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Intensive glucose lowering arm of trial is halted after deaths

Susan Mayor LONDON

The National Heart, Lung, and Blood Institute, part of the US National Institutes of Health, has stopped the intensive glucose lowering arm of a major trial in type 2 diabetes after more patients died than in the standard treatment group.

The action to control cardiovascular risk in diabetes (ACCORD) study involved 10 251 adults aged 40-82 years with type 2 diabetes who had two or more additional risk factors for heart disease or who already had a diagnosis of heart disease.

They were randomised to intensive glucose lowering treatment, in which the target haemoglobin A_{1c} (HbA_{1c}) concentration was <6%, or to less intensive, standard treatment to reach the average HbA_{1c} (7% to 7.9%) currently achieved in the United States by such treatment.

The Data and Safety Monitoring Board, the independent group that was monitoring the trial, recommended that the trial be stopped when it found that more deaths occurred in the intensive treatment group.

A total of 257 patients died in the intensive treatment arm over an average of four years of treatment, whereas 203 in the standard treatment group died. This was a difference of three participants per 1000 each year: 14 per 1000 per year in the intensive group and 11 per 1000 in the standard treatment group.

The death rate in each group was lower than that seen in similar groups of participants in other studies, which has typically been about 50 per 1000 per year.

The ACCORD researchers were surprised by the higher number of deaths in the intensive arm, for which they have no reason so far. They say that it could be due to the adverse effects of lowering blood glucose concentrations too much in older diabetic people or the adverse effects of a particular drug or drug combination or that it could be a spurious observation that might have disappeared with longer follow-up.

The study was designed to test the strategy of intensive glucose lowering rather than any specific drug treatment.

ADRIAN DENNIS/REX

Driving limit should be lowered to 50 mg of alcohol per 100 ml of blood, the BMA says

BMA proposes set of measures to tackle alcohol misuse

Roger Dobson ABERGAVENNY

Routine screening in primary care for alcohol misuse, reduced opening hours of licensed premises, higher taxes on alcohol, a lowering of the drink driving limit, random roadside breath testing, and tobacco style health warnings on bottles are all urged in a new report from the BMA's board of science.

The board's evidence based recommendations for change aim to tackle the burden of alcohol misuse in the United Kingdom and are targeted at policy makers.

"The levels of alcohol related disorder, crime, morbidity, and premature mortality in the UK are unacceptably high," said Charles George, the board's chairman. "It is essential that the UK governments implement alcohol control policies that are evidence based and proven to reduce alcohol related harm."

The report says that since 1950 annual alcohol consumption in the UK has risen from 3.9 litres pure alcohol per person to a peak of 9.4 litres in 2004 and has remained above seven litres since 1980.

It says that it is essential that the excise paid on all alcoholic beverages be increased at a rate higher than inflation and that it be proportionate to the percentage of alcohol. It points out that affordability of alcohol (price in relation to income and adjusted for inflation) in the UK rose by 65% from 1980 to 2006.

It also proposes that the number of hours that on-licensed and off-licensed premises can be open should be reduced to lessen the availability of alcoholic products and that planners should take the density of local on-licensed premises into account when making decisions on licensing. The report points out that public health was not considered as one of the factors when parliamentarians drew up the Licensing Act 2003, which permitted 24 hour opening in England and Wales.

It also recommends a ban on irresponsible promotional activities in licensed premises, minimum prices for drinks, and a ban on broadcasting of alcohol advertising at any time when such advertisements are likely to be viewed by young people.

The legal limit on the concentration of blood alcohol while driving should be reduced from 80 mg per 100 ml to 50 mg per 100 ml, it says, and it advocates legislation allowing random roadside testing without the need for suspicion of intoxication. The report also says that it should be a legal requirement to prominently display a common standard label on all alcoholic products.

***Alcohol Misuse: Tackling the UK Epidemic* is available at www.bma.org.**

IN BRIEF

Italian psychiatrists call for greater access to electroconvulsive therapy: Doctors from medical schools throughout Italy have called on their government to provide more centres for electroconvulsive therapy to treat serious depression during this week's national congress of the Italian Society of Psychiatry. They said that modern methods of applying the treatment have reduced the risk of side effects.

