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GMC: Put patients' needs ahead of your beliefs

Clare Dyer BMJ

Doctors must be prepared to set aside their religious and other personal beliefs if these compromise the care of patients, according to the latest ethical guidance from the UK General Medical Council.

This could include removing a Muslim doctor's face veil if it impedes proper communication between patient and doctor, the guidance implies.

"Some patients, for example, may find that a face veil worn by their doctor presents an obstacle to effective communication and the development of trust," it says.

"You must be prepared to respond to a patient's individual needs and take steps to anticipate and overcome any perceived barrier to communication. In some situations this may require you to set aside your personal and cultural preferences in order to provide effective patient care."

Doctors who oppose abortion on grounds of conscience are told that although they may refuse to carry out the procedure they must tell the patient of her right to see another doctor and make sure that she has enough information to exercise that right. If she cannot readily arrange to see another doctor, they must ensure arrangements are made for an alternative doctor to take over her care without delay and must not leave the patient with "nowhere to turn."

They must also not refuse to provide care for patients before or after an abortion, however much they may object to the procedure. They must also refrain from trying to impose their personal or religious views on patients.

The rules on conscientious objection that cover abortion also apply to doctors who object to the circumcision of male babies, unless clinically indicated, on the grounds that the child cannot give informed consent.

And a doctor who opposes cremation but is the only person legally able to sign the cremation form as medical attendant cannot refuse to sign on the grounds of belief. Refusal could lead to a referral to the coroner and a postmortem examination, causing delay and distress to the relatives.

The guidance also covers Jehovah's Witnesses' refusal to accept blood transfusions. The doctor should not make assumptions about a Jehovah's Witness's attitude to blood and blood products but should seek the patient's views and answer any questions. The guidance suggests contacting the Watch Tower Society, which keeps details of hospitals and doctors specialising in "bloodless" medical procedures.

Sheikh Muhammad Yusuf, fellow of the Interfaith Alliance, said, "We strongly support the GMC's commitment to providing guidance for doctors on issues of belief and faith in clinical practice. Doctors are in a position of power in relation to their patients. This guidance makes it clear that any attempt by doctors to impose their religious or political views would be an abuse of that power."

The GMC's guidance is at www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs/personal_beliefs.asp.

English trusts will be allowed to advertise their services

Deborah Cohen BMJ

NHS trusts and organisations that provide NHS funded health care will be allowed to advertise their services as part of a government drive to improve patient choice, the health minister Ben Bradshaw has said. The announcement came at the launch of a code of practice for services funded by the NHS.

From this April GPs will be able to refer patients to NHS hospitals and some independent sector treatment centres anywhere in England for routine elective treatment.

The government hopes that by allowing providers to promote their services, patients will be empowered "to have a real say in their treatment" and that publication of information on the quality of services will "provide an incentive for improvement."

Healthcare providers will be able to compete for business by advertising results such as their waiting times, surgical outcomes, and rates of methicillin resistant *Staphylococcus aureus*

Testimonials and endorsements from celebrities, medical experts, and patients will also be allowed if they have had direct experience and are not paid to give them.

Hospitals will be permitted to get sponsorship from companies as long as it does not undermine the "NHS brand" and the companies are not associated with gambling, alcohol, tobacco, weight control, or politics.

According to the code, statistics "should be based on the most recently available data." But Jonathan Fielden, chairman of the BMA's Consultants Committee, said, "We still have a long way to go in collecting and having access to accurate, reliable, and meaningful data that enable patients, working with their doctors, to make full knowledgeable choices about their treatment."

Mr Bradshaw also said that the government would start a £600 000 advertising campaign in local newspapers and on radio to promote the principle of patient choice. The government hopes pressure from patients will encourage GPs to offer a broader range of choice.

Patients will be told they have the right to choose

IN BRIEF

Project cuts suicides among men faster than among women: Researchers at Sydney University's school of psychology have found that the rate of suicides among men in Australia has fallen faster than among women since the introduction of a national suicide prevention programme in the mid-1990s (*Health Policy* 2008; Mar 17 doi: 10.1016/j.healthpol.2008.01.009).

