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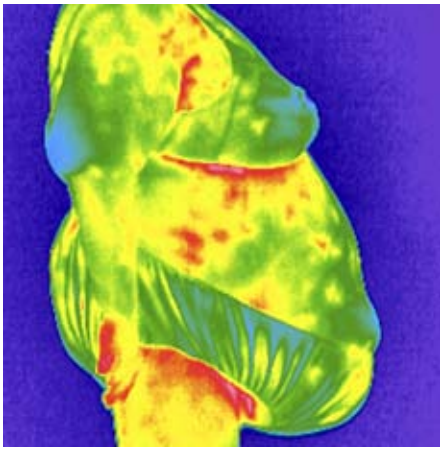
LETTERS

OBESITY SURGERY

Psychiatric needs must be considered



TONY MCCONNELL/SPL

Increasing bariatric surgery for appropriate candidates could be cost effective and save the NHS and the wider community millions of pounds a year.[1] However, such an increase may exacerbate the existing difficulties of obesity services in addressing the preoperative and postoperative psychiatric needs of patients having such surgery.

Many (50-80%) morbidly obese patients seeking bariatric surgery have a history of mental disorder, and psychiatric factors such as comorbid eating disorder and major depression seem to be better predictors of surgical outcome than biophysical variables.[2-4] Hence, bariatric surgical services need to include integral psychiatric expertise preoperatively and postoperatively. Too often the process of assessing suitability for surgery is seen as akin to decision making before cosmetic surgery, rather than as an ongoing process.

Bariatric surgery itself may be regarded as a form of enforced behaviour therapy, and a successful outcome can require many years of psychiatric support in behaviour modification. Comprehensive care may sometimes be challenging, but we have found that candidates rarely receive the preoperative dietary, psychological, and psychiatric care required to successfully adapt to the required changes.

Patients also do not always receive close postoperative follow-up and support from a multidisciplinary team covering surgery, medicine, psychiatry/psychology, nutrition, and exercise science; optimally follow-up should be monthly for the first six months then every two months during the first year after surgery.[5] Services addressing the preoperative and postoperative psychiatric needs of patients having bariatric surgery should be developed with consultation rather than as an afterthought. Obesity services need to consider screening for mental disorder, accessing specialist assessments, providing evidence based treatments, as well as integrating this treatment into the existing service to avoid false mind-body dualism.

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Competing interests: None declared.

1 McGauran A. More obesity surgery in England would be cost effective. *BMJ* 2010;341:c4915. (8 September.)
2 Poole N, Al Atar A, Bidlake L, Fienness A, McCluskey S, Nussey S, et al. Pouch dilatation following laparoscopic adjustable gastric banding: psychobehavioral factors: can psychiatrists predict pouch dilatation? *Obes Surg* 2004;14:798-801.
3 Poole NA, Al Atar A, Kuhanendran D, Bidlake L, Fiennes A, McCluskey S, et al. Compliance with surgical after-care following bariatric surgery for morbid obesity. *Obes Surg* 2005;15:261-5.
4 Scholtz S, Bidlake L, Morgan J, Fiennes A, El-Etar A, Lacey JH, et al. Long-term outcomes following laparoscopic adjustable gastric banding surgery: post-operative psychological sequelae predict outcome at five year follow up. *Obes Surg* 2007;17:1220-5.
5 McAlpine DE, Frisch MJ, Rome ES, et al. Bariatric surgery: a primer for eating disorder professionals. *Eur Eat Disorders Rev* 2010;18:304-17.

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Big questions remain unanswered

Burns and colleagues provide a first and timely major observational study of bariatric surgery in the United Kingdom.[1] They also draw welcome attention to the wide variation in surgical practice, which implies a gap in the evidence or that evidence is simply being ignored.

From a wider health service perspective, the importance of their study may be to highlight, once again, the limits of evidence and the need for long term controlled studies. The rapid growth of bariatric surgery, particularly in treating type 2 diabetes, is like a bandwagon, accelerating beyond its evidence base, with all the attendant dangers at the next bend in the road.[2] Reliance on short term observational data, with the inherent biases and statistical limitations, is like a house built on sand. The place of the various different forms of bariatric surgery in medical practice, and in the wider NHS, will remain unresolved without a commitment to rigorous, long term comparative and controlled studies addressing an appropriate range of end points.

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Competing interests: None declared.

