NEWS

Surgery outcomes are to be made public in three years' time

Caroline White LONDON

The Royal College of Surgeons of England plans to make information on the performance of individual hospital units in all types of surgery publicly available in the next three years.

However, press reports have said that proposals to make data on surgical outcomes public would be included in the NHS operating framework for 2008-9 (*Guardian*, 28 Aug, p 1).

The move is seen as the best way to provide reliable information on which to base NHS commissioning decisions and the recertification of surgeons, as well as to help patients decide where they would like to be treated. It follows the introduction of new standards for judging survival after heart surgery at individual hospitals, the results of which were published by the Healthcare Commission last month (*BMJ* 2007;335:321, 18 Aug).

The performance of individual surgeons will not be made public, said Bernard Ribeiro, president of the Royal College of Surgeons. However it has been done for the majority of heart surgeons.

He explained: "In cardiac surgery you have a very definable end point: death. That's very easy to measure. But in general surgery the risk of death is small. You therefore need to be very careful what end point you are measuring."

The contribution of other medical staff, such as anaesthetists and nurses, all affected outcome of surgery and how patients felt about their treatment, he said. "We must look at how a unit performs rather than an individual."

He dismissed fears that this approach might conceal poorly performing surgeons. "If there are outliers, trust chief executives will know who they are," he said. "This is not a witch hunt."

The college had been agitating for publicly available data on surgical outcomes since 2005 and had reiterated their importance to the health secretary, Alan Johnson, in a meeting three weeks ago, he said.

A Department of Health spokesman refused to confirm or deny the *Guardian*'s report that proposals to provide publicly available data would be included in the next NHS operating framework.

GMC clears GP accused of giving "junk science" evidence

Owen Dyer LONDON

A GP whose expert report to a court highlighting the risks of immunisation of children was criticised as "junk science" by a senior judge has been cleared of serious professional misconduct by the General Medical Council.

Jayne Donegan, of Herne Hill, London, was accused of contravening her duty as a court witness by giving misleading impressions of the research she cited, quoting selectively, and failing to be objective, independent, and unbiased.

Dr Donegan wrote two reports for a case heard in 2002 in the family division of the High Court relating to two families who were unconnected but whose cases became linked in the courts.

In each case the father had sought to have his daughter immunised against the normal range of childhood diseases. Both girls' mothers, who opposed the vaccinations, instructed Dr Donegan as an expert witness. The fathers won the linked case and a subsequent appeal in 2003 (*BMJ* 2003;326:1351).

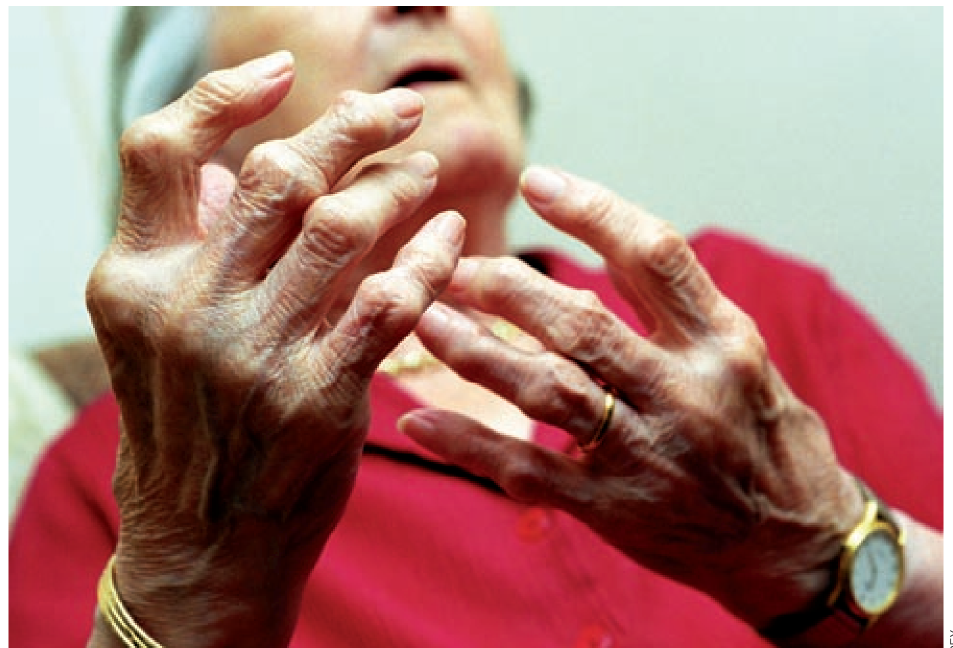
At both the original hearing and the appeal the judges criticised Dr Donegan's evidence. Mr Justice Sumner said, "I am compelled to the reluctant conclusion that in this case Dr Donegan has allowed her deeply held feelings on the subject of immunisation to overrule the duty she owes to the court."

