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NIH needs to tackle conflicts of interest

Janice Hopkins Tanne NEW YORK

The US National Institutes of Health (NIH) is lax in checking for conflicts of interest among the researchers who receive billions of dollars in its grants, says a report by the Office of the Inspector General of the Department of Health and Human Services, the institutes' parent agency.

It has recommended that grantee institutions report the nature of financial conflicts of interest and how they are managed to the NIH. The NIH has objected to that recommendation, however, saying that it should not have to take on that responsibility.

During the fiscal year 2007, the 24 institutes and centres gave more than $29.2bn (£14.7bn; €19.8bn) in research grants, 80% of which was distributed through about 50 000 competitive grants to more than 325 000 researchers at more than 3000 universities, medical schools, and other research institutions in the United States and abroad, the report says.

Although NIH policies require grantee institutions to report and reduce conflicts of interest, records were inadequate when the inspector general's office investigated reporting for 2004, 2005, and 2006.

The inspector general recommended in the report that the NIH take a more active role in overseeing grantee institutions to ensure their compliance with reporting requirements; require grantee institutions to report the nature of financial conflicts of interest and how they are managed, reduced, or eliminated; and to require NIH institutes, which receive the reports, to forward them to the NIH's Office of Extramural Research, which would maintain a central database.

The NIH agreed to increase its oversight of grantee institutions to see that they complied with conflict of interest regulations and to require NIH institutes to forward reports to the extramural research office.

The report and Chuck Grassley's comment are available at http://finance.senate.gov.

JAMES AKENA/REUTERS

Civilians flee fighting in eastern Congo in December as the death toll rises to 45 000 a month

Conflict in Democratic Republic of Congo claims 5.4 million lives since 1998

Peter Moszynski LONDON

As years of violence hopefully come to an end with the signing of a new peace agreement in the Democratic Republic of Congo, a survey of mortality estimates that the ongoing humanitarian crisis has claimed some 5.4 million lives since 1998.

According to figures released last week by the International Rescue Committee, the legacy of conflict continues to result in as many as 45 000 deaths every month.

"The conflict and its aftermath, in terms of fatalities, surpass any other since the second world war," said the relief agency's president, George Rupp.

"Congo's loss is equivalent to the entire population of Denmark or the state of Colorado perishing within a decade. Although Congo's war formally ended five years ago, ongoing strife and poverty continue to take a staggering toll. We hope this week's peace agreement in North Kivu will mean an end to the hostilities and a restart of reconciliation and recovery efforts."

The latest survey was conducted last year in association with the Melbourne based public health research body the Burnet Institute, and it covers January 2006 to April 2007.

Researchers visited 14 000 households in 35 districts in all of the Democratic Republic of Congo's 11 provinces. The final toll combines figures from four previous mortality surveys with data from the newest study.

The survey found that mortality remains "highly elevated" throughout the country, which currently hosts the world's largest United Nations peacekeeping operation in an attempt to end a conflict that has seen neighbouring states, renegade warlords, and tribal militias fighting over the impoverished country's vast mineral resources.

"Since our last study in 2004, there's been no change in the national [mortality] rate, which is nearly 60% higher than the sub-Saharan average," said Richard Brennan, director of the agency's global health programme.

Overall, an estimated 727 000 people "died in excess of normal mortality" during the latest survey period. Almost half of the deaths were among children under the age of 5, even though they comprise only 19% of the total population.

Dr Brennan told the *BMJ* that most of the deaths had non-violent causes, such as malaria, diarrhoea, pneumonia, and malnutrition, which are "easily preventable and treatable conditions when people have access to health care and nutritious food."

US Institute of Medicine recommends new body to assess which treatments work in health care

Janice Hopkins Tanne NEW YORK

The Institute of Medicine, part of the US National Academy of Sciences, recommended last week that the country needs an independent programme to evaluate "which diagnostic, treatment, and prevention services work best for various patients and circumstances."

