NEWS

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JOHN BEHETS

BMA: take politics out of NHS

Zosia Kmietowicz LONDON

The BMA has recommended an independent board of governors to run the NHS in England, to put an end to what its chairman describes as the constant "political dabbling" in the day to day running of the health service.

Although politicians would continue to make important decisions about the health service (such as what core services should be provided across the country), set priorities, and allocate resources, it would be the board—appointed by parliament—that would implement the policies and set standards and ensure these were delivered "without any further political interference," said James Johnson, chairman of the BMA (above left).

"It is absolutely right that politicians should set the general direction for the NHS. But the day to day political dabbling once a topic has become hot news is not good for the service and has led to the separation of managers from clinicians," said Mr Johnson.

Managers, whose job it is to help clinicians deliver effective health care, have in effect become "political foot soldiers" whose role it is to ensure that political targets are met, he said.

Mr Johnson added: "It cannot be good for the secretary of state to have to react to every bit of news that gets into the papers." To have to answer questions in parliament about the latest infection rates was not the responsibility of the secretary of state but should be the responsibility of the management of the hospital concerned, explained Mr Johnson, and it is they who should be made accountable.

The BMA's proposals are the culmination of a nine month review of the NHS, which was sparked by deep unhappiness among clinicians—voiced at last summer's annual representatives' meeting—about the reforms sweeping the health service. It stresses that any future reforms should be made with greater involvement of clinicians and patients.

The document recommends a constitution for the NHS, which would contain the core values of the NHS and a charter explaining what the public can expect from the NHS, what the NHS expects of the public, and the range of available services.

Although the BMA says that it does not advocate rationing of treatments, it recognises that in a climate of increasingly expensive medical advances and an ageing population "it may be necessary to ration some services if society is not prepared to pay higher taxes."

"We do believe that rationing may be inevitable," said Hamish Meldrum, chairman of the BMA's General Practitioners Committee (above right), "but if rationing is to take place it should be done in a consistent, open, and transparent manner that involves the public and clinicians and does not happen in the idiosyncratic way that it happens at the moment."

A Rational Way Forward for the NHS in England **is available at** www.bma.org.

Stroke care is improving in England but not in Wales

Susan Mayor LONDON

A growing number of people in England who have had a stroke are being cared for in specialised stroke units, but no similar improvement has occurred in Wales, says the report of a national audit published this week. The report also warns that waiting times for a brain scan and for starting treatment remain longer than current guidelines recommend.

The 2006 national sentinel audit for stroke is the latest in a two yearly review of stroke care being funded by the Healthcare Commission, the independent body that assesses quality of care in the NHS. The audit was carried out by the Royal College of Physicians on behalf of the Intercollegiate Stroke Group and included all eligible hospitals in England and Wales.

The results showed that the proportion of patients receiving care in a specialist stroke unit had risen. In 2006 nearly two thirds (62%) of patients were admitted to a stroke unit at some point in their stay in hospital, whereas the percentage in 2004 was 46%. Fifty four per cent spent more than half of their hospital stay in a stroke unit (40% in 2004).

The audit found that the results of key indicators among patients who were managed in stroke units were considerably better than those of patients looked after in other settings. Patients in stroke units were much more likely to have had a swallowing screening test (overall assessment including consciousness, truncal control, ability to communicate, and a test to swallow water), to have started aspirin treatment within 48 hours, and to have been assessed by therapists within the recommended time frames.

The report considered that the increase in the number of people being cared for in stroke units was a significant improvement, noting that 91% of all the hospitals now have a stroke unit, an increase from 79% in 2004.

The 2006 National Sentinel Audit for Stroke **is available at www.rcplondon.ac.uk.**

IN BRIEF

UK travellers are contracting more serious form of malaria: Figures from the Health Protection Agency show there were 1758 cases of malaria in UK people who went abroad in 2006, eight of which were fatal. Although the number of UK people contracting malaria has remained stable over the past 20 years, the proportion of cases caused by the more dangerous *Plasmodium falciparum* species has risen to 79% from 40% in 1987.

Immigrants in the Netherlands are the most likely to be uninsured: Nearly 250 000 Dutch people, including 40 000 children, have no medical insurance, figures from Statistics Netherlands show. Children fall through the insurance net because their parents have no cover. The rate of non-coverage among immigrants from Turkey, Morocco, and Surinam is five times that among native Dutch people (www.cbs.nl).

