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bmj.com Rates of mammography in the US may be falling

Study links diabetes drug to heart deaths

Janice Hopkins Tanne NEW YORK

A meta-analysis of 42 trials of the type 2 diabetes drug rosiglitazone (Avandia) has shown a significantly raised risk of myocardial infarction and an increase in cardiovascular deaths that did not quite reach statistical significance (*New England Journal of Medicine* 2007 May 21 doi: 10.1056/NEJMoa072761).

The analysis by Steven Nissen and Kathy Wolski, of the Cleveland Clinic, Cleveland, Ohio, included 15 560 patients randomly assigned to regimens that included rosiglitazone, and 12 283 patients assigned to regimens that did not. The mean age of patients was 56 years, and the mean baseline glycated haemoglobin concentration was about 8.2%.

Patients receiving rosiglitazone had an odds ratio for myocardial infarction of 1.43 (95% confidence interval 1.03 to 1.98, $P=0.03$). The odds ratio for death from cardiovascular causes was 1.64 (0.98 to 2.74, $P=0.06$).

An editorial (doi: 10.1056/NEJMe078099) criticised the Food and Drug Administration for approving the drug on the basis of only its efficacy in glycaemic control in short term studies and also for a poor system for reporting adverse events after marketing.

Bruce Psaty of the University of Washington in Seattle and Curt Furberg of Wake Forest University in Winston-Salem, North Carolina, also say that the Food and Drug Administration Revitalization Act, now moving through Congress, should be strengthened so that the FDA can follow a drug through its life cycle, with new emphasis on postmarketing.

The FDA posted a safety alert on its website, cautioning patients taking the drug who have heart disease or are at high risk of a heart attack to talk to their doctors (www.fda.gov).

GlaxoSmithKline said it “strongly disagrees” with the findings (www.gsk.com).

DMITRY LOVESTKI/AP

Doctors condemn use of drugs as weapons

Zosia Kmietowicz LONDON

Drugs can never be used safely to enforce the law, say doctors in a report published this week by the BMA.

The report highlights the increasing interest among some governments in the use of “tactical pharmacology” or “non-lethal” drugs as weapons. Doctors need to be aware that using medical knowledge for hostile purposes puts human lives at risk and aware of the ethical implications of taking part in developing drugs for non-medical purposes, as well as antidotes and treatments for victims of chemical law enforcement, it says.

The report concludes, “The agent whereby people could be incapacitated without risk of death in a tactical situation does not exist and is unlikely to in the foreseeable future.”

The authors recount events of the Moscow theatre siege of

October 2002 when 800 people were taken hostage by a group of Chechen men and women (above). After two and a half days Russian authorities said that a derivative of the drug fentanyl was delivered through the air conditioning system to end the siege. This killed more than 130 hostages either in the raid or in the days afterwards.

Vivienne Nathanson, head of science and ethics at the BMA, said, “It is important to remember that target groups are likely to comprise people of varying weights, sizes, and ages; some may be pregnant or have pre-existing medical conditions. It is virtually impossible to control the amount of a drug delivered or to ensure it acts without producing toxic effects or causing death.

“It is disingenuous of governments to describe drugs as non-lethal—there is no difference between a drug

and a poison except the dose. Using drugs as a method of law enforcement may constitute a violation of international conventions which prohibit the use of chemical weapons. This is of great concern to the BMA.”

Many governments, including that of the United Kingdom, have policies and development programmes related to the use of drugs as weapons despite an apparent desire to limit their availability globally, says the report. The BMA hopes its report will stimulate debate among the medical profession and policy makers about the use of drugs as weapons.

The report also recommends that guidelines should be developed for healthcare professionals who are involved in research and development of agents, materials, or knowledge that might be put to a dual use.

The report can be seen at www.bma.org.uk.

UK may use hybrid embryos for research

Michael Day LONDON

In an apparent U turn the UK government has signalled its support for controversial research involving hybrid human-animal embryos.

Leading medical scientists were furious when in December last year a Department of Health white paper proposed a ban on such experiments (*BMJ* 2007;334:12).

The researchers said a ban would seriously impede the search for breakthroughs in treatments for illnesses such as Alzheimer's disease and cystic fibrosis.