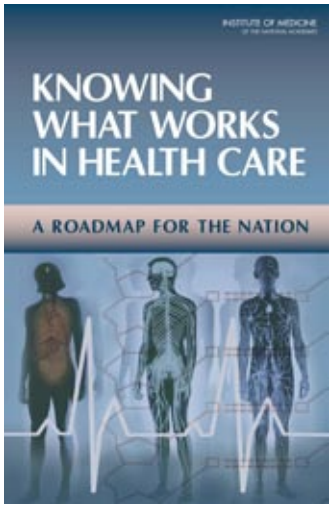
The institute's report proposes a single entity to provide "credible, unbiased information." It would be overseen by an advisory board "constituted to minimize bias," and its scope seems to be similar to that of the United Kingdom's National Institute for Health and Clinical Excellence (NICE).

"Under the status quo, the quality of systematic reviews is variable and findings are often unreliable even when published in peer-reviewed scientific journals," the report says.

Hundreds, even thousands, of competing guidelines exist, and there is uncertainty about which are reliable and objective. Guidelines that are paid for by manufacturers or vendors, as many are, are more likely to show effectiveness.

"Unfortunately, the current processes underlying guideline development are often vulnerable to bias and conflict of interest. Overall, the quality of clinical practice guidelines is often poor," the report says.

The report was sponsored by the non-profit Robert Wood Johnson Foundation. It says that the US Congress should "establish a single national clinical effectiveness program with sufficient resources, authority, and capacity to facilitate the development of standards and processes that yield credible, unbiased, and understandable syntheses of the available evidence on clinical effectiveness."



"Unbiased information" is needed

The highest priority should go to "clinical questions of patients and clinicians that have the potential for substantial impact on health outcomes across all ages, burden of disease, health disparities, and undesirable variation in the delivery of health services," the report says.

The new programme is needed because spending on ineffective as well as effective treatments "contributes to soaring health costs and rising insurance premiums." Furthermore, healthcare providers often disagree on treatments and clinical practice standards, the report says. "Patients and insurance plans cannot always be assured that providers are delivering the best, most effective care. Health [insurance] plans are burdened with the need to constantly learn how their covered populations might benefit from—or be harmed by—newly available health services," it says.

The institute's committee was chaired by Barbara McNeil, professor and head of the department of healthcare policy at Harvard Medical School and professor of radiology at Brigham and Women's Hospital in Boston. She said that the programme "would enable us to sort the wheat from the chaff and make sense of it all."

The committee outlined three steps towards evaluating evidence of effective healthcare services: "Setting priorities for evidence assessment, assessing evidence through systematic reviews, and developing (or endorsing) standards for trusted clinical practice guidelines."

It said that Congress should direct the US secretary for health and human services to create a programme with resources and capability to evaluate clinical effectiveness. The programme should be overseen by an advisory board "constituted to minimize bias" and should have representation from public and private sector interests. The programme should report annually to Congress.

Knowing What Works in Health Care: A Roadmap for the Nation **can be found at www.iom.edu.**

Pressure mounts to cut US spending on health care

Bob Roehr WASHINGTON, DC

Growth in spending on health care will determine the future economic policy of the US government, a financial adviser to the government has predicted.

Spending on health care is rising in the United States: the current cost of 16% of the gross domestic product is projected to reach 20% by 2016.

"In order to avoid an explosion of government debt, you have to cut spending by a third or raise revenue by a third, or some combination thereof," Peter Orszag told a Capitol Hill briefing this week. Dr Orszag is the director of the Congressional Budget Office, which provides analysis of existing programmes and proposed legislation for Congress.