Moderate alcohol intake raises hypertension: Moderate alcohol consumption increases the risk of hypertension, a study based on 28 848 women from the US women's health study and 13 455 men from the physicians' health study has found. The threshold above which alcohol increased risk of hypertension emerged as being four or more drinks a day in women and one or more drinks a day in men (*Hypertension* 2008 Feb 7; doi: 10.1161/HYPERTENSIONAHA.107.104968).

Audit shows violence against mental healthcare professionals: More than half of nurses who work in mental health wards in England and Wales have reported being physically assaulted at work, rising to almost three quarters (73%) of nurses who work in wards that include patients with dementia. The results came from the second national audit of violence in mental health services conducted by the Royal College of Psychiatrists on behalf of the Healthcare Commission.

Bundestag postpones vote on stem cell research: A parliamentary vote on whether to liberalise Germany's embryonic stem cell law, to leave it unchanged, or to make it more restrictive was postponed until at least the middle of March (*BMJ* 2008;336:237, 2 Feb). The controversial matter was debated on 14 February in a packed Bundestag for almost four hours in an emotionally charged atmosphere, with none of the different proposals close to having majority support.

Report warns of limited global efforts on tobacco control: Only 5% of the world's population live in countries that fully protect their population with any one of the key measures, such as legislation, recommended to reduce smoking rates, according to a report from the World Health Organization. It also says that governments around the world collect 500 times more money in tobacco taxes each year than they spend on antitobacco efforts (www.who.org).

Charity names those countries which "squander" resources

Peter Moszynski LONDON

Ten million children under 5 years old die each year across the world, warns Save the Children in a new campaign aimed at getting countries back on target to achieve the millennium development goal to reduce mortality in under 5s by two thirds by 2015.

The charity has compiled a "wealth and survival index" that compares child mortality in each country with its national income per person. It claims that the index shows "who is making the most of what they have and who is squandering their resources."

Its director of policy, David Mepham, said, "A child's chance of making it to its fifth birthday depends on the country or community it is born into. This sounds like a lottery, something beyond human control, but this should not be the case."

He added, "While poverty and inequality are consistent underlying causes of child deaths, all countries—even the poorest—can cut child mortality if they pursue the right policies and prioritise their poorest families. Good government choices save children's lives."

Sub-Saharan Africa accounts for almost half of all childhood deaths and has 19 of the worst performing countries, despite economic growth in the region that is almost three times the global average. Oil rich Angola is singled out for "failing to convert its relatively high income into a real difference to the number of child deaths."

Data for Angola show that despite the country having nearly three times the income of the next on the list (Sierra Leone) mortality among children under 5 is only slightly lower. Angola's death rate of 260 per 1000 is 162 higher than would be predicted for the size of the country's economy.

From 2000 to 2006 Bangladesh's gross national income per capita rose by 23% and its child mortality among under 5s dropped by 25%. India's gross national income per capita rose by 82% but its child mortality fell by only 19% over the same period.

The report considered that Bangladesh is a success. It says, "In 1998 the government put its resources and its political weight behind a national initiative to tackle childhood illness and reduce levels of fertility. Ten years later that policy decision has paid off. Bangladesh, despite its relatively low GNI [gross national income], is one of the few countries on track to meet the child survival millennium development goal."

Save the Children is calling on governments of developing countries and international donors to:

- Invest in free health care, clean water, and sanitation and to support women's education and act against poverty
- Convene a global summit on hunger among children and mothers
- Agree clear targets that focus on the effect of policies on maternal and child health and nutrition, and
- Tackle health inequality as part of the millennium development goals.

"Change is possible," Mr Mepham said. "This report shows what can and must be done to help save children's lives. If we want to get the world on track to deliver the goals we need to maximise the big opportunities of 2008, like the G8 [meeting] in July and the UN general assembly in September."

