NEWS

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Predicting psychopaths' violent behaviour is no better than chance

Cameron reveals plan for seven day access to GPs

Gareth Iacobucci BMJ

The prime minister has set out plans for patients in England to be able to see a GP any day of the week and for longer in the evenings.

The move is intended to make it easier for people to see their GP from 8 am to 8 pm, seven days a week. The extended hours will be piloted in nine areas, which will also trial other new services designed to increase convenience for patients, including greater use of consultations by email, telephone, and internet videoconferencing.

Launching the policy at the Conservative Party's conference this week, David Cameron said that the government would put £50m into the pilot scheme, to be shared among the nine "pioneer" sites, which cover half a million patients.

The government said that the approach was already being successfully piloted in six general practices in Manchester. It said that further pilots would begin in April 2014, with a view to later extending the scheme across the country.

The policy will form part of the government's wider plan to improve care outside hospitals and to reduce pressure on secondary care.[1]

The BMA said that it was open to discussing the plans but that rolling out the policy nationally would require major investment in additional GPs, staff, and resources.

The move echoes efforts by the last Labour government to improve access to GPs, which included targets for practices to open in the evenings and at weekends—with additional funding for those that did—and new primary care centres opening 8 am to 8 pm, seven days a week. However, many of these centres, termed "Darzi clinics" after their architect, the former Labour health minister Ara Darzi, were forced to close after proving too expensive to run.[2] Furthermore the number of practices opening outside normal surgery hours fell after the Conservative government stopped monitoring the target.[3 4]

Launching the policy, Cameron said, "Millions of people find it hard to get an appointment to see their GP at a time that fits in with their work and family life. We want to support GPs to modernise their services so they can see patients from 8 am to 8 pm, seven days a week."

The health secretary, Jeremy Hunt, said, "We live in a 24/7 society, and we need GPs to find new ways of working so they can offer appointments at times that suit hardworking people."

Steve Field, the Care Quality Commission's chief inspector for general practice, also welcomed the move, adding, "I want to see brilliant access to GP services for patients across the country and will be assessing this in each practice I inspect."

Chaand Nagpaul, chairman of the BMA's General Practitioners Committee, said that the committee was open to discussing the plans and said that many practices already offered extended opening hours. But he added, "Without extra GPs the existing workforce will have to be stretched over seven days, meaning potentially reduced services during the week.

"It will also require additional resources and investment in support and diagnostic staff such as district nurses and access to community care so GPs can meaningfully provide a full service across the week, and it remains to be seen if the money set aside will be enough to deliver this."

Cite this as: *BMJ* 2013;347:f5949

Prime Minister David Cameron said GPs needed to modernise their services, which included extending the hours they are open

Independent contractor status model for GPs has had its day, says Gerada

Gareth Iacobucci BMJ

The small business model of general practice in the UK has "served its time" and should be remoulded, with primary, secondary, and community care integrated in single local organisations, the outgoing chairwoman of the Royal College of General Practitioners has said.

In an interview with the *BMJ* ahead of the college's annual conference in Harrogate, which takes place on 3-5 October, Clare Gerada questioned whether GPs' independent contractor status was still fit for purpose and challenged the profession to adapt to new ways of working.[1]

Gerada, who will be succeeded by Maureen Baker as college chairwoman next month, called for GPs to lead multidisciplinary teams that incorporate acute, mental health, community health, and social care services in the community, with all staff employed by the NHS.

Gerada acknowledged that GPs may put up some resistance but said that she wanted to start a debate about new ways of working.

She said, "[The independent contractor status] served us well, but since 1948 what hasn't changed is the way general practice is organised and hospitals are organised.

"We need to protect what's best about generalism but move us closer to our hospital and community colleagues so that we become one organisation and one service. I would challenge whether we need the independent contractor status. I would question whether it actually means anything anymore when we're actually salaried to the state anyway."