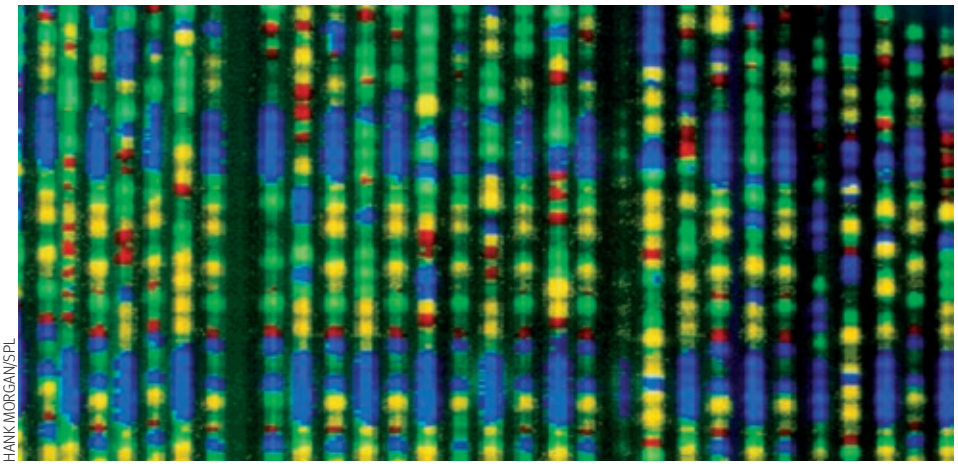
It would be possible to save $1500bn (£800bn; €1000bn) over the next 10 years by implementing a series of changes, said Cathy Schoen, coauthor of a report on healthcare reform from the charity the Commonwealth Fund. The report, released in December, offered 15 policy recommendations to save money.

Suggestions included setting up a centre for medical effectiveness and decision making in health care; introducing episode of care payments and negotiated prescription drug prices; and limiting federal tax exemptions for premium contributions. But it was important to start early for those benefits to accrue, she said.

"There is no magic bullet—no one approach alone gets us there," said Ms Schoen. Change must come through collaboration and integration, not simply dealing with separate pieces of the US healthcare system such as private insurers or the Medicare health insurance programme for elderly people.

"There are tremendous human and economic stakes if we don't come together and start to act now," she added.

Katherine Baicker, an economist at Harvard University, said that rising cost is the primary motivator for political reform, but the goal of reform should be broader than just cost containment: it



HANK MORGAN/SPL

Computer image of a coloured auto-radiogram showing sequenced complementary DNA

Consortium hopes to sequence genome of 1000 volunteers

Jacqui Wise LONDON

A thousand people are to have their genomes sequenced in an ambitious three year project that will create the most comprehensive catalogue so far of human genetic variation.

The 1000 Genomes Project is to be carried out by an international consortium including the Wellcome Trust's Sanger Institute in the United Kingdom, the US National Human Genome Research Institute, and the Beijing Genomics Institute in China. The estimated cost is between $30m (£15m; €20m) and $50m.

A thousand volunteers have already been recruited from Africa, Asia, America, and Europe. They have given informed consent for their DNA to be analysed and placed in public databases. The donors are anonymous and will not have any of their medical information collected because the project is developing a basic resource to provide information on genetic variation. The catalogue that is developed will be used by researchers in many future studies of people with particular diseases.

Data from the project will be made available to the worldwide scientific community through freely available public databases. Researchers will then be able to zero in quickly on disease related genetic variants and eventually use the genetic information to develop new strategies for diagnosing, treating, and preventing common diseases.

"We are moving forward to examine the human genome at a level of detail that no one has done before, expanding and accelerating efforts to find more of the genetic factors involved in human health and disease," said co-chairman of the consortium Richard Durbin, from the Sanger Institute.

To date only a handful of individuals, such as the scientist Craig Venter (*BMJ* 2007;335:530-1), have had their genes analysed in this way, because the process was hugely time consuming and expensive.

"This wouldn't have been possible only a year ago," said Tim Hubbard, head of informatics at the Sanger Institute. "The new types of sequencing technologies mean that we can now sequence a hundred times faster and cheaper than before, so it is economically viable to undertake such a massive project. We will be sequencing the equivalent of a human genome every day just at the Sanger Institute."

For details see www.1000genomes.org.

should seek to achieve better value. And that may sometimes entail more spending.

Dr Baicker noted the benefit of competition in private markets. "When there is more competition among insurers," she said, "that lowers the premium paid by everybody in the market, not just those with the particular companies." A similar effect is seen with compliance with best practices when there is competition among hospital providers: the quality of care improves.

Dr Baicker said that lack of information on effectiveness and cost inhibits rational decision making in health care.

***Bending the Curve: Options for Achieving Savings and Improving Value in US Health Spending* is available at www.commonwealthfund.org.**

Scientists campaign for liberalisation of stem cell law

Ned Stafford HAMBURG

Tensions are growing in Berlin ahead of a parliamentary vote that medical scientists say will determine whether or not Germany can continue to participate effectively in embryonic stem cell research.