Smelly shoes can interrupt a fit: A scientific explanation for the tradition of using smelly shoes as a first aid measure in epilepsy in some poor countries is proposed in *Clinical Neurology and Neurosurgery* (2008 Mar 18 doi: 10.1016/j.clineuro.2008.02.006). H Jaseja of G R Medical College in Gwalior, India, suggests that strong olfactory stimuli can increase the epileptic threshold and interfere with seizure activity in the limbic system.

Control of drug resistant tuberculosis demands better laboratories, WHO says: The World Health Organization says that inadequate laboratory facilities in the Asia Pacific region are hindering efforts to control the spread of drug resistant strains of tuberculosis. Less than 1% of cases of clinically diagnosed multidrug resistant tuberculosis are confirmed by a laboratory in the WHO's Western Pacific region. See www.wpro.who.int.

Agency prosecutes for illegal sale and supply of drugs: The UK's Medicines and Healthcare Products Regulatory Agency has successfully prosecuted a 45 year old man from Sheffield this month for the illegal sale and supply of the obesity drugs orlistat (Xenical) and sibutramine (Reductil). Robin Huxley, who was jailed for 14 months, obtained the drugs while working for the drug industry and later sold them through his slimming clinics in Barnsley. See www.mrha.gov.uk.

Vietnam starts human trials of bird flu vaccine: Vietnam's military is to start human trials of a bird flu vaccine in March at the Military Medical Academy in Ha Tay province near Hanoi. See www.reuters.com/article/healthNews/idUSHAN17707420080318.

Poll shows *BMJ* readers evenly divided on inflight help: *BMJ* readers voted narrowly in favour of the idea that doctors should be legally obliged to offer help in an inflight medical emergency: 53% (452) in favour and 47% (397) against.

Drug industry anxious about scrapping price regulation scheme

Andrew Cole LONDON

Almost half (46%) of the United Kingdom's drug companies expect to cut back on clinical trials in the coming year because of continued uncertainty about future arrangements for pricing drugs.

In a survey of more than 100 companies earlier this month on behalf of the Association of the British Pharmaceutical Industry and the Confederation of British Industry three quarters said they had little confidence in the current UK market environment, and 83% expected things to get worse in the next year.

The survey also showed that 30% of companies expect to cut staff in the next year, and more than a third expect to reduce research and development and investment in buildings and equipment. Two in five anticipated cutting back on manufacturing in the UK.

Despite this, almost two thirds thought their own business would grow in the coming year, and 43% thought their performance would improve. But nearly all respondents thought they would face increasingly difficult conditions and greater uncertainty.

Drug companies' leaders have blamed this erosion of confidence on the government's decision to scrap the pharmaceutical price regulation scheme, which sets the cost of prescription drugs, and to replace it with a new scheme from September 2008.

Nigel Brooksby, the association's president, said a "black cloud of uncertainty" had been hanging over the industry for the past eight months.

The scheme had been in place for 50 years and had provided predictability, stability, and sustainability. Drug companies needed this to make long term investments "but some of this stability has now gone."

Companies were also increasingly concerned about the slow pace at which new drugs were coming onto the market in the UK. The uptake of new drugs had deteriorated in recent years despite extra money being pumped into the NHS.

As a result patients were being treated with older drugs that were less effective. "It is surely in the interests of fairness and patient equality to make sure the right medicine gets to the right patient at the right time."

This was the first time the government had decided to terminate an existing pricing arrangement and renegotiate it, said the association's director general Richard Barker. The industry is discussing a deal with government based on much broader principles than before.

The survey was conducted by the research company ComRes (www.comres.co.uk).

Older, rural, and single handed GPs have highest earnings

Adrian O'Dowd MARGATE

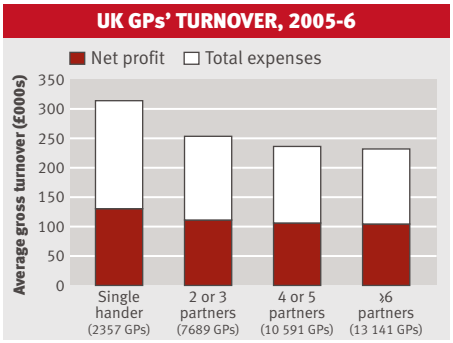
GPs working singlehandedly earn an average of £132 010 (€168 240; $265 100)—about £26 000 more than doctors who work with six or more partners, official data show.

