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# People exposed to H5N1 in English turkey outbreak get antivirals and vaccination

**Susan Mayor** LONDON

All people potentially exposed to H5N1 avian influenza in an outbreak in turkeys at a farm in England have been offered antiviral prophylaxis and seasonal flu vaccination to reduce their risk of infection and were told to see their GP if they get symptoms.

Almost 160 000 turkeys have been killed, and movement restrictions have been introduced at a large turkey farm in Suffolk, in eastern England, after some birds were found to be infected with the H5N1 strain.

Maria Zambon, from the Health Protection Agency, a special health authority providing public health advice to the NHS, said farm workers who had come into contact with infected birds and people involved in the culling process were being offered the antiviral drug oseltamivir (Tamiflu) as a precaution. But she stressed that nobody had developed symptoms of bird flu after similar outbreaks in farm birds in continental Europe.

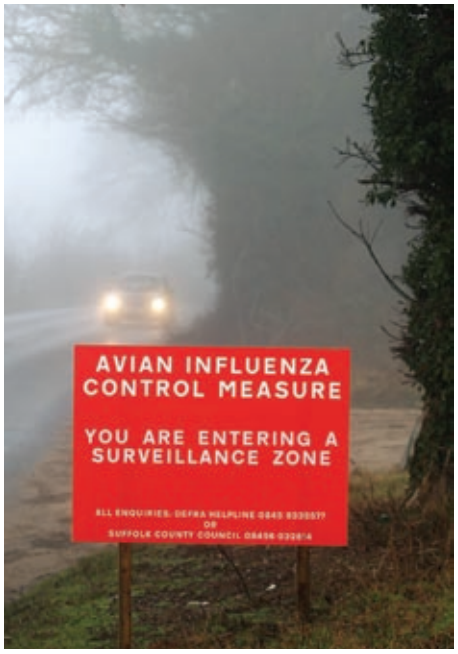
In a statement, the Health Protection Agency said, "Despite this incident the current level of risk to humans from H5N1 remains extremely low. None the less, any possibility of exposure is taken very seriously, and the Health Protection Agency has worked closely with DEFRA [the Department for Environment, Food, and Rural Affairs] and local NHS partners to ensure that all the necessary actions are being taken to protect those people who may have been exposed to the virus.

"These actions include the offering of antiviral drugs and seasonal influenza vaccine where appropriate to people who have been in close contact with the infected poultry."

The Suffolk office of the Norfolk, Suffolk, and Cambridgeshire Health Protection Unit has been providing antiviral prophylaxis and seasonal flu vaccination to people potentially exposed through working in the infected premises. The virus has so far been detected in only one shed out of 22 at the turkey farm, and 100 of the 2000 staff who work there have been given oseltamivir.

The poultry workers have been asked to contact their GP if they experience fever or respiratory symptoms. In a letter from the Health Protection Agency, GPs have been told to assess patients according to an avian influenza flow chart on the agency's website (www.hpa.org.uk).

GPs have been told to reassure and monitor people who have had direct contact with the affected poultry farm but who do not fit the criteria for avian influenza. The "worried well," who are concerned but who have had no contact with the farm, should be reassured and told to contact NHS Direct, a telephone helpline, for more advice.




MAX NASH/AP/EMPICS

The avian flu virus is known to have killed 164 people worldwide—mainly in South East Asia—since 2003. All the people who contracted the virus had come into close contact with infected birds.

The H5N1 virus is most likely to acquire the ability to pass easily from human to human if it mixes with a standard influenza virus and transfers genetic material. To minimise this risk, the Department of Health announced earlier this year that it would offer seasonal flu vaccine to poultry workers throughout England. The theory is that if poultry workers are kept free of normal flu, then even in the highly unlikely event that they were infected with H5N1, the bird flu virus would not come into contact with seasonal flu virus.

**(See Analysis, p 293 and "US expert warns interdependence of countries makes world more vulnerable to flu pandemic" in News Extra bmj.com)**

ARS

## Guidance sent to GPs was "useless"

**Susan Mayor** LONDON

GPs near the outbreak of H5N1 avian influenza at a turkey farm in Suffolk, in the east of England, have found the information they have been sent on how to deal with people presenting with symptoms "useless."