The German parliament, the Bundestag, is scheduled to vote on proposals to liberalise the law on 14 February. The present law does not allow scientists in Germany to grow stem cells from human embryos, and allows them only to import stem cell lines derived from embryos before 2002. German scientists say that they need access to newer stem cell lines to compete and collaborate internationally.

Oliver Brüstle, a neuropathologist at the University of Bonn, told the *BMJ* that he and other stem cell scientists have visited Berlin to plead their case with MPs. Opponents of embryonic stem cell research also are active. "A lot is happening in Berlin behind the scenes," Dr Brüstle said.

Oliver Brüstle

Annette Schavan

Four proposals will be debated in the Bundestag before the vote:

- No change
- Moving the import cut-off date from 2002 to 1 May 2007
- Removing the import cut-off date altogether
- A complete ban on embryonic stem cell research.

Dr Brüstle said that scientists are lobbying for removal of the cut-off date, saying that although a more recent date would be an improvement, in a few years scientists would again not have access to the newest stem cell lines.

If the law is not changed, he said, "That would essentially put an end to human embryonic stem cell research in Germany."

Dr Brüstle, a Catholic, has attracted much criticism from the church, as has the German research minister Annette Schavan, also a Catholic, with a doctoral degree in theology. Dr Schavan in past years was outspokenly opposed to any change in the law but in recent months has given lukewarm support for "a one time move" forwards in the import cut-off date.

Scots try to contain costs of free personal care for older people

Bryan Christie EDINBURGH

Evidence shows that rationing is being introduced in Scotland to control rising demand for free personal care for older people.

Three quarters of Scottish local authorities have introduced eligibility criteria or set priority levels for access to the service. Scotland is the only part of the United Kingdom that provides people older than 65 with free personal care, which includes help with washing, dressing, and feeding.

A review by Audit Scotland has found that central funding for the policy now fails to meet the costs borne by councils, with the shortfall estimated at £46m-63m (€62m-€85m; $91m-$125m) in 2005-6. The report warns that costs will rise further as the proportion of elderly people in the population rises.

The provision of free personal and nursing care was one of the main recommendations of a royal commission that was set up by the UK government in 1997 to examine options for the long term care of elderly people (*BMJ* 1999;318:622 www.bmj.com/cgi/content/extract/318/7184/622). Scotland introduced the policy in 2002 but only free nursing care is available in England and Wales.

The policy has proved controversial, and concern has been expressed about its long term affordability.

It was also opposed by some leading politicians, who claimed it was an expensive policy that subsidised richer people because poorer people already qualified for free support. It has proved popular with older people, however, and by March 2007 about 72 000 people were receiving the service.

Audit Scotland estimates that the policy cost a total of £1.8bn in its first four years, but councils would have spent £1.2bn anyway in providing free care for people who were already eligible. The real additional cost is, therefore, £600m, but central funding is failing to keep pace with demand.

"Councils are using a variety of approaches to manage demand," says the report. "Differences in the use of waiting lists and eligibility criteria mean that older people may receive different levels of service depending on where they live. Older people are unclear about what free personal care means in practice." Eight councils charge for food preparation, for example, but that is provided free elsewhere.

Audit Scotland says that the policy was introduced without any outcome measures which makes it difficult to evaluate its impact.

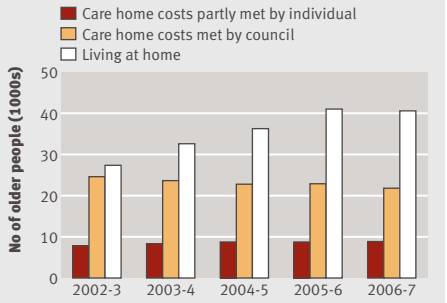
Audit Scotland recommends that

- A national eligibility framework is drawn up to ensure transparency in access to care
- Projections of cost are updated
- Clear information is provided to older people about what is covered by free personal care and who is eligible to receive it.

Robert Black, Scotland's auditor general, said, "It is well documented that Scotland has a growing older population, and demand for free personal care will grow. There needs to be better planning and better funding of this policy."