Now, after intense lobbying by scientists, MPs, and patients' groups, the minister for public health, Caroline Flint, last week announced the draft Human Tissue and Embryos Bill, which calls for an all party parliamentary committee to revise the proposed restrictions.

As it stands the draft bill still outlaws the formation of

embryos with hybrid human-animal genomes.

However, the appointment of Phil Willis, a vociferous supporter of such research, as the new committee's chairman is seen as a clear indication that ministers back such experiments.

The special committee, which will include prominent legal and scientific experts, must report back to ministers by 25 July with its proposals.

Ms Flint has also written to Mr Willis, who also chairs the House of Commons Science and Technology Committee, assuring him that key research projects already proposed by scientists at King's College London and at Newcastle University are permissible under existing legislation.

These projects involve the injection of human genomes into empty animal egg cells. As such the resulting embryos are genetically over 99% human.

Life's lottery: are we slaves to our genetic code?

Annabel Ferriman BMJ

An exhibition of pictures that explore the essence of identity and free will has opened in Ely, Cambridgeshire. The artists, Esther Appleyard and Craig Kerrecoe, use DNA as their subject to investigate these topics.

This picture is entitled *Life Lottery* and shows not only a collection of chromosomes but also faint outlines of UK lottery tickets.

The exhibition, *A Series of Lines*, is at Three Cups Gallery, Ely, Cambridgeshire, until 7 July. See www.ovendenart.com.

BMA chairman resigns over MTAS letter to the *Times*

Lynn Eaton LONDON

In an unexpected move, the BMA's chairman, Jim Johnson, has resigned after protests at a letter he wrote to the *Times* newspaper published on 17 May (www.timesonline.co.uk/tol/comment/debate/letters/article1800798.ece). His letter supported the government's reforms of medical education and stated that continuing to use the flawed medical training application service (MTAS) system for appointing round 1 candidates was the "best available solution."

His letter, written with Carol Black, chairwoman of the Academy of Medical Royal Colleges, upset BMA members and led to Mr Johnson's decision to resign last Sunday.

Jonathan Fielden, chairman of the BMA's Central Consultants and Specialists Committee, was one of the council members who called for Mr Johnson's resignation.

"The history of this goes back to the last annual representative meeting," he said. "There was a considerable amount of concern that Jim was not expressing the views of membership."

"Over the MTAS issue it was clear that his views, particularly around the chief medical officer, don't reflect the huge amount of anger and distress that the profession, in particular junior doctors, are feeling," said Dr Fielden.

Mr Johnson fiercely denied Dr

Fielden's allegations, however, describing them as "absolute nonsense." "I have reflected entirely what members think throughout the year," he said. "And I have never welcomed the government's reforms."

Dr Fielden's allegations were "not borne out by the comments I have been making," said Mr Johnson.

Many junior doctors were furious that the BMA representatives on the MTAS review group had gone along with the proposal to continue with existing interviews despite them being based on the flawed MTAS computer system.

Mr Johnson claims his letter to the *Times* was merely reiterating

existing BMA policy.

Mr Johnson told the *BMJ* that he had not thought it necessary to consult the BMA before writing to the *Times*. "The BMA policy is that we support Modernising Medical Careers," he said. "We can't have a policy we are ashamed of. I don't have to consult every time I write a letter."

Mr Johnson said it was "completely untrue" that he wasn't angry about what had happened over MTAS.

Mr Johnson was going to stand down from the BMA next month in any case, after being at the helm for four years. "I was feeling for a long time that four years was enough," he said. "But I wouldn't have chosen to end it in this way." (see p Ø1067)

"We can't have a policy we are ashamed of"

Judicial review will decide trainees' future in MTAS fiasco

Owen Dyer LONDON

The professional futures of thousands of junior doctors throughout England could hinge on the result of a judicial review of the government's web based medical training application service, known as MTAS.

The MTAS website has been closed since April, and was last week abandoned by health secretary Patricia Hewitt. Its flawed software failed to select the best applicants for jobs and permitted serious security breaches. In some cases doctors were able to read each other's personal data.

