LETTERS

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MEDICAL CORRUPTION IN THE UK

GMC responds to article on the truth about cash for referrals

The General Medical Council takes the issue of conflicts of interests very seriously.[1] We have unambiguous guidance which sets out our expectations—doctors must not allow any potential conflict to influence their practice and must always be open and honest with patients.[2 3]

If a doctor fails to follow our guidance we can and do take action. Since 2006, 34 doctors have been referred to a public hearing following allegations about conflicts of interest—six were struck off the medical register as a result.

We carried out an internal review of the Competition and Markets Authority report and, although we have not found evidence of wrongdoing by individual doctors, we will be seeking assurances from the organisations concerned that they are not operating any inappropriate incentive schemes involving the doctors who work for them.

We do not have powers to inspect organisations or carry out industry-wide enquiries. However, as we made clear to the Health Select Committee, we are responding to understandable concerns about incentive schemes and we are determined to promote our guidance to doctors.

We will also continue to work with the NHS, the independent sector, and other regulators to address any system-wide issues. We are also working with *The BMJ* and the Royal College of Physicians on the handling of conflicts of interests.

As part of our review of how we can make the medical register more useful to patients, doctors, and employers, we are exploring the recording of doctors' commercial interests on the register.

There is certainly more that can be done, and of course the vast majority of doctors just want to do the right thing. Patients should be able to rely on disinterested advice from their doctor. That is in everyone's interest and we must all work together to make sure that they can.

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1 Gornall J. The truth about cash for referrals. *BMJ* 2015;350:h396. (28 January.)

Cite this as: *BMJ* 2015;350:h902

Doctors, declare financial interests to avoid impropriety

We are concerned by the General Medical Council's laissez faire approach to reports of undeclared financial conflicts of interest in the form of financial inducements that may have influenced the referral patterns of UK doctors.[1] We are glad that the editorial prompted a response to these serious allegations from the GMC.[2]

We agree that doctors should make conflicts of interest declarations if these conflicts could affect prescribing and clinical referral behaviour. This information should be made available to employers and patients. Although GMC guidance covers honesty and integrity, including "honesty in financial dealings,"[3] many NHS trusts have no formal or systematic mechanisms to record financial conflicts of interest.

Public Health England requires its staff to complete declaration of interests returns every year. This may stem from the Nolan principles of public life, which require public servants to follow seven principles, including honesty, integrity, and openness.[4]

According to the Committee on Standards in Public Life, the seven principles should apply to all civil servants—PHE staff and those who work in "health, education, social and care services among others.[5]

We suggest that the PHE approach of an annual review of employee declarations of interests could provide a template on which to build a database of doctors' conflicts of interest. Such a register could help tackle the opacity of undeclared financial interests reported by *The BMJ*. However, we agree that a multi-pronged approach is needed and that new conflicts of interests may arise between annual surveys. Nevertheless, we have to start somewhere.

If we do not get our house in order, public trust in our profession will suffer; this we can ill afford.

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1 Adlington K, Abbasi K, Godlee F. The General Medical Council and doctors' financial interests. *BMJ* 2015;350:h474. (28 January.)

Cite this as: *BMJ* 2015;350:h858

NHS doctors should declare interests in private practice

I applaud *The BMJ*'s goal of exposing potential conflicts of interest in doctors,[1] but the article subtly casts the debate in terms of the private sector providing doctors with financial inducements to refer patients to their facilities. This ignores the potential for conflict of interest in small business—particularly doctors' own private practices. I'm all for transparency in disclosing conflicts of interest, but surely this must include full disclosure of individual doctors' interests in private practice.

Currently there is no way to find out from public sources how many NHS consultants also run or participate in private practices, although old estimates suggest that half of them do. Disclosure of financial inducements alone won't expose this because consultants who direct work towards their own private practices don't have to pay themselves anything to gain financially. But they may (consciously or unconsciously) run their NHS practices in ways that drive business to their private interests.

So, if any register of conflicting interests is created, it should include full disclosure of NHS doctors' interests in private practice. Nothing short of this will tackle the pervasive conflicts inside the NHS.

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1 Godlee F. Medical corruption in the UK. Editor's choice. *BMJ* 2015;350:h506. (29 January.)

Cite this as: *BMJ* 2015;350:h845

DOCTORS AND GUIDELINES

When doctors can depart from guidelines

The Medical Defence Union (MDU) is often asked about the medicolegal implications of guidelines so it might be helpful to clarify our advice.[1] Members ask whether they are bound to follow guidelines or whether, after considering an individual patient's circumstances, it may be appropriate to depart from guidelines.

Guidelines inform clinical practice but don't dictate it. They do not replace clinicians' knowledge and skills. Doctors are expected to be familiar with nationally recognised guidelines that are relevant to their specialty, as well as local guidelines. This does not mean they cannot depart from guidance when they consider it to be in the patient's interests to do so.

Doctors must be prepared to explain and justify their decisions and actions, especially if they depart from guidelines issued by a nationally recognised body. It is also important to keep a record of the reasons for the decision, including any discussions with the patient.