In a letter sent to GPs in the area last Monday, the Health Protection Agency (HPA) explained that all the people potentially exposed to H5N1 in the outbreak had "been requested to contact their GP in the event that they experience fever and/or respiratory symptoms."

The letter told GPs to assess patients according to a flow chart on the agency's website (www.hpa.org.uk).

The flow chart advises that a patient meeting certain criteria should ideally be seen in their home, and both GP and patient should wear a surgical mask.

Ian Hume, a GP in Diss, Norfolk, and chairman of the local medical committee, who had difficulty in finding the flow chart, said, "This is useless. Practices generally ask patients to come into the surgery. I would be jolly miffed if by the time I realised that a patient fitted the criteria [for possibly being infected with H5N1] they had been sitting in front of me in the surgery for some time." He added that GPs had no surgical masks. "And we have no idea where Tamiflu would come from."

# Halt to microbicide trial sets back AIDS research

**Peter Moszynski** LONDON

Two phase III clinical trials of cellulose sulphate—a topical microbicide gel being tested for HIV prevention in women—have been halted because preliminary results showed that the compound increased rather than reduced the risk of HIV infection.

The microbicide, a cotton based compound developed under the brand name Ushercell by Polydex Pharmaceuticals, based in Toronto, had shown initial promise and was being tested on 1333 women in South Africa, Benin, Uganda, and India. The study was sponsored by Conrad, a partnership of the Eastern Virginia Medical School and the US Agency for International Development, with funding from the Bill and Melinda Gates Foundation.

Simultaneously, Family Health International halted a second phase III trial of Ushercell on 1800 women in Nigeria. Although this study did not detect an increased HIV risk associated with cellulose sulphate, the decision was made as a precautionary measure, given the preliminary results in the Conrad trial.

Tim Farley, head of microbicide research at the World Health Organization, told the *BMJ* that preliminary data from the Ushercell trials may be released next month, but he emphasised that no one had died as a result of the studies.

Separate phase III trials of three other microbicidal candidates are continuing unaffected, with the first results expected later this year.

Researchers are still unsure why cellulose sulphate was associated with an increased risk of HIV infection. The independent data monitoring committee, an advisory group overseeing the trial, is reviewing the data in detail to understand the findings better.

GUEORGUI PINKHASSOV/MAGNUM PHOTOS

# EC gives options for reducing smoking across Europe

**Rory Watson** BRUSSELS

The European Commission has stepped up its campaign against tobacco by issuing a consultative green paper that gives possible ways to promote smoke-free environments throughout Europe.

The options range from doing nothing, through voluntary measures, to binding legislation. Markos Kyprianou, the European Union health commissioner and author of the initiative, has made clear his personal preference.

"I would like to see a comprehensive complete ban operating everywhere in Europe. This would bring the biggest benefits to society as a whole. It would be easier to enforce and control and would put everyone on the same level playing field," he said.

The commissioner, who used to smoke 60 cigarettes a day before quitting, favours a ban in public places, on buses and trains, in enclosed spaces such as bars and restaurants, and at hospitality events.

"Passive smoking kills more than 79 000 adults each year in the EU. The evidence from European countries that have comprehensive smoke-free policies is that [the policies] work, produce results, and are popular," he explained.

A recent Eurobarometer survey has found that 80% of citizens favour a smoking ban at work and in public indoor places.

All EU countries have some form of regulation to limit exposure to secondhand smoke, but these vary in scope and nature. Now, many are going further. Ireland introduced a ban at work, in bars and restaurants, and in enclosed public places in March 2004. Scotland followed two years later, and the rest of the United Kingdom will do so by this summer.

Two days after presentation of the commission's green paper, France introduced the first of a two stage move banning smoking, after action in 2005 by Italy, Malta, and Sweden. Finland and Lithuania are taking similar measures this year.

The green paper presents the health and economic costs of exposure to environmental tobacco smoke. Passive smoking at work, it says, accounted for more than 7000 deaths in the EU in 2002, and passive smoking at home accounted for a further 72 000.

