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# LETTERS

## CANCER DRUGS AND COPAYMENTS

### Why not adopt the blacklist of yore?

I suppose it is inevitable that the moral and political issue of copayment for cancer drugs will result in an arbitrary, bureaucratic directive, such as that offered by the unelected Lords Finlay and Crisp,<sup>1</sup> whose rules I summarise:

- (1) The drug or device is listed as one for which copayment is allowed.
- (2) The patient should want the treatment (and have discussed the risks, etc).
- (3) The clinician should have a reasonable belief that benefits outweigh the benefits of other treatment.
- (4) Patients who are unable to participate in a clinical trial should be willing for their treatment and its outcomes to be recorded on a register and potentially available to research.

The rules are a sham. Who decides the first, which trumps all others? The second seems absurd, unless doctors foist unwanted treatments on patients. The third is precisely the rational/rationing problem, and begs the whole question. Until the National Institute for Health and Clinical Excellence (NICE) has assessed the evidence and ruled the drug in, only expert specialists (and their peers) can reasonably anticipate NICE judgments—precisely the situation which NICE was invented to contain.

The last rule is high handed and authoritarian. If I did not consent, or was otherwise “unable to participate” in a clinical trial, why should I be required to participate in records, registers, and research? What if I were to refuse? Why is it that NHS managers, doctors, and politicians want to control what I do with my money in a free society? They should limit themselves to that part which is taken from me in tax.

The question is not new, and a working solution has been usual NHS practice for 20 years. In 1986 the NHS decided to formally blacklist several drugs deemed to be of insufficiently evidenced effectiveness. The alternative and presumably effective drugs were later to become known as the whitelist. Patients who insisted that Mogadon was superior to nitrazepam were allowed to pay for it on private prescription from the same general practitioner who was forbidden to prescribe it on an NHS pad. The working rules seem to be:

- (1) The drug or device is blacklisted (not NHS funded).
- (2) The patient should want the treatment (and have discussed the risks, etc).
- (3) The clinician should have a reasonable belief that the prescription is safe, effective, and legal.
- (4) Patients who are unhappy are referred to their elected MP.

L Sam Lewis general practitioner, Surgery, Newport, Pembrokeshire SA42 0TJ; [sam@garthnewydd.freeserve.co.uk](mailto:sam@garthnewydd.freeserve.co.uk)

Competing interests: None declared.

1 Finlay I, Crisp N. Drugs for cancer and copayments. *BMJ* 2008;337:a527. (30 June.)

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### Critical issue is rapidity of review of new drugs

Baroness Finlay and Lord Crisp support copayments with four essential criteria.<sup>1</sup> The fourth criterion will fail as the denominator is described as a small group in the scale of the NHS's customer base. There is also the assurance that this is “mostly” for drugs yet to be reviewed by the National Institute for Health and Clinical Excellence (NICE).

That is not the experience revealed by recent high profile cases in the media where cetuximab for colorectal cancer has featured prominently and it has been rejected by both NICE and the Scottish Medicines Consortium (SMC). Finlay and Crisp say that it is a fundamental and essential principle that all drugs and devices fully proved through appraisal should be available freely, but do they support the corollary that drugs and devices rejected by appraisal are excluded from their approved copayment list? The authors also compare favourably the use by patients of self funded complementary “therapies” nearly all of which have no evidence base and have never undergone the rigours of the appraisal by NICE or SMC. Such self-medication cannot be used as an argument to assist one apparently small group of patients to copay what others will be denied.

The critical issue to address is the rapidity of NICE and SMC review, a process that is often lengthened, not by those bodies but by the time it takes industry to submit to them after licence; to ensure that which is approved is made available at no cost to the patient as soon as possible; and to manage a fair and open system of assessing non-formulary applications.