Saving Children's Lives: Why Equity Matters **is available at www.savethechildren.org.uk.**

Abortion becomes hot political issue in

ANDREAS SOLARO/AFP/GETTYIMAGES

Women scuffle with police at a demonstration in Rome

Fabio Turone MILAN

Men and women took to the streets of Italy last week to protest about police behaviour towards a woman who had had a late abortion for fetal abnormality.

A police patrol of seven rushed into the Naples University Hospital, Federico II, after they received an anonymous phone call saying that an illegal abortion had taken place in the hospital's gynaecology department.

Bipartisan "war cabinet" to improve health of Aboriginal people may prove difficult

Stephen Pincock SYDNEY

The Australian prime minister, Kevin Rudd, has vowed to establish a bipartisan "war cabinet" to help tackle the stark disadvantages faced by indigenous Australians.

The promise, which has been welcomed by many in the field of indigenous peoples' health, followed Rudd's historic apology last week to the "stolen generations"—the tens of thousands of Aboriginal, Torres Strait Islander, and mixed race children taken from their families between 1910 and 1970.

"For the pain, suffering, and hurt of these stolen generations, their descendants and for their families left behind, we say sorry," Mr Rudd said in parliament.

After delivering his apology, Mr Rudd called on the opposition leader Brendan Nelson to co-chair a policy commission. Although details are yet to be made public, its first business would be to implement a housing strategy for remote communities in the next five years.

These goals fit with Mr Rudd's broader stated aims of halving the gap in infant mortality, childhood literacy, and numeracy and employment within a decade. Figures from the 2006 census show that the life expectancy of indigenous Australians is about 17 years less than the rest of the population. Infant mortality is as much as three times higher for indigenous peoples' babies.

Dr Nelson, a GP, has said that he accepts the invitation. Yet Mr Rudd's Labor party, which won office in November last year, has often differed from the Liberal-National coalition, which held power for the preceding decade, on how to tackle health matters for indigenous peoples.

MICK TSIKAS/REUTERS

Kevin Rudd (centre right) and Brendan Nelson pose with Aboriginal performers at the apology ceremony

And in the days after Mr Rudd's announcement, signs emerged that those differences might prove a considerable hurdle in the way of true bipartisanship. The opposition indigenous affairs spokesman, Tony Abbott, for example, expressed concerns in the *Australian* newspaper (www.theaustralian.news.com.au, 15 Feb, "Division hits 'war cabinet'").

"The government will not get bipartisanship from us . . . in watering down the Northern Territory intervention," he said, referring to a controversial initiative launched by the former government to tackle child abuse in indigenous communities (*BMJ* 2007;335:691).

So far almost 6000 children have undergone general primary care health checks as part of the intervention, but concerns have been raised about what is being done to follow up after conditions are identified.

The ophthalmologist and former president of the Australian Medical Association, Bill Glasson, told the Australian Broadcasting Corporation that not one specialist had arrived in the Northern Territory to treat patients.

run up to Italian election after police question a patient

Press reports say that the police interrogated the 39 year old woman as she got back to her room immediately after the procedure and seized the aborted fetus, even though the head of the department rapidly proved that the procedure was legal, as an amniocentesis at week 21 had shown that the fetus was affected by Klinefelter's syndrome.

The police raid was seen by many people as intimidation and caused demonstrations all over Italy. Livia Turco, health minister in Romano Prodi's outgoing centre left government, took part in a demonstration in Rome.

"The witch hunt is on," she said. "What happened reflects the intolerable climate of tension surrounding one of the most dramatic choices for a woman."

Abortion, which has been legal in Italy since 1978, is becoming a major issue as political parties prepare for parliamentary elections in April.

The 1978 law was passed in an attempt to curb widespread clandestine abortions carried out unsafely. Under the law a woman can ask for a termination within the first 90 days of pregnancy when, for economic, social, or family reasons, the pregnancy might put her physical or psychological health at risk. Later interventions, up to the sixth month, are legal when it can be shown that the woman's life is at risk or the fetus is at serious risk of illness.

Recent data that Ms Turco presented to the Italian parliament in October 2007 show that the number of terminations in Italy has been steadily falling since 1982. Around 59% of gynaecologists, 46% of anaesthetists, and 39% of non-medical staff in the units that carry out abortions are conscientious objectors, which often makes it difficult for women to obtain timely assistance.