Overall GPs' average pay has doubled in real terms in the past 20 years, according to newly published figures from the NHS Information Centre.

The figures also show that doctors' earnings rise as GPs get older until the age of 60, with an average earning of £117 820 for GPs in the 50-59 age group.

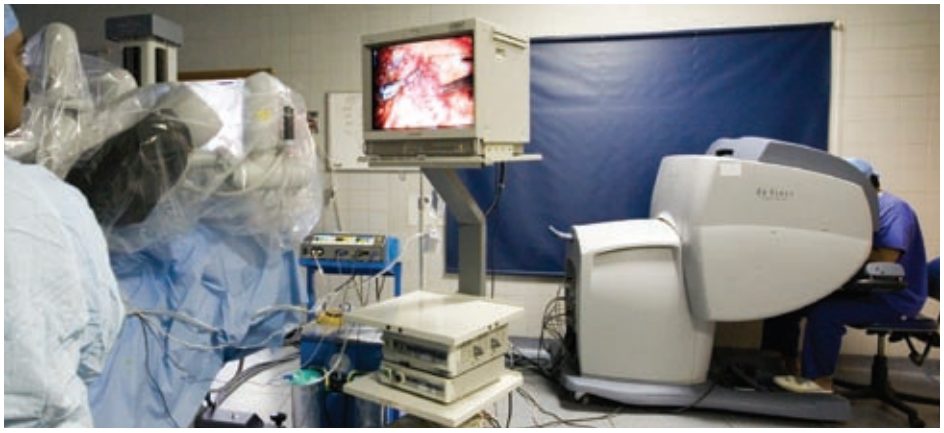
The statistics, from the NHS Information Centre, look at the changes in family doctors' pay as well as how pay varies with factors such as age and number of partners.

The *GP Earnings and Expenses Enquiry 2005/06 Final Report* presents an analysis of tax returns for a sampled 17 581 GPs on contracts and 2743 salaried GPs, who earned an average of £46 905 in 2005-6.



An interim report published last October showed that GPs with contracts in the UK earned on average £110 004 in 2005-6. Doctors working on a general medical services contract (most GPs) earned on average £106 312.

Details in the final report show that this compares with average earnings of £25 254



MARK THOMAS

Prokar Dasgupta performs a prostatectomy using a robot, the video of which is transmitted to a meeting several miles away. Because the surgeon is seated at a console, the operation induces less fatigue.

Robotic prostatectomy transmitted live to engineers

Susan Mayor LONDON

A radical prostatectomy using a robot was transmitted live to a group of surgeons and mechanical engineers last week to stimulate collaboration between the professions and encourage developments in robotic surgery.

The operation was performed at Guy's Hospital, London, by Prokar Dasgupta, reader and consultant urological surgeon at the hospital and King's College London, School of Medicine, and transmitted to an audience at the Institution of Mechanical Engineers in London.

"For the last couple of years we have been collaborating with our mechanical engineers at King's College London to refine and develop new robotic tools," he said. "Working with highly qualified scientists has the potential to take these tools from bench to bedside, which we believe is the way forward."

Consequently he and Jian Dai from King's College London organised a two day conference to discuss the latest developments in robotic surgery; hear about patients' feedback; debate future directions with industry figures; and consider the ethical issues involved.

Although about 60% of radical prostatectomies in the United States are performed using robotic surgery, with more than 400 robots in use, the proportion is much lower in the United Kingdom, where there are only nine robots. Mr Dasgupta estimates that the proportion is 5-10% although other urologists say it could be higher.

Mr Dasgupta says that robotic surgery has several advantages. "Non-randomised results show that the wristed, tremor-free instruments of the robot and the magnified three dimensional vision lead to better results. The operation induces less fatigue in the surgeon, who is comfortably seated at a console.

"We have experimental data to show that a less tired surgeon possibly does a better job for his patients."

He added that patients recover more quickly, usually stay in hospital for only about 36 hours, compared with the usual week. Patients also enjoy better cancer control after such operations and better maintenance of erections because nerves were less damaged.