The next byelection to the UK parliament is in a

constituency where cancer mortality statistics are poor. Allowing those on disability benefit or the old age pension to copay for new cancer drugs will make no impact on that—because they could not. This debate is emotional because it affects lives and, I suspect like 60 years ago, relates not a little to fears over clinical freedom. It needs also to focus on equity and fairness.

Alan Rodger medical director, Beatson West of Scotland Cancer Centre, Glasgow G12 0YN  
[alan.rodger@ggc.scot.nhs.uk](mailto:alan.rodger@ggc.scot.nhs.uk)

Competing interests: I am required to assess all non-formulary medicines requests for our cancer centre.

1 Finlay I, Crisp N. Drugs for cancer and copayments. *BMJ* 2008;337:a527. (30 June.)

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## DARZI REVIEW

### Clinical dashboards and open kimonos

My admission: in a previous life, I was a designer of emperor's clothes. I worked in corporate venturing and management consultancy for seven years. In short, I know a bit about dashboards. So, when I read that Lord Darzi was championing them in hospital foyers,<sup>1</sup> I felt moved to write.

Clinical dashboards aren't a new idea. Googlesearch and you'll get over a million results. In fact, the NHS has already met the dashboard. The top 10 results reveal that Barts and the Royal College of Obstetricians and Gynaecologists use them. Why?

It's an attractive tool which claims to bring simplicity to the complexity of running a large organisation. The root analogy is of a ship's bridge. The captain can see, at a glance, where he's going, how fast, how efficiently, and where the icebergs might be.

There are two problems.

Firstly, the targets you're measuring against are set at a moment in time and are either extremely conservative (set by managers who know they'll be judged on them) or super-ambitious (set by managers to show they are a thrusting team).

Secondly, a Kentuckian management consultant once told me, "if you open your kimono, you better have something worth showing." Same with the dashboard. Its natural history is to arrive to a large fanfare, work, work too well, be fudged, then be withdrawn. Why? The easy stuff gets done, the difficult things don't. Excuses are followed by the realisation that some of the targets are unachievable, even undesirable.

Cynicism aside, the dashboard is a useful tool. I have one now telling me how behind I am with my finals revision. But, who is it useful for? The captain of the ship, not the passengers. A public dashboard is doomed to failure. The complexity beneath it needs a depth of understanding and an ability to change course and do what's necessary to keep the ship moving.

So, a message to Lord Darzi, please sir, keep your kimono closed.

Neil J Hughes third year medical student, St George's University of London, London SW17 0RE  
m0402783@sgul.ac.uk

Competing interests: None declared.

1 Kmietowicz Z. Darzi review: Annual "quality accounts" will help improve services and increase choice for patients, says Lord Darzi. *BMJ* 2008;337:a646. (3 July.)

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## NHS AT 60

### Doctors' infantilisation

I have been both manager and doctor in the "intensive command and control regime of national targets, inspection and regulation, and published league tables" of our 60 year old NHS.<sup>1</sup> My performance as a manager was measured on my team's ability to deliver government efficiency targets, with original thinking commonly stifled. My performance as a junior doctor is assessed on the ability to deliver these targets alongside individual, high quality, evidence based care.

My audit at a foundation trust showed how trust policy actively ignores clinical guidelines to achieve performance indicators. This exposes patients to unnecessary admission and investigations, and prevents junior clinical staff from seeing, learning, and practising good clinical medicine. Junior doctors and their patients have less power than administrative staff and managers chasing after a performance indicator turning red.

Whereas patients now have choice into the who and where of treatment, clinicians grumble they have less choice in how to deliver this. I now have to write up my assessment of a patient on a standard proforma, although the same sized

box obviously does not fit every patient. Through standardisation the nuances of a consultation, the backbone of individual care, are lost. But so are my opportunities to use my ability to think, a skill crafted at university—in my case on behalf of my patient. The proformas symbolise the creation of a monochromatic, uniform NHS and workforce, which of course negates the need for patients to choose who and where.

