Inaccurate assumptions about oropharyngeal cancer

The article by Kim and Goldie on the cost effectiveness of including boys in a human papillomavirus (HPV) vaccination programme made assumptions about oropharyngeal cancers that are inaccurate.1 The prevalence of HPV in oropharyngeal cancer used in the article (31%) is based on worldwide estimates,2 but its prevalence in the US, where the research was done, is much higher.3,4 Source data for the review article referenced by the authors give the US specific HPV prevalence as 47% (42% for types 16/18),1,2 and other more recent high quality studies from the US have found rates as high as 72%.3 Furthermore, a recent population based study within the Colorado SEER registry found an HPV prevalence rate of 79% for oropharyngeal cancers diagnosed after 1994.4 Erich M Sturgis associate professor, Department of Head and Neck Surgery and Department of Epidemiology, University of Texas, MD Anderson Cancer Center, Houston, Texas, USA

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Competing interests: EMS participated as a one-time consultant to Merck in 2007 for a one day meeting discussing the role of HPV in head and neck cancer for which he was reimbursed travel costs and a one time honorarium.


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SEEDING TRIALS

Just say no

The postmarketing observational studies referred to in Annette Tuffs’s news story are sham studies that are generally referred to as “seeding trials.”1,2,3 The actual research taking place is the evaluation of the return on investment (ROI) from paying physician “investigators” to participate in the sham study. The ROI is measured by tracking the increased use of the drug by participating doctors, who are the real subjects of these studies.3

No patient would ever agree to participate in a trial designed to determine how the use of physicians as investigators can increase drug sales. No institutional review board would ever approve such a trial. Unfortunately, the side effects from these sham trials are real.4

Drug companies are systematically misleading patients and doctors in these seeding trials. The Nuremberg Code (and all other medical research codes) requires that research subjects should be informed of the purpose of the research. This never occurs in seeding trials and thus they violate medical ethics and should be stopped.5

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Competing interests: DE testifies at the request of patients injured by drugs and devices in law suits. His father was a prisoner at Buchenwald.

1 Tuffs A. Leading German doctors criticise rising use of post-marketing observational studies by drug companies. BMJ 2009;339:b4199. (13 October.)


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ORGAN DONATION

Informed choice, not coercion

The ACRE trial found that collaborative requesting did not significantly increase consent rates for organ donation, and the authors discussed whether structured training for donor transplant coordinators might make it more effective.1 They cited a recent BMJ editorial by Teresa Shafer on such a structured training programme.2

At that point, conflicting ethical obligations arise—the phrase “structured training” masks the real nature of the strategy recommended by Teresa Shafer, that “successful requestors act as advocates for people on the organ transplant waiting list” and “are presumptive, not neutral.” Unlike collaborative requesting, the “presumptive approach” is far from widely accepted.3 The presumptive approach has been accused of undermining the ethics of informed consent.4

Organ donation and transplantation save
lives, but we have to consider the ethics of different strategies for filling the gap between the number of organs needed and the number of organs donated. Donor transplant coordinators should not be dual advocates—they should advocate for the relatives making the decision, which must be based on informed choice, not uninform ed coercion.

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Competing interests: None declared.


GMC GUIDANCE ON CONFIDENTIALITY

Patients’ right to privacy

When it comes to being criticised in the media, the General Medical Council acknowledges that doctors are in a difficult position. We accept that there can be a public interest in doctors responding to press criticism—if criticism has undermined, or might seriously undermine, confidence in the individual doctor, a health service, or the profession.

But the contention that patients forfeit their privacy rights when they criticise a doctor is unhelpful.

Doctors should seek legal advice about the redress available to them, rather than engaging in public disputes with their patients through the pages of the press.

Public confidence in the profession could be seriously harmed by such behaviour, particularly if it involves breaches of confidentiality, which is central to the trust between all doctors and patients.

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Competing interests: None declared.

1 Gilliat M. Muzzling doctors in the name of confidentiality [electronic response to Dyer C. Doctors get advice on criticism from the media.]. BMJ 2009;339:b4173 (12 October).

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Author’s reply

The point of my letter was not that patients’ confidentiality should be discarded, but that there should be an appropriate balance with the doctor’s right of public reply.

That is why my letter stated that the General Medical Council’s supplementary guideline would have been better off defining how best to protect both parties’ interests. For example, the guideline could protect a doctor’s right of reply by defining certain parameters, such as recommending that the reply contains the minimum factual information to correct grossly misleading medical misinformation that would otherwise damage a doctor’s reputation; that it casts no unwarranted personal aspersions or comments on the patient; that it is entertained only if the patient has been provided with absolute evidence for the correct details but still refuses to retract; and that it is confined as much as possible to those medical aspects already publicly divulged by the patient.

Rarely, patients can be vindictive, and not amenable to logic or the facts of the situation. Doctors should not be left as sitting ducks sacrificed to a blind, dogmatic approach to patient confidentiality. A balanced, more pragmatic approach would be far more likely to protect both parties and “the public confidence in the profession.”

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Competing interests: None declared.

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PHYSICIAN ASSISTANTS

UK universities are on the case

Zosia Knietowicz’s article on physician assistants was encouraging—Ms Allen is an excellent role model. In the UK, a framework defining the role and education of physician assistants has been developed, and some 100 students are currently training in four centres, with two more medical schools planning courses. In 2010, around 55 students should achieve the postgraduate diploma in physician assistant studies and be ready for work.

Physician assistants are not currently registered, but many clinical professions were not registered until recently, and some still aren’t. A voluntary register is being established, as a step towards full registration. Although there are worries that their introduction might reduce training opportunities for junior doctors, in the US they have provided a stable clinical workforce that allows junior doctors in training to focus on their educational needs. There are worries that they cannot learn all that doctors do in only two years. But they can learn enough to work, within a competence framework, under supervision as a dependent practitioner and do so safely and effectively. We believe that the time is right to grow this profession, bringing new people into the health workforce, improving clinical continuity at the sharp end, and facilitating training of junior doctors.

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Leff and Heath identify the need for a multidisciplinary approach in the surgical management of massive weight loss but do not include plastic and reconstructive surgery. In many patients the skin envelope re-drapes and tightens sufficiently to avoid body contouring surgery, but 20-40% of patients will need plastic surgical correction of excess and hanging tissues.

Folds of tissue can interfere with function, develop fungal infections in the recesses, and are unsightly. Surgical correction entails staged and sometimes long operations.

Patients embarking on bariatric surgery need to be informed of all possible outcomes. In our hospital, plastic surgeons are an integral part of the team, and patients are given a comprehensive information leaflet on body contouring after massive weight loss at the initial consultation for bariatric surgery.

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Competing interests: None declared.

1 Leff DR, Heath D. Surgery for obesity in adulthood. BMJ 2009;339:b3402. (22 September.)

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SURGERY FOR OBESITY

Role of plastic surgery