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Haemoglobin based blood substitutes may raise the risk of myocardial infarction

Susan Mayor LONDON

Haemoglobin based blood substitutes are associated with a nearly threefold increase in the risk of myocardial infarction and a 30% higher risk of death in comparison with other solutions used in blood replacement, concludes a meta-analysis published this week.

The authors of the study, published in *JAMA* (doi: 10.1001/jama.299.19.jrv80007), argue that if the results of individual trials had been made public as they became available to researchers, patients may not have experienced adverse events in subsequent studies.

No further phase III studies of the products should be carried out for the time being, say commentators in an accompanying editorial (doi: 10.1001/jama.299.19.jed80027).

A large proportion of blood substitutes—products with a long shelf life that can be used to replace blood lost by trauma patients or patients undergoing surgery—currently in development are based on haemoglobin.

Even though early trials raised questions about the safety of these products and failed to show clinical benefit, at least one product has been approved for use outside the United States, and new clinical trials are being conducted or planned worldwide.

The researchers, from the US National Institutes of Health and the Health Research Group of Public Citizen, a non-profit consumer organisation based in Washington, DC, carried out their meta-analysis to assess the safety of haemoglobin based blood substitutes in surgical, stroke, and trauma patients. In justifying a meta-analysis they argue that all the products share the same mechanism of action and apparent mechanism of toxicity.

The researchers found 16 trials involving five different products and 3711 patients in various patient populations, including patients undergoing surgery and patients who had experienced trauma or shock. Results showed that the risk of death was 30% higher among patients who were given haemoglobin based blood substitutes than among the controls.

BBC HANDOUT/AP

Steven Howarth, aged 18, experienced a marked improvement in his visual mobility in dim light

Gene therapy is in danger of being overhyped, expert says

Geoff Watts LONDON

Two reports published online this week by the *New England Journal of Medicine* have described the use of gene therapy to correct the causes of one form of congenital blindness. Although the gains in both cases were modest, media reports have greeted them with jubilation and the suggestion that the results can be extrapolated to a wide range of eye conditions.

This reaction has prompted one researcher to regret that, once again, enthusiasm for gene therapy may be running ahead of its actual achievements.

Infants born with Leber's congenital amaurosis have profound visual impairment throughout childhood and become completely blind by early middle age. Previous work has shown that in patients with this condition seven genes normally active in the cells of the retinal pigment epithelium (RPE) show mutations.

The two research groups—one based at the University of Pennsylvania's Scheie Eye Institute and the other at the Institute of Ophthalmology in London—have both worked with a gene called RPE65. This codes for an enzyme that catalyses the synthesis of the visual pigment rhodopsin. Both groups have also used a type of adenovirus to carry normal copies of the gene into the retina.

The Philadelphia doctors report that all three of their patients showed evidence of improved retinal function, as shown by measurements of pupillary reflexes to light (doi: 10.1056/NEJMoa0802315). The London researchers also worked with three patients (doi: 10.1056/NEJMoa0802268). Like their US counterparts they detected no adverse or potentially worrisome immune responses to the procedure. But neither did they observe a clinically significant improvement in visual acuity in any of the three. One patient's visual mobility in dim light did, however, improve markedly.

Commenting on media accounts of the work, Len Seymour, president of the British Society for Gene Therapy and professor of genetic therapy at Oxford University, said, "It does seem to me that the reporting has been a bit over the top."

He added: "It does frustrate me that we do have these sessions of hype, particularly in the field of gene therapy.

"I wrote a piece for a newspaper saying that public expectation goes up immediately after this sort of thing happens, and that puts pressure on scientists and clinicians to deliver more and more. It was taken out by the editors."

Cancer centre provides space for patients to think

Susan Mayor LONDON

A new support centre for people with cancer, the latest in a series of Maggie's Caring Centres around Britain, has opened at Charing Cross Hospital in west London. The centres are based on the vision of the late Maggie Keswick Jencks, a writer on Chinese gardens, of places to provide high quality support for people with cancer. While being treated for cancer she identified a need for patients to receive emotional and psychological support and practical information in an uplifting environment.