***A Review of Free Personal and Nursing Care* is available at www.audit-scotland.gov.uk.**

FREE PERSONAL CARE IN SCOTLAND



Source: *Audit Scotland.* A review of free personal and nursing care. Edinburgh: AS, 2008

A fifth of maternity

Susan Mayor LONDON

One in five maternity services in England—mainly in London—are failing to provide adequate quality of care and will have to produce action plans for improvement, warns a comprehensive review of maternity services published last week.

Some obstetricians countered that lack of a central information system and clearly defined quality indicators had prevented maternity services from being able to report data on clinical care requested by the review, resulting in their being labelled as "under-performing, despite other indicators demonstrating high quality care."

The Healthcare Commission, the watchdog that monitors quality of care in the NHS, carried out the assessment after concerns that this area of care currently accounts for one in every 14 cases referred on safety grounds to its investigation unit.

The review set performance benchmarks for maternity for the first time. It assessed all 148 trusts that provide maternity services in England in three main areas: clinical focus, woman centred care, and efficiency and capability. It used 25 indicators that had been identified as important by guidelines, clinicians, and a survey of women. These included the type of scans offered to women, staffing levels, women's assessment of the cleanliness of units, and the

Cancer centre opens in Glasgow

Bryan Christie EDINBURGH

A £115m (€155m; $228m) cancer centre, serving a population of 2.6 million in the west of Scotland and hosting a new clinical trials and research unit, was officially opened in Glasgow this week.

The Beatson Oncology Centre is the culmination of years of work to improve cancer services in the west of Scotland after they reached crisis point in 2001. At that time complaints about underfunding, delays for treatment, and compromised outcomes for patients led to resignations among consultants (*BMJ* 2001;323:1148).

The centre's medical director, Alan Rodger, said, "I am delighted that our staff of more than 700 are now able to work in a modern, purpose built cancer centre."

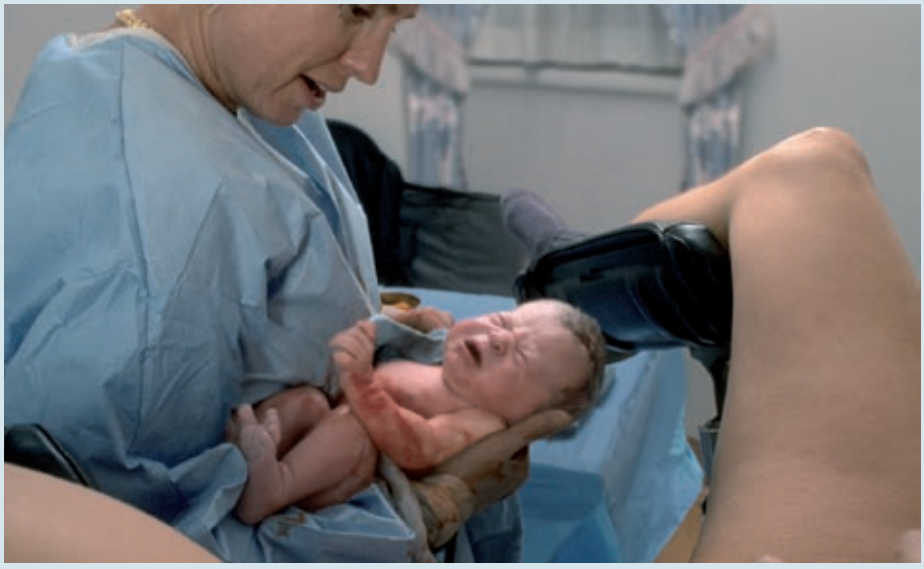
services in England are inadequate, review says

number of contacts with a midwife after women had gone home.

The Healthcare Commission ranked 31 trusts, just over one in five, as being "least well performing." These trusts scored at the lowest end of the performance distribution and lagged behind in a range of key areas. A similar proportion (32 trusts) were "fair performing." They were considered to need major improvement in at least one key area. Nearly a third (47 trusts) were "better performing," with scope for improving in some areas, while only 38 were classed as "best performing."

Trusts in London performed least well, with 19 out of 27 London trusts (70%) falling into the "least well performing" category. In contrast, trusts in the north of England performed relatively well, with 33 out of 44 trusts (75%) judged as "better performing" or "best performing."