WHO launches new clinical trials portal: The World Health Organization has launched a new website offering access to several high quality registers of clinical trials (www.who.int/trialsearch). The registers providing data to the portal are all members of WHO's network of collaborating clinical trial registers, which sets out standards for supplying data.

"Postcode lottery" is rife in English plastic surgery, survey shows: Only 11 NHS trusts in England are accurately following national guidelines for bilateral breast reduction surgery. Findings from 245 out of 303 trusts in England that responded to a survey show that many included restricting criteria not in the NHS guidelines for a type of surgery that is often considered cosmetic and thus rationed. "The so-called postcode lottery of healthcare in the UK is rife within plastic surgery," the researchers write in the *Journal of Plastic, Reconstructive & Aesthetic Surgery* (doi: 10.1016/j.bjps.2007.03.002).

"Cigarette" sweets increase risk of smoking: A study of 25 887 US adults shows that the odds of smoking for those who ate candy cigarettes as children was 2.0 (95% confidence interval 1.8 to 2.2) for current and former smokers and 1.8 (1.6 to 2.1) for current smokers, compared with those who had not eaten them as children. "Elimination of candy cigarettes may protect children from products that promote the social acceptability of smoking," say the researchers (*Preventive Medicine* doi: 10.1016/j.ypmed.2007.04.006).

Services don't match regional variation in heart disease

Roger Dobson ABERGAVENNY

A new study that compared the prevalence of heart disease in different areas in England with the number of revascularisation procedures carried shows a mismatch between the two.

Some affluent areas with a low prevalence of disease had greater provision of procedures than more deprived areas with a high prevalence, says the study, published online on 29 April in *Health & Place* (www.sciencedirect.com).

The study looked at data on prevalence of heart disease and on mortality from 1999 and from 2003, as well as 2001 census data, taking into account socioeconomic data. It estimated the prevalence of heart disease by age, sex, and ethnicity for each of the 354 local authority areas in England.

The results show a clear divide in prevalence between the North and the South and between affluent and poor areas. With few exceptions, areas north of a line between the River Severn and the Wash have a higher prevalence of heart disease, and deprived areas tend to have higher prevalence than more affluent ones.

The study then looked at variation in the availability of revascularisation procedures. "Assessment of health care interventions is often based simply on league table rankings without any reference to morbidity, or indeed mortality. A useful application of prevalence measures is in assessing how far intervention rates correspond with health need," says the report.

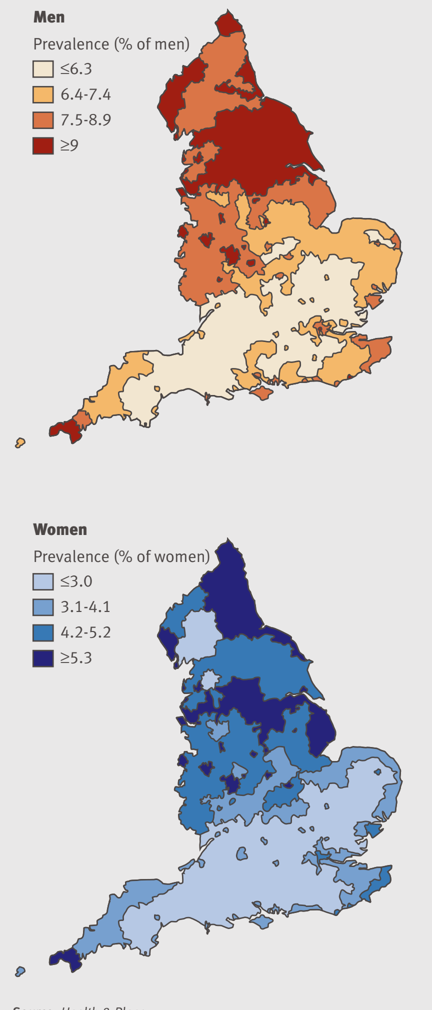
The 2002 data showed that there were 42 000 such procedures in men and 16 000 in women. The results show some discrepancies between provision of the procedure and local prevalence of heart disease.

The report says that some relatively affluent areas with a low prevalence of disease, such as Bedfordshire, Hertfordshire, Surrey, and Sussex, have an above average provision of revascularisation, while some high prevalence areas, including Cheshire, Merseyside, Greater Manchester, Shropshire, and Staffordshire, seem to have poorer provision.