BMA polls GPs on extended hours and private provision

Adrian O'Dowd MARGATE

GPs are being asked by the BMA to comment on government health policy and on new private providers in general practice as part of an ongoing argument over extended hours.

The BMA launched a poll of its GP members on the two options put forward by the government to extend opening hours but included several other political questions in the poll.

Although the BMA is unhappy about either option, it has urged its members to choose the government's first option as the lesser of two evils. Under this option GPs' surgeries would be open for an extra 30 minutes a week per 1000 registered patients, after 6 30 pm or before 8 am or on a Saturday morning (*BMJ* 2008;336:351). The extension would be funded by redirecting £158m (€210m; $308m) from the 2007-8 contract together with an extra 1.5% uplift in the value of the contract.

Under the alternative proposal, general practices would lose 135 quality and outcomes framework (QOF) points, and money for increasing access would be transferred to primary care trusts, which could spend it on using private providers.

Both options are voluntary, but failure to participate will mean a loss of earnings. The BMA says that under the first option an average practice will lose £18 000 in resources if it does not provide extended hours, but under the second option it would lose £36 000.

Government must do more to support war veterans, MPs say

Helen Mooney LONDON

The government must do more to support war veterans and the families of service personnel, says a report published by the House of Commons Defence Select Committee.

The report, published on Monday, has found that although the clinical care of servicemen and servicewomen injured in manoeuvres is "world class," more needs to be done to help veterans and the families of personnel in the armed services, particularly in the provision of mental health services.

The chairman of the committee, James Arbuthnot (Conservative MP for Hampshire North East) said that the Ministry of Defence (MoD) needed to do more to look after families and veterans.

He said that although the government had made steps to extend priority, fast track, access to health care for veterans "too much is being left to good intentions and good luck."

"Unless the NHS can identify those who are entitled, priority access can be an empty promise. There also needs to be better recognition of the challenges service families face."

Mr Arbuthnot also called on the defence ministry to ensure "better long term mental health care for veterans."

"People who have served their country often develop psychological problems many years later, and there have to be more effective ways of tracking, monitoring, and treating them properly. We need to ensure that veterans are handled by those who understand their experiences and the challenges they face," he said.

The committee visited the ministry's Royal Centre for Defence Medicine in Birmingham where most service personnel are treated.

It found that although the clinical care given to injured service personnel at the centre was "excellent," welfare provision was not of the same standard. "The committee urges the MoD to make welfare provision an integral part of its plan for Birmingham," the report says.

It also says that the treatment of mental health problems in service personnel and veterans is "mixed" and it adds that although the provision for serving personnel is "adequate" there is room for improvement.

Restricting entry of overseas medical

Lynn Eaton LONDON

Health secretary Alan Johnson defended his department's decision to try to restrict the number of medical graduates entering the United Kingdom from outside the European Economic Area (EEA) during his evidence on Monday afternoon to the parliamentary health select committee.

Kevin Barron, chairman of the committee, which is investigating the government's Modernising Medical Careers (MMC) policy, asked whether the minister felt a moral obligation towards those overseas doctors who had helped to support the NHS for so long.

"No one could suggest in any way that this is failing to meet some moral obligation. This is the right way to go," Mr Johnson said. "The contribution international medical graduates have made has been enormous.

"You are quite right we would not have been able to run the health service without their contribution. But we have drained the world of medical graduates. I don't think it was the right policy for other countries."

Now that there were four new medical schools in England it "simply didn't make sense," he said, to continue to accept overseas graduates into specialist training posts.

