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Cancer body gets tough on conflicts

The 20 000-member American Society of Clinical Oncology (ASCO) last week adopted one of the toughest conflict-of-interest policies of any scientific body.

Research leaders seeking to present studies at ASCO conferences or to publish articles in the society's journals must now disclose any financial support from a project sponsor in excess of $100, including gifts and travel expenses. In comparison, the US National Institutes of Health only requires researchers who receive grants to disclose to their institutions payments or stock in excess of $10 000 a year from a study sponsor.

ASCO president Paul Bunn, an oncologist who directs the University of Colorado's Cancer Center in Denver, explains that a plethora of conflict-of-interest cases prompted the rewriting of a previous policy that dates from 1996. 'We really felt a need to tighten up,' says Bunn. The new policy will come fully into effect in a year's time.

Nature 2003;423:108

Blair says whole of NHS should be opened up to competition

Prime Minister Tony Blair told a meeting of private healthcare executives that he wanted to open the whole of the NHS to outside competition.

Mr Blair met managers from private US, European, and South African companies bidding to run 11 diagnostic and treatment centres, which will perform operations in specialties that have the highest waiting times – such as knee, hip, and cataract surgery.

According to a report in the *Guardian*, Mr Blair said: 'We are anxious to ensure that this is the start of opening up the whole of the NHS supply system so that we end up with a situation where the state is the enablers, it is the regulator, but it is not always the provider.'

In total, there will be 46 diagnostic and treatment centres run by the NHS, 11 by the independent sector, and eight run jointly by the NHS and the independent sector. The Department of Health hopes that the centres will do 39 500 operations a year by 2005, treating an extra 54 000 patients a year.

BMJ 2003;326:1106

Strategies to improve outcomes after acute stroke

Over the past 25 years there has been a quiet revolution in care of patients with stroke, with the introduction of effective interventions to minimise the impact of stroke after its onset.

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Stroke care units were introduced in the mid-1970s. However, not until 1993 did it become clear that management in a stroke care unit reduced morbidity and mortality compared with general ward management and, more recently, that patients treated in physically discrete units have better outcomes than those who are dispersed in different locations and rely on mobile stroke teams. Thrombolysis with tissue plasminogen activator (tPA) (given within three hours of stroke onset) was introduced in 1995 and with aspirin (given within 48 hours of onset) in 1997. Neuroprotection with agents such as glutamate antagonists, among others, is still being evaluated.

It is salutary to compare the effects on death and disability of the three proven strategies for stroke intervention – management in a stroke care unit, and aspirin and tPA administration. Using broad assumptions about the current uptake of these strategies, the absolute benefits of stroke care unit management clearly outweigh those of aspirin and tPA administration.

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