Nationally, the review showed weakness in the availability and quality of data. A total of 103 trusts were unable to provide full data, which reduced their score. In the assessment of clinical care 11% of trusts were unable to provide data on major haemorrhages after delivery, which is considered important in managing this major risk. Sixty two per cent of trusts were unable to provide complete data on the effectiveness of interventions to manage the number of caesarean sections.



MICHAEL SALAS/RISER/GETTY IMAGES

Trusts in London performed least well, with 19 out of 27 falling into the lowest category

One of the major problems has been the failure of the National Programme for Information Technology to provide a system that maternity services can use, argued Derek Tuffnell, consultant in obstetrics and gynaecology at Bradford Hospitals NHS Trust. "The maternity module they offer has been a disaster," he said.

His unit was one of those labelled as "least well performing" in the review, even though the provision of care had already been judged to be good in other audits. It received low scores in some areas because the lack of an information system meant that the service did not have the required data.

Details of the maternity services review are available at www.healthcarecommission.org.uk.

Obstetric care must change if Netherlands is to regain its reputation for safe childbirth

Tony Sheldon UTRECHT

The number of deaths of babies during childbirth in Dutch hospitals is considerably higher at night than during daytime, claim two leading clinicians writing in the journal of the Dutch Medical Association (*Medisch Contact* 2008;63:96-9).

A lack of 24 hour cover by gynaecologists could be to blame, say the authors, Gerard Visser and Eric Steegers, heads of the obstetric departments of, respectively, the Utrecht university medical centre and the Erasmus university medical centre in Rotterdam. They write that the figures elicit a "strong suspicion" that obstetric departments are less safe outside normal working hours.

However, they argue that the whole chain of obstetric care, including the Netherlands' strong tradition of home births, needs to be scrutinised. Dutch obstetric care must "dare to make choices" and challenge "conservatism" if the country is to regain its leading position on perinatal deaths. The number of perinatal deaths in the Netherlands is 3.5 per 1000 births, the second highest in Europe.

Their article cites figures from the Dutch Foundation for Perinatal Registration covering 380 000 hospital births from 2000 to 2004. During weekdays the number of intrapartum and neonatal deaths was 23% higher between 11 pm and 8 am than during the daytime. At weekends the number of such deaths was 7% higher than during weekdays.

The professors say that, although gynaecologists have the final responsibility for patients, they are present on obstetric wards only during normal working hours, five days a week, before handing over to junior doctors.

Gynaecologists, they argue, are needed to interpret the monitoring of fetal heart rate or to avoid complications such as with the uterus or placenta, especially where women have a history of caesarean section. Such situations, they write, may require swift action not just from a gynaecologist but also from an anaesthetist, a paediatrician, and the operating theatre team.

Professor Visser said, "If you are there you act proactively. The moment you are home you are reacting: first there is a problem, and then they phone you. Most caesarean sections should be carried out within 30 minutes. That should be possible, but if you need an anaesthesiologist [and] a paediatrician, it can take longer.

"Do we want to pay for a healthcare system that has the same quality over 24 hours? If not, then we will not share the improvements seen in other countries."

IN BRIEF

Medical profession supports new training organisation for England: The Joint Medical Consultative Council, which includes representatives from the BMA and the medical royal colleges, has agreed unanimously to support the creation of a new national organisation, NHS Medical Education England, to oversee the funding and provision of medical education and training.

Deaths after experimental probiotics to be investigated: The Netherlands Healthcare Inspectorate is looking into an apparent increase in mortality in a trial of an experimental probiotic treatment for acute pancreatitis. Of 152 patients who were given probiotics 24 died (16%), whereas nine of 144 patients (6%) in the placebo group died (relative risk 2.5 (95% confidence interval 1.2 to 5.3)), in the Utrecht University Medical Centre's randomised, double blind trial.

Medical students report poor sex lives: Many medical students are dissatisfied with their sex lives, a survey at the University of California at San Francisco has found (*Journal of Sexual Medicine* 2008 Jan 15 doi: 10.1111/j.1743-6109.2007.00744.x). The results showed that 28% of male students were dissatisfied with their sex lives, 30% had erectile dysfunction, and 6% had low sex desire. Two thirds of female medical students (63%) were at high risk of sexual dysfunction.