The London centre is the first of seven new caring centres planned for England and Wales, bringing the total to 13 by 2012. It was designed by architects from the Richard Rogers' partnership, Rogers Stirk Harbour and Partners. Other leading architects—including Richard Murphy, Frank Gehry, and Zaha Hadid—are designing further centres.

RICHARD ANDERSON

Maggie's Caring Centres aim to provide help, information, and support for people with cancer to enable them to manage the process of diagnosis and treatment as effectively as possible and to enjoy the best possible quality of life. They are funded by voluntary donations.

Robert Leonard, a consultant medical oncologist at Charing Cross Hospital, said, "The centre gives the patients somewhere to go and talk about how they feel. This might happen in outpatient departments, but we have limited time for patients to explore their own thoughts during consultations."

He explained that the centre has a central kitchen, where people can share a coffee around the kitchen table. Other rooms are available for counselling, group discussions, and relaxation and other therapies. A new garden provides outside space for reflection.

For more information on Maggie's Caring Centres see www.maggiescentres.org.uk.

A state run healthcare system still works, debate finds

Tessa Richards BMJ

A debate to consider whether the NHS still meets the needs of the population 60 years after it was established decided that it still does. In fact the proportion of the audience who thought it was still a suitable system today rose by seven percentage points during the course of the debate.

The debate was organised by Capse Health Knowledge Systems, a private company that measures the performance of UK hospitals, and was held at the Tate Britain art gallery, in front of an invited audience of around 160 hospital managers, academics, healthcare economists, clinicians, and journalists.

The wording of the motion was "This house believes that a state run healthcare system can no longer meet the needs of the population and that greater competition will improve the quality of care and secure its future."

The case for the motion was put by Nick Bosanquet, professor of health policy at Imperial College London, and Mark Adams, chief executive of Virgin Healthcare.

Professor Bosanquet pointed to the failings of the NHS, including its inability to support its staff, its adherence to obsolete and expensive practices, such as sending outpatient letters by post, its myriad of perverse incentives, and its obsession with rolling out large capital schemes that were not designed to meet patients' needs.

He said that public-private partnerships between the NHS and independent providers had, by contrast, raised standards of provision in several areas, including mental illness and chronic obstructive pulmonary disease.

Without more input from the private sector the NHS would be wholly unable to deliver new treatments and services in future, such as the requirement for higher doses of radiotherapy.

The motion was opposed by Frank Dobson, Labour MP for Holborn and St Pancras and a former secretary of state for health, and Calum Paton, professor of health policy at Keele University, Staffordshire.

Mr Dobson rejected Professor Bosanquet's arguments. Marketisation of health care was an act of faith, not a policy tool of proved effectiveness, he argued. The idea that competition between healthcare providers was good had come from the United States, where health care was in "meltdown" and health budgets were being "squandered" on "ludicrously high" transaction costs.

The US experience was that the market provided worse services at inflated costs, he said, and the "story so far" of marketisation in the United Kingdom was little different. Private providers charged around 10% more for services and failed to meet their targets, such as for cataract operations. They "cherry picked" low risk patients, restricted patients' choice, despite claiming the opposite, and failed to deliver either innovative services or better outcomes.

When the debate was opened to the floor, members of the audience expressed frustration that neither side had discussed quality and safety in health care or how to tackle health inequity. Nor had there been a serious attempt to say how the NHS, with or without the help of independent providers, would be able to cope with the rising demand for services and high expectations of patients.

When the results were announced, the vote against the motion had climbed from 57% to 64%. Furthermore, the percentage of people who rejected the idea that the UK will inevitably move to a point where the state will have little or no role in provision of health care remained high, at 87%.

Decision to split role of purchaser and provider may "end up in the dustbin"

Nick Timmins FINANCIAL TIMES

Plans to turn the NHS into a "world class" commissioner of health care are highly unlikely to work, a former health department head of strategy has warned.

But if the government does succeed, its achievement will be "a world first," said Chris Ham, professor of health services management at Birmingham University and former head of the Department of Health's strategy unit.