Although the decision to abandon MTAS was widely welcomed, no agreement has been reached on what to do with the thousands of applications that have already led to interviews.

An MTAS review group appointed by the government, in which the BMA participated, hammered out a compromise solution in April, in which every junior doctor is guaranteed one interview for their preferred post, and an overhaul of the system is planned for next year.

But junior doctors' group Remedy UK disagreed with the review group's recommendation that job offers made after the first round of MTAS applications should stand. Remedy UK applied for judicial review of the review

group's decisions, arguing that this year's application process was "so conspicuously unfair as to amount to an abuse of power."

Since winning leave for judicial review, Remedy UK has dropped its call to reopen applications for posts for which interviews had already been held.

"We are arguing that the posts awarded should be made temporary, just for this year, until a fairer applications system is in place," said Remedy UK spokesman Matthew Jameson Evans, a junior surgeon.

Thomas de la Mare, counsel for Remedy UK, last week told the High Court that Ms Hewitt's announcement of the abandonment of MTAS made the case for judicial review "yet more imperative."

He told Mr Justice Goldsmith that there would be "no advantage whatsoever for affected doctors in reverting to a system of deanery appointments." Changes made by the review group, which prevented applicants from reordering their preferences, had removed the "only remaining feature of MTAS with any merit," he added.

A decision was expected on Wednesday 23 May, and any job offers stemming from the first round of interviews will probably be withheld until then.

"Posts awarded should be made temporary"

Incidence of euthanasia in the Netherlands falls

Tony Sheldon UTRECHT

Five years after it was legalised, euthanasia in the Netherlands seems to be declining in favour of palliative sedation, whereby terminally ill patients are kept in a coma while decisions that may shorten their lives are made, such as withdrawal of fluids.

Now the euthanasia lobby and MPs are warning that palliative sedation, which does not involve the same reporting obligations as euthanasia does, must never become a convenient "short cut" to ending the life of someone who is dying.

New government sponsored research that evaluated the effect of the 2002 euthanasia law shows that the number of cases of euthanasia fell from 3500 (2.6% of deaths) in 2001 to 2325 (1.7%) in 2005. By contrast the number of cases of palliative sedation rose from 8500 (5.6%) to 9700 (7.1%). The number of requests for euthanasia and assisted suicide fell from 9700 to 8400.

Dutch law requires doctors to report euthanasia to committees that assess whether the legal requirements have been met. Patients have to be experiencing hopeless and unbearable suffering and to have made a voluntary request for euthanasia, and a second opinion has to have been found.

The researchers, who questioned doctors about more than 5000 deaths, conclude that the 2002 law has more or less achieved its aims of creating legal certainty and greater transparency and control and improving the quality of care.

Reporting of cases has risen sharply, from 54% to 80%. Most of the unreported cases involved the use of morphine, and doctors did not perceive their actions to be necessarily "life ending." The researchers used responses to confidential questionnaires to estimate the number of unreported cases.

The health minister, Jet Bussemaker, said that the increase in the number of cases being reported demonstrated the care with which decisions about euthanasia were now being made. "There can be no question of a slippery slope in the Netherlands."

Evaluation: the Termination of Life on Request and Assisted Suicide Act is available at www.zonmw.nl

Developing countries need stronger research guidelines

Rory Watson BRUSSELS

The European Commission has begun to work more closely with developing countries to establish high ethical standards for research worldwide. It is examining ways to involve such countries more in drawing up, disseminating, and implementing ethical guidelines that are adapted to their specific circumstances.

Impetus for the initiative came at a two day conference in Brussels last week on ethics, research, and globalisation that brought together 150 delegates from international organisations, governments, research bodies, and academia.

Janez Potočnik, the European Union's commissioner for science and research, told participants:

"Globalisation of research requires better implementation of international ethical guidelines. This is particularly true in areas like health research. But new areas, such as nanomedicine and bio-piracy, also call for new or adapted standards."

The conference learnt that of the 100 000 clinical trials carried out around the world each year, some 10% occur in developing countries, where patients are readily available, regulatory requirements are less strict, and costs are lower. By 2010 European and US drug companies are expected to spend \$1.5bn (£0.8bn; €1.1bn) on trials in India alone.

