WHO launches campaign to make drugs safer for children

Geoff Watts LONDON

An initiative from the World Health Organization has been launched to make drugs as simply and safely available to children as they are to adults.

Speaking last week at the launch in London, WHO's assistant director general, Howard Zucker, said that "there is a gap between the availability of children's medicines and the actual need. That gap is global and must be addressed."

The problem is not new. "It's a reality we've lived with for many years," Dr Zucker admitted. Most drugs are developed for and tested in adults. Less than a third come in a form appropriate for children.

As a result, many children are treated using drugs that are effectively unlicensed. Medical staff may be obliged to estimate the appropriate fraction of an adult dose, and then crush tablets or extract part of the contents of a capsule.

One study by WHO has shown that drug errors are three times as common in children as in adults (*JAMA* 2001;285:2114-20). Unicef claims that of the 10 million under 5s who will have died by the end of this year, specific products for children could have saved two thirds.

Hans Hogerzeil, WHO's director of drugs policy and standards, listed areas in which more effort is needed, in which drugs do exist but were of unknown safety and efficacy. Examples include agents for dealing with tuberculosis; HIV; and several neglected conditions, such as schistosomiasis.

Development is essential in areas in which adult drugs need to be adapted to make them suitable and safe for children. Illnesses in this category include malaria, neonatal infections that could be treated by antibiotics, and tuberculosis.

Finally, said Dr Hogerzeil, improved access is the priority where drugs exist but are prevented from reaching the children who needed them because of cost.

"Make medicines child size" is at www.who.int/childmedicines/en.

PETER MOSZYNSKI

More than 2.6 billion people worldwide lack access to clean water and sanitation

Diarrhoeal diseases still kill more than 1.5m children a year

Peter Moszynski LONDON

The number of children under 5 dying each year has fallen to below 10 million for the first time, but a lack of sanitation is still causing many unnecessary deaths, a new report from Unicef revealed this week.

A new statistical review launched to coincide with the United Nations General Assembly's special session for children, 10-12 December, has published detailed figures on child health worldwide in four categories: health, HIV/AIDS, education, and the protection of children.

Progress for Children gives the latest global, national, and regional statistics on how the world is progressing towards achieving the millennium development goals (MDGs) and the child specific targets set out at the previous special session five years ago.

In 2006, for the first time, the annual global deaths of children under 5 have fallen below 10 million, to 9.7 million—a 60% reduction since 1960. Overall, in most regions, in addition to improvement in child survival rates, progress has also been made in education, gender equality, and child protection.

However, a lack of basic sanitation, along with poor hygiene and unsafe drinking water, still contribute to the deaths of more than 1.5 million children from diarrhoeal diseases each year. The report shows that in 2004, 41% of the world's population—2.6 billion people—did not have access to adequate sanitation facilities. The year 2008 has been declared the International Year for Sanitation.

Half a million women still die each year from problems relating to pregnancy and childbirth, and pneumonia kills more children than any other illness—"more than AIDS, malaria and measles combined," according to Unicef. Little progress has been made in increasing the number of under 5s with suspected pneumonia who are taken to health providers for treatment.

Sub-Saharan Africa is the region most clearly lagging behind in progress toward the millennium development goals. For example, the lifetime risk of maternal death is 1 in 22 in sub-Saharan Africa, compared with 1 in 8000 in industrialised countries.

Dr Peter Salama, Unicef's chief of health, told the *BMJ* that the 20 countries with the highest under 5 mortality had a high prevalence of either conflict or HIV. Progress had been greatest in interventions that required the least formal infrastructure.

***Progress for Children: A World Fit for Children Statistical Review* is available at www.childinfo.org**

US needs universal access to health care, physicians say

Janice Hopkins Tanne NEW YORK

The American College of Physicians says that the United States needs a healthcare system that provides care for everyone, either through a universal health insurance system, such as the UK NHS, or through a pluralistic system that involves the government and private organisations.