Gerada, who hopes to advance her vision in her new role as NHS England's clinical chairwoman for primary care transformation in London, called for the model proposed by the former health minister Ara Darzi to be revisited. In 2008 Darzi proposed that the historical separation between primary and secondary care be broken down.[2]

FEATURE, p 16

Cite this as: *BMJ* 2013;347:f5922

IN BRIEF

GMC is to examine deaths of doctors facing investigation: The General Medical Council is to review whether it provides appropriate support to doctors being investigated over their fitness to practise, after a freedom of information request from the campaign group Doctors4Justice found that 96 doctors have died since 2004 while waiting for their cases to be heard. It is not clear how many of the deaths involved suicide.

English cancer drugs fund is extended to 2016: The government has extended the cancer drugs fund for another two years in England, making an extra £200m a year available to pay for drugs that have not yet been approved by the National Institute for Health and Care Excellence. The scheme was to end in March 2014. Plans are still afoot for value based pricing of drugs, linking a drug's NHS price to the value it offers.

Acute hospital trusts face financial crisis: The summer report from the NHS Trust Development Authority has for the first time given secondary care trusts an "oversight score" that encompasses their quality of care, ability to deliver against key standards, and financial stability.[1] All the five trusts that "require urgent action" (the worst score) were from the acute sector (George Eliot Hospital, United Lincolnshire Hospitals, East Lancashire Hospitals, North Cumbria, and Buckinghamshire Healthcare).

Baby is born after doctors treat early menopause: A woman who had an early menopause has had a baby after doctors removed her ovaries and treated the tissue to stimulate the pathways that govern follicle growth, before replacing fragments of the tissue and treating her with in vitro fertilisation.[2] The team has treated 27 women and another woman is pregnant.

MMR vaccination rates reach record high in England: The proportion of children reported as vaccinated against measles, mumps, and rubella by the age of 2 years reached 92.3% in 2012-13, the highest since the vaccine was introduced in England in 1988, show figures from the NHS Health and Social Care Information Centre.[4] Coverage reached its lowest in 2003-04, when just 80% of 2 year olds received the vaccine.

Cite this as: *BMJ* 2013;347:f5921

GP is struck off after television documentary exposed his failings

Clare Dyer BMJ

A GP who was secretly filmed telling an undercover actor who presented with signs and symptoms typical of bowel cancer to "eat some mangoes" has been struck off by a panel of the Medical Practitioners Tribunal Service.

Inayat Inayatullah, 73, was investigated by Channel 4's *Dispatches* as part of a documentary examining doctors who had returned to work after being disciplined by the General Medical Council. The programme aired in October 2011.

A fitness to practise hearing in 2006 imposed conditions on Inayatullah's registration for three years for ignoring the symptoms of patient Linda Geden, who in 2002 presented at his surgery with a lump on her neck. He told her to take paracetamol, and when she returned for a second visit he shouted at her that she was wasting his time. She registered with another doctor, was diagnosed with cancer, and died in 2006 aged 38.

The conditions imposed on Inayatullah were removed in 2009 after a panel found that he had improved the standard of his practice and addressed his previous shortcomings.

But Inayatullah's behaviour with the actors sent by *Dispatches* to his surgery in East Ham, London, showed the same failings as the previous case, a panel in Manchester heard. When "Patient AC" complained of rectal bleeding, Inayatullah failed to elicit details of the bleeding, or an adequate history.

He did not examine the patient, but falsely wrote in the record that he had. The panel rejected Inayatullah's claim that

Competition "is holding back quality care"

Gareth Iacobucci BMJ

New laws promoting competition in the health service in England may need to be rewritten because they are hampering efforts to improve services, the outgoing chief executive of the NHS has warned. Speaking at a seminar hosted by the *Health Service Journal*, David Nicholson said that the new rules enshrined in the Health and Social Care Act 2012 had led to specific cases where efforts to reconfigure and improve services had been blocked.[1]

He said that examples were emerging of unintended consequences of the law changes and that the government may need to make further changes to ensure that the act's true intent remained intact. "All of [those who devised the 2012 act] wanted competition as a tool to improve quality for patients. That's what they intended to happen, and we haven't got that," he said. Examples cited by Nicholson included hospital trusts that have been stopped from consolidating services by the competition laws.