**The green paper and address for submissions are available at ec.europa.eu/health/ph_determinants/life_style/Tobacco/tobacco_en.htm.**

# Doctors must stay within their competence when giving evidence

**Clare Dyer** BMJ

Doctors acting as expert witnesses in court must ensure that they stay within the limits of their professional competence, says draft guidance from the UK General Medical Council.

The guidance follows controversy over the role of the retired paediatrician Roy Meadow in giving misleading statistical evidence in the case of Sally Clark, a solicitor convicted of murdering her two baby sons and later freed on appeal.

The guidance says, "You must provide advice and evidence only within the limits of your professional competence. When giving evidence or writing reports, you must restrict your statements to areas in which you have relevant knowledge or direct experience.

"You should be aware of the standards and nature of practice at the time of the incident under proceedings. If a particular question or issue falls outside your area of expertise, you should make this clear."

The guidance, which is open for consultation until 26 March, is at https://gmc.e-consultation.net/references_expert_witnesses/index_https.asp.

# World's first public-private cord blood bank launched in UK by Richard Branson

**Susan Mayor** LONDON

Obstetricians and midwives are calling for discussions on the logistics of collecting umbilical cord blood for banking, after the launch of the world's first dual private and public cord blood stem cell bank in the United Kingdom.

The Virgin Health Bank will provide parents with the facility to store their child's umbilical cord blood in two portions—one as a private sample for the sole use of the child and his or her family and the second as a public sample, available free of charge to anyone requiring stem cell transplantation.

It is expected that about 80% of each sample will be placed in the public bank and 20% held in the private bank, although this will depend on the individual cord blood sample, stem cell expansion, and whether cells meet the regulatory requirements for the international transplantation registry.

Storage of umbilical cord blood has been growing in popularity in the past few years, with private banks being established in several countries. Umbilical cord blood is rich in stem cells, which can be used to treat patients with abnormal haematopoietic cell lines, childhood leukaemia, and a range of immune and metabolic diseases. Cord blood is cheaper and easier to obtain than bone marrow.

The Royal College of Obstetricians and Gynaecologists welcomed the public nature and the international accessibility of the Virgin Health Bank. However, it warned in a statement, "Our prime concern remains the process of collection of the cord blood and the health of mother and baby. It is imperative that the collection should not in any way compromise the attention of the carers to the delivery, and ideally the sample should be collected by a trained third party once the placenta has been delivered."

It added, "Further dialogue with the profession and involved maternity units is essential."

Maggie Blott, a consultant obstetrician at University College Hospital, London, said, "In practice, collecting cord blood is fairly straightforward. But I would hate to think that people might be concentrating on collecting cord blood and take their eye off the mother and baby."

The Royal College of Midwives warned that accountability was a key concern. Sue Jacob, a midwife and student services adviser with the college, said, "A midwife is accountable to the mother and her baby. Anything that detracts from that would not be helpful."

She said that when a woman has given birth, the midwife's primary concern must be to ensure her health and that of her baby, to ensure that bonding takes place, and to safely manage the third stage of labour.

The college reported that preliminary findings of a survey of maternity units in the UK showed that most NHS trusts do not have policies on the collection of cord blood. A spokesperson for the college said that midwives were reporting difficulties with commercial cord blood banks, feeling under pressure from women who had paid commercial banks for storage to collect cord blood after delivery.

Virgin Health Bank has appointed a team of local advisers who will work with healthcare professionals involved in maternity services.

Sir Richard Branson, owner of the Virgin Group, who set up the bank, said that any future profits from the Virgin Health Bank to the Virgin Group or to himself will be donated to charities "that are helping to fully realise the potential of cord blood stem cells."

Leroy Edozien, consultant obstetrician and gynaecologist at St Mary's Hospital, Manchester, who has a particular interest in risk management, said, "The proposal entails NHS staff collecting cord blood. This concerns me. NHS staff—both doctors and nurses—are already overstretched. To impose another burden would really increase the risk of human error and compromise patient safety."

**"I would hate to think that people might be concentrating on collecting cord blood and take their eye off the mother"**

Collecting cord blood can appear a simple procedure, but Dr Edozien warned that it entails gaining informed consent and ensuring that the sample is not contaminated and that samples are correctly labelled and not mixed up.