At the appeal Lord Justice Sedley said: "Most of the published papers cited by her in support of her views turned out either to support the contrary position or at least to give no support to her own. Not to mince words, the court below was presented with junk science."

Although the courts lodged no complaint, the GMC began an investigation.

After a three week hearing in Manchester, which ended last week, the GMC panel concluded that all of the substantive

Patients' groups welcome NICE decisions



REX

Woman with rheumatoid arthritis

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WORLD NEWS WHO says infectious diseases are spreading more rapidly, p 418
bmj.com NIH investigates one of its own institutes

charges against Dr Donegan were unproved except for the charge of quoting selectively from research.

The panel declared, however, that "it is normal practice in the preparation of reports to quote selectively from references, which indeed you did."

Dr Donegan agreed that she had cited research whose conclusions differed from her own, but the panel accepted her argument that she had performed her duty by providing the references.

Sheila Hewitt, who chaired the panel, told Dr Donegan: "The panel were sure that at no stage did you allow any views that you held to overrule your duty to the court and the litigants. You demonstrated to the panel that your report did not derive from your deeply held views, and your evidence supported this."

TEK IMAGE/SPL

A doctor prepares a syringe of the combination MMR vaccine

on arthritis and multiple sclerosis drugs

Andrew Cole LONDON

Patients' groups have welcomed the decision by the National Institute for Health and Clinical Excellence (NICE) to give the go ahead to two new drugs for arthritis and one for multiple sclerosis.

NICE has approved for use in the NHS in England and Wales rituximab (MabThera) for severe active rheumatoid arthritis and adalimumab (Humira) for active and progressive psoriatic arthritis. It also recommended natalizumab (Tysabri) to treat rapidly evolving, severe relapsing-remitting multiple sclerosis.

Rituximab in combination with methotrexate will be available to NHS patients who have failed to respond to other antirheumatoid drugs, including at least one tumour necrosis factor (TNF) inhibitor. But NICE says that the treatment should continue only if there is an "adequate" response to the new drugs.

Adalimumab will be available to patients with peripheral arthritis who have three or more tender joints and three or more swollen parts and who have not responded to the more standard antirheumatoid drugs. It should be discontinued if the patient has made no progress after 12 weeks.

Recent trials showed that rituximab reduced symptoms of rheumatoid arthritis by more than 50% in more than a third of patients, although some patients reported a higher likelihood of serious infection (*Lancet* doi: 10.1016/S0140-6736(07)60784-3).

Meanwhile it is estimated that around 3000 people with severe relapsing-remitting multiple sclerosis could benefit from the decision to make natalizumab available on prescription.

Rituximab and adalimumab are already available in Scotland after an earlier ruling by the Scottish Medicines Consortium.

Health trusts in England and Wales have three months from 22 August to ensure that the approved drugs are available to all NHS patients who meet the criteria.

For more information go to www.nice.org.uk.

Out of hours cover in Scotland is unsustainable

Bryan Christie EDINBURGH

The present system of out of hours cover for primary care services in Scotland seems unsustainable and will need to change, a review of the service says.

The report, from Scotland's public spending watchdog, Audit Scotland, says that the country's health service has coped with the major challenge in 2004 of 95% of its GPs opting out of providing out of hours cover. But the number of GPs willing to continue providing this cover in return for payment has fallen from 1696 in 2004-5 to 1440 in 2006-7, it says, putting out of hours services under increasing pressure.

More commitment to developing extended roles for nurses and paramedics is needed, says the report, as well as more salaried GPs and better joint working with organisations such as NHS 24 (Scotland's 24 hour online and telephone information and advice service) and the Scottish Ambulance Service. It recommends that the Scottish Executive Health Department develop a clear strategy for improving out of hours services, with national benchmarking and better performance monitoring to show clearly the standard of service it provides.

Audit Scotland says that the overall effect of the changes since 2004 in out of hours cover on care of patients is unclear, as they have been introduced alongside other developments. A lack of national data has made it difficult to assess whether patients are benefiting. But a telephone survey of 600 patients found that 85% were satisfied with the service they received under the new arrangements.