The mindsets of my generation of clinicians will lead the NHS at its centenary birthday. Then we may well be desperate for a new policy toy or proforma to implement. Because, unless Daddy tells us, how will we know how to think and what to do? Our patients with their powers to choose and assess performance will be more grown up than the children inside but leading the NHS.

Alexandra Thomson-Moore foundation doctor, West Suffolk Hospital, Bury St Edmunds, Suffolk IP33 2QZ  
1977atm@doctors.org.uk

Competing interests: None declared.

1 Delamothe T. A fairly happy birthday. *BMJ* 2008;337:a524. (30 June.)

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## MEDIA AND HEALTH SERVICE

### How the government is failing the health service

Snow's article is a refreshing reminder that most of the NHS works very well.<sup>1</sup> But it's not just the media that concentrate on the rare instances of poor practice to make sensational claims that sell their papers: the government does exactly the same, apparently to turn our patients against us and support their political reforms.

A good example comes from the government's own £23m survey showing that 84% of patients are content with their general practitioners' opening hours; its response (presumably premeditated) is to beat us over the head with the other 16% and impose extended opening hours.

An insight into the government's philosophy was provided by its health minister in national news broadcasts on 3 July. Ben Bradshaw announced that gentlemen's agreements operate that mitigate against lists being open to new patients and therefore work against real patient choice. Bradshaw was forced to climb down by balanced journalism on the BBC Radio 4 *Any Questions* programme on 4 July. The transcript I

compiled is illuminating:

Jonathan Dimbleby (chair):

When you say that they have this "gentleman's agreement" to undermine patient choice, what are you claiming that they are doing? . . .

Ben Bradshaw (health minister):

In a very small number of places in the country people tell us that when they try to change their GP they're told by their GP practice, "No you can't because we . . . will not take patients from other practices." It's . . . certainly not the biggest obstacle to patient choice, which is one of the things that we want to try to encourage; there are far bigger obstacles to patient choice, but I have to say . . . we were inundated by emails and calls from people who had—

JD: [interrupting]: What does "inundated" mean?

BB: I had more emails than I've ever had on any other issue from members of the public

JD: Is that 10 or a hundred or a thousand? Ten thousand?

BB: No, to my parliamentary office it's more than 10, which I can tell you is a lot.

JD: More than 10.

BB: A lot. [Laughter from audience]

JD: With respect, is more than 10 enough to use "people tell us" [as] evidence to make a statement which has so outraged the BMA—namely, that they're operating a gentleman's agreement? . . . Isn't that sort of pushing it a bit?

BB: It's enough to indicate to me that the claim by the BMA leadership . . . that this never happens is not true.

It's pretty demoralising for us to witness such prejudice in our policymakers, knowing that this attitude is fed down to the primary care trusts. Now the cat is officially out of the bag I hope they will understand any reluctance we may have to believe what they say and cooperate with their reforms.

Richard A D O'Brien general practitioner principal, East Quay Medical Centre, Bridgwater, Somerset TA6 4GP  
RichardA0B@aol.com

Competing interests: RADO'B is a hard working general practitioner.

1 Snow J. How the media are failing the health service. *BMJ* 2008;337:a572. (30 June.)

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## KEY OPINION LEADERS

### Thus are our medical meetings managed

Outraged key opinion leaders will undoubtedly protest that their opinions are unaffected by industry honorariums and hospitality.<sup>1</sup> In some cases this is true. According to an anonymous

industry insider interviewed by a publicly funded project I direct (PharmedOut.org), academic physicians are tracked by industry from early in their careers. Promising young faculty are invited to one on one meetings by pharmaceutical company executives, who interview them about their work and opinions over an expensive meal with excellent wine. Each potential recruit is flattered and well fed. However, only those whose opinions align with marketing messages are taken under a company's wing, to be financially supported, pampered, and admired while being flown around to speak at academic medical centres and medical conferences.