The department announced on 6 February that, from 28 February, overseas migrants newly applying under the highly skilled migrants programme will not be able to take

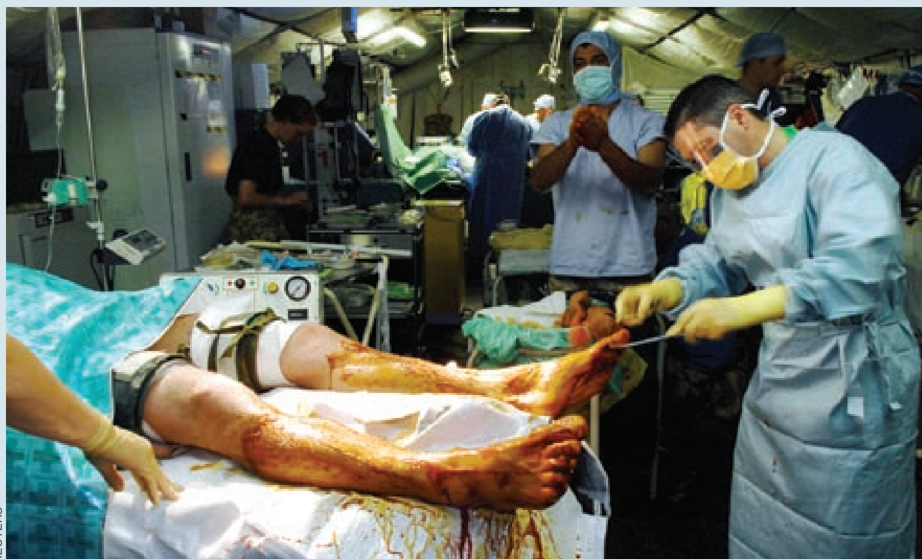
Artist consults children over works for new centre

Susan Mayor LONDON

Abigail views one of the works of art commissioned specially for Sunshine House, a new £8.5m (€11.3m; $16.6m) centre in Southwark, south London, that brings together a range of specialist services for children and young people with special needs, disabilities, and complex needs.

The artist, Milou van Ham, from Rotterdam, involved the centre's children in deciding the themes and words for her sculptures. The works were commissioned and paid for by Guy's and St Thomas' Charity.

RICHARD BAILEY/GUY'S AND ST THOMAS' CHARITY


REUTERS

The work of British surgical staff in places such as Afghanistan (above) is "world class," MPs say

However, it warns that "many problems only come to light several years after people have left the armed forces, and there is currently no proper system for tracking ex-servicemen and women and making support available to them."

The committee acknowledged that the defence ministry works with the charity Combat Stress to provide respite care but concluded that "more needs to be done."

It said that the NHS currently had no systematic way of deciding which veterans were eligible for care. "A more robust tracking system would allow those who have served their country to receive the benefits to which they are entitled. This is part of what should be 'wrap around' care for veterans."

***Medical Care for the Armed Forces* is at www.publications.parliament.uk/pa/cm200708/cmselect/cmdfence/327/32702.htm.**

graduates is the "right way to go"

up a post as a doctor in training. This will affect the 2009 intake but not those already accepted under the programme and who are already working here in training posts.

The department is also consulting on plans to restrict entry to specialist posts from 2009 to people who fall within a strict definition of EEA citizen. It is also awaiting a House of Lords hearing into whether it acted illegally by trying to impose a series of restrictions on overseas graduates.

The committee had earlier heard from Home Office officials that the Department of Health's move to restrict applicants from overseas was first mooted in 2005, before the first major change to the rules in April 2006.

The restriction imposed on doctors by the highly skilled migrant programme had, said MPs, been criticised by the Foreign Office as an "unwelcome precedent." Mr Johnson said it was a "government decision."

He outlined the department's plans for handling international medical graduates should the House of Lords appeal fail. The preferred option, he said, was to introduce restrictions through employment law, stating that non-EEA graduates would be accepted only for places that could not be filled by EEA graduates.

"If the appeal is not upheld we will look to other options," he said. "We don't like using the highly skilled migrant programme. The Home Office were reluctant to take that route."

One option, he said, was to charge a fee to all doctors who did not work a set number of years in the NHS after training. This would mean that the cost of their training was covered and also that migrant doctors could compete directly for posts.

"The other is to see where we could just introduce legislation from my department."

Under questioning Mr Johnson rejected suggestions that it might have been better to phase in MMC gradually.

England's chief medical officer, Liam Donaldson, who also appeared before the committee, said that phasing in MMC could have created problems for doctors applying for posts in different specialties had one specialty switched to the new system while another remained on the old system.