This would include the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, which have been provisionally blocked from merging by the Competition Commission—despite widespread support from doctors—on the grounds that a merger would reduce patients' choice.[3]

Nicholson said, "Trusts have said to me they have organised, they have been through a consultation, they were centralising a particular service, and have been stopped by competition law. And I've heard that a federated group of general practices has been stopped from coming together because of the threat of competition law."

He also cited one chief executive of a foundation hospital trust who wished to "buddy" with a nearby trust, as recently directed by the government,[4] but was told he could not because "it was anticompetitive."

"All of these [proposals] make perfect sense from the point of view of quality for patients, yet that [blocking of the proposals] is what has happened," said Nicholson. "I know the secretary of state would be prepared to take legislation back [and rewrite it] if that's what needs to happen."

Cite this as: *BMJ* 2013;347:f5862

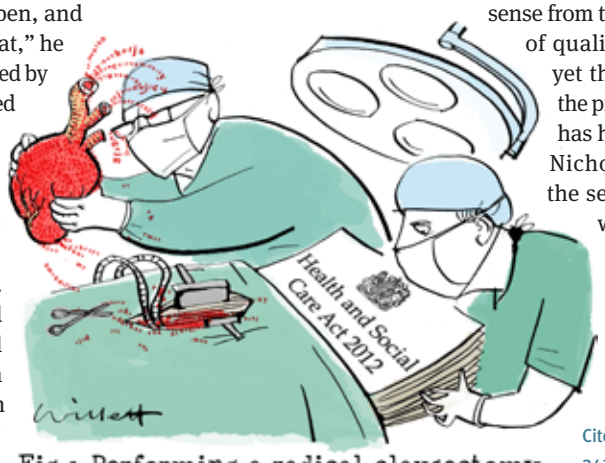

Fig.1 Performing a radical clausectomy

an examination had taken place but had been edited out of the film.

The GP was also found to have failed to listen properly or maintain eye contact with the patient, instead making phone calls on unrelated matters during the consultation.

In the case of "Patient JB," an actor whose patient health questionnaire suggested high cardiovascular risk, Inayatullah failed to appropriately assess, diagnose, or treat the patient, or follow up JB's report of "strange episodes" involving his left arm.

The panel's chairman, Ian Spafford, said that Inayatullah's answers during testimony were frequently "evasive, repetitive, and unreliable" and that his position changed on several occasions. "Your actions demonstrate a lack of insight which was persistent throughout these proceedings," he added.

"There is limited evidence that you are capable of remediation as this requires insight which you have persistently failed to demonstrate. The panel concluded that your unremedied misconduct is fundamentally incompatible with continued registration as a doctor."

Cite this as: *BMJ* 2013;347:f5914

Inayat Inayatullah was secretly filmed by *Dispatches*. He made phone calls on unrelated matters during consultations with actors

Hackney GPs win bid to run out of hours service

Zosia Kmietowicz BMJ

GPs in the London borough of Hackney have won their bid to run the out of hours service in the area for the next four years, taking over from private company Harmoni.

Clare Highton, a GP and chair of NHS City and Hackney Clinical Commissioning Group, said that while she was not involved in the decision about the £6.4m (€7.6m; $10.3) contract, to avoid a conflict of interest, she was delighted with the outcome of the tender.

"Local people deserve the best quality out of hours GP service," she said. "The new service will mean the care of local people is led by local doctors and I am very confident CHUHSE [City and Hackney Urgent Healthcare Social Enterprise] will give a first class service to our patients. We hope patients will now ring CHUHSE first when they are ill and need help out of hours."

Deborah Colvin, a local GP who helped set up the enterprise, told the *BMJ*, "This is a triumph of good sense on the part of City and Hackney CCG and an outcome which I sincerely hope will be a triumph for the citizens of City and Hackney. Local GPs working closely with patients, community services, and our local hospital is going to result in a more intelligent service, with gains for patients and the health economy across the board."

The GPs set up City and Hackney Urgent Healthcare Social Enterprise in 2012 to try to take back the running of urgent and out of hours care for their patients from the private company Harmoni, with which they had become dissatisfied.[1] In a report in the *Guardian* newspaper, local GPs alleged that staff shortages had made the service unsafe and that the company had masked delays in the time it took to see patients.[2] Harmoni refuted the criticisms.