Peter Brett, chairman of the institution's medical committee, said that more than 20 000 patients in the United Kingdom had benefited from some kind of robotic surgery in the past year but that this was "merely scratching the surface. In terms of the potential for robotic surgery," he said, "we are right at the beginning.

(£51 512 in today's terms, taking inflation into account) in 1985-6, although work done has changed. Doctors who work on a personal medical services contract earned an average £120 272 in 2005-6, an increase of 9% since 2004-5. GPs on contracts in rural practices earned on average £116 967, compared to £108 455 for urban GPs.

A spokesperson for the NHS Information Centre, said, "Our figures for 2005-6 show that GPs' earnings vary widely depending on a range of factors, including the size of their practice. At £132 000 the average earnings of GPs working in singlehanded practices continues to be substantially more than GPs working in larger practices."

Laurence Buckman, chairman of the BMA General Practitioners Committee, said that earnings for 2005-6 had been superseded by events, and two years of zero pay awards had left most GPs worse off than they were in 2005-6.

***GP Earnings and Expenses Enquiry 2005/06 Final Report* is at www.ic.nhs.uk.**

Agency rejects research on food additives

Rory Watson BRUSSELS

The European Food Safety Authority has rejected suggestions in a study by researchers at Southampton University last year of a link between hyperactivity in children and two mixtures of food colours and the preservative sodium benzoate (*Lancet* 2007;370:1560-7).

In a highly critical assessment, the authority points to considerable uncertainties, lack of consistency, and absence of information in the study, which was commissioned by the UK Food Standards Agency.

As a result, the authority, which advises the European Union on food safety, maintained that there is no basis for changing present recommendations on the acceptable daily intake of the food colours or sodium benzoate.

After a request from the European Commission, the Parma based authority asked its panel on food additives, flavourings, processing aids, and food contact materials to assess the study's findings that the colourings and preservative in the diet led to more hyperactivity in 3 year old and 8-9 year old children.

In its report, published on 14 March, the panel listed its many reservations about the study's findings. It pointed to the lack of consistency in the results with respect to the age and sex of the children and the type of observer (parent, teacher, or independent assessor); the unknown clinical relevance of the effects measured; and the lack of information on any dose-response relation.

The panel also maintained that the fact that mixtures were studied made it impossible to identify the effects of individual additives and noted the absence of a plausible biological mechanism that might explain the possible link between behaviour and the consumption of colours.

The report is at www.efsa.europa.eu.

Compulsion replaces persuasion in open access

As the National Institutes of Health makes it compulsory for its researchers to publish their results on an open acess site, **Susan Mayor** looks at the policies of other funders

Susan Mayor LONDON

The chief public funding body for medical research in the United States, the National Institutes of Health (NIH), is introducing a mandatory open access policy from next week. All papers resulting from research that it has funded will have to be made freely available to the public no later than one year after they have been published.

This is the latest policy from key research funders to promote open access to research findings (table). It is based on the argument that the public should have free access to results from research that it has funded, and researchers should have free access to papers they have written or reviewed rather than have to pay subscriptions or single access fees to journals. Open access publishing also makes research freely available to help advance research around the world.

There are two main publishing models for open access. Researchers can publish their findings in a journal that offers an open access option, such as journals published by BioMed Central and the Public Library of Science, by contributing towards the costs associated with publication. Alternatively, they can submit their research to a journal that charges readers to access papers provided that the research is placed in a free online repository after a certain time. The *BMJ* uses a third way, however, charging neither authors nor readers for full and immediate access to research papers, funding this from the journal's overall revenue.