The college's three-part position paper was published on its website (www.annals.org). It will appear in the 1 January issue of the *Annals of Internal Medicine*. The college has 124 000 members and is second only to the American Medical Association in membership.

The college released the report "to provoke a national discussion, during this critical election year, on how to make the US the best performing healthcare system in the world. . . our country's current pluralistic system without universal healthcare coverage is unacceptable and puts us behind other countries."

It proposed two possible ways to achieve universal health coverage for Americans.

A single payer, government run system would cover everyone, without barriers, based on ability to pay. Single payer systems are more equitable; have lower administrative costs; greater user satisfaction; and better quality and access, the report said. However, such a system may restrict spending, leading to shortages of services, delays in elective treatments, and limits on the people's freedom to choose.

A pluralistic system that involves the government as well as private, for profit, and not for profit organisations could ensure universal access while giving consumers freedom to buy private supplemental coverage. It would have to include a guarantee that everyone has access to coverage and government subsidies for people who cannot afford to buy coverage. A pluralistic system is more likely to produce inequities in coverage and to have higher administrative costs.

In either case, consumers should receive a core package of benefits, including preventive care, primary care that includes management of chronic illness, and protection from catastrophic healthcare costs.

Until a national political consensus is reached on achieving universal health coverage, states should be encouraged to develop their own programmes.

The American College of Physicians position paper is at www.annals.org.

Opposition grows in France to new

Brad Spurgeon PARIS

As France prepares to enforce on 1 January its latest non-reimbursable medical fee, opposition is building to what critics have called everything from unconstitutional to the only unpopular measure proposed by the president, Nicolas Sarkozy, since he came to power last May.

Furthermore, critics say that this and other such measures are moving France towards a healthcare system that is based upon payment according to means, which would leave many people either unable or unwilling to pay for medical treatment.

Introduced on 24 September among a series of measures to reduce a social security deficit predicted to reach €12.7bn (£9.1bn; $18.7bn) in 2008, the law was passed in parliament on 23 November. It calls for a non-reimbursable charge of €0.50 on every drug packet and every visit to paramedical staff, such as physiotherapists, and €2 on the cost of transport related to treatment, such as an ambulance ride (*BMJ* 2007;335:690).

Although the charges will not be reimbursed by public or private health insurance, the government set an annual limit of what any one person would have to pay, of €50. Pregnant women, children, and people below the poverty line are exempt, and the money that is raised will go towards France's Alzheimer's and cancer treatment programmes.

But the measure has led to demonstrations from labour unions, special interest groups, and others, who complain that "the ill are paying for the ill." On 28 November the opposition Socialist Party filed a complaint with the Constitutional Council saying that the law violated the "right of health to all and the principle of equality."

MARBURGER BUND

Doctors' leader Dr Rudolf Henke is demanding better pay

Doctors at church

Ned Stafford HAMBURG

Tensions between church operated hospitals and the nation's largest medical trade union are growing in Germany after the Catholic church failed last week to agree a new contract with its 480 000 health and social workers.

Germany's largest medical trade union, the Marburger Bund, wants better pay and working conditions for doctors in Catholic and Evangelical hospitals, demanding that church hospitals adopt a wage agreement

EC wants to loosen rules on advertising drugs to patients

Anna Sayburn BMJ

The European Commission is considering tabling legislation next year that would change the rules on the information that drug companies can provide to patients.

The proposals look likely to relax the current laws, which prohibit provision of information by drug companies to patients except through strictly controlled mechanisms, such as information leaflets provided within drug packaging. The European Commission has been consulting about its proposals since April (*BMJ* 2007;334:1025 and 2007;335:526).

Speaking at a meeting at the European parliament last week, Christian Siebert, department head at the European Commission's Directorate General for Enterprise and Industry, said that the most likely date for publication of the proposed legislation was October 2008.

He said there was an "emerging consensus" from the consultation that change was needed, but that "the ban on direct to consumer advertising should be maintained."

He said the commission wanted to establish criteria to govern patient information, and that it should be evidence based, up to date, peer reviewed, and free from bias.