They had thought they would be able to start running the service in April when the Health and Social Care Act came into force. But they were told in January that they would not be allowed to bid for the contract because of competition rules.[3] Harmoni was given a nine month extension to the contract, but the new contract was awarded to the social enterprise.

The CCG said that Harmoni had prepared a bid but that it had missed the deadline because of technical difficulties.

The independent panel that assessed the bids said that the bid from the social enterprise had scored highly and impressed members by its detailed submission and clinical model.

Victoria Holt, medical director of the social enterprise, said, "We are enormously excited to have been awarded this contract. We have received support from almost all local practices, and already GPs from a wide range of practices have signed up to work out of hours shifts for us. By harnessing this local experience and knowledge, we intend to provide a high quality and accessible service. Furthermore CHUHSE is a social enterprise, meaning that every penny of the money provided by the CCG will be used to provide that service."

Cite this as: *BMJ* 2013;347:f5915

Research shows risks of HRT outweigh benefits for chronic disease prevention

Jacqui Wise LONDON

Hormone replacement therapy (HRT) is not recommended for chronic disease prevention as the risks outweigh the benefits, further follow-up from the large Women's Health Initiative trials has found.[1]

The studies included more than 27 000 postmenopausal women aged between 50 and 79 who were enrolled at 40 centres in the US.

One trial was for women with an intact uterus who received either conjugated equine oestrogens (0.625 mg/day) plus medroxyprogesterone acetate (2.5 mg/day) or placebo for a median 5.6 years. The second trial was for women who had undergone a hysterectomy who received conjugated equine oestrogen alone or placebo for a median 7.2 years. The women were followed for an additional six to eight years until 30 September 2010.

The latest results, reported in *JAMA*, show that among the women given oestrogen plus progesterone there were 206 cases of invasive breast cancer, compared with 155 in the placebo group (hazard ratio 1.24 (95% confidence interval 1.01 to 1.53)).

Benefits included decreased hip fractures, diabetes, and vasomotor symptoms. Most of the risks dissipated after the intervention ended, although the risk of breast cancer persisted during the follow-up.

For women who had undergone a hysterectomy who only received oestrogen, the benefits and risks during the intervention phase were more balanced, with increased risks of stroke and venous thrombosis, reduced risk of hip and total fractures, and a non-significant reduction in breast cancer. Among women given oestrogen alone, the results were more favourable among younger women (aged 50-59) for all cause mortality and myocardial infarction.

The authors wrote, "The risks associated with hormone therapy, in conjunction with the multiple testing limitations attending subgroup analyses, preclude a recommendation in support of conjugated equine oestrogen use for disease prevention even among younger women."

Cite this as: *BMJ* 2013;347:f5895

REALIMAGE/ALAMY

Taking hormone replacement therapy increased the risk of breast cancer

More biopsies "should be carried out on secondary breast cancers"

Nigel Hawkes LONDON

Ten "critical gaps" in breast cancer research need to be filled if further substantial progress is to be made in preventing and treating the disease, a team of British researchers has concluded.

Among the most important, say lead authors Sue Eccles and Alastair Thompson, is better provision of biopsy material from patients in whom the cancer has spread, since secondary cancers can differ in important ways from primaries.

Thompson, of the University of Dundee, told a press conference at the Science Media Centre in London, "We have only begun to appreciate the heterogeneity of cancers in the past five years, but only a very small percentage of patients with secondaries have biopsies. There's been a reluctance to put patients through biopsies, but knowing the genetics of the secondary cancers can change treatment in one in six cases."

Eccles, of the Institute of Cancer Research in London, said that patients in whom the cancer had spread were still being treated as if the secondaries were identical to the primaries.

B. BOISSONNET/BSIP/SPL

"Only a very small percentage of patients with secondaries have biopsies," the authors say

SPL

"Until you know what you're shooting at you don't know if it's the right treatment" she said. "Twenty years ago breast cancer was thought to be a single type of disease, then it was two, then five, and now, depending on who you talk to, there are 20 different varieties. There's so much more to understand."