However, many developing countries, especially in Africa, do not have the logistical support,

financial resources, or trained personnel to establish effective ethical committees or to supervise the research being carried out among their citizens.

The European Commission now intends to use part of its long term research budget to help countries looking to develop their capacity to implement high ethical standards.

Initially, the practical focus is expected to be on training key personnel, raising awareness, and creating an administratively efficient infrastructure. Once in place, national ethical committees should be able to assess clinical trials and ensure that the results of research are made publicly available.

Dr Potočnik said that as the number of clinical trials in developing

countries grows it is increasingly important to ensure that participants enjoy the best possible protection.

"This requires analysis in many areas, including access to health care, cultural and local traditions, and the role of multinational companies, particularly in the pharmaceutical sector," he said.

The commission is hoping that its own ethics reviews may serve as an example that can be adapted to local conditions.

These reviews ensure that EU funded research undertaken anywhere in the world complies with fundamental ethical principles. Those trials that do not—and 10% of research proposals for EU funding raise serious ethical and social issues—are rejected.

Cost of prescribed drugs can vary fourfold, audit shows

Adrian O'Dowd LONDON

Up to £300m (€440m; \$590m) could be saved every year in England through smarter prescribing by GPs, the government's spending watchdog said last week.

The National Audit Office (NAO) has published a report saying that smarter prescribing—and particularly the prescribing of generic drugs—could save primary care trusts more than £200m a year, and cutting back on unused drugs could save a further £100m.

For the report the NAO surveyed 1000 GPs, polled advisers on prescribing in primary care trusts, analysed prescriptions written between August 2005 and July 2006, and interviewed GPs, NHS trusts, academics, pharmacists, and the drug industry.

The report identifies wide variation among trusts in the extent to which local GPs prescribe cheaper drugs for the same conditions.

The authors analysed the way in which four common types of drug were prescribed. They looked at:

- The percentage of statins prescribed as generic simvastatin
- The percentage of drugs affecting the renin-angiotensin system prescribed as angiotensin converting enzyme (ACE) inhibitors
- The percentage of proton pump inhibitors

Unused drugs returned by a single patient to Derbyshire County Primary Care Trust in 2006

RANGE OF COST PER DOSE FOR CERTAIN TYPES OF DRUGS IN ENGLISH PRIMARY CARE TRUSTS

*Data were derived from analysis of prescriptions written August 2005 to July 2006
Source: National Audit Office

"Smarter prescribing could save PCTs more than £200m a year and cut back on unused drugs"

- that were prescribed as generic drugs, and
- The volume of clopidogrel prescribed (guidelines say that it should normally be prescribed for no more than a year after a cardiovascular event).

These four groups represent 19% of the overall drug bill, and the report claims that more than £200m could be saved if all primary care trusts prescribed as efficiently as the top performing 25% of trusts.

The NAO also found that the cost per dose of the first three of these drug groups varied almost fourfold across primary care trusts. The cost of a daily dose of a statin in North Eastern Derbyshire, for example, was only 10p, whereas in North Norfolk it was 37p.

GPs find it difficult to assimilate all the information they receive on prescribing, the report says. A fifth of those surveyed said that drug companies had more influence on their prescribing than prescribing advisers.

The report also said that as much as £800m worth of drugs may be being wasted every year by patients collecting their drugs but not taking them. It recommends that GPs take steps to counter this by limiting the time period of prescriptions for new patients and by giving repeat prescriptions for only 28 days at a time. Primary care trusts could also run public awareness campaigns.

Practice based commissioning could be a way to improve value for money in prescribing, says the report.

Prescribing Costs in Primary Care is accessible at www.nao.org.uk.

The use of Africa for drug trials came under scrutiny in the film *The Constant Gardener*

Screening for abdominal aortic aneurysms could save lives

Susan Mayor LONDON

Ultrasound screening of men aged 65 to 79 for abdominal aortic aneurysms significantly reduces the number of men who die from the condition, a systematic review has concluded.

The review of trials that evaluated screening says that between 5% and 10% of men in this age group have abdominal aortic aneurysms of which they are unaware (*Cochrane Database of Systematic Reviews* 2007;(2):CD002945).