See Career Focus doi: 10.1136/bmj.39485.377002.DB. Proposals for managing applications from overseas medical graduates are at www.mmc.nhs.uk.

BMA calls for NHS constitution to reduce political interference

Owen Dyer LONDON

The BMA is urging the government to adopt a formal NHS constitution that would set out the responsibilities of the service in England and a new governance structure for administering it.

Under the plan, an NHS board of governors and an NHS executive management board would take responsibility for managing the day to day running of the NHS and for overseeing performance.

The medical profession, says the BMA, has become concerned that the volume and pace of reform in recent years have "destabilised the health service and alienated large sections of its dedicated staff."

Noting that "much of the intervention from the centre results from the politicians' fear that their careers may suffer at the hands of a stuttering NHS," the BMA also calls for a greater role for parliament in setting broad health policy. Although the secretary of state would continue to determine overall priorities, the document says that "the element of the department concerned with NHS matters should be significantly reduced."

Hamish Meldrum, chairman of the BMA council, said, "Such an important institution as the NHS should not be used by competing politicians trying to outbid each other with extravagant and unrealistic claims. We need to transform the culture of the health service from one of politicisation to one of professionalism."

The BMA is also calling for a new patients' charter, but the proposed document would bear little resemblance to the Patient's Charter established in 1992, which was formally abandoned in 2001. Although that charter set maximum waiting times and guaranteed patients rights in areas such as choice of hospital food, the BMA argues that such details are better left to "other governance structures."

Instead, it proposes a charter that would set out the fundamental rights of patients, in the manner of the *European Charter of Patients' Rights*. This would include the right to confidentiality, the right to a choice of treatment where feasible, and the right not to accept treatment.

See Career Focus doi: 10.1136/bmj.39485.377002.DB. *An NHS Constitution: NHS Values, a Patients' Charter and Greater Independence* is at www.bma.org.uk.

FDA officials admit they inspected wrong heparin plant

Janice Hopkins Tanne NEW YORK

Baxter Healthcare Corporation, which provides half the supply of heparin in the United States, recalled multidose vials of heparin sodium last month after four deaths and 350 reports of adverse events, 40% of which were serious.

More than one million multidose vials are sold each month in the US, and half of them are produced by Baxter, the US Food and Drug Administration said. The source of the heparin, which is made from pig intestines, was imported from China. The FDA said it had not inspected the Chinese plant that produced it.

The initial recall of heparin last month involved nine lots of multidose vials. Since then, Baxter has received reports of adverse reactions with other lots, the company said. Baxter and the FDA are investigating the problem.

A report in the *New York Times* said that a manufacturing facility in China, Changzhou SPL, which produced the ingredient for heparin, does not have a Chinese drug licence, although it has not been accused of providing a harmful product (www.nytimes.com, 16 Feb, "China didn't check drug supplier, files show"). The article said that the plant has no drug certification, so the Chinese drug agency did not inspect it, and the FDA said it had not inspected the plant either, "a violation of its own policy."

Attempts to reach Changzhou SPL were directed to Scientific Protein Laboratories in Waunakee, Wisconsin. As the *BMJ* went to press the company had not returned the *BMJ*'s telephone calls. Scientific Protein's website says that Changzhou SPL is one of its manufacturing sites. The website states, "Heparin Sodium USP, produced at this site, was approved by the FDA in 2004 under a US NDA [new drug application] for import and use in the United States."

On Monday the FDA said it had not inspected the Changzhou plant that produced the heparin ingredient because it confused the name with that of a similar plant it had already inspected, the *Washington Post* has reported (www.washingtonpost.com, 19 Feb, " FDA says it approved the wrong drug plant").

GPs challenge PCTs as practice contracts go to private firms

US firm takes control of three GP surgeries

JOHN BEHETS

Brunswick Medical Centre alerts patients to change

Susan Mayor LONDON

Two groups of GPs have written to two primary care trusts (PCTs) in London expressing concern about the potential effect on the quality of care after a second contract to run a general practice has been awarded to a private company rather than to local GPs.