The new gap analysis, published in *Breast Cancer Research*,[1] was the result of a consultation involving more than 100 scientists from British and Irish universities, facilitated by the Breast Cancer Campaign. It follows a similar exercise published five years ago and is accompanied by a report by the campaign,[2] which details the actions needed to fill the gaps identified.

Delyth Morgan, chief executive of the charity, denied that there was any falling-off of public support for breast cancer research or unwarranted complacency, though she did warn that research spending on all cancers, after rising until four years ago, was now tailing off.

"When you talk to the public, there's no waning of the passion," she said. "There is a sense that we've been talking about it for a long time, true. But 12 000 women are still dying every year in Britain from breast cancer. We could say we're happy with that, but I'm not. I feel very, very optimistic about the future if we address these gaps, but we have to recognise that it's now time to do the really difficult stuff."

Among the gaps identified is the need for better understanding of the genetic changes underlying cancer, the molecular processes that encourage different types of breast cancer to grow, and those that allow tumours to become resistant and spread.

Cite this as: *BMJ* 2013;347:f5856

Doctor who fabricated claims she had been raped is suspended

Clare Dyer BMJ

A junior doctor who falsely claimed to have been raped twice on hospital grounds has been suspended for 12 months by a panel of the Medical Practitioners Tribunal Service.

Hannah Farnsworth, 26, told the hearing in Manchester that she "embellished" details of two real attacks that occurred while she was a foundation year 1 doctor at Bassetlaw District General Hospital in Worksop, Nottinghamshire.

She told colleagues at the hospital that she had been tied up, beaten, and raped by two men on 1 April 2011. The attackers cut her with a knife, burned her with a lighter, and filmed the attack on a mobile phone, she claimed.

She later suggested that two fellow doctors at the hospital were "involved in some way" and had watched the video. She reported receiving threats on her hospital bleeper.

On 3 June 2011, Farnsworth turned up with facial injuries at the home of another woman doctor, claiming to have been threatened by two men in the hospital car park with a knife and raped.

The hospital trust launched an investigation and spent about £10 000 to increase security. But when Farnsworth was asked to give a statement to Nottinghamshire police the following month, she quickly retracted the rape allegations.

She told the MPTS hearing that she had been attacked twice but not raped, adding, "I wanted some support and to ensure I was supported I did embellish my account. I think it was a way of trying to express the distress I was feeling."

The tribunal found her revised account of events to be "implausible," and held that the alleged attacks had never happened at all.

Cite this as: *BMJ* 2013;347:f5859

BMJ author defends finding of possible racial bias in RCGP exam

Zosia Kmietowicz BMJ

The author of a paper in the *BMJ* that found evidence of possible "subjective bias owing to racial discrimination" in the exam for membership of the Royal College of General Practitioners (MRCGP) has hit out at the college and the GMC for trying to play down his findings.

Aneez Esmail, a UK authority on racial discrimination whom the GMC had asked to investigate whether there was any evidence of racial bias in the clinical skills assessment part of the MRCGP exam, told the *BMJ* that he had been "taken aback by the vehemence of [the GMC's and RCGP's] attempt to exonerate themselves" from accusations of possible racial bias in the exam.

He said it was difficult to identify any other explanation for his findings.

Clare Gerada, chair of the RCGP, refuted the allegations and claimed that the GMC report that Esmail coauthored made no findings of potential discrimination in the exam.

She criticised the *BMJ* for "rushing through with undue haste" the publication of Esmail's findings to appear in the *BMJ* on the same day as the GMC report. The publications were based on the same data.

Esmail said he had sought to have his research published in a peer reviewed journal to give his findings an independent voice that was "not determined by the regulator."

In the *BMJ* paper Esmail concluded that "subjective bias owing to racial discrimination" in the exam could not be excluded.

His data showed that UK doctors from black and other ethnic minority groups were nearly four times as likely as white UK candidates to fail the clinical skills assessment part of the MRCGP exam at their first attempt

Firm censured for using "fear to sell private health insurance" on website

Jacqui Wise LONDON

A private health insurance comparison website has been forced to take down an advertisement claiming that the NHS in England was responsible for 13 000 needless deaths since 2005.

The Advertising Standards Authority said that the claim made by bestmedicalcover.co.uk was misleading and used an "appeal to fear to sell private health insurance and that it was not justified to do so."

