DO PATIENTS’ PREFERENCES MATTER?

Patients’ preference and mental capacity

When McPherson writes: “Where treatment choices have different and well understood outcomes, what matters most when deciding which treatment is best is the patient’s preference,” I presume he refers to patients who have capacity.1 Even the preferences of patients who have capacity may be based on misinterpretation or perceived benefit of less effective drug or treatment. For example, hypomanic patients may prefer to continue with less effective drugs so as to remain in an aroused “grandiose and elated” state, and psychotic patients may have a delusional explanation for their preference.

In mental health patients’ preferences need to be balanced with the right of patients to be treated with the most effective treatment. Randomised evidence should be considered important in many of the psychological therapies but, again, are not always in the best interest so far as the effectiveness of treatments for that patient is concerned. For example, a severely psychologically depressed patient may prefer cognitive behavioural therapy to antidepressant treatment though antidepressants are known to be more effective.

In mental health patients’ preferences need to be balanced with the right of patients to be treated with the most effective treatment. Randomised Evidence should be considered best, at least in treating severe mental illness, despite the “preference effect elephant” in the room.

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Competing interests: None declared.


Cite this as: BMJ 2009;338:b385

FISH OIL AND ARRHYTHMIAS

Pro-arrhythmic effects of fish oils

In their systematic review of the effect of fish oils on arrhythmia and mortality, León and colleagues did not mention the potential for fish oils to be pro-arrhythmic in some subgroups of patients with heart disease.1 In animal experiments and cellular electrophysiological studies fish oils have a diverse action on several cardiac ion channels not dissimilar to some broad spectrum

PATIENT REPORTED TRIAL OUTCOMES

What about the cost to use the measures?

Garratt highlights the standard use of patient reported outcome measures in trials.1 He advocates SF36 but does not mention that you must pay to use the measures. For example, from last year you must pay for EuroQol EQ-5d if a given trial has more than 5000 participants.

If CONSORT were to include a list of suggested patient reported outcome measures, their application should be without having to pay a registration fee or fee per patient—at least for publicly financed non-commercial research. A review of payment schemes for the various measures is needed, and it should include the time to complete the form and control for its contents.

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Competing interests: JML is currently in favour of using EuroQol EQ-5d in clinical studies.


Cite this as: BMJ 2009;338:b387

GP PERFORMANCE WEBSITE

A waste of time and money

As division chief of obstetrics for Calgary Health Region, I looked up the Rate your MD website.1 The results were exactly the opposite from those that my colleagues and I would have expected. Excellent, conscientious physicians rated as marginal, while some others—I won’t share my views—rated as 5/5.

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Competing interests: None declared.

1 Eaton L. GP performance website will aid communication with patients, says government. BMJ 2008;337:a3180. (31 December.)

Cite this as: BMJ 2009;338:b394

CHOOSE AND BOOK UPDATE

Patients’ attendance at clinics is worse with choose and book

In 2006 Wood described how the choose and book appointment system had been imposed with detrimental effects.1 It was intended to improve attendance at clinics, patients choosing the hospital and the time and date of appointment.

We have found that attendance in clinics is worse with choose and book than with traditional general practitioner referrals. In a pilot study at our hospital we observed a significant difference of 18% (choose and book) v 12% (general practitioner) for non-attendance in clinics ( 2=9.6, df=1, P=0.002). According to a recent study, most patients are not experiencing a significant choice in appointment time, date, or hospital.2 Choose and book has failed to achieve its main goal of improving patients’ satisfaction and attendance. Moreover, it creates an unnecessary economic burden on the health system and jeopardises the prioritisation process by removing clinicians from the process.

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Competing interests: None declared.


2 Green J, McDowall Z, Potts WHH. Does choose and book fail to deliver the expected choice of patients? A survey of patients’ experience of outpatient appointment booking. BMC Medical Informatics and Decision Making 2006;8:36

Cite this as: BMJ 2009;338:b396
anti-arrhythmic drugs currently used in clinical practice. Some of these effects such as sodium channel blockade and shortening of action potential duration could enhance the risk of arrhythmias due to a re-entrant mechanism.

Raitt et al showed that fish oils could increase the incidence of ventricular tachycardia in a subset of patients with implantable cardioverter defibrillators whose qualifying arrhythmia was ventricular tachycardia. Similarly, fish oil supplementation increased the risk of cardiac death in patients with angina. These contradictory effects may be related to different mechanisms of the prevailing arrhythmia in different subgroups. Arrhythmias after myocardial infarction and heart failure are induced by triggered activity, while those in myocardial ischaemia are caused by re-entry.