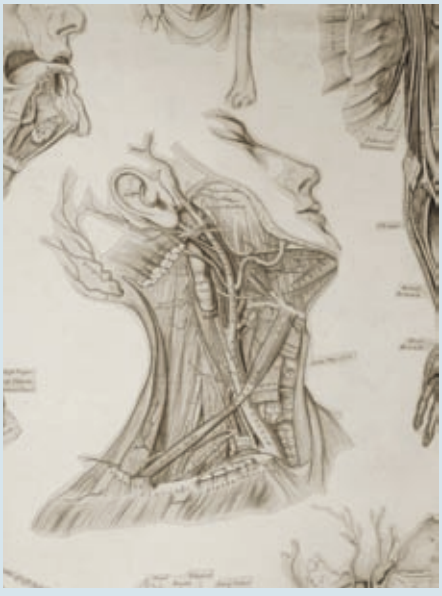
The NIH policy uses the term "public access" rather than the more common "open access." It makes it mandatory for researchers to make electronic versions of any peer reviewed papers they publish that are based on NIH funded research available on the National Library of Medicine's PubMed Central, the free NIH digital archive of full text, peer reviewed journal articles, no later than one year after publication. This replaces a previous voluntary policy, which had a poor compliance rate, of less than 10%. The change follows a law passed by Congress at the end of December 2007 that requires research funded by the NIH to be openly accessible (*BMJ* 2007;335:906).

Policies mandating open access to publicly funded research have been in place in Europe for some time. The Wellcome Foundation, a large UK based charity that funds medical research, introduced a policy in October 2006 that requires electronic copies of research papers accepted for publication in peer reviewed journals that they supported wholly or in part by its funding to be made available through PubMed Central and UK PubMed Central "as soon as possible and in any event within six months of the journal publisher's official date of final publication."

The UK Medical Research Council (MRC) has a similar policy, also introduced in October 2006, that requires researchers to make papers freely available within six months of publication.

In its latest guidelines, the scientific council of the European Research Council (ERC) reduced the time from one year to six months by which peer reviewed publications from council funded research projects should be available on open access. In an indication that the timescale may be shortened further, the guidelines noted that "the ERC is keenly aware of the desirability to shorten the period between publication and open access beyond the currently accepted standard of six months" (*BMJ* 2008;336:176-7).

Universities are also starting to require their staff members to make their papers freely available. In February Harvard University's faculty of arts and sciences (which does not include the medical school, although a university spokesman said it is working on an open access policy), adopted a policy that will put faculty members' papers in an open access repository hosted by the university. Details are yet to be decided as to how quickly faculty members would have to place papers in the repository.



Exhibition hopes to give *Gray's Anatomy* artist his

Wendy Moore LONDON

When two friends, both young surgeons at St George's Hospital, London, joined forces in 1855 to create a practical and affordable anatomy textbook for students they could have had little idea of the eventual success of their project. Celebrating its 150th anniversary this year, with its 40th edition about to roll off the press, *Gray's Anatomy* has become the world's longest running and probably best known anatomical work.

Yet, although the book's author, Henry Gray, has become a household name, its illustrator, Henry Vandyke Carter, has rarely been honoured.

Attempting to redress the balance, the Royal College of Surgeons of England is staging an exhibition at its headquarters in Lincoln's Inn Fields, London, from 3 April to 2 May, which tells the story of the origins of *Gray's Anatomy*. The display will include two first editions of the book as well as first proofs of the wood block engravings made from Carter's exquisite drawings.

Gray, a well off and well connected surgeon and anatomist, worked shoulder to shoulder with Carter, his shy and retiring colleague, performing the dissections required for their book. While Gray wrote the clear and straightforward text, Carter provided the detailed illustrations.

When finally published in 1858, as *Anatomy, Descriptive and Surgical*, the work was immediately acclaimed for its simple, well organised layout and clarity. Uniquely, as in the illustration of the arteries of the neck from the proofs of the first edition (pictured), labels were integral to the drawings. Yet Gray attempted to sideline Carter's contribution,

Open access policies

Funding body	Where to archive	Start date	Deadline after publication (months)	Voluntary or mandatory
National Institutes of Health	PubMed Central	7 April 2008	12	Mandatory
Wellcome Trust	PubMed Central and UK PubMed Central	1 October 2006	6	Mandatory
Medical Research Council	PubMed Central and UK PubMed Central	1 October 2006	6	Mandatory
European Research Council Scientific Council	Appropriate repository	17 December 2007	6	Mandatory
Canadian Institutes of Health Research	Online repository, such as PubMed Central or grantee's institutional repository	All grants awarded from 1 January 2008	6	Mandatory
Harvard University's faculty of arts and sciences	Harvard University repository	12 February 2008	Not yet decided	Mandatory
Agency Nationale de Recherche (France)	In a named repository and the Hyper Articles on Line (HAL) repository	All projects from 14 November 2007	At the earliest opportunity	Mandatory
Institut National de la Santé et de la Recherche Médicale (INSERM; France)	In a named repository and HAL INSERM	All new projects from 1 January 2008	6	Mandatory
Fonds zur Forderung der wissenschaftlichen Forschung (Austria)	Appropriate institutional and disciplinary repositories	—	6	Mandatory
Australian Research Council	Appropriate institutional and disciplinary repositories	—	6	Voluntary