"A lack of national data has made it difficult to assess whether patients are benefiting"

The report also found that the changes have helped GPs. Two thirds of the GPs who replied to an Audit Scotland survey said that their job had become more attractive.

Primary Care Out-of-Hours Services **is available at www.audit-scotland.gov.uk.**

IN BRIEF

BMA quits talks over SAS contract: BMA negotiators representing staff and associate specialist (SAS) doctors and dentists have withdrawn from further talks with the government over their stalled contract. The BMA will now survey SAS staff on the next steps and will hold a special conference in November to decide on further action, which could include industrial action.

Blocking of patients at Israeli border is "unethical": The Physicians for Human Rights-Israel group has said that the current policy of preventing patients from the Gaza strip entering Israel for treatment is unethical. The only ethical action was to demand access to appropriate care for all people who needed it, they said in a position paper (www.phr.org.il/phr/files/articlefile_1187523262828.doc).

Number of applications to work overseas falls: The number of UK doctors seeking to work overseas has fallen this year, despite fears that many would leave the country because of difficulties over the new medical training application service (MTAS). Figures from the General Medical Council show that a total of 2003 certificates of good standing (needed for working overseas) were issued in the first half of 2007, down from 2265 in the first half of 2006.

Car makers to compensate asthma patients: The Tokyo High Court has ruled that seven Japanese car makers have to pay €7.7m (£5.2m; $10.5m) to hundreds of people with asthma to settle an 11 year court battle over air pollution caused by diesel emissions.

Online medical ethics course is launched: A new free online course in medical ethics for doctors has been launched by the World Medical Association, the body that represents more than 80 national medical associations. The course, which is provided in cooperation with the Norwegian Medical Association, is accredited with eight hours or points in postgraduate and continuing education. See http://lupin-nma.net.

Concern grows at agencies working in Sudan: United Nations officials are concerned by a renewed crackdown on relief workers in Sudan, after the expulsion of Paul Barker, director of Care, one of the largest non-governmental agencies remaining in Darfur. Sudan has also declared European Union and Canadian diplomats as personae non grata.

WHO says infectious diseases are spreading more rapidly

Adrian O'Dowd MARGATE

Infectious diseases are spreading around the world faster than ever, says the World Health Organization, and new diseases are emerging at the unprecedented rate of one a year.

WHO has appealed in its annual world health report for international cooperation to tackle infectious diseases, which it says are a serious threat to public health worldwide. The disease situation is "anything but stable," the report says.

Several factors have helped accelerate the spread of diseases around the world: the increasing ease of international travel (each year airlines carry more than two billion passengers), population growth, resistance to drugs, under-resourced healthcare systems, intensive farming practices, and degradation of the environment.

"A sudden health crisis in one region of the world is now only a few hours away from becoming a public health emergency in another," it says.

The biggest fear is that other new diseases on the scale of AIDS or severe acute respiratory syndrome (SARS) will emerge. The report says, "It would be extremely naive and complacent to assume that there will not be another disease like AIDS, another Ebola, or another SARS, sooner or later."

Also, it says, new diseases are emerging at an unprecedented rate, often with the ability to cross borders rapidly.

Since 1967 at least 39 new pathogens have been identified, including HIV, Ebola haemorrhagic fever, Marburg fever, and SARS.

At the same time, old infections, such as pandemic flu, malaria, and tuberculosis, continue to pose a threat to public health through a combination of mutation, rising resistance to antimicrobial drugs, and weak health systems.

The key recommendations include:

- Full implementation of the revised international health regulations (IHR 2005) by all countries
- Global cooperation in surveillance and outbreak alert and response measures
- Open sharing of knowledge, technologies, and materials, including viruses and other laboratory samples
- Cross sector collaboration within governments, and
- More international and national resources for training, disease surveillance, laboratory capacity, response networks, and prevention.

Margaret Chan, WHO's director general, said, "International public health security is both a collective aspiration and a mutual responsibility. The new watchwords are diplomacy, cooperation, transparency, and preparedness."

"The new watchwords are diplomacy, cooperation, transparency, and preparedness"

A spokesperson for the Department of Health in England said, "We are aware of the issues raised in the WHO report and strongly support the approach of managing these risks through cooperation."

See Picture of the Week.

