Chair of RCP working party responds to editorial

Joe Collier’s editorial about the Royal College of Physicians (RCP) working party report—Innovating for Health—is a satirical fairytale of wonder and mystery.1 Joe says that “the interests of patients seem to have been a secondary consideration.” Joe: have you actually read our report? Derek Calam was our patient representative and spoke on behalf of the RCP’s patient and carer network, a group of patients—not doctors—who advise the college on patient related matters. Derek completed a survey of his members for us, and their views informed not only the chapter entitled “Patient Care” (the longest chapter in our report) but also the entire document. All 10 recommendations we made in that chapter came directly from our consultation with patients.

Joe also took evidence from consumer organisations—for example, Which?, Diabetes UK, and SANE—and we received written evidence from many individuals and groups from the non-professional, non-industry sector. Joe took part in a consultation at the college in which I explained all this in great detail. For whatever reasons he now chooses to ignore the very patient focused methods we adopted.

Joe says that our real agenda was to rehabilitate the image of industry. That will be a surprise (and possibly an insult) to Derek and to seven other members of the working party who are neither pharmaceutical physicians nor work directly for industry.

What all members of the working party wanted to do was end the slanging match between critics of pharma, doctors, and industry—a slanging match that does no one much credit, and certainly doesn’t help patients get the medicines they need. Joe says there is little direct criticism of industry in our report. Not true. We review masses of past evidence about industry spin, manipulation, adverse influence, and substandard research, and we underline the lack of industry leadership to clean up its act.

But we wanted to go beyond that kind of stand-off and see if we could find a point of appropriate collaboration between the NHS and industry. Surely, we asked, appropriate collaboration with the interests of patients as the governing principle was better than simply shouting at one another, as we have largely done for decades.

Joe’s editorial wants us to fight the old battles all over again, but that is not what we wanted to do. More importantly, it is not what patients told us they wanted us to do. We listened to these patients, and our report is the outcome.

Author’s reply

Richard Horton’s letter serves only to strengthen my view that his working party and its processes were flawed.2,3 He does not quibble with most of my observations. His two concerns are with my comments that “the interests of patients seem to have been a secondary consideration,” and that “there is little direct criticism of industry.”

Ian Gilmore, president of the Royal College of Physicians (RCP), in his foreword prioritised the need to create new partnerships between industry, academia, clinicians, and the public. Assuming that the public and patients are interchangeable in this context, and that partnership means a relationship among equals, it might follow that the report would make recommendations on how, for example, patients, industry, the NHS, and doctors should work together as equals on key issues of policy and decision making. However, of the dozen or so patient related recommendations, patients feature as subjects of a real partnership in only one, and even then are mentioned last. The remaining patient oriented “should”/“must” recommendations are directed towards the other players, and in most of them patients are depicted as a group to be helped.

Horton argues that the report was critical of industry because much of the received/gathered evidence published in the report was critical. But such material can only offer indirect criticism. For direct criticism one needs to look at the nature and wording of the working party recommendations—and in this respect members remain essentially silent.

Working parties offer a real opportunity to change how we think and act. Sadly, however, an opportunity has been wasted. The RCP should now establish guidelines for working parties that will avoid such miscarriages in the future.

Voluntarism is not enough

Krumholz and Ross’s six recommendations to regulate the pharmaceutical industry make sense but do not go far enough to assure compliance.4 They are much too dependent on the voluntarism of the healthcare industry and professions to give up self serving and lucrative interactions.

Government power of the purse is needed to counteract ingrained behaviours, as well as sanctions to punish scofflaws. Like with current compensation of chief executive officers in the US, the public is increasingly outraged by those who hide behind or manipulate legalisms to take advantage of consumers. Hoodwinking consumers with the shibboleths of physician “first do no harm” and researcher “for the greater good of society” is the ultimate and most cynical betrayal of the public trust. Now is the time to embrace reforms and sanctions that the healthcare industry and professions will never accept except at the point of the sword.

An insider writes

As a medical doctor working as an epidemiologist and clinical researcher in a contract research organisation, I am a privileged witness and actor in some of the debated misbehaviours.1
Part of my work is to design seed studies or even crude prescription buying studies, which seem to be standard practice for expensive medical devices or prostheses. Regulatory provisions against such practices exist in EU member countries. Nevertheless, people like me are paid to make these studies look scientifically honourable, and they unfaithfully pass all the required boards and committees.

I also do a lot of ghost writing. Sometimes I report good quality studies to which I am proud to contribute, albeit anonymously. Yet, too often, I write so called reviews, amounting to mere panegyrics of the discussed drugs, or I report poorly designed and implemented “epidemiologic” studies, bearing gross biases. Many of the (paid) signing authors of these papers do not read the manuscript, let alone provide feedback. I am surprised at how easily such papers are accepted by some journals and how rarely their flaws are challenged.