Separating the role of purchasing from the provision of health care has now been tried in various ways in several European countries, in New Zealand, and in the United States, Professor Ham said in a paper on international experience of the exercise. It was introduced into the NHS in 1991 by the then health secretary, Kenneth Clarke. But "in no system is commissioning done consistently well," Professor Ham said, and the government faces "huge obstacles" to make it work.

A better answer may be to go for competing integrated healthcare systems, of the type run by Kaiser Permanente in the US, he said, where one organisation provides the full range of health care but patients can choose between competing providers.

In England primary care trusts are being asked to contract elements of care from a wide range of sources: public and private hospitals, GPs, social entrepreneurs, and the voluntary sector.

But health care is highly complex, Professor Ham said: services are difficult to define in contractual terms; sellers—chiefly hospitals and GPs—tend to know far more about their service than buyers; clinicians retain considerable professional discretion; and some services more or less have to be local monopolies.

In the face of these "huge obstacles," commissioning organisations need to be large, strong, and highly skilled. That means "hiring experts with relevant skills on a scale far greater than the government has hitherto contemplated."

Even if "world class commissioning" is developed—and Professor Ham judges that to be "highly unlikely"—the evidence from publicly funded systems such as New Zealand's is that politicians continue to find it difficult not to intervene, creating "politically managed markets that fail to deliver the intended objectives."

International evidence, Professor Ham said, "shows that integrated delivery systems perform better than systems where the roles of commissioner and providers are separated."

If "commissioning ends up in the dustbin," Professor Ham said, "then competing integrated systems may emerge as a more promising alternative."

Health Care Commissioning in the International Context: Lessons from Experience and Evidence is at www.hsmc.bham.ac.uk.

ADAM BUTLER/PA

FIONA HANSON/PA

The purchaser-provider split: born under Kenneth Clarke (left), is failing to thrive under Alan Johnson (right)

Women in academic medicine still have to battle against macho culture

Zosia Kmietowicz LONDON

Women trying to carve out a career in academic medicine in the United Kingdom continue to face a dominant male "club culture," misplaced competition, exclusion, and lack of support, says a report out this week.

Despite the fact that women have made up more than 40% of medical graduates in the past 20 years and now account for 60% of medical students, women doctors are still strikingly under-represented in the university sector, especially in senior posts, says the report from the women in academic medicine project, a research venture funded by a variety of sources, including the government and the BMA.

The report makes a raft of recommendations for government, institutions, professionals, and journals aimed at rectifying the imbalance, which currently leaves one in five medical schools without a female professor. Of the 33 heads of UK medical schools only two are women, says the report, and 11% of professorships are held by women.

"Given the demographic changes in medical schools and the availability of a major competitive employer such as the NHS, unless the reasons for this [to attract and retain women doctors] are addressed it is unlikely that this situation will be reversed," it says.

The report includes a survey of the factors that doctors think impede their careers and compares for the first time the progress of doctors working in higher education with those in clinical posts. It found that although men and women experienced barriers to progression in their career, such barriers were more likely to be faced by women and were most acute among women in academic posts.

Of 1162 respondents more than half of the women (52%) and 40% of the men said that workplace factors or personal circumstances had an especially detrimental effect on their career. As important factors they cited lack of support and encouragement, a culture of long working hours, and the attitudes of colleagues and senior management.

Themes from focus groups showed, the report said, that many women thought that "there is a folklore that if you are a woman you won't get ahead in academic medicine."

Women in Academic Medicine can be seen at www.bma.org.uk.

IN BRIEF

Southall may continue to work, pending appeal: Paediatrician David Southall has won the right to keep working while he waits to appeal against his erasure from the medical register. A High Court judge overturned the immediate suspension imposed by a General Medical Council panel, which struck off Dr Southall last December (*BMJ* 2007;335:1174). The GMC conceded that the suspension order was flawed by "a misapprehension as to the applicable legal test." But conditions imposed by the GMC in 2004 will apply, including a bar on child protection work.