"It is important to note that revascularisation treatments have been shown to be beneficial for subjects with coronary heart disease," says the report.

(See Feature, p 976)

PREVALENCE OF CORONARY HEART DISEASE IN ENGLISH ADULTS AGED OVER 35



Source: *Health & Place*

Patients are shown

Janice Hopkins Tanne NEW YORK

Patients and families are often seen as valuable collaborators in improving safety by recognising and reporting medical errors, but a recent study says that they often get it wrong—mistaking delays and poor quality of service for errors.

Patients' safety has received prominent attention in the United States since the Institute of Medicine's 1999 study *To Err is Human: Building a Safer Health System*, which said that almost 100 000 Americans died each year from medical errors (*BMJ* 1999;319:1519).

In the latest study researchers from the Dana-

CNRI/SPL

Number of sperm donors rises in UK despite removal of anonymity

Michael Day LONDON

The number of men registering as sperm donors in the United Kingdom rose by 6% last year. This was despite a new law removing anonymity, which many feared would deter new donations.

In the 12 months to 31 March 2006, the year after the law change, 265 new sperm donors registered with the Human Fertilisation and Embryology Authority (HFEA), of whom 208 were based in the UK. The previous 12 months had seen 250 new donors, of whom 197 were based in the UK.

Shirley Harrison, the authority's chairwoman, said: "These new figures show that the predicted drop in sperm donor numbers is a myth.

"The decision by the UK parliament to remove anonymity for those sperm and egg donors who registered after 1 April 2005 has always been controversial. Many commentators continue to claim that the change in the law to remove anonymity for sperm and egg donors would lead to an immediate and steep fall in the number of donors."

However, she added, "More and more individual clinics are increasing their efforts to recruit sperm donors. These figures show that these efforts have been paying off and the early indications are that the numbers of sperm donors are continuing to increase all the time."

Mark Hamilton, chairman of the British Fertility Society, said he "noted with interest the HFEA's report of a slight increase in the number of sperm donors registering in the UK in 2006."

But he added that the society "remains concerned that availability of sperm donation services remains patchy at best throughout the country.

"The society is aware of several centres which have now withdrawn donor insemination services to patients; and for those [patients] who may be fortunate to be able to access treatment, costs and waiting times have greatly increased."

Last September a BBC survey of 84 fertility clinics and one sperm bank in the UK found that more than two thirds said they were getting "no sperm" or are having "great difficulties" in getting supplies.

Dr Hamilton said that a working party convened by the British Fertility Society, with representation from providers, patients, the regulator, and the Department of Health, would be reporting shortly with an analysis of the present situation and would make recommendations on national service delivery to address the present difficulties.

In 2005 the HFEA issued the report *Who are the Donors?* which showed that sperm donors are now typically family men in their 30s.

The Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations 2004 are at www.opsi.gov.uk/SI/si2004/20041511.htm.

not to be accurate at detecting medical errors

Farber Cancer Institute in Boston, which is affiliated to Harvard University, looked at unsafe events reported by adult oncology patients treated between February and September 2004 in an outpatient chemotherapy infusion unit. The infusion unit, which could accommodate 46 patients, had 31 702 visits during the fiscal year (*Journal on Quality and Patient Safety* 2007:33;83-93).

Volunteers who were trained to liaise with the patients over safety interviewed 193 patients, of whom 83 reported 121 incidents.

The investigators disagreed with the patients' reports, however. More than half the incidents reported by patients were problems with the service rather than medical errors, they said.

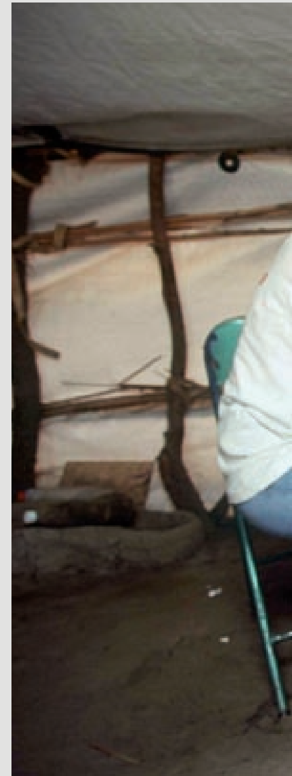
The incidents were classed as "adverse events," in which the patient was injured as a result of medical care; "close calls," in which an error had potential for injury but the injury was averted; and incidents with minimal risk of harm, such as poor food, long waits, and poor communication.