A Safer Future: Global Public Health Security in the 21st Century **is available at www.who.int.**

Growing displacement of refugees in Iraq

Peter Moszynski LONDON

The UN refugee agency is warning that the "incessant violence across much of Iraq" is presenting the international community with "a humanitarian crisis even larger than the upheaval aid agencies had planned for during the 2003 war."

The United Nations High Commission for Refugees (UNHCR) estimates that more than 4.2 million Iraqis have now left their homes. Of these, some 2.2 million Iraqis are displaced internally, and more than two million people have fled to neighbouring states, particularly Syria and Jordan. Many were displaced before 2003, but an increasing number are fleeing current unrest. In 2006 Iraqis had become the foremost nationality seeking asylum in Europe.

Humanitarian agencies had been planning for the large scale return of people in the aftermath of the 2003 invasion, but instead increasing numbers of people are now becoming displaced. As a result, the entire relief strategy needs to be rethought, say senior aid officials.

Of particular concern is the fate of some 15 000 Palestinians

ALEX MAJOLI/MAGNUM

The lowest life expectancy for women is in Liverpool (78.1 years) and, for men, in Manchester (72.5 years)

Web tool shows which measures work in deprived areas

Lynn Eaton LONDON

Primary care trusts in some of England's poorest areas have a new web based management tool to assess how they can improve mortality in their local population.

The programme, devised by the London Health Observatory and the Yorkshire and Humber Public Health Observatory for the Department of Health, allows trusts in deprived areas to see what measures would help save the most lives. It looks at four specific interventions known to have a major effect on mortality: smoking cessation; reducing infant mortality; prescribing antihypertensives; and providing statins for people with cardiovascular disease.

The site also breaks down life expectancy data in each area by disease, for men and for women, and indicates how many people in the population have undiagnosed cardiovascular disease.

The data cover 70 local authority areas in England that the government identifies as "spearhead areas"—those with major health inequalities. Average life expectancy in 2003-5 in England was 76.9 years for men and 81.1 years for women, but in spearhead areas the average was 74.9 for men and 79.6 for women.

The government has set a target to reduce the gap in average mortality between spearhead areas and the rest of England to 10% by 2010. Three fifths of the areas are on track to achieve this, says the DH.

The health inequalities intervention tool is available at www.lho.org.uk.

Canada's health system needs overhaul, say doctors

Barbara Kermode-Scott CALGARY

Canada's public health system, created in the 1960s, needs to be modernised to expand access and improve patient care, according to Canada's doctors.

The system primarily funds services provided by hospitals and doctors; it pays for 98.7% of doctors' services but only 45.6% of the cost of prescription drugs, according to the Canadian Medical Association. Canadian residents, or their insurance plans, are responsible for paying for other health services, such as crutches for someone who has broken a leg, an ambulance for someone who has had a heart attack, and even painkillers. Currently a large but unknown number of poor people have no insurance and cannot afford to pay for these items.

"The needs of Canadians are changing and our system needs to be changed and updated to address the healthcare challenges of the 21st century," said the association's outgoing president, Colin McMillan, at the association's annual meeting in Vancouver, British Columbia.

"While the Canadian Medical Association believes that change is required, we stand firm, however, on the basic underlying principle that access to quality healthcare services in this country will be based on medical needs and not your ability to pay."

"Our system was built to meet the needs of the underprivileged. It is now failing both them and everyone else because it has not adapted to the times," said the incoming president, Brian Day. "The greatest deficiencies are in the poorest regions of our nation, especially Aboriginal communities."

causes new problems, warns UN agency

trapped in Iraq, especially that of 1400 who the UNHCR says are living in "desperate conditions in refugee camps along the Iraq-Syria border, unable to cross the frontier into a country already straining to cope with hundreds of thousands of Iraqi and Palestinian refugees. A steady flow of Palestinians have fled Baghdad since March 2006, when intimidation, forced evictions, and attacks against their community began mounting."

A group of seriously ill Palestinian refugees have been denied medical treatment. A UNHCR spokesperson told the *BMJ* that four have now been allowed into Syria for medical treatment, of whom two were flown for emergency care to Norway, but they are still concerned about "dozens of individuals who have serious conditions and could die without urgent attention," particularly as the temperature often exceeds 50°C at this time of year.

The UNHCR cautions that the rising number of displaced people in Iraq is presenting "an enormous humanitarian challenge" and "extreme hardship" for those displaced.