1 Burns EM, Naseem H, Bottle A, Lazzarino AI, Aylin P, Darzi A, et al. Introduction of laparoscopic bariatric surgery in England: observational population cohort study. *BMJ* 2010;341:c4296. (26 August.)
2 Pinkney JH, Johnson AB, Gale EA. The big fat bariatric surgery bandwagon. *Diabetologia* 2010;53:1815-22.

Cite this as: *BMJ* 2010;341:c5304

SMOKING *v* OBESITY

Sedentary health strategy is illogical

It is illogical to place so much emphasis on obesity as a leading public health concern.[1] Population attributable risks suggest that physical inactivity causes about 35% of coronary heart disease, 32% of colon cancer, and 35% of type 2 diabetes.[2] In another study, population attributable risks for coronary heart disease were smoking 43%, saturated fatty acid intake 13%, obesity (body mass index >30) 14%, and sedentary lifestyle 40%.[3]

Increased physical activity reduces mortality by as much as smoking cessation, even in later life,[4] and the comparative risk of obesity is not so clearly defined.

A recent *BMJ* poll suggested that when presented with the evidence most readers (83%) understand that health strategy should focus on increasing physical activity, rather than treating obesity. Many undesirable health risks are greatly reduced by physical activity and improved fitness, even in the absence of weight loss.[5]

To suggest smoking and obesity, rather than physical activity, have a comparable impact is dangerously misleading. All independent risk factors are important, but lack of physical activity and smoking are far greater public health threats than obesity.

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Competing interests: None declared.

1 Kamerow D. Smoking versus obesity: must we target only one? *BMJ* 2010;341:c4631. (24 August.)
2 Powell KE, Blair SN. The public health burden of sedentary living habits: theoretical but realistic estimates. *Med Sci Sports Exerc* 1994;26:851-6.
3 Ruwaard D, Kramers PGN. Volksgezondheid Toekomst Verkenning 1997: de som der delen. Elsevier/De Tijdstroom, 1997.

4 Byberg L, Melhus H, Gedeborg R, Sundström J, Ahlbom A, Zethelius B, et al. Total mortality after changes in leisure time physical activity in 50 year old men: 35 year follow-up of population based cohort. *Br J Sports Med* 2009;43:482.
5 Weiler R, Stamatakis E, Blair S. Should health policy focus on physical activity rather than obesity? Yes. *BMJ* 2010;340:c2603.

Cite this as: *BMJ* 2010;341:c5292

Author's reply

Weiler is of course correct that physical inactivity is a very strong risk factor for several diseases and for mortality.[1] No one would argue otherwise. I chose to focus on comparing smoking with obesity in my column because that is where the funding seems to be going.

Similarly, no one would argue that obesity is not a pervasive health problem that needs attention. While increasing physical activity has positive effects independent of weight loss, most authorities would agree that we need population-wide changes in both diet and physical activity to prevent and treat obesity.

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Competing interests: None declared.

1 Weiler R. Sedentary health strategy logic. *BMJ* 2010;341:c5292.

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VEGETABLES AND DIABETES

Is nitrate the answer?

Carter and colleagues' systematic review and meta-analysis showed that a diet rich in green leafy vegetables but not fruit and vegetables or vegetables may confer protection against the risk of developing type 2 diabetes.[1] They attribute this protective effect to the possible role of various antioxidants.

A diet rich in fruit and vegetables would be expected to increase consumption of these antioxidants, but it does not confer the same degree of protection as a diet rich in green leafy vegetables. A similar result was reported by Jae et al during a prospective study examining rates of cognitive decline.[2] Again, green leafy vegetables were protective when other dietary components were not.

The green leafy vegetables described—for example, spinach, kale, and lettuce—differ from fruits and other vegetables in one important way—all have a high nitrate content. Nitrate from the diet has numerous beneficial physiological effects,[3] including lowering blood pressure, improving endothelial function, and protecting against ischaemia reperfusion injury. Dietary nitrate is metabolised in humans to nitric oxide by sequential bacterial and chemical reduction,[4] and may be able to restore the deficient levels that are postulated to mediate the genesis and consequences of type 2 diabetes.[5]

The protective effect seen in Carter and colleagues' analysis may be a consequence of the vascular actions of nitrate from the diet.

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Competing interests: NB is a cofounder of Heartbeet, a non-profit making organisation set up to promote the health benefits of dietary nitrate.