When investigators reviewed the incidents, they classified two as adverse events, four as "close calls," 14 as errors without risk of harm, and 101 as problems with service quality, such as delays.

In one of the incidents classed as an adverse event a magnetic resonance imaging technician missed the vein when placing an intravenous catheter, causing infiltration into the tissue. In the other a patient experienced nausea after radiation therapy because he had not been pretreated with an antiemetic.

The four "close calls" included giving heparin to a patient with an allergy, administering an intravenous infusion with codeine to a patient whose notes mentioned an allergy to the analgesic, failure to give a drug to a patient, and a situation in which the patient said that other patients and visitors had "fiddled" with infusion pumps.

BMA tells doctors to take career breaks in world's poorest countries



Adrian O'Dowd LONDON

British doctors should consider volunteering their time to work abroad to help improve the health of poor people overseas, a new BMA report says.

The report on the health of the world's poor, which was published this week, says that the NHS should actively support health improvements in poor countries.

The United Kingdom, which has recruited many thousands of health workers from poor countries in the past decade without incurring training costs (see Observations, p 981), has a duty to assist financially poor countries to rebuild their health systems, argues the report, which was partly funded by the Department for International Development.

It claims that 57 countries now have a critical shortage of health workers because of this "brain drain" effect, especially in South and South East Asia and sub-Saharan Africa.

As well as providing financial help, policy makers in the UK should provide other forms of support, such as encouraging UK health workers and management staff to spend time abroad as a part of their career pathway, says the report.

It cites several statistics about the scale of the problem of poor health globally, including:

- 42% of the population of sub-Saharan Africa lack access to clean water
- 820 million people in poor countries remain undernourished, despite global food production having doubled in the last 40 years
- 1.3 billion people lack access to basic health care

The BMA's chairman, James Johnson, says in the report: "We share the view that there is a pool of untapped expertise and insight amongst UK health professionals which, if harnessed, could make a huge difference to health in the developing world."

Although Mr Johnson said that global health was currently enjoying a high profile in the UK, partly because of the recently published government consultation on a UK global health strategy, more could and should be done.

"This publication is a powerful indictment of the state of world health and the inability—or even unwillingness—of those in power to take remedial action," he says in the report.

Improving Health for the World's Poor: What Can Health Professionals Do? **is at www.bma.org.uk.**

Rembrandt's Anatomy Lesson to be shown at National Gallery in London

Annabel Ferriman BMJ

An upcoming exhibition at the National Gallery in London is to include the iconic Rembrandt painting *The Anatomy Lesson of Dr Nicolaes Tulp*—which has not been seen in the UK for 40 years.

In the picture, which was commissioned by the Amsterdam surgeons' guild, Dr Tulp is shown conducting an anatomy demonstration on the body of an executed criminal. Several physicians crowd at the head of the cadaver, observing the lesson with rapt attention.

The painting, which dates from 1632, is on loan from the Royal Picture Gallery Mauritshuis, The Hague.

"Dutch Portraits: The Age of Rembrandt and Frans Hals" runs at the National Gallery from 27 June to 16 September.

Indian doctors are promised help to fight abuse of prisoners

Vivienne Nathanson, BMA NEW DELHI

The Indian Medical Association has vowed to secure better resources for prison doctors and to provide protection for those doctors who speak out against abuse. It has also publicly stated that it opposes interrogational torture—an illegal but widely used practice in the country.

Delegates at a conference in Delhi last week on medical ethics in places of detention described how many prisoners and detainees are subject to torture or to cruel, inhumane, and degrading treatment, especially before formal remand to prison or another place of detention.

The conference, organised by the Indian Medical Association in collaboration with the International Committee of the Red Cross and the World Medical Association, heard that the frequent movement of prisoners makes detailed assessment of their medical and psychological condition very difficult or impossible. But without such examinations, evidence of abuse is largely missed and opportunities to combat systematic abuse are lost.

SIPA/REX

A doctor from Médicins Sans Frontières checks a young child in the Sudan

Israeli surgeon is arrested for suspected organ trafficking

Merav Sarig JERUSALEM

A leading kidney transplant surgeon from Israel has been arrested in Turkey on suspicion of involvement in an illegal organ transplantation ring that performed operations at a private hospital in Istanbul.