He asked who would train staff to collect cord blood and questioned the medicolegal situation regarding indemnity were collection to go wrong and no sample be available for storage.


IMAGEWISE

**Richard Branson said all profits would be donated to charity**

# Care of dying patients and safety dominate commission's report on NHS complaints

**Susan Mayor** LONDON

Complaints about the care of dying patients and patient safety dominate a report published last week that reviewed complaints referred to the Healthcare Commission, the NHS watchdog in England.

The report analysed 16 000 complaints sent to the commission for independent review between July 2004 and July 2006. More than half (54%) of complaints about hospitals were about care surrounding a death. In many cases, families complained that they had received contradictory or confusing information from different staff caring for a relative. In other cases, relatives felt that they were unprepared for the death or had no time to arrange for family members to be present.

Nearly one quarter (22%) of total complaints were about patient safety. One of the most serious incidents was a mix up over names leading to a child having the wrong injection.

In relation to primary care, the biggest concern was about misdiagnosis or delays in referring patients, accounting for 66% of complaints. Patients often complained that they should have been referred sooner for specialist treatment or further investigation of their symptoms.

The commission urged NHS trusts to do more to learn from patients' complaints and to handle the issues raised "quickly, efficiently and locally."

Anna Walker, the commission's chief executive, said, "Complaints represent the raw feelings of patients and the NHS must listen and learn from them. At the centre of each one is an individual who often has genuinely suffered. Too often, this was not just because of what went wrong but because of the way people were dealt with."

Thirty three per cent of complainants wanted a better explanation of what went wrong, 23% service improvements, 10% an apology, 9% the event acknowledged, 8% action against staff, and 8% for the same thing not to happen again.

**More than 50% of terminally ill patients would prefer to die at home but only 20% do so**

Gill Morgan, chief executive of the NHS Confederation, which represents most NHS trusts, said, "Over 90% of complaints are handled at a local level, so most trusts have good systems in place to respond to patients and their families quickly and appropriately."

She noted that figures from the National Council for Palliative Care showed that more than 50% of terminally ill patients would prefer to die at home but only 20% currently do so. And only 11% of people want to die in hospital, but that's where 56% spend their final hours. "It is therefore essential that the golden opportunity provided by the out of hospital white paper to improve end of life care is seized."

Lancashire Teaching Hospitals NHS Trust—one of those named in the report as a poor performer—"categorically refuted" the commission's figures. A spokesperson said, "The Healthcare Commission has inaccurately tried to portray us in a bad light at resolving such issues locally."

The commission has legal responsibility in England for reviewing complaints in which a patient is dissatisfied with the response of a trust. This happens in about 8% of the 95 000 formal complaints made each year about the NHS, which annually provides 380 million treatments. The commission deals with about 8000 unresolved complaints a year. Just under 70% of these were upheld in favour of the patient.

As a result of the findings, the commission is planning the first national audit of how NHS trusts deal with patients' concerns. It will look at good and poor practice, inspecting 50 trusts after analysing performance indicators covering all trusts in the country. Inspectors will check whether trusts give high enough priority to handling complaints and whether they learn from the issues raised. They will consider whether complaints systems are accessible and understood by people using them. If trusts are not up to standard, this will be reflected in their annual performance rating.

*Spotlight on Complaints: A Report on Second-Stage Complaints About the NHS in England* is available at www.healthcarecommission.org.uk.

**No evidence to support claims of poor training, says Peter Rubin**

# GMC to gather data on prescribing errors

**Zosia Kmietowicz** LONDON

The UK General Medical Council will fund new research into the prevalence and causes of errors in prescribing in the NHS—after media reports blamed the poor teaching of therapeutics to medical students for an apparent rise in safety incidents caused by poor prescribing.

The GMC, which sets the undergraduate curriculum in medical schools, says that no evidence supports recent claims that trainee doctors are insufficiently prepared for prescribing when they reach the wards or that they are responsible for a rise in drug safety incidents.