1 Carter P, Gray LJ, Troughton J, Khunti K, Davies MJ. Fruit and vegetable intake and incidence of type 2 diabetes mellitus: systematic review and meta-analysis. *BMJ* 2010;341:c4229. (20 August.)
2 Jae HK, Alberto A, Francine G. Fruit and vegetable consumption and cognitive decline in aging women. *Ann Neurology* 2005;57(5):713-20.
3 Gilchrist M, Winyard PG, Benjamin N. Dietary nitrate—good or bad? *Nitric Oxide* 2010;22:104-9.
4 Lundberg JO, Weitzberg E, Cole JA, Benjamin N. Nitrate, bacteria and human health. *Nature Rev Microbiol* 2004;2:593-602. (Erratum *Nat Rev Microbiol* 2004;2:681.)
5 Scherrer U, Sartori C. Defective nitric oxide synthesis: a link between metabolic insulin resistance, sympathetic overactivity and cardiovascular morbidity. *Eur J Endocrinol* 2000;142:315-23.

Cite this as: *BMJ* 2010;341:c5306

BISPHOSPHONATES AND CANCER

More data using same database

Green and colleagues report the risk of various gastrointestinal cancers with oral bisphosphonates.[1] Using a similar dataset from the same database, we independently compared bisphosphonate prescribing in cases of upper gastrointestinal cancer with that in controls from 1995 (when alendronate was first licensed) to 2007.

The odds of being a case increased 1.17 times for those taking bisphosphonates (odds ratio 1.17, 95% confidence interval 1.04 to 1.31). The effect was greater in women alone (1.29, 1.12 to 1.47) with no effect in men (0.95, 0.77 to 1.17).

We found a smaller effect than Green and colleagues, presumably because we combined oesophageal and gastric cancers. We did this to maximise the number of cases and because most of the increase in oesophageal cancer is adenocarcinoma, and lower oesophageal tumours and gastric tumours at the cardia may have a similar aetiology.

Indeed, Green and colleagues found the adjusted relative risks for one or more bisphosphonate prescriptions versus no prescription were 2.02 (1.02 to 4.01) for adenocarcinoma and 0.83 (0.36 to 1.93) for squamous cell carcinoma.

When we compared cases of oesophageal cancer and controls the odds of being a case increased to 1.24 (1.08 to 1.44), with a greater effect in women alone (1.40, 1.18 to 1.67) and no effect in men (0.97, 0.74 to 1.26). Green and colleagues found no effect of sex, which may be partly because women have been exposed to bisphosphonates for longer.

Our initial analysis suggests that 85 out of 4442 female cases of upper gastrointestinal cancer annually in the UK could be linked to bisphosphonate use.

Cardwell et al investigated the same question in a cohort design using the same database.[2] We three research teams did not know about each other before publication. Is this common?

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Competing interests: None declared.

1 Green J, Czanner G, Reeves G, Watson J, Wise L, Beral V. Oral bisphosphonates and risk of cancer of oesophagus, stomach, and colorectum: case-control analysis within a UK primary care cohort. *BMJ* 2010;341:c4444. (1 September.)
2 Cardwell CR, Abnet CC, Cantwell MM, Murray LJ. Exposure to oral bisphosphonates and risk of esophageal cancer. *JAMA* 2010;304:657-63.

Cite this as: *BMJ* 2010;341:c5315

EFFICIENCY OF USER CHARGES

Reducing user fees often reduces supply of services

Thomson and colleagues' analytical framework for understanding the impact of user fees is useful for developing countries.[1] However, for developing countries with weak public delivery systems, user fees in public clinics are associated with higher output because of a mix of staff incentivisation and the production benefit of having the extra resources available in the clinic. To determine the effect of a reduction in user fees on the use of services in such settings, the impact of the decrease in supply for high and medium value services must also be taken into account. This supply reduction could potentially dominate the effect of the increase in demand resulting from the lower prices paid by users. The best way to

analyse the effects of user fee reduction is discussed in a Global Health blog.[2]

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Competing interests: None declared.

1 Thomson S, Foubister T, Mossialos E. Can user charges make health care more efficient? *BMJ* 2010;341:c3759. (18 August.)
2 Over M. User fees for health goods and services. Center for Global Development. Global Health blog, 2008. http://blogs.cgdev.org/globalhealth/2008/01/user-fees-for-health-goods-and.php.