Camden Primary Care Trust announced in late January that it had awarded the tender to run three GP surgeries—King's Cross Road Practice, Camden Road Practice, and Brunswick Medical Centre—to UnitedHealth Primary Care (*BMJ* 2008;336:295, 9 Feb).

Four local GPs who bid for Brunswick Medical Centre, which they had been managing successfully for the previous six months, have written to Camden PCT expressing their concern that "patient care will suffer." They believe that the decision was based "purely on cost, as opposed to quality."

Previously, another London PCT, Tower Hamlets, awarded a tender to run St Paul's Way Medical Centre to Atos Origin, an international information technology services company. Again, local GPs who had bid to run the practice were unsuccessful.

Tower Hamlets Local Medical Committee (LMC), which represents practices in the area, wrote to the PCT outlining its "loss of confidence in the PCT's commitment to providing good quality primary care." It said, "The LMC is concerned that factors such as continuity of care and the doctor-patient relationship will ultimately have to be sidelined in order to meet the financial targets put forward by Atos Origin."

The GPs bidding for the Brunswick Centre practice said that their bid had initially been approved by Camden PCT as "affordable" and was judged to be of higher quality in some areas than the bid from UnitedHealth. Camden PCT scored the group of GPs higher than UnitedHealth in clinical areas, with 468/550 points (85%) for core services and 37/50 points (74%) for clinical governance. UnitedHealth scored 360/550 (65%) and 31/50 (62%) in these areas. The GPs also scored higher in the service development plan total, with a score of 761/950 (80%), against UnitedHealth's 645.5/950 (68%).

The trust's service specification stated that submitted bids would need to achieve a minimum of 80% of points available in each section in order to be shortlisted. Even though neither of the two bidders achieved this (although the GPs scored just over 80% overall), both groups continued to the next stage.

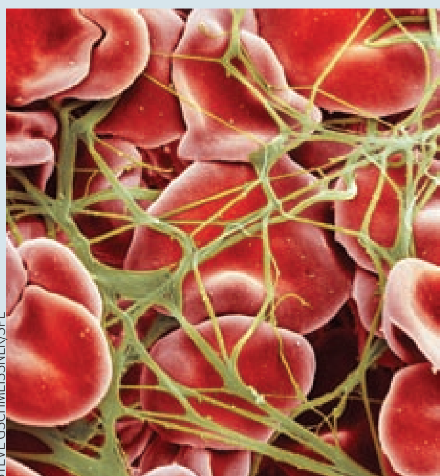
The trust then added a value for money measure, which the GPs said had not been mentioned to them in the specification, by comparing the service development plan total with the proposed baseline price. This gave a total score for the GPs of 7.61, against 8.62 for UnitedHealth, and the trust gave the contract to UnitedHealth.

One of the group of GPs, Stephen Graham, said that because they had costed their bid on the basis of providing services that scored as high as possible in terms of quality of care, their bid had inevitably been more expensive. He said, "It appears that cost cutting has won hands down over quality of service provision."

Another of the GPs, Richard Halvorsen, added, "This is another example of a cut price privatised service being imposed on patients against their will. I fear that patients will suffer as a result of this cut price privatisation."

In response Peter Smith, director of primary care at UnitedHealth, said, "UnitedHealth's focus in delivering primary care services is to strengthen the quality and availability of health care where it's needed most. Like all GPs we are contracted by the local PCT to deliver high quality care, and we can only succeed if we meet the targets demanded of us. We use our experience to understand the unique needs of community and develop services to meet these identified needs in partnership with patients, staff, and local PCTs."

The local medical committees remain concerned that GPs missed out in the PCTs' decisions. Stephen Amiel, chairman of Camden and Islington LMC and a GP in Kentish Town, London, said, "There was clear evidence that the bid accepted did not score the highest on quality markers." He said that the value for money measure used by Camden PCT should


STEVE GSCHMEISSNER/SPL

Four US patients died after being given doses of the clot busting drug heparin from China

be made public to ensure that the decision making process is completely transparent.

Commenting on its decision Camden PCT said, "It was clear from the start that we were looking for the best bid at the best value. This is standard procurement practice."