Dutch mumps epidemic is confirmed: The first mumps epidemic in the Netherlands for 20 years has been confirmed by its Centre for Infectious Disease Control. The 61 cases since August are believed to be a small proportion of the total. Most cases have occurred in the country's central "Bible belt," where opposition from conservative Protestant communities has seen the uptake of vaccination fall to as low as 78%.

Glasgow hospital project is to be wholly publicly funded: Scotland's biggest ever hospital building project is to be paid entirely from public funds. The announcement of an £842m (€1.1bn; $1.7bn) integrated children's and adults' hospital in Glasgow comes at a time of uncertainty over the use of private sector finance for public services in Scotland.

Spanish doctors are still underpaid by Western standards: Half of all Spanish doctors have an annual gross income of less than €45 000 (£35 000; $70 000), shows a survey of its readers by the Spanish edition of the journal *Medical Economics*. However, more doctors earned more than €65 000 than earned less than €30 000. Income tended to be higher in urban areas and among men.

***BMJ* readers vote by nearly two to one in favour of screening for aortic aneurysm:** In last week's *BMJ* poll 503 readers voted on the question of whether we should screen for abdominal aortic aneurysm. A total of 330 voted in favour and 173 against.

Enterovirus kills 20 in China: Beijing has ordered daily reporting on an outbreak of enterovirus 71, which causes hand, foot, and mouth disease and has killed 20 children in Anhui province since March, China's Xinhua news agency reports. (See http://news.xinhuanet.com/english/2008-04/29/content_8070187.htm.)

MEPs shun cancer advocacy group because of funding by the pharmaceutical industry

Ned Stafford HAMBURG

A group of members of the European parliament with a special interest in breast cancer has cut its ties with a breast cancer advocacy group, Europa Donna, because of the group's acceptance of financial support from drug companies.

Karin Jöns, chairman of the European parliamentary group on breast cancer (EPGBC), issued a press release last week announcing the decision, saying that 86% of Europa Donna's income of about €424 000 (£330 000; $660 000) in 2007 came from the industry.

"We at EPGBC reject further cooperation with Europa Donna because the board of the European umbrella group became more and more a lobby instrument for the market interests of the big pharmaceutical companies," said Mrs Jöns, an MEP representing the Bremen region in Germany.

Europa Donna's executive director, Susan Knox, rejected the press statement from Mrs Jöns, saying that it had "always denied a financial dependency from the pharmaceutical industry."

"We have never denied accepting these donations," said Mrs Knox, an American expatriate who is based in Milan and who has been treated for breast cancer. "But it in no way influences any of our decisions or anything we do."

Her group receives no government support and therefore needs the donations from drug companies to function, she said.

Mrs Knox said, "Europa Donna will continue to work with members of the European parliament and national parliaments to keep breast cancer on the health agenda and to see that the European Union guidelines for quality assurance in breast cancer screening and diagnosis get implemented across Europe."

Mrs Jöns said that about 40 MEPs belong to the informal breast cancer group, which was formed in 2001 in conjunction with Europa Donna. She declined to say how many MEPs were present at the 16 April meeting but said that all members present agreed to cut ties with Europa Donna.

Children taking drugs for hyperactivity

Janice Hopkins Tanne NEW YORK

Children with attention deficit hyperactivity disorder should have an electrocardiogram taken and a cardiac evaluation before they begin to take drugs for the disorder, the American Heart Association said in a scientific statement published on 21 April.

The stimulant drugs used to treat the disorder can increase heart rate and blood pressure and may be a concern if children have a heart condition, says the statement, published online in *Circulation* (doi: 10.1161/circulationaha.107.189473).

As many as 2% of apparently healthy school age children have potentially serious undiagnosed heart conditions that can be identified by electrocardiography but that may not be detected on routine physical examination, said Victoria Vetter, head of the committee that wrote the statement and

STEVE LISS/TIME AND LIFE PICTURES/GETTY IMAGES

Nineteen children taking drugs for hyperactivity died suddenly between 1999 and 2004

Collection of cord blood is to be regulated from July to reduce contamination of samples

Owen Dyer LONDON

The fast growing practice of collecting blood from the umbilical cords of newborn infants is to be regulated for the first time in the United Kingdom. Cord blood, a source of very "naive" blood stem cells, is used to treat some types of anaemia and leukaemia and may hold promise in treating other diseases.