Rupture of these aneurysms carries a very high risk of death. Screening by abdominal ultrasonography can detect these aneurysms, many of which can be treated with surgery.

In its review the Cochrane peripheral vascular diseases group searched its trials register for randomised controlled trials of population screening for abdominal aortic aneurysms. They found four studies, conducted in the United Kingdom, Denmark, and Australia and involving 127 891 men and 9342 women. (Only one of the studies included women.)

All four studies offered one-off abdominal ultrasonography screening for abdomi-

nal aortic aneurysm to people aged over 65 years. Participants with a strongly positive result were investigated further and offered surgery.

The results of the review showed a significant 40% decrease in mortality from abdominal aortic aneurysm among men three to five years after screening (odds ratio 0.6 (95% confidence interval 0.5 to 0.8) but not among women (odds ratio 2 (0.4 to 10.9)). Mortality included death from rupture and from emergency or elective surgery for aneurysm repair.

Screening was also associated with a lower incidence of ruptured aneurysm in men (odds ratio 0.5 (0.2 to 1) but not in women (odds ratio 1.5 (0.3 to 8.9)). Men who were screened were more likely than men who weren't screened to undergo surgery for abdominal aortic aneurysm (odds ratio 2 (1.6 to 2.6). This was not reported in women.

Mortality from all causes did not differ significantly between screened and unscreened participants, in either men or women.

Croatian academic is found guilty of plagiarism

Geoff Watts LONDON

A Croatian government committee that is investigating a senior academic and obstetrician has ruled unanimously that allegations of plagiarism in his published work are well founded.

In an opinion issued on 15 May the Committee for Ethics in Science and Higher Education declared that Asim Kurjak of Zagreb University Medical School was guilty of "violations of the [committee's] ethics code . . . and of common norms in biomedical publishing."

The allegations were originally made in the *BMJ* by Iain Chalmers of the James Lind Library in Oxford (*BMJ* 2006;333:594-7 doi: 10.1136/bmj.38968.611296.F7).

The saga began in the late 1980s when Dr Chalmers was preparing a systematic review of epidural anaesthesia. He noticed that much of the text and data in a 1974 paper co-authored by Professor Kurjak were identical to those in a paper from a different group of authors published three years previously.

He reported his observations to the editor concerned and to Professor Kurjak's university. Both requested that the matter be handled discreetly.

In 2006 Dr Chalmers discovered that Professor Kurjak continued plagiarising.

"When I found out after 14 years that he (Professor Kurjak) was still at it, I felt stupid for having acquiesced in the [original] request to be discreet," said Dr Chalmers.

As at the beginning of this week the dean of the medical school, Nada Cikes, said that she had still not received a copy of the committee's opinion.

However, she confirmed that she was aware of its content, she said. All she could say was that it would be considered by the university's "court of honour."

She added: "This has to analyse all relevant facts, including [holding] a hearing with Professor Kurjak, and then it will reach a final decision."

When asked to comment on the committee's decision, Professor Kurjak said (on 21 May) that he had not received a copy of the decision and had been informed by the medical school that no decision had been made. He added that the medical school's internal investigation into the allegations against him of plagiarism was "not finished."

IN BRIEF

US drug maker fined for misleading public:

The Connecticut based Purdue Frederick Company has pleaded guilty to misbranding the opiate analgesic OxyContin (oxycodone hydrochloride) with intent to defraud and mislead the public over its addictive qualities. The drug maker was fined \$634.5m (£320m; €470m).

Watchdog calls for vitamin enriched bread:

Bread should be fortified with folic acid to reduce birth defects such as spina bifida, the UK Food Standards Agency recommended last week. Government ministers will consider the move. There are concerns that adding the vitamin could mask a deficiency in vitamin B-12 in some patients.

Stabbing related admissions rise by almost a third:

The number of stabbings resulting in hospital admissions in England has increased by almost a third in eight years. Between 1997 and 2005, admissions after an assault involving a sharp object rose from 3770 to 4891 (*Journal of Public Health* 2007 May 11 doi: 10.1093/pubmed/fdm018).