Doctors often worry about what might happen if something goes wrong and there is a clinical negligence claim after treatment that departed from guidelines. Although the demonstration that a doctor followed widely accepted guidance, supported by expert opinion, can help in the defence of a claim, it is equally possible to defend cases where a doctor did not follow guidelines because it was not in the patient's interests.

MDU members are welcome to contact us if they need specific advice on the use of guidelines.[2]

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1 McCartney M. Don't be bullied into prescribing Tamiflu. *BMJ* 2015;350:h417. (22 January.)

Cite this as: *BMJ* 2015;345:h841

CLINICAL PHYSIOLOGISTS

PSA accredited registers for clinical physiologists

Casey seems not to understand the purpose of accredited registers and is perhaps unaware of the improvements they have made to patient safety.[1]

It is now two years since the Professional Standards Authority began its new role, under the Health and Social Care Act 2012, of accrediting registers of people who work in health and care occupations that are not regulated.[2] This provides assurance to employers and the public by ensuring that the registers meet our exacting standards.

Casey makes non-specific insinuations of malpractice in clinical physiology, and she argues that clinical physiologists pose a danger to the public. While heavily criticising voluntary registers, she does not acknowledge that clinical physiologists have two options available to reduce the risks of harm to patients. They can register immediately with the Academy for Healthcare Science—an accredited register backed by the government and its chief scientific officer. Those working in clinical physiology at scientist level can also apply to register as clinical scientists with the Health and Care Professions Council through an equivalence route managed by the academy.

Such alarmist tactics are unhelpful and disrespectful of the many dedicated skilled practitioners who work alongside their regulated colleagues every day, as vital members of the team. The presumption that regulated professions are superior misunderstands the purpose of regulation, which is to protect patients, not to confer status on professionals.

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1 Casey A. Without mandatory regulation, clinical physiologists put patients at risk. *BMJ* 2015;350:g7860. (13 January.)

Cite this as: *BMJ* 2015;350:h847

WHO'S GOAL FOR PHYSICAL ACTIVITY

Getting sedentary people moving through active travel

We welcome the recent focus on whether current international physical activity targets are appropriate given that the largest health benefits come from increasing activity in the most sedentary.[1 2] In the discussion on how to increase physical activity, however, walking and cycling for travel (active travel) received only a perfunctory mention. Sparling and colleagues recommend activities such as pacing while on the phone,[2] which have not to our knowledge been studied in terms of contributions to levels of activity or health benefits. They also suggest that walking rather than driving for short trips can increase physical activity in sedentary groups, such as older people. Public transport is often overlooked as a contributor to activity levels, but walking to and from transport access points and interchanges increases physical activity levels.[3]

Active travel is increasingly recognised as an important component of physical activity in low and middle income countries. A third to a half of Brazilian adults walks or cycles to work regularly. Increasing car use, linked to economic development, has been associated with increasingly sedentary lifestyles and adiposity in several low and middle income countries.[4] Thus, immediate action to protect high levels of active travel in these settings would be better than waiting until levels of motorisation increase. Interventions that tackle the environmental, structural, and financial barriers to active travel should be prioritised to make it easier for people to build physical activity into their daily lives. These interventions have considerable potential to increase population levels of physical activity globally. In addition to the potential benefits of getting the sedentary active, increased active travel will lower air pollution, noise, and the likelihood of anthropogenic climate change.

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Full response at: www.bmj.com/content/350/bmj.h23/rr.

1 De Souto Barreto P. Global health agenda on non-communicable diseases: has WHO set a smart goal for physical activity? *BMJ* 2015;350:h23. (21 January.)

Cite this as: *BMJ* 2015;350:h725

TREATMENT OF SEX OFFENDERS

Mental health detention should be for treatable conditions

Evidence for the rehabilitation of sex offenders is contentious and inconsistent and Ho is justified in sharing his concerns with the medical fraternity,[1] but he argues for doctors to "take ownership" without presenting evidence for psychiatric interventions.

Continued mental health detention is appropriate only if relevant medical treatment, which may include pharmacological, psychological, occupational, or nursing care, is available. But if, as Ho argues, this does not exist in the criminal justice system, then it is hard to argue for its existence in a healthcare setting. His closing paragraph implies that the mandatory detention of sex offenders in secure settings may, in itself, be the objective in some cases, but this contravenes the Mental Health Act code of practice, which states that "simply detaining someone does not constitute medical treatment."[2] Furthermore, in the absence of evidence for treatment, detention under the Mental Health Act could be challenged by the tribunal system, leading to premature return to the community for such offenders and an increase in risk to the public.

Diagnostic classification remains imperfect, and the inclusion of paraphilic behaviour closely associated with offending within current *Diagnostic and Statistical Manual of Mental Disorders* and *International Classification of Diseases* manuals does not justify diversion to hospital for such offenders without evidence of comorbid and treatable psychiatric diagnoses. Resources in secure mental health services are limited and admissions are expensive. There are many people with psychotic illness in our prisons awaiting hospital transfer for whom clear and unambiguous treatment pathways with robust evidence base exist. In this climate of austerity, secure services should allocate their resources to treat patients for whom they have the specific and exclusive therapeutic skills.

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1 Ho D. Ineffective treatment of sex offenders fails victims. *BMJ* 2015;350:h199. (27 January.)

Cite this as: *BMJ* 2015;350:h842