Given the financial interests at stake, I do not see what recommendations or regulations will put an end to such long debated practices.

Name and address supplied
Competing interests: None declared.

1 Krumholz HM, Ross JS. Relationships with the drug industry: More regulation, greater transparency. BMJ 2009;338:b211. (3 February.)

Cite this as: BMJ 2009;338:b765

Entanglement in Scotland
We surveyed all anaesthetic departments in Scotland to assess links between anaesthetists and companies through sponsored “free lunches.” After institutional approval, one of us (YK) telephoned all 34 anaesthetic departments in April 2008. A standardised questionnaire was used and the respondents remained anonymous.

There were two refusals, giving a response rate of 94%. Twenty six of the 32 respondents had sponsored meetings. In all, 21 received food, while one was unsure, 22 accepted gifts. Two had more than one meeting a week, four had one meeting a week, six more than one meeting a month, six a monthly meeting, and three less than one meeting a month. Two described their contact as variable, one was unsure, and one had meetings by invitation only.

Only two of the 32 departments replied that they followed a guideline for these contacts—one its hospital policy and the other its own internal guidance.

In the light of the entanglement of anaesthetic departments in Scotland with drug companies, our department restricts company visits to invitation only.

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Competing interests: None declared.

1 Angell M. Relationships with the drug industry: Keep at arm’s length. BMJ 2009;338:b222. (3 February.)

Cite this as: BMJ 2009;338:b763

Drug companies are not alone
Although I agree with Godlee about pharmaceutical companies and their interaction with doctors and continuing medical education, they are not the only sinners. The same could just as easily be said about medical device manufacturers and their relations with clinicians—for example, about joint prostheses and orthopaedic surgeons and pacemakers and cardiologists.

If we are going to address this issue, let’s do it comprehensively, not just for drug companies.

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Competing interests: None declared.

1 Godlee F. Doctors, patients, and the drug industry. BMJ 2009;338:b463. (5 February.)

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MYOCARDIAL INFARCTION
We need to address the issue of “mild troponinaemia”

The new definition of myocardial infarction (MI) is timely but does not address the main issue of mild troponinaemia and overdiagnosis. Slight increases in troponin are often seen in patients with multiple comorbid conditions such as diabetes and heart or kidney failure who present with dyspnoea, infections such as pneumonia, exacerbation of chronic obstructive lung disease, or atypical symptoms. These patients, no doubt, are at increased risk of cardiovascular mortality. However, these episodes do not fulfil the definition of acute myocardial infarction but are often diagnosed as “non-ST elevation MI (NSTEMI),” increasing the incidence of myocardial infarction.

Labelling all cases of cardiac arrest as type 3 myocardial infarction undermines the importance of other treatable causes, whereas establishing a correct diagnosis is important to tailor treatment and advocate preventive strategies in family members. Similarly, dividing myocardial infarction following cardiac procedures into two types (4 and 5) doesn’t make sense when it does not consider the mild troponinaemia seen with cardiac procedures such as defibrillation and electrical cardioversion.

A new term such as “mild troponinaemia of indeterminate origin (mTIO)” would be akin to monoclonal gammopathy of unknown significance (MGUS) in paraproteinaemic disorders with abnormal monoclonal bands that don’t fulfil the criteria of multiple myeloma. It would identify patients with mild troponinaemia who don’t fulfil the criteria for myocardial infarction but are at increased risk compared with the normal population, to help to determine the true incidence of myocardial infarction exaggerated by current criteria, and help to use limited resources effectively.

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Competing interests: None declared.

2 Hagen TP, Reikvam A. [Marked increase of the number of myocardial infarctions following introduction of the new diagnostic criteria]. Tidsskr Nor Laegeforen 2003;123:3041-3.

Cite this as: BMJ 2009;338:b769

Build rather than burn bridges
As a practising doctor, I still derive almost childish pleasure in taking some pens or sticky notes for the secretary and an occasional USB stick for myself. If taking these trinkets is believed to influence my prescribing practice, then I am quite offended. The integrity of ordinary jobbing doctors is questioned without much hard evidence.

Consider the hospitality stands that various industries have to entertain clients, including government departments. Nearly all are busy lining their own pockets. Of course I do not agree with bribery and corruption, but to say that sponsoring an educational event or occasional dinner or the free gift of a stapler is lining their own pockets. Of course I do not see what recommendations or regulations will put an end to such long debated practices.

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