Peter Rubin, chairman of the GMC education committee and professor of therapeutics at the University of Nottingham, said, "Those who are claiming that new doctors are inadequately prepared had not presented evidence to support their claims. Strongly held opinions were being offered, but there was nothing to back them up."

He was commenting on an editorial published in the *BMJ* last September that claimed that medical students were "not adequately instructed" in practical drug treatment and prescribing and that the prescribing skills of newly qualified doctors were not sufficiently tested (2006;333:459-60).

# Attempt to undermine European ban on advertising drugs fails in France

**Ray Moynihan** BYRON BAY, AUSTRALIA

A controversial proposal to have drug companies' "patient compliance" programmes declared legal in France has failed.

Critics described the proposal as a backdoor attempt to introduce into France direct to consumer drug advertising, which is currently banned throughout Europe, but is legal in the Unites States, where such advertisements are common (see above).

Compliance support programmes organised by drug companies can include telephone reminders to consumers, personalised information for patients, and even home visits from nurses. The drug industry defends public health programmes as valuable for boosting adherence to treatment; others argue the programmes are marketing strategies intended to boost profits.

A recently formed advocacy group called the Medicines in Europe Forum, which comprises patients, professionals, and others, successfully lobbied French politicians last month to reject the proposal. The group claims that compliance programmes are often little more than advertising stunts, designed to build brand loyalty and "increase the quantity of drugs consumed."

The group's materials, sent to French politicians, cite examples from the business press in which compliance programmes are clearly described as a way of increasing company revenue. An article in the magazine *Pharmaceutical Executive* states, "A patient compliance strategy must be part of the DTC [direct to consumer] programme and subsequent patient information materials" (www.pharmexec.com, 1 Sep 2003, "DTC's new job: boosting compliance").

Business consultants Frost & Sullivan recently released a paper called "The evolution of patient adherence programmes: moving from mass market relationships to a personal approach." The consultants, who produce marketing intelligence, explicitly describe these programmes as part of marketing strategies, designed to build loyalty and profits. "It costs less to retain a patient than to acquire a new one," they say.

The body representing French drug companies, Les Entreprises du Médicament, argues that the programmes lead to fewer complications and help patients with long term illness.

Although the French plan to legalise company compliance programmes was defeated last month, it will debated again in the French parliament later this year.

# after criticism of doctors' training

Professor Rubin defended the council's guidance to medical schools on the teaching of clinical pharmacology. "The outcomes that we require both at the time of graduation and then when they [trainee doctors] finish their first year after qualifying on the safe and effective use of drugs are writ large," he said. "There are a number of areas where we are very clear where students and then doctors have to show that they are confident and safe at prescribing."

After a meeting at the GMC at the end of January, attended by representatives from a number of key organisations, the GMC is putting out to tender a research grant initially worth £100 000 (€151 000; $196 000) to find out more precisely the prevalence and causes of prescribing errors in the NHS among all doctors, not just juniors. Anecdotal reports indicate that prescribing errors that are seen are "of the human error rather than the knowledge error variety," said Professor Rubin—for example, the wrong dose is prescribed often because of basic errors in arithmetic. Although research into the extent of prescribing errors is ongoing, the GMC is convening a working party to produce recommendations on how to reduce human errors in prescribing, he added.

# Drug advertisements in US paint a "black and white scenario"

**Janice Hopkins Tanne** NEW YORK

An analysis of drug advertising on US television for four consecutive weeks in 2004 showed that one of the most powerful messages used by advertisers to sell their products was the idea that taking a prescription drug gives you back control over your life.

US television viewers see as many as 16 hours of advertising for prescription drugs a year, much more time than spent seeing public health messages or with their primary care doctors, said lead author Dominick Frosch, assistant professor of medicine at the University of California in Los Angeles (*Annals of Family Medicine* 2007;5:6-13).

The investigators reviewed television advertisements for prescription drugs broadcast in the evening news hour and in the prime time viewing hours of 8 to 11 pm on the four main US channels (American Broadcasting Company, CBS, NBC, and Fox) for four consecutive weeks from 30 June to 27 July 2004.

"The advertisements tend to have narrative plot lines to make prescription drugs attractive to consumers," Dr Frosch told the *BMJ*. About half of the advertisements have "before and after" scenarios.