Competing interests: AS is an editor for BMJ BestTreatments.

charges for drugs and ambulance trips

In an annual opinion poll that measures satisfaction with public services published by *La Tribune* newspaper, the French health system received a 14 percentage point drop compared with a year earlier. Although 74% of those polled were satisfied with the speed of reimbursements, only 51% were satisfied with the amount that was being reimbursed (www.latribune.fr, 7 Dec 2007, "Les services publics sont-ils en danger?").

An article in *L'Express* magazine called the non-reimbursable charge Mr Sarkozy's only unpopular measure in his six months in power (Dec 2007, p 66)

Since 2004 patients have already been paying a €1 non-reimbursable charge for every visit to a doctor (*BMJ* 2004;328:1278) but critics fear the trend will leave a portion of the population without full health coverage.

PHILLIPE WOJAZER/AFP/GETTY IMAGES

President Nicolas Sarkozy's health proposals have been described as his only unpopular measure

operated hospitals in Germany demand better pay and conditions

already approved last year by university and public hospitals.

About 300 doctors demonstrated earlier this month in Bad Honnef, the town where contract negotiations were being held in the labour rights commission of Caritas, the Catholic church's organisation that oversees 500 of Germany's 2100 hospitals. The commission consists of an equal number of representatives of the employers and employees.

The mood between Marburger Bund and the churches in recent weeks has rapidly deteriorated after the trade union publicised results of its own poll of doctors indicating widespread dissatisfaction with church hospitals.

The German Association of Catholic Hospitals (KKVD), which is part of Caritas, also took offence at the trade union's press release which was headed: "Exploitation and salary theft: church hospitals are the worst employers." The union asserted that in comparison with public and university hospitals, church hospitals pay less, force doctors to work "illegal shifts," and often do not pay for overtime.

Church officials were particularly unhappy with a statement in the release from Frank Ulrich Montgomery, a former head of the Marburger Bund, that said that churches were committing "exploitation in the name of the Lord."

The Catholic and Evangelical hospital associations refuted the allegations of doctor dissatisfaction, saying that their doctors are generally highly satisfied. They both questioned the accuracy of the Marburger Bund poll.

Rudolf Henke, the new head of the Marburger Bund and a doctor at the Catholic church operated St Antonius Hospital, in Eschweiler, told the *BMJ*, "I am not disrespectful of the church in any way. We love the ethical approach of church hospitals. But what we want is that working conditions improve."

See www.marburger-bund.de/marburgerbund/index.php.

FDA may allow drug companies to promote "off-label" uses

Janice Hopkins Tanne NEW YORK

The US Food and Drug Administration (FDA) is proposing that drug and device companies can send doctors journal articles and reference materials about "off-label" or unapproved uses.

Representative Henry Waxman, the California Democrat who chairs the House of Representatives' Committee on Oversight and Government Reform, has strongly criticised the FDA's proposal and has posted the FDA's draft "Guidance for Industry" document on his website together with a letter that he has sent to Dr Andrew von Eschenbach, the FDA commissioner.

"Until the Bush administration, these risks of permitting dissemination of journal articles on off-label uses were recognized by the FDA," which had expressed "grave concerns" about the practice, he wrote.

The draft guidelines "would carve a large loophole in the law and create a pathway by which drug and device manufacturers can promote unapproved (off-label) uses of their products without first obtaining FDA approval . . . The draft guidelines appear to be an effort by FDA to displace Congress and establish by administrative fiat a new system for use of journal articles that lacks the safeguards set by Congress."

Waxman asked von Eschenbach not to implement the draft guidelines and to provide documents about communications between the FDA and executive branch (the White House and presidential staff) about the new guidelines.

Rita Chapelle, an FDA spokeswoman, told the *BMJ*, "Currently it is against the law for drug companies to market and sell drugs for off-label uses. The FDA will be responding directly to Representative Waxman" to address the contents of his letter.

GMC approves change in the standard of proof for fitness to

Clare Dyer BMJ

The General Medical Council approved a controversial new rule last week which will apply the lower civil standard of proof instead of the higher criminal standard at hearings to decide a doctor's fitness to practise.