West African countries get \$58m for yellow fever vaccines:

The Gavi Alliance is to give a \$58m (£29m; €43m) grant to support special immunisation campaigns in 12 west African countries at high risk of yellow fever epidemics. The aim is to vaccinate more than 48 million people in the next four years.

Extra support for families with disabled children:

The UK Treasury has announced that families caring for children with disabilities are to receive £340m (£500; \$670) in the next three years to improve childcare and support. Sir Al Aynsley-Green, the children's commissioner for England, said the extra cash was a good "down payment," but he called for better funding "to deliver a comprehensive and well funded service" for disabled children.

Global Fund says AIDS treatment reached a million people:

The Global Fund to Fight AIDS, Tuberculosis, and Malaria announced this week that more than one million people with HIV have received antiretroviral treatment through the AIDS programmes that it supports, approximately doubling the results reported last year. The fund's programmes to fight malaria have also distributed around 30 million insecticide treated nets to families at risk. See www.theglobalfund.org.

US comes last in international comparison of health systems

Janice Hopkins Tanne NEW YORK

Three times in a row the US health system has come last in the US Commonwealth Fund's survey of health systems in six industrialised nations.

The United Kingdom was ranked first overall, scoring highest on quality, efficiency, and equity. In terms of "healthy lives"—measured by numbers of preventable deaths and life expectancy—Australia ranked highest.

The US and the UK had poor scores on indicators of healthy lives, the report said. Both countries had high mortality (in 1998) from treatable conditions. Mortality was 25% to 50% higher in the US and the UK than in Canada and Australia.

The US ranked last on the five dimensions of a high performance health system: quality, access, patients' safety, efficiency, equity, and healthy lives. The analysis drew results data from three international surveys of patients and primary care doctors.

The US performed best of all the countries in preventive care, "an area that has been monitored closely for over a decade by managed care plans," the fund said.

The non-profit Commonwealth Fund, which works for improvements in health care, found that the US system did not achieve better health for its citizens than systems in Australia, Canada, Germany, New Zealand, and the UK—even though \$6102 (£3100; €4540) is spent on health care for each citizen in the US, more than twice the median spend of \$2571 in other countries in the Organization for Economic Cooperation and Development. The fund's comparisons in 2004 and 2006 showed similar results.

Unlike the other five industrialised coun-

tries in the comparison, the US does not have universal health insurance coverage. About 47 million US citizens, or about 16% of the population, do not have health insurance. While other countries provide citizens with a "medical home," a long term tie to a general practitioner or family doctor, US citizens with insurance must often move from one doctor to another if they change jobs or if their company changes health insurance provider.

Karen Davis, president of the Commonwealth Fund, said that the US's "failure to insure health insurance for all and encourage stable, long term ties between physicians and patients shows in our poor performance on measures of quality, access, efficiency, equity, and health outcomes."

"In light of the significant resources we devote to health care in this country," Dr Davis added, "we should expect the best, highest performing health system."

Without access to a family doctor many Americans did not seek care that could have been provided by a family doctor, or they went directly to an emergency department.

Americans with below average incomes were much less likely than similar people in other countries to visit a doctor when they were ill, the survey said.

The US is also behind other countries in adopting information technology. The survey says that the US spent only \$0.43 per person on health information technology in 2005, whereas in the UK the figure was \$192 per person.

Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care at www.commonwealthfund.org.

AVERAGE ANNUAL SPENDING ON HEALTH CARE PER PERSON

Source: Commonwealth Fund

COMMONWEALTH FUND'S RANKINGS OF HEALTHCARE SYSTEMS IN FIVE INDUSTRIALISED COUNTRIES (2007)

	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Ranking						
Overall	3=	5	2	3=	1	6
Quality care	4	6	2=	2=	1	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy lives	1	3	2	4=	4=	6

Source: Commonwealth Fund

Keeping the scientists in step with society

In the week that the UK government unveiled its bill merging the Human Fertilisation and Embryology Authority and the Human Tissue Authority, **Lisa Hitchen** talks to the woman who is currently in charge, **Shirley Harrison**

HFEA

Lisa Hitchen LONDON

Hardly a week goes by in the United Kingdom when the Human Fertilisation and Embryology Authority (HFEA) is out of the news. With one in seven couples having problems conceiving and greater pressure on assisted reproduction clinics to improve their success rates, together with rapid progress in research using embryonic stem cells, this is not surprising.