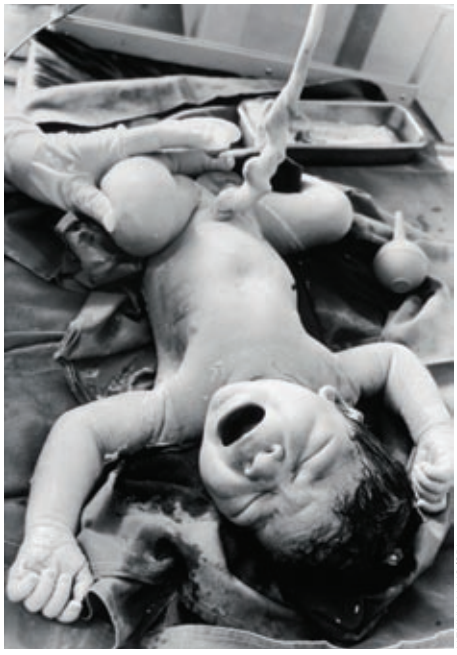
The Human Tissue Authority announced this week that all maternity units, whether NHS or private, that collect cord blood must be operating under a licence by 5 July.

An unknown number of private companies are currently offering a cord blood collection service. They too will need a licence under the new regulations and must give an undertaking that cord blood will be collected by people with specialist training on premises that meet set standards. The authority estimates that between 100 and 250 public and private organisations will apply for a licence under the new rules.

Adrian McNeil, chief executive of the authority, said, "We are introducing this regulation to make sure that the best quality samples are taken in the safest way. We have heard that fathers, who of course have no experience in collecting cord blood, may be involved in this procedure. The worry is that if inexperienced people are involved this will not be done at the right time and in the right way."

Peter Braude, the King's College London professor who chaired the Royal College of Obstetricians and Gynaecologists' expert group on cord blood, said that as many as 30% of early collections for the NHS Cord Blood Bank showed bacterial contamination.

An enlarged NHS Cord Blood Bank would be useful for patients, he said, because a patient's own stem cells are often not appropriate for transplantation. "With many genetic diseases your own cells would have the same defect, and you'd be better off with a heterologous transplant."



HENNY ALLIS/SPL

should be tested for heart problems

professor of paediatrics at the University of Pennsylvania School of Medicine in Philadelphia. An electrocardiogram is needed to detect conditions such as hypertrophic cardiomyopathy, long QT syndrome, and Wolff-Parkinson-White syndrome, the statement says.

Data from the US Food and Drug Administration for 1999 to 2004 showed that 19 children taking drugs for attention deficit hyperactivity disorder died suddenly and that 26 children experienced cardiovascular events such as strokes, cardiac arrests, and heart palpitations. Data from a later period showed 11 sudden deaths in children associated with methylphenidate, 13 with amphetamines, and three with atomoxetine.

The disorder is the commonest neurobehavioural disorder of childhood, the authors say, affecting 4% to 12% of school age children. In 2003 2.5 million US children took a drug for the disorder. It may be more common in children with heart disease than in the general paediatric population. About 33% to 42% of children with heart disease have been reported to have attention or hyperactivity problems, the authors write.

Drugs prescribed for the disorder include methylphenidate, amfetamine, atomoxetine, clonidine, guanfacine, desipramine, imipramine, bupropion, and modafinil.

Since 1999 the FDA has required manufacturers of drugs approved for treating the disorder to develop guidelines to alert patients of possible cardiac risks.

Warnings relating to the drugs say that they should not be used in children with serious structural cardiac abnormalities, cardiomyopathy, heart rhythm disturbances, or other problems that may make them more vulnerable to the sympathomimetic effects of stimulant drugs, the authors write.