HO NEW/REUTERS

The Al Waleed camp on the Iraq-Syria border

20TH CENTURY FOX/EVERETT/REX

TV doctors Wayne Rogers and Alan Alda, from MASH, stop for a martini

Dying for a drink

Toby Reynolds BMJ

Doctors die less often from alcohol related causes than the general population, a report in the Office for National Statistics' *Health Statistics Quarterly* has shown. The proportion of such deaths among male medical practitioners aged 20-64 in England and Wales in 2001-5 was 0.58 (95% confidence interval 0.37 to 0.85). In the 1960s, '70s, and '80s the proportion of deaths among male medical practitioners in England and Wales caused by alcohol was much higher than the proportion in the overall population. The authors say that the change may be because of a shift in drinking culture in the profession in recent years.

See www.statistics.gov.uk

Childhood leukaemia in England and Wales increases since 1970s

Roger Dobson ABERGAVENNY

The incidence of leukaemia in children in England and Wales rose by 20% between the early 1970s and the end of the century, new research shows, an increase of 4% every five years.

The incidence of childhood leukaemia rose from 38.3 per million person years in 1971-5 to 46.1 in 1996-2000, found the study, in the *British Journal of Cancer* (doi: 10.1038/sj.bjc.6603946). The results also show that throughout the 20th century the incidence of the disease and mortality were at least 15% higher in boys than in girls.

The authors, from the London School of Hygiene and Tropical Medicine, say that the increase cannot readily be explained by a number of theories, including changes in cancer registration. "We are forced to conclude that the increase in incidence is largely real," they say.

The authors examined all the available data on trends in incidence of and mortality from childhood leukaemia in England and Wales for most of the 20th century.

The average five yearly increase in incidence over the period 1971-2000 was significant in all age groups, but the overall increase was much larger among children aged under 5 years (46% in infants under 1 year; 24% in children aged 1–4) than in older children (12-15%).

The authors say that five year survival has improved markedly, from less than 5% in the early 1960s to almost 80% by the end of the 1990s.

Data confirm that gestational age predicts infant mortality

Toby Reynolds BMJ

Babies born at 37 weeks' gestation are three times more likely to die in their first year than those born at 40 weeks, show government data for England and Wales in 2005 that link infant mortality to gestational age.

However, infant mortality in this gestation range was still low, at 4.1 deaths per 1000 live births among babies born at 37 weeks and 1.3 per 1000 among those born at 40 weeks, says the report, published by the Office for National Statistics in *Health Statistics Quarterly* (2007;35:13-27).

The data covered all 645 887 live births in England and Wales in 2005. Overall mortality in the first year of life was five deaths per 1000 live births.

Babies born before 37 weeks made up 7.6% of live births but two thirds of the deaths in the first year of life.

Babies born before 37 weeks made up two thirds of the deaths in the first year of life

"It has never been possible before to produce data on gestation specific infant mortality," said Kath Moser, one of the report's authors and a researcher in the child health team at the Office for National Statistics. She said that the collation of the data had been enabled by the introduction in 2002 of the NHS numbers for babies service (NN4B), which created a small data set for each baby, including gestational age, and linked this to a new NHS number.

The latest statistics show that mortality in the first year of life was 986 deaths per 1000 among babies born before 22 weeks (and weighing less than 1 kg) and 947 per 1000 for babies born at 22 weeks, the report said. Ms Moser said she had expected higher mortality in these groups.

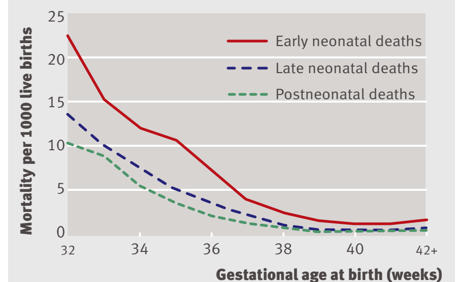
She said, "We are concerned that there are recording errors at these very low gestational ages. We are going to do further investigation in this area to validate our data . . . We would advise great caution in interpreting these data for very low gestational ages."

The data for babies born before 22 weeks were based on 212 live births and those for babies born at 22 weeks on 152 live births. "It is routine data… so there are inevitably some recording errors," Ms Moser said.

Infant mortality was 582 deaths per 1000 for babies born at 24 weeks and 237 per 1000 for those born at 26 weeks.

Health Statistics Quarterly **is available at www.statistics.gov.uk.**

INFANT DEATHS, ENGLAND AND WALES, 2005



Source: *Health Statistics Quarterly*