The character is shown as having a health problem that is out of control, causing professional and social problems. Through use of the drug, he or she regains complete control. "It's a black and white scenario," Dr Frosch told the *BMJ*, "but we know from clinical trials that it's rarely that black and white."

Almost all of the advertisements "used positive emotional appeals," often by depicting a character happy after taking a product. In all, 69% of the advertisements used negative emotional appeals, such as showing a character in a fearful state before using the product. Almost a third of the advertisements used humour to appeal to viewers, the article says. Some of the advertisements used jingles to spread the message.

US television advertisements for prescription drugs promoted seven of the 10 best selling drugs in 2004.

Only about a quarter of the advertisements mentioned risk factors that might cause the problem; or lifestyle changes that could reduce a person's risk. Often the advertisements indicated that the drug would help when changes to lifestyle did not work.

## IN BRIEF

**New York bulk buys condoms:**
The New York city health department will buy more than 20 million condoms and packets of lubricant to prevent HIV/AIDS. Special packaging will allow it to track usage. The department promotes free condoms and distributes 1.5 million each month through bars, health clubs, advocacy groups, restaurants, nail salons, night clubs, and prisons.

**Italian anaesthetist wins vote of confidence:**
The Medical Board of Cremona has decided unanimously that the Italian anaesthetist Mario Riccio, who last December sedated the terminally ill patient Piergiorgio Welby and detached him from the ventilator at his own request, acted according to medical ethics (*BMJ* 2007;334:9).

**NICE sticks by its colorectal cancer guidance:**
The National Institute for Health and Clinical Excellence (NICE) has published final guidance on the treatment of metastatic colorectal cancer in England and Wales. Despite pleas from Bowel Cancer UK and Cancerbackup and an appeal by Merck, it does not recommend the use of bevacizumab for first line treatment or cetuximab after the failure of a regimen containing irinotecan chemotherapy. See www.nice.org.uk.

**Polypill goes on trial in Iran:**
A clinical trial will examine the effects of a polypill on middle aged and elderly Iranians. The study is scheduled to recruit 500 men and women without raised blood pressure or raised cholesterol concentration. The theory is that combination therapy with aspirin, antihypertensive drugs, and a statin will reduce incidence of cardiovascular disease. The polypill will contain 75 mg aspirin, 1.25 mg hydrochlorothiazide, 2.5 mg enalapril, and 10 mg atorvastatin.

**South African health professionals offered amnesty:**
The Health Professions Council of South Africa has agreed to a one-off waiver until 30 April 2007 of penalties for practitioners who failed to pay their annual registration fees on time or who were abroad and allowed their registration to lapse without informing the council. The aim is to increase the number of doctors on the register and so broaden access to health care. They will be expected to work for 100 hours in the public health service within six months of their restoration.

# Irish study shows women stop taking tamoxifen too early

**Janice Hopkins Tanne** NEW YORK

A large Irish study of women who were prescribed tamoxifen showed that 22.1% had stopped taking the drug within a year (*Cancer* 2007 Jan 27, doi: 10.1002/cncr.22486). Within 3.5 years, the number who had stopped had risen to 35.2%.

Thomas Barron and colleagues from Trinity College and St James's Hospital, Dublin, warn that the study raises concerns about patients failing to persist with oral hormonal treatments for breast cancer and oral antineoplastic agents in general.

"Five years of adjuvant tamoxifen is the recommended treatment and results in a reduction in the relative breast cancer recurrence risk of 46% and the relative risk of death of 26%," the authors wrote.

Women who receive fewer than five years of tamoxifen have significantly higher rates of recurrence and death, they say. Not adhering to treatment or, particularly, stopping it early are "likely to result in significantly worse outcomes."

About 75% of breast cancers are hormone receptor positive, and, therefore, the women are candidates for treatment with tamoxifen or other hormonal agents.

Using the pharmacy database of the Irish Health Service's Executive Primary Care Reimbursement Service, the investigators identified all women older than 35 years who began taking tamoxifen between January 2001 and January 2004. The service provides free health care, including prescription drugs, to 1.15 million people, about a third of the total population.