The move to the civil standard of proof, which forms part of the Health and Social Care Bill now before parliament, is strongly opposed by the BMA. Moreover, all the medical defence organisations, which represent doctors facing disciplinary hearings, have voiced concerns about the change.

From April 2008, when the new rule is due to come into operation, fitness to practise hearings will no longer require facts in dispute to be proved beyond reasonable doubt (the criminal standard of proof), but only on the balance of probabilities (the civil standard).

However, the GMC insists that in the most serious cases, where a doctor's livelihood is at risk, the change will make little difference. It has taken advice from a QC, who confirmed that case law requires the civil standard to be applied flexibly and the more serious the allegation the more cogent will be the evidence required.

The QC, who the GMC refused to name, has told the council that in the more serious cases "application of the civil standard with the flexibility appropriate to the seriousness of the allegation and of the consequences for the practitioner should lead to the same result as would application of the criminal standard."

Graeme Catto, the GMC's president, said he was disappointed the BMA did not accept the new rule: "It will allow us to address more satisfactorily some of the less serious cases that come our way and ensure that doctors abide by conditions and address their practice before things get more serious."

He said six of the nine healthcare regulators already used the civil standard and others would have to adopt it if the bill became law.

Under the bill, the GMC will—from a date still to be decided—lose its right to rule on whether or not doctors are fit to practise. A new Office of the

NHS lambasted for not tackling race inequality

Caroline White LONDON

The NHS national director for equality and human rights, Surinder Sharma, has lambasted NHS trusts, including those taking a lead on the issue, for failing to make better progress on race equality.

Mr Sharma was speaking in London last week at the annual conference of the government sponsored Race for Health programme, which aims to boost race equality in the NHS.

Black and minority ethnic people were experiencing glaring inequalities in health outcomes, service provision, and employment opportunities in the NHS he said.

These were "unacceptable" and were a flagrant breach of the values on which the health service was founded, and they constituted a failure to deliver "fundamental human rights," he said. "We talk about it, but put it in the 'too difficult to do box'."

"We are not performing, and the boards and the chief executives need to take responsibility," he said, adding that the solutions were often not complicated.

But trusts even found it difficult to comply with basic legislation, Mr Sharma said. In November the Healthcare Commission's online audit of trusts' compliance with the Race Relations (Amendment) Act of 2000 showed that just 9% had published all the legally required documentation on their websites (www.healthcarecommission.org.uk).

This finding prompted the health services watchdog to announce an inspection of more than 40 trusts to check on what steps they are taking to meet their legal duties.

A number of the then 15 primary care trusts in the Race for Health programme were among those that were not fully compliant, said Mr Sharma.

Health minister Ivan Lewis, whose portfolio includes the race equality agenda, praised the achievements of the Race for Health trusts.

"But there's a long, long way to go," he said. "We won't be able to make the kind of progress I would like to see unless [race equality] becomes a mainstream issue for the NHS.

Exhibition celebrates work of pioneering plastic surgeon Archie McIndoe in second world war

Zosia Kmietowicz LONDON

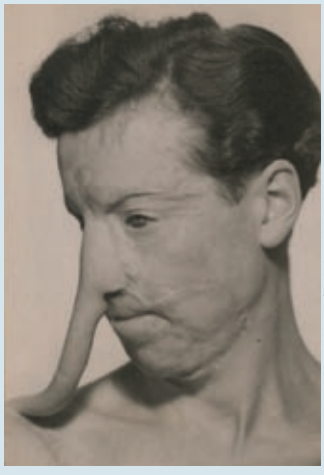
When he set off to fight for his country in the second world war, more than 60 years ago, it's unlikely that Bill Foxley ever imagined that his photograph would end up centre stage in an exhibition at the Royal College of Surgeons of England.

Mr Foxley, together with other RAF servicemen, received pioneering reconstructive surgery after burns injuries he sustained during the war. An exhibition of portraits by Nicola Kurtz of the surviving members of the Guinea Pig Club, which is what the group called themselves, can be seen at the Hunterian Museum until the end of the year.