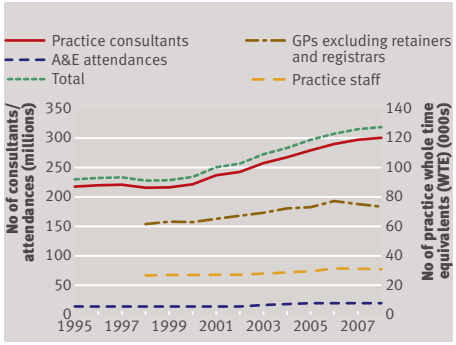
Cite this as: *BMJ* 2010;341:c5300

User charges require objective analysis

Thomson and colleagues explain how charges are being refined to reduce low value care in Europe but conclude that the UK does not need this strategy because it uses others.[1] To reduce low value care, every effective strategy is needed.

User charges for prescriptions in the UK raise about £1bn (€1.17bn; $1.57bn) annually. The efficiency argument for such charges (using them instead of tax financing) is unjustified, but the resources that they generate should not be dismissed. If they stay, prescription charges should be reformed to avoid the need to claim exemptions. The current income limit is so low that adverse health impacts may occur in those with below average incomes. Moreover, prescriptions are initiated by doctors, so there is little justification for charging. So where else could £1bn be found?

Logically, user charges should be instituted for patient initiated direct access to primary care, including accident and emergency and GP attendances. From 1995 to 2008, the consultation rate per person year in general practice increased 32% from 3.88 to 5.45 (figure).[2] GPs and other practice staff have increased, but more slowly.[3] Accident and emergency attendances increased from 12.5 million to 18.8 million, and contacts with new NHS funded providers have also grown.[4] Thomson and colleagues concede that a charge could remain for low value care but ask why provide it at all. Unless they are suggesting that walk-in primary care should cease, strategies—including carefully crafted user charges—are urgently needed to reduce low value attendances.



Trends in estimated practice consultations, new attendances at the accident and emergency department, and GP and practice staff, England

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Competing interests: None declared.

1 Thomson S, Foubister T, Mossialos E. Can user charges make health care more efficient? *BMJ* 2010;341:c3759. (18 August.)
2 Hippisley-Cox J, Vinogradova Y. Trends in consultation rates in general practice 1995/1996 to 2008/2009: analysis of the QResearch database. Information Centre for Health & Social Care, 2009. www.ic.nhs.uk/cmsincludes/_process_document.asp?sPublicationID=1251287163774&sDocID=5312.
3 Information Centre for Health and Social Care. NHS Staff 1997-2007 (general practice). Information Centre, 2008. www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1999--2009-general-practice.
4 Department of Health. A&E attendances Timeseries. 2010. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_113249.xls.

Cite this as: *BMJ* 2010;341:c5303

SHIFTS AND HANDOVERS

EWTD not responsible for near misses

In a two month period, 73 admissions after 5 pm were included in the Blackburn urology out of hours admissions audit.[1] It is disappointing that such small numbers of patients were not handed over adequately, leading to near misses.

Surely the threat to patient safety is a consequence of poor handover, poor tracking of out of hours admissions, and lack of senior input at night (on-site or by phone), rather than the shift system as the authors suggest.

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Competing interests: None declared.

1 Manjunath A, Srirangam SJ. Shorter shifts and more frequent handover. *BMJ* 2010;341:c4858. (7 September.)

Cite this as: *BMJ* 2010;341:c5318

Make systems fit for purpose

The results of the Blackburn urology out of hours admissions audit are worrying.[1] However, just as worrying is the authors' conclusion that reversing the changes in shift patterns is the only way to prevent serious consequences to patient care.

The logic behind this conclusion is hard to follow. Evidence shows that serious medical errors increase with prolonged shifts versus restricted hours.[2] Implementation of the European Working Time Directive (EWTD) legislation was meant to improve patient and doctor safety through reducing working hours. The concern that the increase in handovers heightens the risk of adverse incidents is misdirected. Instead we should ensure that systems are fit for purpose in the new environment—that we have robust handover procedures with clear accountability and rotas that ensure appropriate staffing and adequate supervision. It would have been helpful if the Blackburn study had analysed the reasons for the identified errors.