More people quit after English smoking ban: The number of people who quit smoking through the NHS stop smoking services in England between April and September last year, during which the ban on smoking in public places came into force, was 28% higher than in the same period in the previous year. Nearly 165 000 smokers gave up. (See www.ic.nhs.uk/pubs/sss07q2.)

Health output rises but productivity falls: The volume of patient services provided by the NHS rose by 50% between 1995 and 2006, or 3.8% a year, according to estimates from the Office for National Statistics (www.statistics.gov.uk). However, since health spending increased faster than output, productivity fell by an average of 1% a year.

UK research application process is streamlined: A new online system called the integrated research application system has been launched to allow researchers to use just one form to apply to seven research bodies for approval for their projects (www.myresearchproject.org.uk).

Karolinska expels student after finding murder conviction

Ned Stafford HAMBURG

The Karolinska Institute, in Stockholm, has expelled a first year medical student who it admitted last year without knowing that he had served time in prison for murder with a firearm. The story has ignited parliamentary discussion in Sweden about the need to better screen medical students.

The Karolinska Institute first learnt of the student's violent past in early autumn through anonymous tips. Tipsters, who also notified news organisations, alleged that the 31 year old medical student Karl Svensson had been a Nazi sympathiser convicted of a murder in 1999 under his former name, Hampus Hellkant. The university and news organisations confirmed that Mr Svensson had been released from prison in early 2007 after serving six and a half years of an 11 year murder sentence.

Despite widespread, but not universal, sentiment in the medical community that a murderer should not be admitted to medical school, the university could not legally revoke Mr Svensson's admission on the grounds that he was a convicted murderer. In reviewing Mr Svensson's application, however, the institute learnt that his high school transcript had been falsified to show his current surname in place of his former name, giving the university legal grounds for his expulsion on 24 January.

Harriet Wallberg-Henriksson, president of the Karolinska Institute, told the *BMJ* that Mr Svensson would not have been admitted had admissions officials known he was a murderer.

Mr Svensson's fellow students last autumn were informed of his past, she said. Some students thought that he had paid his debt to society and should be given a second chance in life, including medical school, while others were frightened by the fact that they had a murderer in their midst. Asked about the mood on campus after the expulsion, Dr Wallberg-Henriksson said, "My general feeling is that most people are relieved."

Eva Nilsson Bågenholm, president of the Swedish Medical Association, said that a convicted murderer would not be allowed to practise medicine in Sweden. "If this case would have involved a medical doctor, he would have lost his authorisation immediately."

After paedophiles were found to be working in daycare centres a few years ago, Sweden adopted a new law mandating that schools and daycare centres check criminal records of job applicants, Dr Bågenholm said.

LASSE SKOG

Harriet Wallberg-Henriksson spoke of relief at the university after the student's expulsion

Last year police discovered child pornography on the computer of a doctor of internal medicine, sparking discussion about whether doctors should have to make any criminal convictions known, she said. Some doctors feared an invasion of privacy, and the discussion subsided with no action, she said.

But the Karolinska Institute case has revived the discussion, Dr Bågenholm said, adding, "The result of this could be that people going into medical school will have to show criminal records."

Strategy to stem

Henry Creagh LONDON

The UK government has launched a new strategy to encourage exercise and healthy eating in an effort to tackle the obesity "time bomb."

The strategy report, published by the health secretary, Alan Johnson, and the secretary of state for schools, children and families, Ed Balls, has pledged £372m (€500m; $740m) between 2008 and 2011 as part of a package to encourage healthy lifestyles in all age groups in the UK.

Measures include making cookery lessons compulsory in schools by 2011 and reviewing the restrictions on advertising of unhealthy foods. There will be investment in the cycling infrastructure, as well as efforts to get the food industry to reduce sugar, salt, and saturated fat in its products.

The strategy report suggests introducing a single approach to food labelling for use throughout the food industry. It does not favour a particular scheme, even though public health campaigners have been pressing the government to adopt the traffic light system, which is favoured by the Food Standards Agency. The report says that the government's future recommendations will be based on research

Double blind peer reviews are fairer and more objective, say academics

Zosia Kmietowicz LONDON

A large survey of academics from around the world has found strong support for the double blind system of peer review of research papers, where the reviewers and authors are unaware of each other's identity.