The company, which compares private health insurance packages, had a web page headed "Your 3-step guide to avoid the NHS crisis." In the piece it stated, "The most recent report by NHS England medical director, Professor Sir Bruce Keogh, highlighted the staggering 13 000 deaths that occurred between just 14 NHS sites since 2005. This awful statistic, he believes, is likely to have been a tragic consequence of negligence which could have been easily avoided."

The article went on to promote health insurance, saying, "Prevent your health from becoming part of the scandal." It added, "Health insurance could quite literally save your life."

The Advertising Standards Authority received 54 complaints about the advertisement. These said that the references to the Keogh review were misleading and had misrepresented the report.

A number of articles in national newspapers published before the Keogh report was published had referred to excess deaths of up to 13 000 patients. However, Keogh's report gave no figures about numbers of deaths.

The Advertising Standards Authority said that Bestmedicalcover had based the claims only on press reports, rather than the actual review.

Cite this as: *BMJ* 2013;347:f5933

Death rate from hip replacement almost halved in eight years

Jacqui Wise LONDON

The number of deaths after total hip replacement, though small, fell substantially in England and Wales from 2003 to 2011, a retrospective analysis has found.[1]

Death within 90 days of hip replacement surgery is rare, but the study in the *Lancet* showed that the death rate dropped from 0.56% in 2003 to 0.29% in 2011, after data were adjusted for age, sex, and comorbidity.

The researchers used the UK's national joint registry, the biggest joint replacement database in the world, to analyse more than 400 000 primary hip replacements carried out to treat osteoarthritis. The data were linked with the national mortality database and the Hospital Episode Statistics database.

Over the eight years 1743 patients died within 90 days of surgery. The death rate increased with age and was higher in men than in women. The researchers acknowledged that the mortality trend may have resulted from a cohort effect, as recent generations of older people are generally fitter and less frail than the same age groups at the start of the study.

MARK THOMAS

The posterior approach led to fewer deaths than the lateral approach, maybe because it preserves more muscle

The type of implant did not affect perioperative mortality, but the researchers found that several modifiable clinical factors were associated with decreased mortality. A posterior surgical approach was associated with lower mortality than a lateral approach (hazard ratio 0.82 (95% confidence interval 0.73 to 0.92; P=0.001)). The authors said that this may be because the posterior approach results in more muscle preservation and therefore less bleeding than a lateral approach.

Use of spinal anaesthetic rather than general anaesthetic was also associated with lower mortality (hazard ratio 0.85 (0.74 to 0.97; P=0.019)).

Cite this as: *BMJ* 2013;347:f5895

Aneez Esmail, who wrote both reports, said the GMC and RCGP needed to act on his findings

(17% versus 4.5% of candidates).[1] Among overseas graduates, non-white candidates were more likely to fail the exam than white graduates, but this difference was no longer significant after data were adjusted for scores in the applied knowledge test and language skills tests.

The GMC's report said that "unintended discrimination" could exist at the stage at which candidates were selected for GP training and that those who performed less well were assigned to the least popular training placements, thus "encouraging a cycle of educational deprivation."[3]

In a statement Gerada said, "We are shocked and bemused that on the very day that Professor Esmail's official and independent GMC investigation report finds no evidence of discrimination, the same author is publishing a contradictory paper that misleadingly suggests we may be guilty of bias."

Esmail said that the RCGP and GMC were quoting his report selectively. He defended the *BMJ*'s process of peer review of his paper. "To suggest that it was not effectively peer reviewed is a travesty," he said.

He said that the GMC and RCGP were missing the point. "One of the most important findings that I have made is that, despite controlling for prior attainment, UK ethnic minority candidates still do worse in the CSA examination," he told the *BMJ*.

"I think the regulator and the RCGP should accept my findings, stop trying to justify their position, and address the problems that I have identified.