The EWTD led changes are relatively new. A transition period during which systems and working practices that are most suited to the new structure evolve is inevitable. Rather than throwing our hands in the air and harking back to the old way of working, which was dispensed with for good reason, we should focus on ensuring appropriate systems for the new way of working.

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Competing interests: None declared.

1 Manjunath A, Srirangam S. Shorter shifts and more frequent handovers. *BMJ* 2010;341:c4858. (7 September.)
2 Landrigan CP, Rothschild JM, Cronin, JW, Kaushal R, Burdick E, Katz JT, et al. Effect of reducing interns' work hours on serious medical errors in intensive care units. *N Engl J Med* 2004;351:1838-48.

Cite this as: *BMJ* 2010;341:c5320

CARDIOVASCULAR RISK FROM DRUGS

What is an appropriate degree of risk?

In the light of her recent comments on rosiglitazone in the *BMJ* and the popular press, I wonder what Godlee would consider to be an appropriate degree of cardiovascular risk for any drug.[1]

The most recent data from the Office of National Statistics show that deaths related to the illicit use of cocaine have been steadily increasing in this country and reached 235 in 2008. Most of these deaths were in young men and from a cardiovascular cause.

Although no substantive data are available, it's reasonable to assume that the illicit use of cocaine was also associated with a considerable number of non-fatal coronary events, quite possibly amounting to many times the number of recorded deaths as these events are likely to be under-reported.[2] Cocaine use was also responsible for more than 3% of sudden deaths in southern Spain, the authors concluding that no level of use could be considered safe.[3]

If this degree of cardiovascular risk were evident in a prescription drug it would be immediately withdrawn from the market, or at least subject to highly restrictive prescribing practices and vastly increased scrutiny. Why should this not also apply to a controlled drug when the same hazards to the "patient" are evident?

Rolles recently argued in the *BMJ* that cocaine and other "recreational" drugs should be made widely available to the general public through "specialist pharmacies,"[4] and both Godlee and the outgoing president of the Royal College of Physicians have endorsed this proposal.[5 6] But what method is to be used to establish the safety

and efficacy of these drugs in that setting if we are to ignore the requirements of the Medicines Act?

Godlee's position on this issue is not consistent with the stance she has adopted on the safety of prescription pharmaceuticals in general.

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Competing interests: None declared.

1 Godlee F. Rosiglitazone: a cautionary tale. *BMJ* 2010;341:c4896. (6 September.)
2 Wood DM, Hill D, Gunasekera A, Greene SL, Jones AL, Dargan PI. Is cocaine use recognised as a risk factor for acute coronary syndrome by doctors in the UK? *Postgrad Med J* 2007;83:325-8.
3 Lucena J, Blanco M, Jurado C, Rico A, Salguero M, Vazquez R, et al. Cocaine-related sudden death: a prospective investigation in south-west Spain. *Eur Heart J* 2010; doi:10.1093/eurheartj/ehp557.
4 Rolles S. An alternative to the war on drugs. *BMJ* 2010;341:c3360.
5 Godlee F. Ideology in the ascendant. *BMJ* 2010;341:c3802.
6 Top doctor Sir Ian Gilmore calls for drugs law review. 17 August. www.bbc.co.uk/news/health-10990921.

Cite this as: *BMJ* 2010;341:c5319

Editor's reply

On the face of it, Keegan makes an interesting comparison.[1] But on closer inspection the flaws in his logic are evident, to me at least.

Rosiglitazone is legal and non-addictive, and its production and supply are in the hands of one manufacturer. So too is most of the evidence of its benefits and harms. It was heavily marketed as being of benefit to patients with diabetes, but we now know that its benefits are limited and that it carries a small absolute risk of serious harm. Our regulatory systems failed to protect patients from harm and ensure that public money was well spent. The problem is a lack of transparency from regulators and industry and a failure to mandate high quality independent evaluation of this and other patented drugs before and after licensing.

Cocaine is illegal, addictive, and widely available despite the costly so called "war on drugs." We're all agreed that we don't want people taking cocaine. It is a highly harmful drug with no beneficial effects. The question is, what is the best way to minimise its harms? The current approach isn't working—as shown by the growing number of deaths from cardiovascular effects cited by Keegan[1] and the enormous additional harms for individuals and society described by Rolles.[2]

ALAIN DEX, PUBLIPHOTO DIFFUSION/SPL

So let's try something else. The principles of harm minimisation and experience in some other countries suggest that decriminalisation and controlled availability—along with education, accurate unbiased information about a drug's effects, and an absolute ban on marketing and advertising—may be a more cost effective approach to managing the impact of this highly dangerous drug.

