and hinder eradication strategies.

Confidentiality is not absolute, but it underpins the doctor-patient relationship.[11] Without reiterating countervailing ethical and professional duties, the GMC recently emailed all doctors about their obligation to breach confidentiality if the government has made a law compelling them to do so.[12] But such law is unnecessary and misguided. The government still has time to reflect and pull back from a policy that wrecks the basic medical promise of confidentiality.

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Full response at: www.bmj.com/content/350/bmj.h1467/rr.

1 O'Dowd A. Improve reporting of female genital mutilation, MPs tell doctors. *BMJ* 2015;350:h1467. (18 March.)

Cite this as: *BMJ* 2015;351:h5146

MINIMUM UNIT PRICE FOR ALCOHOL

Minimum unit pricing: better late than never

Now that the advocate general of the EU has given his opinion on minimum unit pricing, the case is expected to return to the Scottish courts, where the issue of whether the policy is "appropriate" and "superior to alternative measures such as increased taxation" will be further debated.[1] We welcome this as an opportunity for new evidence to be considered.

Minimum pricing was passed as legislation in Scotland in 2012 when alcohol related deaths had been falling for a decade, albeit from very high levels. However, we have since seen a worrying increase in the number of people in Scotland dying as a result of alcohol.[2] This coincides with the decline in population consumption halting, driven by more alcohol being sold through supermarkets and other off-licences in 2014 than in recent years.[3]

Several factors might explain these trends. Disposable incomes in Scotland have recently increased as a result of the recovery from recession, and alcohol duty changes have helped to keep the price of some alcohol low. In fact, the average price of alcohol sold through off-sales was the same in 2014 as in 2013, the first time that there hasn't been an annual increase since 2007.[3] Although we can't attribute any changes specifically to these factors, there is good evidence that alcohol affordability—a combination of income and alcohol price—is one of the strongest drivers of alcohol consumption and related harms.[4] Minimum unit pricing would offer an evidence based policy that would make the cheapest alcohol less affordable, reduce harmful levels of consumption, and provide the context to ensure that these worrying trends are only temporary.

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1 Christie B. Alcohol campaigners welcome preliminary opinion from European Court of Justice. *BMJ* 2015;351:h4756. (4 September.)

Cite this as: *BMJ* 2015;351:h5127

UK ACADEMIC GENERAL PRACTICE

Plymouth medical school aims at producing GPs of the future

Retired GP leader Pereira Gray snipes at medical schools in general and his local universities in particular.[1 2] He might better direct his attention to those who have driven primary care into chaos and made it a less popular choice for trainees.

Had he asked before firing his broadsides we could have told him that our undergraduate medical curriculum addresses general practice from a variety of angles, with community placements from years 1 to 5. GPs are very much involved in core teaching—facilitating problem based learning groups and reflective groups (including reflection on GP placement experiences). They also act as academic tutors, clinical skills assessors, and examiners. The final year programme specifically includes areas on management and change management from a primary care perspective. There is a GP society for students interested in general practice

He complains: "Some medical schools send students into general practices, without teaching the theory of general practice and leave GP teachers without a GP-curriculum and not knowing what has been covered previously."[2] All our tutors (including primary care tutors) attend regular training to ensure that student learning is spiral and that tutors know what has previously been covered, details of the curriculum, and what to expect from a specific year group.

"The two newest UK Medical Schools—Exeter and Plymouth—do not even give their students a general practice reading list."[1] In fact our students receive a study guide and online materials including a reading list.

Our medical school is completely committed to supporting primary care and producing the GPs of the future.

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1 Pereira Gray D. Research and teaching in general practice/primary care. *BMJ* 2015;351:h4737. (8 September.)

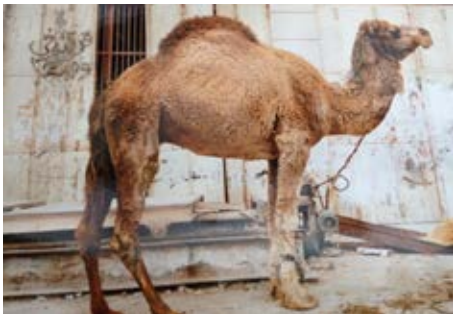
Cite this as: *BMJ* 2015;351:h5130

MERS-CoV AND THE HAJJ

MERS-CoV in pilgrims returning from the Hajj

Last month around two million international pilgrims travelled to Mecca in Saudi Arabia to join in the annual Islamic Hajj pilgrimage before returning home to their countries of origin. Crowded close human and animal contact has caused previous communicable disease outbreaks.[1] Coronaviruses[2] such as Middle East respiratory syndrome coronavirus (MERS-CoV), which causes Middle East respiratory syndrome (MERS), have resulted in nosocomial outbreaks characterised by early nosocomial super-spreading events and transmission patterns involving healthcare workers. This poses great clinical concern as a potential cause of epidemics and threat to global health.