The airmen were treated by the pioneering plastic surgeon Archibald McIndoe. The first photograph shows Mr Foxley undergoing a pedicle graft, during which the skin being donated remains attached to the donor site until the blood supply is established; the second as he is today.

Hamish Lang, secretary of the British Association of Plastic, Reconstructive, and Aesthetic Surgeons, said, "The exhibition at the Hunterian Museum is a great way of celebrating the modern roots of plastic surgery, then and now at the cutting edge of medicine."

The exhibition is at 34-43 Lincoln's Inn Fields, London WC2.



COURTESY OF BILL FOXLEY/THE GUINEA PIG CLUB ARCHIVE

NICOLA KURTZ

practise hearings

Health Professions Adjudicator (OHPA) will take decisions on conduct and fitness to practise for the healthcare professions, with the GMC and other regulatory bodies investigating and presenting cases.

The office's fitness to practise panels will consist of a medical or lay chair plus at least one lay and one professional member. The right of appeal against unduly lenient decisions, now with the Council for Healthcare Regulatory Excellence (CHRE), will be handed over to the GMC.

The bill puts the GMC's fitness to practise sanctions guidance on a statutory footing, and the Office of the Health Professions Adjudicator will be required to take account of the guidance.

Older people will be given budgets to buy personal care

Zosia Kmietowicz LONDON

A new way of funding social care in England was announced by the government this week. In future, individual budgets will be given directly to older people and people with disabilities so that they can buy their own personal care.

In what will be seen by many as a monumental shift away from top-down management from Whitehall, Alan Johnson, the secretary of state for health, said, "We want to give people more control over their services in order to increase their quality of life."

He announced £520m (€720m; $1100m) of ringfenced money, half of which would come out of the health budget, to support councils to redesign their services to better meet the needs of people who have to buy care.

He described the concordat *Putting People First* as "groundbreaking" for being the first time that central government has instigated a major shift in the way public services are delivered together with other agencies, this time including local government, the NHS, service users, and their carers.

Under the new system, which will take effect from next April, there would be more competition between service providers, which would leave no room "for care homes which do not respect people's dignity," said Mr Johnson.

Councils would also be expected to provide a "one stop shop," where people needing to buy care could get advice on the services available locally.

Putting People First **is at www.dh.gov.uk.**

UK government to spend £105m extra on stroke services

Robert Short LONDON

The health secretary, Alan Johnson, last week launched a new strategy for the treatment of stroke in the United Kingdom, aimed at preventing 1600 strokes a year and cutting 6800 deaths and disabilities. Stroke is the third biggest killer in the UK and the largest cause of severe disability.

Mr Johnson said, "What we are publishing today is a bold vision for the stroke services—covering prevention through to lifelong support."

This strategy has been developed in partnership with stakeholders, including representatives from stroke charities; stroke professionals in the NHS and social care professionals; and people affected by stroke and their carers. The national director for stroke and heart disease, Roger Boyle, supported by these stroke experts, led this work.

The strategy comes with £105m (€146; $215m) for national implementation. Most of this—£77m—will go into the development of acute and community demonstration sites to pioneer best practice.

Roughly £16m is allocated for 2008-9 to training for stroke consultants, nurses, and allied health professionals, and for 30 extra training posts for specialist stroke doctors. The remaining £12m is for activities to raise awareness of stroke nationally.

Professor Boyle said, "This is a very welcome investment up-front to redesign our services and improve them. We are looking forward to spending this £105m to good effect."

He outlined the key measures in the strategy. They include magnetic resonance imaging within 24 hours of symptoms for people who are at higher risk of full stroke who present with transient ischaemic attacks.

In the case of people at low risk, scans should be within seven days. This could lead to an 80% reduction in the number of people who go on to have a full stroke. Currently, less than 35% of providers manage to treat transient ischaemic attacks within seven days.