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Competing interests: FG is the editor of the *BMJ* and responsible for all it contains.

1 Keegan NJ. What is an appropriate degree of risk? *BMJ* 2010;341:c5319.
2 Rolles S. An alternative to the war on drugs. *BMJ* 2010;341:c3360.

Cite this as: *BMJ* 2010;341:c5390

CAUSES OF AVOIDABLE HARM

Widen the perspective

Caldwell's points about the causes of avoidable harm to patients could be expanded and enhanced by a view from general practice.[1] The pressure that Caldwell describes "to get patients out of hospital" results in them being deposited at home at no notice or short notice, occasionally to an empty house. One of my consultant colleagues was told recently by the hospital manager to do a ward round at 2200 to identify suitable patients to send home there and then because of a lack of beds for admissions accumulating in the accident and emergency department. Readmission of ill people sent home in such a way is common, necessary, and understandable and currently generates more revenue for the hospital trusts until the suggestions of Mr Lansley are implemented.

Caldwell gives examples of errors in working diagnoses caused by unavailability or disorganisation of notes. I observe that errors are also caused by a lack of continuity of care from the working arrangements imposed on doctors, and not merely the doctors in training. A discharge letter may be composed by the most junior member of the team who has never seen the patient. Frequently the consultant allegedly responsible for the patient has not supervised this discharge letter for detail and quality.

A useful means of arriving at a working diagnosis in hospital might be to contact the patient's general practitioner for further information. This is seldom done, again to the detriment of the care of the patient.

Formal ward rounds with medical staff and nursing staff no longer exist in some hospitals.

Need I say more?

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Competing interests: None declared.

1 Caldwell G. What is the main cause of avoidable harm to patients? *BMJ* 2010;341:c4593. (9 September.)

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Consider paternalism

Misdiagnosis can and does have disastrous consequences for patients and carers.[1] However, risk management from Caldwell's old fashioned, doctor centric standpoint means that equally valid opportunities to reduce avoidable risk are overlooked.

Patient centred clinicians are no less concerned with getting the diagnosis right but they insist that patients should be given the opportunity to be fully engaged in all the decisions that affect their health.[2] Caldwell emphasises how difficult it is for healthcare professionals to make sensible decisions when they are in a rush, have incomplete and sometimes inaccurate facts, and are in uncomfortable surroundings. How much more difficult must it be for patients to give valid consent? At least doctors are working in a familiar environment and using language they understand.

In my experience, great harms are done inadvertently to patients by benign paternalists who genuinely believe that their decisions are more important than their patients.[3]

Cardiology has been the major beneficiary of the last administration's "generosity" and has everything Caldwell asks for. Last year cardiologists performed around 50 000 palliative angioplasty procedures. COURAGE showed that most of these were avoidable and 8% were inappropriate.[4] Over 16 000 of these patients sustained sufficient myocardial injury to increase mortality by 33%.[5] Does anyone imagine for a moment that these patients knew when they gave their consent that angioplasty for stable angina is purely palliative; commonly causes irreversible harm; provides only a small temporary benefit; might be placebo; and could have been avoided by optimal conservative management? So much for avoiding harm by making the decision making process easier for clinicians.

GP commissioners beware. Paternalism is alive and well and has little time for the moral imperative of "No decision about me, without me."

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Competing interests: MRC acts as a patient-centred commissioning consultant.

1 Caldwell G. What is the main cause of avoidable harm to patients? *BMJ* 2010;341:c4593. (9 September.)
2 General Medical Council. Good medical practice. www.gmc-uk.org/guidance/good_medical_practice/index.asp.
3 Bridson J, Hammond C, Leach A, Chester MR. Making consent patient centred. *BMJ* 2003;327;1159-61.
4 Boden WE, O'Rourke RA, Teo KT, Hartigan PM, Maron DJ, Kostuk WJ, et al, for the COURAGE Trial Research Group. Optimal medical therapy with or without PCI for stable coronary disease. *N Engl J Med* 2007;356:1503-16.
5 Cuculi F, Lim CCS, Banning AP. Periprocedural myocardial injury during elective percutaneous coronary intervention: is it important and how can it be prevented? *Heart* 2010;96:736-40.

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