So the job of heading a n organisation that is responsible for monitoring treatment and research in the area of assisted reproduction is a formidable one. That task has been given to Shirley Harrison, who from January this year has been chairing the HFEA as well as the Human Tissue Authority, the body responsible for monitoring the use and storage of tissue samples.

Ms Harrison will oversee the work of both authorities until, through new legislation, they merge to become the Regulatory Authority for Tissue and Embryos (RATE), expected to be in place in 2009 (see News p1075). A review of the 1990 HFEA Act is also due to take place, because many of today's ethical dilemmas were not anticipated when it was passed.

After taking a philosophy degree at Lancaster University, Ms Harrison worked in marketing and public relations, later taking a variety of roles in public sector organisations, while in a non-professional role she has been involved in criminal justice, education, and health. She was chief publicity officer at Sheffield City Council from 1986, where she managed the city's communications concerning the Hillsborough stadium disaster. Later she lectured on public relations at Leeds Metropolitan University, and she has written or edited two books, *Public*

Relations: An Introduction (a standard public relations textbook) and *Disasters and the Media: Managing Crisis Communications*.

She was also a member of the Human Tissue Authority and its interim chairwoman before the latest appointment.

A patient herself—having had breast cancer, which is now in remission—she has been involved in several bodies that represent patients, and it is through this work that she has found her way to her present position. Among the groups she has been involved in are the National Cancer Research Network's consumer liaison group, the North Trent Cancer Research Network's consumer research panel, and the Sheffield cancer services advisory group.

But Ms Harrison is not someone who overplays her personal story. Instead she uses it to inform her work.

"You use the experience you have had to inform how you explore other parts of the forest, if you like, rather than taking a personal agenda," she said. She thought that people who pursued a personal agenda too closely discredited patients' groups in the eyes of clinicians and scientists.

Just five months into the job and Ms Harrison is already overseeing some big debates. The authority is holding two consultations at present: one on multiple births after in vitro fertilisation (IVF) and one on the ethical implications of using human-animal embryos (hybrids and chimeras) in research.

The HFEA is often expected to comment on issues that are connected with its work but are not within its control. However, it is the authority's ability to anticipate what researchers, the public, clinic staff, or the

media might throw at it that enables it to respond promptly when called on.

One such example arose in the past few weeks, when the HFEA received applications from two couples with a history of breast cancer asking for pre-implantation genetic diagnosis.

The HFEA had anticipated that it would eventually be confronted with such requests and had already taken the step of approving the extension of embryo gene screening—from genetic mutations with 100% penetrance (those in which an individual who inherits the mutation will definitely develop the illness, such as Huntington's disease) to those with lower penetrance, such as BRCA1 and BRCA2 mutations for breast cancer, in which people with the mutation have a 50% to 80% chance of developing the disease.

Again, Ms Harrison's own experience and interest in research gave her insight into the complexity of the issues involved.

"I had genetic testing because of my family history. It was in its infancy [then]. Everything in this field moves so fast, and because it makes such a great story it is always the latest breakthrough in the newspapers.

"It is difficult to get across to people that these are individual cases and that you have to look at each on a case by case basis, because each will differ depending on the effect [that the genetic mutation] is likely to have through the generations."

Using pre-implantation genetic diagnosis for a wider range of diseases has brought the HFEA into conflict with disability groups, who

see it as a tool that is increasingly being used to select out people with disabilities or illnesses altogether. Does she fear that embryo screening

could go too fast and too far?

"Because we look at each disease on a case by case basis, I don't think we are in danger of going too fast. Always there will be opportunities to find things out in science. Just because you can do it does not mean that you should.

"That is why we have an ethics and law committee in the authority, which will look at any sort of potential for a slippery slope, for (the dreaded word) 'eugenics' or 'designer babies,' [and] to ensure that we are not going any faster than society is keen for us to go."

The full version of this article is at bmj.com.