Immediate transfer of people with suspected stroke to a specialist centre offering immediate clinical assessment, scans, and clot busting drugs is another priority. All local areas will have 24 hour coverage seven days a week by at least one specialist centre.

People affected by stroke and their carers should have immediate access to high quality rehabilitation and support from stroke services in hospital, allowing people to get home faster. This specialist care should continue for as long as it is needed.

Professor Boyle emphasised that assisted discharge schemes would be important to insure "that patients get their rehabilitation services at home or in the community setting to the same level that they would expect in the hospital setting."

The strategy sets goals which NHS commissioners are expected to meet over the next 10 years. Noticeable progress over the next three years should be seen through the national stroke sentinel audit, Professor Boyle said.

Jonothan Earnshaw, secretary of the Vascular Society, said that patients in the United States already receive better treatment than the strategy proposed for the UK. "Patients in the United States can expect to be treated within one to two days of a TIA [transient ischaemic attack]. This report's recommendation for surgery within seven days is a step in the right direction but shows that, even if it is achieved, the NHS would still be some way off the ideal treatment for stroke."

SIMON FRASER/HEXHAM GENERAL/SPL

About £16m is allocated for 2008-9 to train stroke consultants, nurses, and other staff

He added, "Vascular surgeons know that preventative stroke surgery saves lives if it is carried out early. At present the ultrasound services that are vital for diagnosis are a log-jam as they are closed at weekends."

The report is at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062.

IN BRIEF

Screening halves the risk of dying from breast cancer: Screening for breast cancer lowers the risk of death from the disease, according to a case-control study of screening in East Anglia. "The effect of actually being screened was a 48% breast cancer mortality reduction," says the report in the *British Journal of Cancer* (2007 Dec 4 doi: 10.1038/sj.bjc.6604123).

Herbal products are found to contain prescription drugs: Investigations by the Medicines and Healthcare Products Regulatory Agency in the United Kingdom have found that some products being sold as herbal, natural, and safe contain prescription only drugs, such as sildenafil, tadalafil (Cialis), finasteride (Proscar) and clotrimazole. See www.mhra.gov.uk.

Mia Farrow warns of "genocide" in Sudan: The actress Mia Farrow (left) has highlighted the need to support victims of "the first genocide of the 21st century" at the launch of Fund4Darfur (www.fund4darfur.org), a charity set up to help survivors of the ethnic cleansing in the country.

ANDREW PARSONS/PA

Talks with Pfizer over drug trial in Africa suspended: Nigerian officials have walked out of settlement talks with Pfizer over a 1996 study in Kano, Nigeria, in which Pfizer gave an experimental drug to children during a fatal meningitis epidemic. A lawyer for the families in the $2.75bn (£1.3bn; €1.9bn) civil suit said that Pfizer had not shown "any seriousness" during talks (*BMJ* 2007;334:1181).

BMJ readership reaches all time high: Readership of the *BMJ* has reached an all time high: 69% of GPs and hospital doctors read it each week, the latest figures from the Joint Industry Committee of Medical Advertisers for Readership show. Readership among GPs grew by nine percentage points in the 12 months up to August 2007. Readership of the clinical research edition among hospital doctors rose by one percentage point in the same period. Readership of the *Lancet* and the *New England Journal of Medicine* stands at 9% among UK hospital doctors. Surveys by the *BMJ* before and after the redesign in January also identified a rise in regular readership among GPs and hospital doctors. The closure was announced this week of two medical magazines, published by Reed Elsevier: *Hospital Doctor* and *Doctor*.

Europe's research councils call for spending to be doubled

Rory Watson BRUSSELS

Europe's medical research councils have made a strong plea for an increase in public funding to strengthen research in this area and prevent Europe falling further behind the United States.

The call for public funding of medical research in Europe to be doubled over the next decade so that it reaches a minimum level of 0.25% of gross domestic product (GDP) comes with the publication on 6 December of a white paper by the European Medical Research Councils (EMRC).

In concrete terms, this would mean increasing the €40 (£29; $59) per capita now spent annually on medical research from the public purse in Europe to €80 by 2017.