Some key opinion leaders are genuinely unaware of the marketing message they are disseminating. A key opinion leader's opinion that a certain disease is underdiagnosed, undertreated, or more serious than commonly believed can align perfectly with a company's marketing goals even if drugs are never mentioned. Pharmaceutical companies seek long term relationships with the key opinion leaders whom they recruit—or create. Constant support, treats, and the gentlest of suggestions by one's "friends" ensure the continued alignment of a key opinion leader's statements with a company's marketing messages. It is absolutely essential to maintain the illusion of the key opinion leaders' independence and integrity.

Most "experts" are some company's key opinion leaders. Thus are our medical meetings managed to limit discourse to competing profitable therapies, and to overwhelm non-industry funded voices.

**Adriane Fugh-Berman** associate professor, Georgetown University Medical Center, Washington DC, 20057, USA  
ajf29@georgetown.edu

**Competing interests:** The author has been a paid expert witness on the plaintiff's side in litigation regarding pharmaceutical marketing practices.

1 Moynihan R. Key opinion leaders: independent experts or drug representatives in disguise? *BMJ* 2008;336:1402-3. (21 June.)

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## Getting them while they're young

Having read Moynihan's piece about key opinion leaders,<sup>1</sup> we would like to describe another "communication platform" that the drug industry uses to influence the prescribing habits of doctors.

Although it is not strictly a condition of employment, many deaneries promote doctors.net.uk and request that medical students and foundation programme doctors open email accounts with the company. Accounts allow access to forums where doctors can discuss cases, resources including the *Oxford Textbook of Medicine*, and CPD accredited online



educational modules. But should deaneries be promoting this service?

The company claims to be run by doctors and for doctors. However, its chief executive officer, Richard Adams, began his career as a medical representative for Wellcome, and operations director Paul Concannon has 22 years' experience in the drug industry. The company receives funding from drug companies that in return market their products to a selection of the service's subscribers.

The website describes their marketing methods (see [doctors.net.uk/marketing](http://doctors.net.uk/marketing)). One campaign to increase the depth of prescribing used a key opinion leader webcast. Another delivered 3500 accredited disease education modules to doctors. Colourful graphics demonstrate the effects their marketing campaigns have on "knowledge," "prescribing," and "prescribing intentions."

Data needed to establish the size of the effect that online marketing has on prescribing practices are not freely available. Nevertheless, drug companies and doctors.net.uk apparently find this to be a profitable investment.

Deaneries are charged with turning graduates into competent doctors who prescribe drugs rationally on the basis of objective evidence. It is therefore highly regrettable that they are encouraging medical students and doctors to have drug company sponsored email addresses.

**Carl J Reynolds** foundation programme year 1 doctor, Basildon Hospital, Basildon SS16 5NL

[zchaxy6@ucl.ac.uk](mailto:zchaxy6@ucl.ac.uk)

**Tom Yates** medical student, Royal Free and University College Medical

**Robert Hughes** foundation programme year 1 doctor, Whipps Cross University Hospital, London E11 1NR

**Competing interests:** None declared.

1 Moynihan R. Key opinion leaders: independent experts or drug representatives in disguise? *BMJ* 2008;336:1402-3. (21 June.)

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## How it really works

Buckwell pleads for an idealised state of transparent relations between the industry and key opinion leaders.<sup>1</sup> The reality is different. Here is a description from an internationally recognised clinical scientist about his

experience with the industry. I respect his confidentiality and that of the corporation. My colleague's experience is not atypical.

"When [the company] first began trumpeting the success of [their drug], I was asked to be on their speakers' bureau. In a large audience ... I departed from the script I was given for the published data to note that the effect size ... was significantly lower than the [alternative treatments]. Since most [of the audience] had no idea what "effect size" is, I gave a brief explanation. That evening I received a phone call in my hotel room from [the company's] director of the program. He chastised me for being off message and warned me not to make these intrusive statements. I told him that I did not work for [the company], and that presumably I was asked to give these talks because I was a respected researcher in the field and had participated in some of the early trials of their drug, including meetings to develop a protocol for their FDA submissions. I repeated my performance the next day, and was never asked to talk for them again."