Thus, fish oils may have a combination of anti-arrhythmic and pro-arrhythmic properties in different subsets of patients with heart disease, and the beneficial effects in some subgroups may be negated by the pro-arrhythmic effects in others in clinical trials in unselected patients with heart disease.

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Competing interests: None declared.


Cite this as: BMJ 2009;338:b393

INTO THE THERAPEUTICS VOID

Let us protest loudly

We are concerned about any outsourcing of medical education to pharmaceutical companies. Common sense tells us this could only be harmful, and a growing literature suggests contact between healthcare providers and pharmaceutical companies leads to irrational prescribing and to the provision of biased or inaccurate information, with inaccuracies favouring the products of the company.

If we know that most doctors fail to spot misinformation provided by pharmaceutical company employees, can we expect medical students to fare any better?

Recognising this, US medical schools have commendably started to limit contact between medical students and pharmaceutical companies (www.amsascorecard.org). If budgets do not allow the provision of comprehensive teaching in pharmacology to medical students given by independent academics and clinicians then let us protest loudly rather than resorting to unacceptable alternatives.

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Competing interests: All of the authors are or have been medical students. Some teach or have taught medical students.


Cite this as: BMJ 2009;338:b397

A student from BSMS writes

It is crucial to be aware of the role and scope of pharmaceutical advertising (in whatever form it may take) and its effect on prescribing. I have campaigned on such issues, and as a student at Brighton and Sussex Medical School (BSMS) I originally raised my concerns about the module there.

However, I must clarify two points.

• So far as I am aware, BSMS is unlikely to be “filling the therapeutics void” with this module. For one thing, only a maximum of 10 students a year can take it as it is one of about 60 student selected components that we are allocated for one afternoon a week over a period of 8 weeks in the third year
• BSMS does not have its own clinical pharmacology department, and, although some students think that this aspect of teaching could be increased, all our pharmacology teaching is currently provided by the School of Pharmacy at Brighton University as part of a series of lectures given in the third year.

I am concerned that medical students

A lecturer from BSMS explains

I thought that it might be helpful to set the record straight on the undergraduate curriculum at Brighton and Sussex Medical School (BSMS).

The student selected project on drug development is precisely that: student selected. It is not core material, and in fact comparatively few students have chosen to take it. It is not concerned with the teaching of clinical pharmacology or therapeutics but with understanding the complexities of pharmaceutical research and development.

Core teaching of clinical pharmacology and therapeutics is undertaken throughout the BSMS undergraduate programme, and rapid responders to the news story who believe that this student selected component contributes to the latter misunderstood. The BSMS course has very recently been assessed and approved by the General Medical Council, and indeed as part of the recent quality assurance process an external examiner (a clinical pharmacologist) commented that he “was particularly pleased to see a distinct emphasis on therapeutics in one of the papers, and in the extent of topics covered in the OSCE [objective structured clinical examination].”

Colleagues and students can rest assured that we at BSMS take the teaching of therapeutics extremely seriously and that the external quality assurance process has shown that the curriculum is delivered appropriately and to a high standard.

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Competing interests: ML is senior lecturer in therapeutics at Brighton and Sussex Medical School.

Cite this as: BMJ 2009;338:b398
**CASE OF BABY P**

There are no “basics” in child protection

In response to Irani’s letter,1 there are no “basics” in child protection. Identifying professionals with a “common sense approach” to safeguarding children is problematic and, more likely, unrealistic. Child protection is a complex issue, with research showing that professionals are affected by personal attitudes that influence their ability to recognise and notify child abuse to authorities.2 4 Data from six of the eight Australian states and territories indicates that medical practitioners notified between 0.2% and 1.7% of total cases reported to authorities1—this is alarmingly low given the frontline nature of these professionals.

It is important not to focus only on child physical abuse. The “battered” child was described over 45 years ago,3 but child abuse literature has developed significantly since then. Neglect is also a serious and fatal condition. Where is the evidence suggesting that broadening the definition of child abuse has led to an increased risk to children? Rather, broadened definitions may lead to identifying more children at risk.

Given the number of professionals coming into contact with Baby P, assessing systemic issues is crucial. Effective communication and information systems aim to ensure that the fate of a child is not left to the discretion of one professional alone. A “whole of system” assessment is necessary when many agencies are involved concurrently with the same case.

Child abuse is abhorrent. Solutions to child abuse are not straightforward, and returning to basics will essentially negate the progress otherwise achieved.