Professor Liselotte Højgaard, the councils' chairwoman, said: "To be competitive worldwide, basic funding is important. We need to change our attitude towards research funding. The US has a large pot and spends half of it on medical research. Europe has a smaller pot and devotes only a quarter to this research."

According to the Strasbourg based body, which has 75 member organisations in 30 countries, the report is the first comprehensive analysis of the level of medical research funding in Europe.

It reveals that in 2004 (the most recent figure available), the US public sector spent between 0.37% and 0.40% of GDP on biomedical research and development whereas the then 15-member European Union devoted 0.17%. If the 12 countries that have since joined the EU were included, the gap would be even wider.

The white paper contains a bibliometric analysis of the output of medical research. This confirms that American biomedical publications attracted far more citations between 1996 and 2003 than their European counterparts. US publications received about 50% of total world citations, European publications 40%.

The medical councils are hoping that by drawing attention to the low levels of research funding in Europe they will be able to build up momentum among governments and the public for increases in the current rates. As part of their campaign they are organising a conference on the subject in Frankfurt at the end of January.

National authorities, rather than the European Union, would seem to be the best route for any early boost in funding. The European Commission has already committed €6.1 billion to health research for the 2007-13 period. This is unlikely to be increased before the next multiannual financing package is agreed four or five years from now.

Increased finance is just one of the five recommendations proposed in the white paper for strengthening medical research in Europe. Others are wider implementation of best practice for funding and performing research and more extensive collaboration and sharing of research results.

Present Status and Future Strategy for Medical Research in Europe **is available through www.esf.org**

Doctors' leaders were partly to blame

Adrian O'Dowd LONDON

Doctors' leaders are partly to blame for the disruption caused by the chaotic recruitment system for junior doctors earlier this year, MPs have been told.

The pressure groups Remedy UK and Fidelio, which took up the cause of junior doctors and senior doctors, respectively, told the parliamentary health select committee that their own existence and success was evidence of failings of the medical profession's leaders.

The committee questioned representatives from the two organisations as part of its inquiry into the Modernising Medical Careers (MMC) programme.

The committee chairman, Kevin Barron, Labour MP for Rother Valley, asked whether the leaders of the medical profession had lost touch with doctors.

Matthew Jameson-Evans, cofounder and press coordinator for Remedy UK, said, "It was apparently obvious in our success this year as an organisation that there was a failure of communication between the leaders of the profession and a feeling that the whole of MMC had been conceived behind closed doors.

"That's why we have succeeded. We have seen changes in the way the BMA communicates with their members and changes in the way the colleges behave with their members."

PRADO/GIRAUDON/BAL

Raphael, who painted the *Holy Family of the Oak Tree* (detail above) lived to the age of 37 years

Did sculpting give artists a health advantage before antibiotics?

Roger Dobson ABERGAVENNY

A study has shown that great sculptors live longer than great painters, and the reason may lie in the greater level of exertion needed for the first job compared with the second.

Old master sculptors lived on average three years longer than old master painters, and the physical work involved may have helped boost the ability of their immune systems to fight off infections in the age before antibiotics, researchers say (*Age and Ageing* 2007 Dec 3 doi: 10.1093/ageing/afm172).

In the study, the authors created a database of European old master painters and sculptors, excluding those who had lived in the 20th century. Although Michelangelo was also a painter, he is classed as a sculptor because, say the authors, that is how he saw himself. The final analysis was of 262 great painters and 144 great sculptors. All but six in the database were men.

Results show that that painters lived three years fewer than sculptors (63.6±0.9 versus 67.4±1.1), a difference that was statistically significant ($P<0.01$).

Painters were much more likely to die before the age of 40 than were sculptors (9.1 versus 2.7% of the population), and many more sculptors lived into their 80s (21% versus 13% of the population). Sixty per cent of the painters compared with 48% of the sculptors died before the age of 70.