Over the years I have given many talks sponsored by corporations, but I gave *my* talk, using *my* slides, and choosing *my* topic. These presentations were designed for educational impact, and the company's drugs were never the central focus. They were extremely popular. About five years ago I was informed that henceforth I must use the company's topics and slides, with no deviations allowed. The corporate material provided was mediocre in quality and infomercial in tone. That is when I stopped giving company-sponsored lectures in the US.

**Bernard J Carroll** consultant, Pacific Behavioral Research Foundation, PO Box 223040, Carmel, CA 93922-3040, USA  
[bcarroll@redshift.com](mailto:bcarroll@redshift.com)

**Competing interests:** None declared.

1 Buckwell C. Should the drug industry work with key opinion leaders? Yes. *BMJ* 2008; 336: 1404. (21 June.)

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## How to spot one

The key opinion leader may be an independent expert or a drug company representative in disguise, but not both at once.<sup>1</sup> The drug company representative in disguise is easy to spot. His expenses and remunerations are shamelessly high and he uses proprietary names and drug company slides. Sometimes he praises a mediocre drug to the skies. He is engaged for multiple appearances and is referred to by colleagues as "a traveller for a drug company."

Fortunately, I believe that the independent expert is more likely to be hearkened to than the drug rep in disguise.

**Alexander S D Spiers** professor of medicine (retired), Cookham Dean, Berkshire [spiersuk@thamesinternet.com](mailto:spiersuk@thamesinternet.com)

**Competing interests:** None declared.



- 1 Moynihan R. Key opinion leaders: independent experts or drug representatives in disguise? *BMJ* 2008;336:1402-3. (21 June.)

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## High tech gadgetry introduced by stealth

Key opinion leaders also promote technical devices developed for minimally invasive surgical approaches.<sup>1</sup> Clinicians are offered training and mentoring by an expert on condition that they guarantee advance purchase of a substantial number of interventional procedures by their trust or commissioning body. In national priority areas such as cancer and cardiology some commissioners accede to persistent clinical demands, even though the devices may be at an early stage of their development. Purpose built suites and infrastructure may also need to be provided.

By their acquiescence, a few commissioners inadvertently exert indirect pressure on their colleagues elsewhere. Clinicians and trusts are anxious not to lag behind in the race for the latest technological advance, but the casualty is an evidence based, clinically and cost effective commissioning strategy underpinned by an objective critique of the limited evidence. Commissioners are left to pursue rearguard damage limitation by constructing retrospective clinical governance controls.

The losers are patients at the receiving end of an intervention that lacks an evidence base. Medical science also loses because if phase three trials are ever done, they will report so late that their results are meaningless because the technological goalposts will have shifted by then.

Commissioners must stand firm and agree only to well researched interventions backed up by health economic evaluation. Proposers of new clinical developments must declare conflicts of interest and financial links with the industry at the outset. Acute trusts and commissioners should make it a condition of releasing doctors from service provision for training programmes that the training fits with agreed commissioned service developments. To do otherwise jeopardises the many other patients whose conditions are not interesting, are not amenable to treatment with high profit drugs, or do not require the use of high tech gadgetry.

**Su Sethi** consultant in public health medicine, North West Specialised Services Commissioning Team, Quayside, Warrington WA4 6HL [su.sethi@northwest.nhs.uk](mailto:su.sethi@northwest.nhs.uk)

**Claire O'Donnell** clinical effectiveness in public health, North West Specialised Services Commissioning Team, Quayside, Warrington WA4 6HL

Competing interests: None declared.

- 1 Moynihan R. Key opinion leaders: independent experts or drug representatives in disguise? *BMJ* 2008;336:1402-3. (21 June.)