It further said, "Camden PCT's procurement policy is to ensure that contracts offer both high quality services for local people and good value for money for the taxpayer, in line with current procurement legislation."

It added that the winning bidder scored highest against the overall selection criteria communicated to all bidders. "The successful bidder will be contractually required to deliver the service specification in its entirety and not a percentage of it."

Doctors' leaders fear that GPs are doomed to fail in bids to run practices. Dr Amiel said, "The dice are loaded against GPs in lots of ways. Even when they have demonstrated quality in the practice they are bidding for, with the advantage of local experience and knowledge, they are unable to compete."

The GPs who had been running the Brunswick Medical Centre had increased the practice's opening hours from 36 to 45 hours a week and set up several new initiatives designed to meet local needs.

And GPs bidding for the St Paul's Way practice had previously been praised by the PCT for their high standards of care, Tower Hamlets LMC said. Its chairman, Sella Shanmugadasan considers that further bids to run practices will be awarded to private companies rather than to GPs. He said, "The LMC is concerned about the implications for the future . . . especially [about the fact that] six practices are still currently managed by the PCT and that these could potentially be awarded to private organisations."

Indian doctors hope that scandal over illegal kidney transplants will spur cadaver scheme

Ganapati Mudur NEW DELHI

India's health ministry, in the wake of a racket involving illegal kidney transplantations, has announced plans to promote donations from cadavers. It will allow more hospitals to harvest organs from brain stem dead patients and offer incentives to relatives of dead donors.

Police have arrested a doctor, Amit Kumar, and his associates, for allegedly performing hundreds of clandestine kidney transplantations in Gurgaon, an industrial town near New Delhi. Police claim that Dr Kumar used a network of touts to lure poor people into giving up their kidneys for payments of about 60 000 rupees (£770; €1030; $1510) and that the organs were transplanted into patients from India, Europe, and the United States.

India outlawed trade in human organs in 1994, but transplantation surgeons have said that organ sales have persisted because of a shortage of cadaver donors and collusion among donors, doctors, and patients.

But the scale of the operation in Gurgaon has surprised health officials and the medical community. Police have alleged that Dr Kumar transplanted kidneys into some 600 patients in a residential building turned into a transplantation clinic.

The health ministry will seek to introduce free medical insurance, free periodic medical check-ups, and a priority position on organ waiting lists for relatives of brain dead patients whose organs are used.

"A massive public education campaign is long overdue," said Samiran Nundy, the head of surgical gastroenterology at the Sir Ganga Ram Hospital, New Delhi, who had helped draft India's Human Organ Transplantation Act of 1994.

Doctors estimate that fewer than 1200 cadaver organs have been donated in India since the act banned the organ trade and defined brain death to facilitate cadaver transplantation. About 3000 kidney transplantations and some 150 liver transplantations are carried out each year, most of them involving organs from live, related donors. Transplantation surgeons are hoping that the Gurgaon scandal will accelerate plans to launch a national organ transplantation programme.

The health ministry is also assessing proposals to make it mandatory for hospital staff to ask for organs in the event of brain death, to educate the public on cadaver transplantation, and to ensure that hospitals where organs can be retrieved are not linked with hospitals where transplantations are performed.

"Such a delinking will dramatically increase the number of organs available," said Sunil Shroff, managing trustee of the Multi Organ Harvesting Network Foundation, a non-government agency that has been promoting cadaver transplantations in southern India.

"India's transplant scandals have themselves created an environment where doctors find it difficult to approach relatives of brain dead patients for organs," said Subash Gupta, a liver transplantation surgeon at the Apollo Indraprastha Hospital, New Delhi.

Last year police in Tamil Nadu investigated the sale of kidneys by women from a settlement for survivors of the 2004 south Asian tsunami.

In two unrelated cases earlier, police had arrested doctors from Mumbai and Amritsar for facilitating trade in kidneys (*BMJ* 2004;328:246; *BMJ* 2003;326:180).

MANAN VATSAYAYANA/AFP/GETTYIMAGES

Indian labourer Mohammad Salim lost a kidney in the latest scandal in Gurgaon, 30 km south of New Delhi