The survey, which resulted in 3040 responses to a questionnaire sent to more than 40 000 authors and editors (a response rate of 7.7%), found that 71% of respondents rated double blind reviewing as effective. In comparison, 52% rated single blind review, where only the reviewer is anonymous, as effective; and 37% considered post-publication review effective, in which anyone can review and rate a paper once it has been peer reviewed and published.

Open review, where the author and reviewer know each other's name, was the least popular method of peer review, with just 26% of respondents rating it as effective.

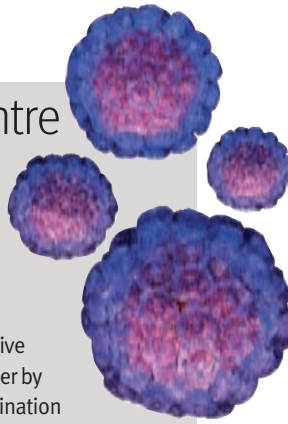
The survey respondents overwhelmingly favoured the double blind system of review because they said it was more objective and fair and removed potential biases, for example, because of the author's institution, race, or country or because of a reviewer's personal opinion of an author.

The survey was commissioned by the Publishing Research Consortium (a group of publishers and publishing associations that supports research into academic communication) to help understand peer review and to inform debate about its future role.

It found that 93% of respondents agreed that peer review was necessary and valuable in controlling the quality of published research. And although most respondents (64%) were satisfied with the current system of peer review, some also said that they had misgivings about the ability of the peer review process to detect plagiarism, fraud, or misconduct. Nearly a third of the respondents thought that the current system could be improved.

The survey can be seen at www.publishingresearch.org.uk.

European centre urges HPV vaccination



Rory Watson BRUSSELS

European governments are being urged to take preventive action against cervical cancer by organising nationwide vaccination programmes for young girls against the human papillomavirus (HPV).

The advice from the Stockholm based European Centre for Disease Prevention and Control (ECDPC) is contained in its latest scientific report, which was released at the European Cervical Cancer Summit in Brussels last week. However, it insists that this is no substitute for screening programmes.

Johan Giesecke, the ECDPC's chief scientist, said, "Vaccinating young adolescent girls against HPV is likely to reduce the number of women who develop cervical cancer, provided that cervical cancer screening programmes are maintained."

For guidance see http://ecdc.europa.eu.

RUSSELL KIGHTLEY/SPL

the rise of obesity criticised as "feeble fantasy"

now being undertaken by the agency.

The government also intends to investigate whether financial incentives such as payments or vouchers could be used to encourage people to lose weight. The report said that in the United States small financial payments, as part of broader programmes to tackle obesity, have proved effective.

The strategy was attacked by Jack Winkler, director of the Nutritional Policy Unit at London Metropolitan University, who claimed it was a "feeble fantasy" to say that labelling was the key. He said that there was a need to improve the food that people already eat.

Obesity rates in the UK have been rising for 30 years, and the report identifies an acceleration of this in the late 1980s and early 1990s. The rate of increase in England is greater than most comparable European countries, it says.

In England, nearly a quarter of men and women are now obese. According to the Foresight report published last year, on current trends nearly 60% of the UK population will be obese by 2050.

The chief medical officer, Liam Donaldson, said the strategy had come at a vitally important time. "Physical activity, healthy eating, balanced marketing, and promotion of food to children and clear and consistent food labelling are all key components in beating the obesity time bomb," he said.

Ed Balls said: "Tackling obesity in the adults of tomorrow requires winning the hearts and minds of the young people today." He said he wanted to see an end to the "no ball games culture," increased play and sports facilities, food education for children, and the stamping out of the junk food culture in schools.

The idea of tackling poor diet at an early age was to combat the "conveyor belt" effect, where statistics have shown that childhood weight problems continue into adulthood.

See www.dh.gov.uk and "Is it acceptable for people to be paid to adhere to medication?" (*BMJ* 2007;335:233).

PAUL DOYLE/PHOTOFUSION

Children in Hounslow: learning about food is crucial to tackling obesity