Of the study cohort of 2816 women, 16.7% were lost to follow-up (because of death, loss of eligibility for the health insurance, and other factors). Another 25.4% stopped tamoxifen and switched to a different hormonal treatment within 180 days. About 26% were "considered non-persistent with therapy" because they either stopped tamoxifen and did not take another hormonal therapy until after 180 days; or stopped tamoxifen for at least 180 days before restarting it; or stopped it entirely, without restarting it or changing to another hormonal therapy. Only 31.4% persisted with tamoxifen to the end of follow-up at 3.5 years.

"This is the largest study of tamoxifen persistence to date … The results demonstrate that persistence with tamoxifen in clinical practice is lower than previously reported."

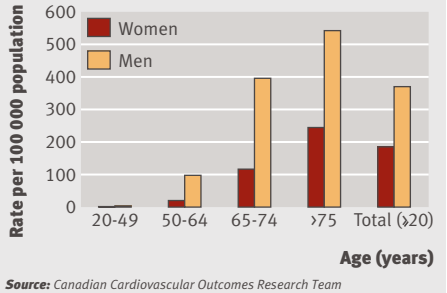
# Gender gap persists in treatment of Canadians after heart attack and stroke

**David Spurgeon** QUEBEC

A Canadian woman's risk of dying within the first 30 days after a heart attack is 16% higher than a man's, and after a stroke it is 11% higher, even after taking into account age and other health conditions, the Canadian Heart and Stroke Foundation's annual report on Canadians' health said this week.

The reasons for this are unclear, but compared with men, women are less likely to be treated by a specialist; less likely to be transferred to another facility for treatment; and less likely to have cardiac catheterisation or revascularisation, says the report.

**PERCUTANEOUS CORONARY INTERVENTION (ANGIOPLASTY) IN CANADA, 1997-8 TO 2000-1**

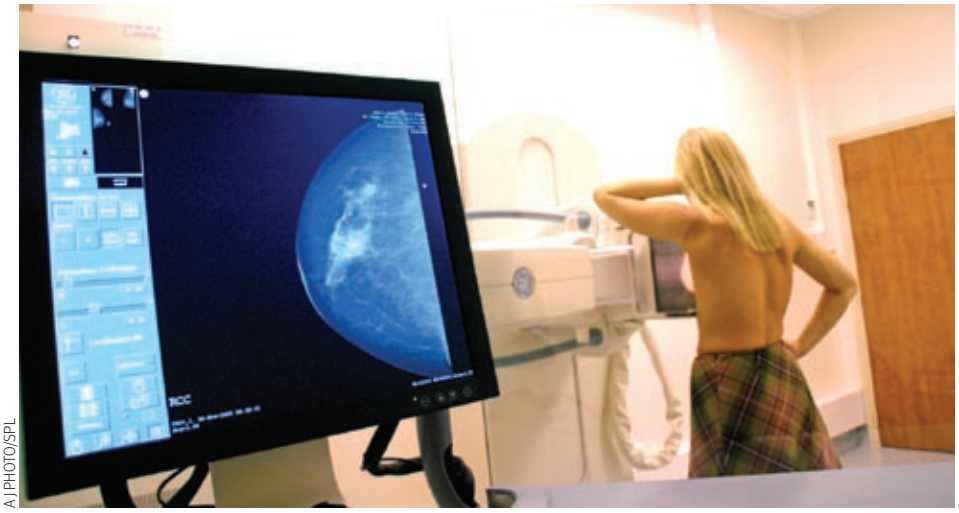



**Source:** *Canadian Cardiovascular Outcomes Research Team*

Beth Abramson, cardiologist and spokesperson for the foundation, says this is a concern: "There has been some progress in closing the gender gap, but when it comes to Canada's leading cause of death, there are women who may be underserved on the front lines compared with men."

The foundation also said that for the first time in 30 years women have caught up with men in the number of deaths from cardiovascular disease.

"Canadians have this cosy misperception that having a heart attack or stroke is no longer a big deal—that you can be hospitalised, treated, and return home as good as new," said Dr Abramson. "But the reality for a lot of people… is very different."