The American Heart Association committee recommends that, before a drug is prescribed to treat a child with attention deficit hyperactivity disorder, the child's personal and family history is evaluated, with a focus on symptoms of heart problems or events; the child is physically examined for heart murmurs, other cardiovascular abnormalities such as hypertension or a rapid or irregular heart rhythm, and Marfan syndrome; and an electrocardiogram is read by a paediatric cardiologist or a doctor with experience reading paediatric electrocardiograms.

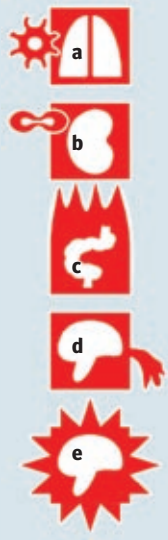
Icons developed to cut drug errors

Susan Mayor LONDON

French researchers have developed a new drug information system based on symbols inspired by road signs in an effort to reduce prescribing errors (*BMC Medical Informatics and Decision Making* 2008;8:16).

The system, Visualisation des Connaissances Médicales, uses a small set of graphical signs that can be combined to build simple sentences to provide information on a drug, such as its side effects, interactions, or contraindications.

Testing of the system with a group of volunteer GPs showed that they read the signs significantly faster than the equivalent text, with fewer errors.



The icons stand for: a) pulmonary bacterial infection; b) renal tumour; c) intestinal inflammatory diseases; d) cerebral haemorrhage; e) headache

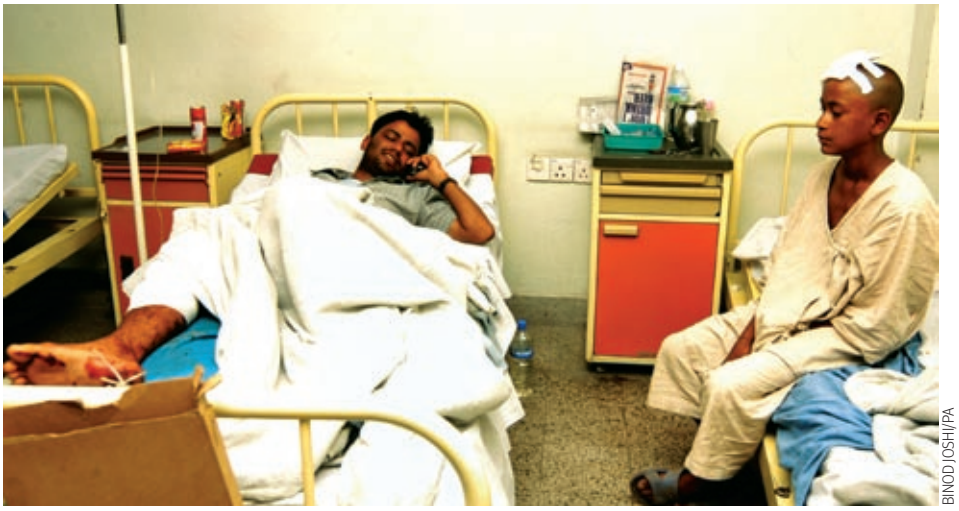
Proportion of people paying for their care rises in poor countries

Roger Dobson ABERGAVENNY

The proportion of the cost of health care that is paid directly by patients themselves varies widely in Asia, with the Japanese paying the least out of their own pockets and the Nepalese paying the most, new research shows (*Journal of Health Economics* 2008;27:460-75).

The researchers looked at healthcare financing in 13 countries and territories in central, southern, and eastern Asia, accounting for 55% of the total population of Asia and 33% of the world population. Direct payments by patients accounted for at least 30% of healthcare costs in all countries or territories except Japan, where the percentage was 13%. In Nepal the figure was 75%. In eight of the 13, including China, the proportion funded by patients themselves was more than 49%.

The proportion of healthcare costs paid from direct taxation also varied greatly, with 27% of costs in Hong Kong paid from direct taxes, whereas in the rest of China the figure was only 2%.



BINOD JOSHI/PA

Three quarters of health costs in Nepal (above) are met by patients out of their own pockets

Indirect taxation contributes to 3% of healthcare costs in Taiwan and to 32% in Sri Lanka. The share paid from social insurance varies from zero in Sri Lanka to 54% in Japan.