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## A FRIEND IN NEED

### General practitioners must have their own list

What a great synopsis of our work as general practitioners.<sup>1</sup> How impossible to quantify for any assessment. What a gap there will be should polyclinics take over and patients see strangers, oblivious to the bond that Loxterkamp extols.

Like him, I am the son of a country general practitioner, who practised in the era of Balint training. Now that I am well retired, I just wish that I had listened more carefully and touched more often. Yet I was rewarded by "that sense of connection, the feeling that they were personally known," which always left me convinced that an "own list" was the only way to practise.

Regrettably, it is disappearing fast.

**Alexander Michael Hall-Smith** retired general practitioner, Wisbech PE14 0BQ  
[am.hs@virgin.net](mailto:am.hs@virgin.net)

Competing interests: None declared.

- 1 Loxterkamp D. A friend in need: why friendship matters in medicine. *BMJ* 2008;337:a528. (1 July.)

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## Caring still lives

The practice of friendship and compassion in medicine is alive and well.<sup>1</sup> Medicine is not merely a cold, competency based, clinical science but a warm, profound, and tactile art. Proficiency at medicine cannot be measured by exams or research but only that most potent of barometers, patients' satisfaction. We are the most privileged profession in society; people from all walks, sexes, and colours will take their time to divulge innermost hopes and fears, but only if we take our time to reach out and listen. Patients and doctors both want to feel valued and to be remembered, and this will be achieved only by a mutual sharing in each other's experiences and lives. Don't blame your lack of training, time, or team members, because this is a skill that cannot be taught, rushed, nor delegated. This skill is called caring.

**David R Warriner** F2 doctor (general practice), Derwent Surgery, Malton YO17 8PH



MUSEE D'ORSAY, PARIS, FRANCE/GIRAUDON/BAL

Competing interests: None declared.

- 1 Loxterkamp D. A friend in need: why friendship matters in medicine. *BMJ* 2008;337:a528. (1 July.)

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## MANNERS IN MEDICINE

### What's in a name?

As a patient I have been quite taken aback that whenever I've seen doctors recently they have called me by my first name while introducing themselves by their title and surname. I find it distinctly unhelpful in my interaction with another adult to be addressed like a child by their teacher when the experience of illness is already making me feel unsettled, vulnerable, and anxious.<sup>1</sup>

Whenever I have raised this matter of unequal address during a consultation, it has been met with surprise and the mention of wanting to make me feel at ease. In Germany it would be unthinkable for a doctor to introduce himself as Dr Schmidt while summoning a patient from the waiting room by calling out "Helmut" or "Angela."

I am curious as to whether there have been any recent guidelines to encourage this practice in Britain, why it seems to be the norm, and why do so few people question, let alone challenge, it? This is occurring at the same time as there is so much talked and written about patients' dignity, the doctor-patient partnership, respect, and empowerment.

**Anke Medrington** interpreter and translator  
Stockport SK4 2QU

[ankevondallau@googlemail.com](mailto:ankevondallau@googlemail.com)

Competing interests: None declared.

- 1 Richards T. Manners in medicine. *BMJ* 2008;336:1408. (21 June.)

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## ANTIPSYCHOTICS FOR DEMENTIA

### Antipsychotics for dementia is metaphor for elderly care

The blunt treatment of so called behavioural and psychological symptoms of dementia with antipsychotics is a metaphor for medical care of the older patient.<sup>1</sup> Individualised care plans with a true patient focus in a supportive environment will filter many prescriptions. The problem very often isn't the patient but the provider and the care setting. Our residential prevalence of prescribing antipsychotics has fallen from 36% to 20% in 18 months, thanks to a concerted team approach to challenging behaviours.

**Paddy Quail** medical director, Intercare, Holy Cross Centre, Calgary, Alberta, Canada T2S 3C3  
[quail@ucalgary.ca](mailto:quail@ucalgary.ca)

Competing interests: None declared.

- 1 O'Brien J. Antipsychotics for people with dementia. *BMJ* 2008;337:a602. (9 July.)

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