The researchers also found that the difference in longevity between sculptors and painters was not related to geographical location. The same trend in longevity of sculptors compared with painters was seen among artists in each of the individual countries, which included Italy, England, France, the Netherlands, and Germany.

The biggest difference, a full 10 years, was in Germany, where sculptors lived to a mean of 71.6 years compared with 61.1 for painters.

The report says there are many possible explanations, including differences in diet and social class, as well as working with different toxic materials—solvents and heavy metals for painters and stone and silica dust for sculptors.

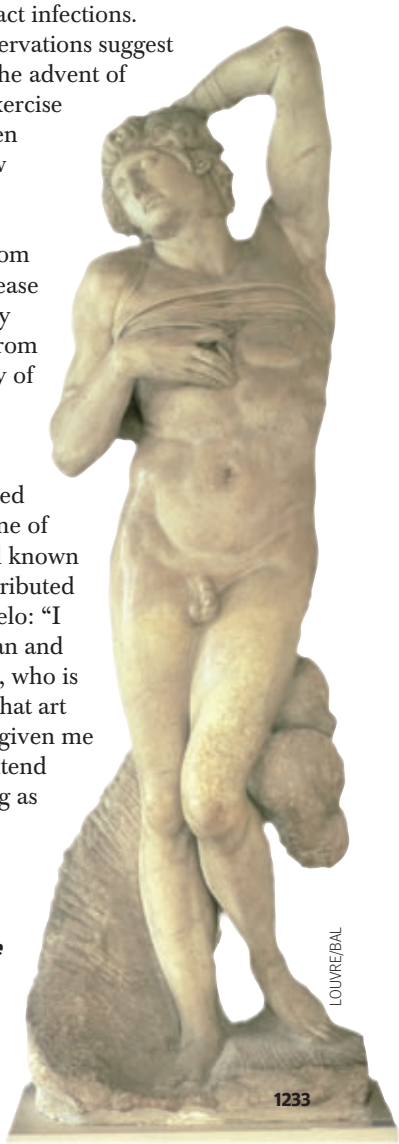
The authors say that any explanation for the significant difference in the age of death between sculptors and painters must take into account the leading cause of death in Europe before the 20th century—infectious diseases.

"One intriguing possibility in explaining the mortality difference between sculptors and painters is the effect of moderate exercise on the immune system, which affects both cardiovascular mortality and death due to infectious diseases," say the authors, who point out that sculpting stone expends more energy than applying tempera and oil to canvas or wood.

They say moderate exercise has been associated with increased B cell response and cite other research that shows that exercise in humans improves the antibody response after immunisation for influenza and reduces susceptibility to upper respiratory tract infections.

"These observations suggest that prior to the advent of antibiotics, exercise may have been one of the few interventions protecting individuals from infectious disease mortality," say the authors, from the University of Georgia.

That explanation may give added meaning to one of the more well known quotations attributed to Michelangelo: "I am a poor man and of little worth, who is labouring in that art that God has given me in order to extend my life as long as possible."



LOUVRE/BAL

Michelangelo, who sculpted the *Dying Slave* (right) lived until he was 89 years old

for recruitment chaos, MPs told

John Tooke, dean of Peninsula Medical School and head of the independent Tooke inquiry into MMC commissioned by the government, also gave evidence to the committee.

Sir John said a major failing of the system had been the lack of clear accountability, and added, "To set up something of this complexity and to introduce it at the speed that was required with ambiguous accountability around arrangements, deficient project management, and woefully inadequate risk escalation processes was the structural fault where much of the blame lies.

"But the very fact that accountability was ambiguous makes it difficult to pin singular responsibility."

When asked whether the medical profession was partly to blame, Sir John said, "I do think the medical profession failed to exhibit sufficient leadership, and we should have ensured that we had more influence.

"But the very fact that the accountability arrangements were not organised by the profession puts the weight of accountability towards the Department of Health."

As part of the consultation, Sir John's team had held eight "workshops" around the country with trainee doctors.

"It was that that revealed to us the distress at first hand that has been caused but also gave us a very real sense of the aspiration that trainees had for their future."