AJ PHOTO/SPL

# Radiologist missed 38 breast cancers in two years

**Zosia Kmietowicz** LONDON

The delayed diagnoses of breast cancer in 18 women in north Manchester, one of whom has since died of the disease, have been blamed on the "individual failings" of one radiologist.

The doctor missed 38 cancers in two years but, in 20 cases, his colleagues picked up his mistakes.

But a report into the incident, commissioned by the NHS North West Strategic Health Authority, showed that the work of the radiologist went unaudited for 17 months after concerns about him were first raised.

The report, written by Mark Baker, director of the Clinical Centre for Cancer at Leeds Teaching Hospitals NHS Trust, criticises the Trafford Healthcare NHS Trust, one of the two trusts involved, for "weaknesses and lack of leadership in the diagnostic role of the breast multidisciplinary team."

It shows that no steps were taken to audit the work of Amjad Husien, a consultant radiologist at Trafford Healthcare Trust who also worked locum shifts at North Manchester General Hospital, after concerns about his work were raised by colleagues in November 2003. He continued to work in isolation until April 2005, when his diagnostic mistakes came to light and he was suspended.

In that month, bosses at the strategic health authority ordered a review of nearly 2500 mammograms that had been done at the Trafford and North Manchester General hospitals. More than 150 women were recalled to check their diagnoses and treatment.

Altogether Mr Husien missed 40 breast cancers in the two years that he worked at the hospitals. Out of 24 cancers he missed at Trafford, eight were picked up by other members of the breast cancer team.

Fewer cancers went undetected at North Manchester General Hospital because colleagues in the unit routinely double or triple checked Mr Husien's findings, something that had also happened at previous hospitals at which he had worked. Of 14 cancers that Mr Husien failed to diagnose using mammography at North Manchester General Hospital, 12 were spotted by colleagues.

Professor Baker concludes, "The precipitating cause of the misreading of the mammograms was the personal failure of a radiologist. However, this was exacerbated by his isolated working in a small imaging department and a generally weak diagnostic setting in the breast service."

Mr Husien, who is referred to in the report as Dr A, had worked as a consultant for 10 years. He "almost immediately aroused concern" when he took up his post at Trafford General Hospital in April 2003, says Professor Baker.

The errors could have been spotted earlier if a clinical audit of Mr Husien's work had been ordered when colleagues raised these concerns in November that year. "It is difficult to draw conclusions about the origin of Dr A's clinical failures," he said.

**The Baker report is available at www.northwest.nhs.uk/baker.html.**

# GPs and consultants should work together in one stop health centres

**Oona Mashta** LONDON

GPs should work alongside consultants in health centres providing a "one stop service" for patients to get treatment and tests in a single visit, says the UK government's GP tsar.

Specially trained GPs could refer patients to senior consultants who are literally down the corridor, operating on cataracts, hernias, and varicose veins, for example, reducing hospital waiting times and saving money, David Colin-Thomé, national director for primary care, recommends in the latest report on reconfiguring services.

Dr Colin-Thomé makes the clinical case for expanding the services provided by GPs, nurses, and pharmacists in the report, which is in line with government reforms to bring care closer to patients.

In the report he also calls for GPs with specialist skills to do more minor operations and recommends that GPs take responsibility from consultants for the traditional check-up six weeks after surgery, which currently happens on an ad hoc basis around the country.

Dr Colin-Thomé believes that this approach would free consultants' time to see patients with more serious conditions.

Dr Colin-Thomé said, "Patients trust GPs. We're highly trained, offer high quality cost effective services, and our communities respect us; so why aren't we doing even more?

"The evolution of GP services is about adding and improving, not cutting and rationing services. It is designed to take the pressure off hospitals and recognises that 21st century hospitals should be centres of excellence, but only for care that has to be delivered there—emergency and core specialist services."

The health secretary Patricia Hewitt welcomed the report: "We know from the citizens' summits ahead of our community white paper that patients want more services closer to their homes.

"Services on their doorstep are more convenient, keep people out of hospital, and are a more efficient use of NHS resources."

**The report, Keeping it Personal: Clinical Case for Change, is available at www.dh.gov.uk.**