Zaki Shapira, former head of the transplant centre at Rabin Medical Center in Petah Tikva, to the north east of Tel Aviv, was arrested in the course of a gun battle between police and armed robbers at the hospital on 27 April.

Turkish sources say that police officers who searched the hospital after the shooting discovered that it had been shut down by court order a month earlier for illegal transplantations. During the search the officers found four patients—three of them Israelis—at the hospital. Two had donated organs for transplantation and one had received a transplant. The patients were transferred to other hospitals in Istanbul.

"During the operations, robbers attacked the hospital," the Israeli transplant recipient said afterwards. "A few people were killed, and the patients had to be evacuated immediately so they wouldn't be killed too. The police took advantage of the opportunity and arrested the doctors because the transplant operations weren't authorised."

Professor Shapira is among the pioneers of organ transplantation in Israel. In 1996, however, Professor Shapira was prohibited from performing live donor transplantations in Israel after an investigation by the health ministry suspected him of being involved in organ trafficking. Since retiring he has accompanied transplant recipients on trips abroad for surgery, particularly to Turkey.

The incident "sullies the reputation of everyone in the field in Israel"

Professor Eitan Mor, director of the transplant centre at Rabin Medical Center and a member of the Israel Transplantation Society's board of directors, said, "We express our regret for this incident, which sullies the reputation of everyone in the field in Israel."

Yair Skalki, the lawyer who is representing Professor Shapira, said, "Professor Shapira did not violate any law relating to organ trafficking, or any other law."

German council demands opt-out system for transplants

Annette Tuffs HEIDELBERG

An influential German advisory body is proposing a change in the law on organ donation so that it is assumed that everyone in the country has agreed to be a donor after death unless they have specifically opted out by registering their objection to donation.

The proposal from the German National Ethics Council has had a mixed reception, with opposition coming from politicians and a doctors' organisation.

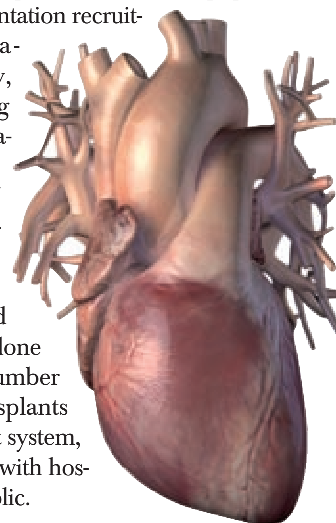
The council's paper, published in April, was designed as an urgent response to the plight of the 12 000 German patients waiting for organs by asking for a change in legislation.

The council, which is independent, issues regular statements and opinion papers on important ethical topics (www.ethikrat.org). It has up to 25 members who represent scientific, medical, theological, philosophical, social, legal, ecological, and economic interests.

The current German law on transplants, which dates from 1997, does not assume that everyone is prepared to be a donor after death. It requires that donors—or relatives—have opted in to the idea, either by the donor carrying a card, if available, or by the relatives giving permission when the patient is brain dead. The council wants to change this to an opt-out system where everybody is assumed to have consented unless they have previously registered their objection.

Their objection could, for instance, be registered on their health card—which is currently subject to trials and which in future everybody may have to carry at all times.

Reacting to the publication of the paper, the main transplantation recruitment organisation in Germany, Deutsche Stiftung Organtransplantation (the German Foundation of Organ Transplantation), said that before a new law was introduced more should be done to increase the number of available transplants under the present system, through working with hospitals and the public.


ZYGOTE MEDIA/NEWSCOM

Three into two won't go

Amid the chaos over applications for medical training posts in the UK, everyone is asking: how could the government have got its numbers so wrong? **Lynn Eaton** reports

FIONA HANSON/PA

In the quagmire of statistics relating to the issue of training posts for junior doctors in the United Kingdom one fact stands out clearly: more than 30 000 doctors are applying for about 20 000 training posts. How did this happen? Who are the applicants? And are they all on an equal footing, or are some more equal than others?

A large number of people will undoubtedly fail to secure a training post through the medical training application system (MTAS) and will end up in the less desirable staff grade position, from where it will be almost impossible to become a consultant. Some might not get a job at all; some will undoubtedly go abroad. But it is not clear who will fall into each category.