**COMPETING INTERESTS:** None declared.

1 Irani M. Let’s go back to basics in child protection. BMJ 2009;338:a3137 (5 January.)

Cite this as: BMJ 2009;338:b390
education, correspondence, and comments? This would be the way forward to transform the publishing world from a business into a service and a resource, decoupling the circulation wars and business aspects from the health science. The underlying idea of such a move would be to recognise that research and health are not a business but a shared asset. If this is the ultimate aim of BMJ pico then you have our wholehearted support. However, as journals push the electronic further, the context of the journal and its history and traditions may be lost, especially if access is through a search engine (the so-called single article economy). This may provide a stimulus to develop critical skills in readers or it may be taken as carte blanche to enfranchise anything which is published in a certain format on the web.

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Competing interests: 1) produces research and his capacity to do so could be enhanced or be damaged by international publishers’ strategies. LDF works in the medical communication industry and his business could improve or be damaged by international publishers’ strategies


Cite this as: BMJ 2009;338:b392

Editor’s note: Since posting this as a rapid response, Tom Jefferson and his co-authors have agreed to be “piconeers.”

Different strokes may be needed for different folks

I support going for both BMJ pico—a new evidence abstract prepared by the authors—and a Short Cuts article written by the BMJ for the time being.1 2

For those brought up (or into) the ways of evidence based medicine (as our recent graduates ought to be the pico format ought to be preferable as it provides a pithy summary of the evidence acquired in a way that exposes any limitations or flaws starkly and minimises any overstatement or understatement of conclusions.

However, the short summary is an easier read and does make the study more accessible to those older physicians who would be more used to receiving their information in this rather more digestible format. For the visually inclined the graphs are also an accessible summary that is not an integral part of pico.

A further advantage of providing both is that older graduates will become familiarised with how pico formatted abstracts in other publications translate into the language of their youth. Furthermore, one is still inclined to want to have one’s cake while also having eaten it.

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Competing interests: None declared.

1 New format for BMJ research articles in print. BMJ 2008;337:a2946. (29 December.)

2 Torhat M. Rapid response. Can we have both? www. bmj.com/cgi/eletters/337/dec29_1/a2946#206533

Cite this as: BMJ 2009;338:b391

OBESITY AND PREGNANCY

Obesity is a risk factor for thromboembolism

Stotland’s review of obesity and pregnancy hardly mentioned thromboembolism,1 yet pulmonary embolism is the leading direct cause of maternal death in the UK, with 33 deaths between 2003 and 2005. Of the 21 women who died for whom body mass index could be calculated, 12 were obese and eight morbidly obese.2

A prospective case-control study of antenatal pulmonary embolism undertaken through the UK Obstetric Surveillance System between February 2005 and August 2006 showed 94 cases, including several deaths. The adjusted odds ratio for obesity was 2.8 (95% confidence interval 1.12 to 7.02). The Royal College of Obstetricians and Gynaecologists refers specifically to obesity in its thromboembolism guideline.3

The choice of methods for screening for gestational diabetes was also surprising. The one hour 50 g glucose load test is not universally regarded as reliable, most British obstetricians choosing the standard two hour 75 g glucose tolerance test.4 5

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Competing interests: None declared.

1 Stotland NE. Obesity and pregnancy. BMJ 2008;337:a2450. (15 December.)


Cite this as: BMJ 2009;338:b388

PROMOTION OF EXERCISE BY GPs

Results not strong enough for GPs to implement BMJ study

So, after 7-13 minutes with a practice nurse and five phone calls of 15 minutes each, those who come for another 30 minute appointment with the nurse tell her they are exercising more but all firm data such as blood pressure, weight, waist circumference, lipid measurements, and current drug treatment are unchanged? People are generally keen to please, and it would seem ungrateful to report to the nurse that little has changed.

I don’t yet share Iliffe and colleagues’ conclusion that, “Lawton and colleagues’ study shows that exercise promotion through general practice can change behaviour if it is embedded in routine care, based on continuing contact and dialogue, and tailored to individual needs.”1 2

I believe that increasing exercise is important for all age groups, particularly elderly people, but, in the absence of stronger evidence, I cannot back adding this huge burden to our practice clinic system.

I agree we should encourage activity, but when one of my elderly patients requested if any light exercise group such as Tai Chi existed locally for elderly patients none of our local myriad of overlapping, opaquely titled acute intervention or chronic rehabilitation services seemed sure. And I remain unaware of any except for the local Water Mobility Association, set up and run on a non-profit making basis by an enthusiastic local swimmer and diver over 20 years ago; it has helped many, and I hope survives the recent death of the founder in his late 80s.

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Competing interests: None declared.