The report says that generally the percentage of costs paid for by patients themselves was lower the wealthier the country was (in terms of national income).

Private insurance played a relatively minor role in most of the healthcare systems. In eight countries or territories it was zero or less than 1%. The largest proportion of healthcare costs paid from private insurance was in Hong Kong (12%) and the Philippines (10%).

The results also show that in the poorest countries and territories that rely most heavily on direct payments from patients, such as Bangladesh and Indonesia, better-off citizens receive more health care than poorer people.

"This suggests that the poor in these low-income countries pay less and receive less health care since they simply cannot afford to pay and so forgo treatment," says the report.

Canada's drug advisory committee says emergency contraception should be available over the counter

Barbara Kermode-Scott CALGARY

Canadian women are one step closer to being able to get the emergency contraceptive levonorgestrel over the counter without a prescription or counselling by a pharmacist.

Currently a woman in Canada who wishes to have levonorgestrel for emergency contraception can either seek a prescription from a doctor or buy it in a pharmacy after a consultation with a pharmacist. (Emergency contraception has "behind the counter" status, similar to "pharmacy only" status in the United Kingdom.)

Paladin Labs, a Canadian specialty drug company, applied for full over the counter status for the emergency contraceptive, known as Plan B in Canada and the United States and marketed as Levonelle in the United Kingdom.

The company pointed out that many leading Canadian healthcare organisations, including the Society of Obstetricians and Gynecologists of Canada, the Canadian Federation of Medical Women, and the Canadian Association for Adolescent Health, support making emergency contraception available over the counter to reduce the number of unwanted pregnancies in Canada.

On 6 April Canada's National Drug Scheduling Advisory Committee recommended to the National Association of Pharmacy Regulatory Authorities that levonorgestrel (when sold in concentrations of 0.75 mg or 1.5 mg per oral dosage unit and packaged and labelled for emergency contraception) should be given full over the counter status (as a "schedule III" listed drug).

If the recommendation is approved, Canadian women will be able to buy the drug from pharmacy shelves like any other over the counter product. Any objections to the committee's recommendations must be received by the National Association of Pharmacy Regulatory Authorities by 14 May 2008.

The Canadian Women's Health Network had been pushing for "unscheduled" status for emergency contraception, so that it could be available in any retail outlet, said Vyta Senikas, associate executive vice president of the Society of Obstetricians and Gynecologists of Canada.

"We are happy to see the decision," added Dr Senikas. "There were no issues or great concerns about safety with this drug . . . The change of schedule status was based on the excellent safety profile of the medication, which scientifically is well evidence based."

The US Food and Drug Administration approved non-prescription, "behind the counter" access to levonorgestrel for women aged 18 years or older in August 2006 (*BMJ* 2006;333:461). It is available at some pharmacies in Alaska, California, Hawaii, Maine, New Mexico, New Hampshire, Vermont, Massachusetts, and Washington, although some states have passed laws to protect pharmacy employees' right to refuse to sell the drug for reasons of conscience.

PULSE PICTURE LIBRARY/PA

Surgeon who owned hospital faces 69 charges of flawed treatment and four of manslaughter

Ned Stafford HAMBURG

A chief surgeon who also owned the village hospital in Germany where he practised is in jail awaiting trial in connection with the deaths of seven patients.

Arnold Pier, 52, has been accused by prosecutors in a 400 page court document of making incorrect diagnoses and carrying out unnecessary operations (such as removing appendices or gall bladders) at the St Antonius Clinic in Wegberg, in the western state of North Rhine-Westphalia.

In addition, Dr Pier, who was also chief administrator at the hospital, allegedly followed lax standards of hygiene, including using lemon juice as a disinfectant during surgery.

Prosecutors issued a statement on 21 April announcing that Dr Pier faces 69 charges of flawed treatment of 17 patients between the ages of 50 and 92. The most serious charges include four counts of involuntary manslaughter, three counts of causing bodily harm leading to death, and one count of causing major bodily injury.