Cite this as: *BMJ* 2013;347:f5871

EDITORIAL, p 7; RESPONSE, p 23

bmj.com Research (*BMJ* 2013;347:f5662)

AP/PA

Syrian doctors, seen here treating victims of a chemical attack at a hospital in Aleppo, are said to have been shocked by the death of Dr Osama Baroudi, who had been in prison since February 2012

Syrian doctor who gave medical aid to protesters dies in custody

Sophie Arie LONDON

A Syrian doctor who was deeply involved in coordinating efforts to provide medical help to injured people during Syria's uprising has died in a Damascus prison.

Although Syrian officials have not confirmed a cause of death, relatives believe that Osama Baroudi, a 37 year old gastroenterologist who had diabetes and hypertension, was repeatedly tortured and denied medical assistance and food. Another doctor detained with Baroudi at the Saydnayha Prison has told the family that he died in a coma after refractory diarrhoea.

Authorities told the family of the doctor's death on 2 August and said that the body had been buried in a military burial ground. Syrian government authorities never confirmed what the charges were against Baroudi.

Baroudi had treated many antigovernment demonstrators in the early months of the Syrian uprising, and he was a founding member of the Union of Free Doctors in Syria, one of many non-governmental organisations to have emerged from the conflict and that is openly supportive of the revolution.

"The Syrian medical community is shocked by the news of Dr Baroudi's death," said Monzer Yazji, a member of the board of an international organisation working to provide assistance to wounded people in Syria, the Union of Syrian Medical Relief Organisations. He said, "When I first met him in Turkey in 2011 I was impressed by his willingness, readiness, and eagerness to help the wounded—risking his life in order to meet with other doctors, and planning and coordinating the medical works on the highest levels, just to ensure the preparedness of the medical services inside the country facing the unthinkable challenges."

Baroudi was arrested at work in Damascus on 18 February 2012 and held in several different detention centres. In April 2013 Amnesty International reported that a doctor released from the Air Force Intelligence branch in Damascus, one of the most notoriously brutal elements of Syrian intelligence services, had seen Baroudi and another doctor, Mahmoud al Refaal, being repeatedly tortured there. Amnesty had previously warned that the two men were facing imminent sentencing by a military field court and could face death sentences.[1]

Baroudi is one of scores of doctors who have been detained in Syria after treating demonstrators injured during antigovernment protests. The Union of Syrian Medical Relief Organisations said that since March 2011 17 medical professionals have died or been executed in detention (www.uossm.org). In many cases of death in prison relatives are told that they can retrieve the body if they sign papers confirming that the detainee was a terrorist.

bmj.com UK doctor Saleyha Ahsan's blog from Syria is at blogs.bmj.com/bmj.

Cite this as: *BMJ* 2013;347:f5951

NICE guidelines urge local authorities to "spend to save" on public health

Helen Mooney LONDON

The National Institute for Health and Care Excellence has published new guidelines on how local councils can simultaneously improve people's health while also saving money, a move which it calls a "win-win" situation.[1]

The briefing paper sets out ways that local authorities can judge the health and economic gains that they can achieve if they "place greater focus on prevention rather than cure."

Mike Kelly, director of the Centre for Public Health at NICE, said, "Action to prevent ill health improves and saves lives. In this cash strapped economic climate, the bottom line is that these public health activities can save local authorities money. The comparatively small cost of interventions to tackle issues like obesity, physical activity, and smoking is outstripped by the savings in the medium to longer term due to improved health and related factors like greater productivity and lower benefit bills."

Kelly said that the findings showed that actions aimed at a whole population, including mass media campaigns to promote healthy eating or legislation to reduce young people's access to cigarettes, were among the best value for money.

"Tackling smoking is one of the most cost effective of all preventive strategies. An example analysis for Bury Metropolitan Council found that each pound invested in a range of smoking cessation interventions will lead to a return of £2.82 after 10 years. Smoking currently costs the NHS and businesses in Bury over £10m each year," he said. From its analysis in Bury, NICE found that investing £751 692 in smoking cessation interventions for one year would achieve estimated gross savings of £321 579 overall in the first two years. It suggests that implementing a range of activities to combat tobacco use would cost Bury council an additional £9 per smoker over two years but lead to a saving of £199 per smoker over a lifetime.

Cite this as: *BMJ* 2013;347:f5878

NICE says that mass media campaigns to promote healthy eating (above) are good value for money