In Saudi Arabia, 1231 MERS-CoV infections have resulted in 521 deaths and onward transmission to 21 countries.[3-6] The initial infection causes an upper respiratory tract illness with an incubation period of 14 days and an average case fatality around 35%. Delayed diagnosis in a South Korean traveller infected with MERS-CoV in Saudi Arabia recently caused the largest outbreak of MERS outside Saudi Arabia, with onward transmission of 186 infections, resulting in 36 deaths and an estimated socioeconomic impact of up to $10bn (£6.6bn; €8.94bn).[7-9]



GAIL BECKETT

MERS: associated with the dromedary (Arabian camel)

PHE case definition—possible case of Middle East respiratory syndrome coronavirus (MERS-CoV)*

Any person with severe acute respiratory infection needing admission to hospital with symptoms of fever (≥38°C), or history of fever, and cough

AND

With evidence of pulmonary parenchymal disease (such as clinical or radiological evidence of pneumonia or acute respiratory distress syndrome (ARDS))

AND

Not explained by any other infection or cause

AND at least one of

History of travel to, or residence in an area where infection with MERS-CoV could have been acquired in the 14 days before symptom onset†

OR

Close contact during the 14 days before onset of illness with a confirmed case of MERS-CoV infection while the patient was symptomatic

OR

Healthcare worker based in intensive care unit (ICU) caring for patients with severe acute respiratory infection, regardless of history of travel or use of personal protective equipment

OR

Part of a cluster of two or more epidemiologically linked cases within a two week period requiring ICU admission, regardless of history of travel

*www.gov.uk/government/uploads/system/uploads/attachment_data/file/461192/MERS-COV_RA_sep_2015_final.pdf

†This definition includes all countries within the geographical Arabian Peninsula, plus countries with cases that cannot be conclusively linked to travel; as of 16 September 2015: Bahrain, Jordan, Iraq, Iran, Kingdom of Saudi Arabia, Kuwait, Oman, Qatar, United Arab Emirates, Yemen, and South Korea.

Awareness of MERS in healthcare workers remains low. Yet the risk of returning Hajj pilgrims contracting and spreading MERS-CoV from Saudi Arabia is high.[10] To help to identify cases and stop similar preventable tragic outbreaks, Public Health England has issued a warning to be aware of MERS in Hajj travellers, as well as full guidance on the samples required, diagnostics, management, and reporting of suspected and confirmed cases.[11 12]

MERS-CoV should be considered in any patient presenting to frontline medical services with a flu-like illness or pneumonia who has travelled within 14 days before symptom onset to any high risk countries, including in the Arabian peninsula; a risk assessment is required using the PHE case definition for possible MERS-CoV (box). There is no specific treatment of or vaccine against MERS-CoV but patients can recover with early supportive care.[13]

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Full response at: www.bmj.com/content/346/bmj.f1301/rr.

2 Pebody R, Zambon M, Watson JM. Novel coronavirus: how much of a threat? *BMJ* 2013;346:f1301.

Cite this as: *BMJ* 2015;351:h5185

PUBLISHERS' FEES FOR SCORING SYSTEMS

Fees for reproducing tables in journal articles are exorbitant

Publishers' charging for reproducing scoring systems is indeed a growing problem in medical publishing that is anti-scientific and not in the best interests of patients.[1] Medical students, physicians, and other health professionals should not have to pay a licensing fee to obtain a simple question and answer screening test such as the mini-mental state examination, or pay for each test administered using a mobile application.[2] Many patients will risk going unscreened and unidentified, and perhaps not receive the interventions that they should.

But the problem is worse, because it extends beyond scoring systems. I am editor of *American Family Physician*, which publishes clinical review articles. Such articles often incorporate tables and figures from other journal articles. Permission fees have become exorbitant. One table had 40 words, and the permission fee requested was $4400 (£2893; €3913)—more than $100 per word. One journal wanted almost $5000 for a table of drug treatment that largely consisted of product labelling information (public domain information).

This practice seems to be driven totally by profit motives and goes against the dissemination of medical knowledge designed to help patients.

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1 Farne H. Publishers' charges for scoring systems may change clinical practice. *BMJ* 2015;351:h4325. (12 August.)

Cite this as: *BMJ* 2015;351:h5128