Other charges include 24 counts of causing dangerous bodily harm and 30 counts of intentional bodily harm. Potential flawed treatment of four additional patients is still under investigation, and further charges could be filed.

Dr Pier, who faces up to 15 years in prison if convicted, was arrested on 17 April and remanded in custody pending trial.

Eight other doctors at the hospital, three of whom still practise there, also face charges in varying numbers and degree of seriousness.

Lothar Gathen, a prosecutor in charge of the case, said that his office in the nearby city of Mönchengladbach received an anonymous tip-off in late 2006 alleging flawed treatments at the hospital. He said that his office still does not know who the information came from. But because of the detailed nature of the allegations the person was likely to be a member of the hospital staff, he said.

When asked why it took so long to file charges Mr Gathen noted the complexity of the case, saying of his staff: "We are not doctors."

Robert Schäfer, managing director of the Medical Association of North Rhine in Düsseldorf, said that his office had been informed of the "rumours" by the investigating coroner. "We provided an expert to support the coroner in judging the findings, and after a few weeks . . . Dr Pier's licence was suspended," he said.

Noting that some doctors on the staff had "severe doubts" about the "professional activities" at the hospital under Dr Pier, Dr Schäfer said, "What seems to be most discomfiting is that doctors on the staff were aware of this affair and kept silent."

He said that 20 years ago the association had installed a voluntary quality assurance programme in hospital surgery departments. "But the hospital association as well as the insurance organisations of our compulsory health insurance scheme . . . did not want us to take part in this programme any more," he said, adding that the hospital and insurance organisations successfully lobbied for changes in state law to exclude the medical association.

"Many hospitals try to keep the performance results hidden," he said.

Registrar who used excessive force in forceps delivery is struck off the medical register

Owen Dyer LONDON

A locum registrar who killed a baby girl when he used "grossly excessive force" in a forceps delivery was struck off by the General Medical Council last week. However, he continues to evade police seeking to charge him with manslaughter in the case.

Vladan Visnjevac is now in Sarajevo, and Surrey police say that the Bosnian authorities are refusing to extradite him. He made no submissions to the hearing.

Newborn Hollie Dinning died at St Peter's Hospital, Chertsey, Surrey, two days after delivery in May 2002, from a fractured skull and "massive" brain injuries. Dr Visnjevac had made four attempts to deliver her with forceps, using such force that her mother feared that she would be pulled off the table. "He was yanking so hard I thought my baby's head was going to be pulled off," Tracey Dinning told the hearing in a statement.

Dr Visnjevac should never have attempted a vaginal delivery in the first place, said expert witness John Hare, as the mother's pelvis was too small and the baby's position was not suitable. But Dr Visnjevac had ruled out a caesarean delivery over the telephone, without examining the patient.

He then attempted forceps delivery without ascertaining the position of the baby's head. Instead of closing on the baby's temples the forceps seized her head at the wrong angle and crushed it on closing. Hollie was delivered, not breathing, at the fourth attempt. No competent obstetrician, said Dr Hare, would have continued with the forceps after the second attempt.

Later, after the parents complained, Dr Visnjevac was questioned by police. He told them that the maximum force acceptable for a first baby delivered with forceps was 60 kg, nearly three times the actual limit of 23 kg. He failed to appear for a subsequent police interview in December 2002.

Hollie's parents had already experienced a long string of misfortunes in their efforts to have children. Ms Dinning had had at least six miscarriages in her first marriage, which broke down as a result. In 2000 her best friend, Caroline Freeman, went to St Peter's Hospital to deliver a child but died in labour.

Ms Dinning moved in with her friend's partner, Jim, to help care for his two year old son. They fell in love, and she became pregnant, reaching term for the first time in her life with Hollie.

Last weekend the *Daily Mail* photographed Dr Visnjevac on a Sarajevo street and interviewed his parents, with whom he now lives (*Daily Mail*, 25 Apr, p 11). His mother told the newspaper that he had been unemployed since leaving Britain.

COURTESY DAILY MAIL

Vladan Visnjevac now lives in Sarajevo