One potential problem for researchers is that they have to find the costs of publishing in an open access journal if they choose this route. The NIH has said that it will reimburse publication costs. In the United Kingdom, the Wellcome Trust and the MRC provide grant holders with additional funding to cover open access charges, providing these have been included in grant proposals and that the costs fall within the period of the grant.

Another problem is enforcing open access policies. "They are not easy to monitor in practice," acknowledges Tony Peatfield, head of corporate governance at the MRC. He notes that a recent survey of all units funded by the MRC shows that more than 90% had an open access policy in place. However, there is no mechanism for recording publications by MRC grant holders working in other institutions. In the United States, the NIH will ask researchers to include evidence of submissions in grant applications and reports as part of monitoring its public access policy.

Publishers of journals are having to introduce new mechanisms to support open access. Peter Ashman, publishing director of the *BMJ* and BMJ Journals, said, "We remain committed to supporting open access and to fulfilling the criteria set out in the NIH directive." He explained that the company introduced a hybrid option for all the BMJ Group's specialist journals in 2006. This allows authors to pay a subsidised fee to ensure that their article is freely available from publication.

Mr Ashman also commented on the fact that all original research articles published in the *BMJ* are freely available from publication. "I like to think of this as 'pure open access' as we don't charge subscribers or authors for this service." He added, "Other publishers are having to make adjustments to their publishing policies to accommodate the demands of the NIH and research communities. They will need to make similar commitments to offer hybrid open access policies in order to continue to attract the high quality research funded by NIH."

It is still relatively early days to determine the effects of open access policies. Mr Peatfield reported that some researchers funded by the MRC have found that journals without open access arrangements have introduced mechanisms to facilitate this when necessary. Research so far has indicated that researchers may gain greater exposure for their work because studies have shown that open access articles are cited more often than non-open access articles from the same journal (www.nature.com/nature/debates/e-access/Articles/lawrence.html; *BMJ* 2005;330:1128).

This picture is from a calendar entirely devoted to the matter of open access, with important dates in the movement's history displayed on the right hand side. It was designed by the scholarly information specialist Alma Swan and can be seen at www.keyperspectives.co.uk/aboutus/Being_creative/OA%20calendar%202008.pdf.

Policies

National Institutes of Health (http://publicaccess.nih.gov)
Wellcome Trust (www.wellcome.ac.uk/About-us/Policy/Spotlight-issues/Open-access/Policy/index.htm)
Medical Research Council (www.mrc.ac.uk/PolicyGuidance/EthicsAndGovernance/OpenAccessPublishingandArchiving/PositionStatement/index.htm)
European Research Council (http://erc.europa.eu/pdf/ScC_Guidelines_Open_Access_revised_Dec07_FINAL.pdf)
Canadian Institutes of Health Research (www.cihr-irsc.gc.ca/e/34846.html#6)

proper recognition

which has been overlooked ever since.

The author Ruth Richardson, whose book on the history of *Gray's Anatomy* is to be published in September, hopes that the exhibition will help put Carter's name on the map. "Carter has never had his proper due and that seems quite inexplicable to me," she said. "When you look at the first edition it is not the text that is original. The originality of the volume resided in the illustrations."

The exhibition is being launched with a lecture by Dr Richardson on the story of *Gray's Anatomy* and the two surgeons who created it, at 7 pm on 3 April. The college is offering 30 tickets to the lecture free to readers of the *BMJ*. To reserve tickets, email museums@rcseng.ac.uk quoting "*BMJ* reader offer" with your name, address, and the number of tickets you need (maximum two per person).