Until the government announced in March this year that doctors who qualified in countries outside the European Economic Area (EEA) would be eligible to apply for the training posts (which had not been the plan in 2006), the figures were not quite so startlingly mismatched. As many as 11 400 of those currently applying may have qualified abroad, although many are already working in the NHS. If that number is subtracted from the estimated number of applicants (which varies from about 32 000 to 36 000), and the number of jobs is about 20 000, the shortfall might have been as little as 600—although there would still have been a shortfall. But why should doctors who qualified outside the EEA not be allowed to apply?

The applicants, whether home grown or trained overseas, fall roughly into four categories: those in foundation year 2 (F2) posts; those in senior house officer posts; those in staff grade posts; and doctors working abroad—some in the EEA and some outside it.

Almost 6000 of the applicants are doctors in F2 posts, who are coming out of their second year of training and applying for a post in their first year of specialist training (ST1). This group is considerably larger than it would have been five years ago because of the big expansion in medical schools' intake, which over the last six years has seen the number of medical graduates increase from less than 4000 each year to more than 6000. Inevitably this creates more pressure for jobs.

The second category is doctors in senior house officer (SHO) posts. The current shake-up in doctors' training, known as Modernising Medical Careers, is intended to make it easier to become a consultant sooner. As a result of the changes the post of senior house officer is disappearing. So, doctors who are currently in such posts are having to apply for specialist training posts, albeit at higher levels (ST3 and ST4).

What will happen to non-EEA graduates in the second round is still unclear

Currently England alone has some 18 200 SHOs. Although it is difficult to get accurate data from published sources, it is estimated that there are a further 2000 SHOs in Scotland, about 1000 in Wales, and just under 1000 in Northern Ireland. Some SHOs are in "trust" or staff grade posts, rather than training posts, but NHS Employers has been unable to tell the *BMJ* how many.

At one stage it looked as though changes in immigration rules, announced in March 2006, might have prevented SHOs who had graduated from countries outside the EEA and were here with "permit free training" immigration status from applying. But then two things have happened to change that situation.

Firstly, there was a legal challenge to the ruling that all doctors from non-EEA countries needed work permits. Although the organisation bringing the challenge, the British Association of Physicians of Indian Origin, lost in the High Court in February, (*BMJ* 2007;334:333, 17 Feb), it was given leave to appeal. Pending the results of that appeal the Department of Health has said that non-EEA medical graduates on permit free training will be considered in the first round of MTAS. What will happen to them in the second round is still unclear. (See www.mmc.nhs.uk/pages/oseas.)

Secondly, many of those doctors already working in the NHS as SHOs but who qualified outside the EEA have switched from their previous permit free training status to that of "highly skilled migrant," which automatically entitles them to be considered as equals to EEA applicants.

The third category of doctors who could be applying for the new training posts are those in staff posts who will apply in the hope of one day becoming a consultant.

Currently, some 5710 doctors are working in the NHS in England in staff grade posts. Many of them (3676) are from outside the EEA and could, like the SHOs in training posts, face difficulties meeting the new immigration requirements introduced earlier this year—unless they have acquired highly skilled migrant status (bmj.com, 22 April 2006, News Extra). Doctors in staff grade posts outside the NHS in England could also be applying. There are approximately 200 such posts in Wales, for example, but it is difficult to ascertain from published statistics how many staff posts there are in Scotland and Northern Ireland.

Finally, there is the category of doctors working abroad, itself falling into two groups: medical graduates from other EEA countries, who do not face a problem with immigration status, and those who qualified outside the EEA.

For full version of this article see bmj.com.

Who is applying for the 20 000 training posts across the UK?

Doctors in foundation year 2 (F2) posts:	6000
Senior house officers (SHOs) in England:	18 200
SHOs in Scotland, Wales, and Northern Ireland:	4000
Doctors in staff grade posts in UK (out of a total of >6000):	Not known
Doctors working outside the European Economic Area (EEA):	2000
Doctors currently working inside the EEA (but outside UK):	Not known
Total:	**>30 200**

Notes Estimates of the total number of available training posts vary: the BMA says there are 18 500 posts; the Department of Health says 23 000. The number of SHOs and staff grade doctors working in the NHS in England who qualified outside the EEA is 11 400 (7700 senior house officers and 3700 staff grade doctors). Associate specialists have not been included because, although they are in career grades, they are at a more senior level than the staff grade and are therefore unlikely to apply for specialist training posts.