PRIVATE MENTAL HEALTHCARE

Patients should fear private mental health providers

Commercial transactions involve contracts between two or more parties, each of whom can make decisions and advance their interests. In mental healthcare provided by for profit companies, stakeholders are executives whose jobs and bonuses depend on profit, shareholders who want maximum return, commissioning agencies that want services for the lowest price, and patients with mental illness, who may lack the mental resources necessary to advance their interests. Financial profitability trumps patient care in such a system.

Many inpatients are detained under the Mental Health Act and discharge depends on hospital employees’ decisions. Profit depends on bed occupancy. Any transaction where sellers decide what buyers buy cannot represent the best interests of buyers, especially when they are vulnerable. Assertions that the goodwill of private companies or government regulation will protect patients’ interests ignore the state of mental health services in the US.

In this country the private sector has already entered more profitable parts of mental healthcare, mostly as specialist inpatient units. Money has been diverted from generic services (providing inpatient care, care in the community, educational and research benefits) to private units limited to inpatient care. Patients always come back to the NHS for costly follow-up. Private units—ranging from non-evidence based inpatient personality disorder units to segregated black units—ranging from non-evidence based inpatient psychosis units to segregated black patients. Without the active input and support of local NHS teams, many patients with long term dementia in private care will continue to experience substandard care.

If long term dementia care in the private sector is anything to go by, other mental health service users have much to fear from privatisation.

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Competing interests: PSGC is a practising NHS consultant psychiatrist.

1 Murphy E, Sugarman P. Should NHS mental health services fear the private sector? No. BMJ 2010;341:c5385. (4 October.)

Cite this as: BMJ 2010;341:c6139

CARDIOVASCULAR RISK FROM DRUGS

Response to the editor

In her reply to my previous letter, 1 Godlee refers to a recently published article by Rolles which highlights the supposed “failure” of the so-called war on drugs. 2 But Rolles has ignored data from the United States showing that cocaine use has fallen by 75% in the past 20 years, 3 and that opiate abuse is much less than in the United Kingdom, 4 and he has instead concentrated on a comparatively narrow subset of data on teenagers in Portugal. 5

The proposal by Rolles to make powder cocaine available to the general public without prescription through “specialist pharmacies” would also facilitate the widespread availability of crack cocaine as one is easily made from the other. In my opinion, Godlee would be well advised to reconsider her endorsement of the same, 6 which has received widespread exposure in the press.

We already know that cocaine is not a “safe” drug, though it can be extremely effective as a local anaesthetic, that’s why we have severely restricted its use in clinical settings. Godlee and Rolles have lost sight of the original purpose of the Medicines Act, which is to protect patients and assist suitably qualified individuals in making rational choices about using therapeutically active substances.

Why should “recreational” users be entitled to a lesser degree of protection? And if we are to make a special case for them and abandon the fundamental concept of offsetting benefit against risk, what are the implications for the licensing of substances that are potentially of real clinical benefit?

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Competing interests: None declared.

1 Godlee F. Editor’s reply. BMJ 2010;341:c5390. (28 September.)
2 Keegan NJ. What’s an appropriate degree of risk? BMJ 2010;341:c5319. (28 September.)
3 Rolles S. An alternative to the war on drugs. BMJ 2010;341:c3160. (13 July.)

Cite this as: BMJ 2010;341:c6137

PROHIBITION OF CANNABIS

Legalisation doesn’t work

The recent report of the International Centre for Science in Drug Policy (ICSDP) claims that cannabis should be legalised because its use has increased in the past 20 years despite increasing resources being spent on the criminal justice system. 1 The BMJ’s uncritical endorsement of these claims is surprising.

The ICSDP did not look at data before 1990: use of marijuana in the past month by US high school seniors peaked in 1978 at 37.1% and declined to its lowest level of 11.9% in 1992. Similar trends have been observed for all drug use. 2 The prohibition that the ICSDP report claimed had not
worked was associated with a two thirds reduction in cannabis use.

The report has a cavalier attitude towards the harms of cannabis. However, since 2002 several key studies have shown the clear link between cannabis and serious mental health problems, including an increasing risk of developing schizophrenia.¹

The report claims that selling cannabis through legal outlets would not result in increased cannabis use. However, in the Netherlands use increased sharply after quasi legalisation: in those aged 18-20 use in the past year increased from 15% in 1984 to 44% in 1996. This contrasts with steady or declining use in cities such as Oslo, Stockholm, and Hamburg, and countries such as Denmark, Germany, and the US over the same period.² Empirical data therefore contradict the ICSDP claims.

The report does not mention Sweden, whose drug policy aims at creating a drug-free society. Sweden now has among the lowest rates of drug misuse, including cannabis misuse, in Europe.³ The Swedish example shows that the most successful approach to drug policy is based on drug prevention, not legalisation.

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Competing interests: None declared.

1 Room R. Prohibition of cannabis. BMJ 2010;341:c5492. (6 October.)

Cite this as: BMJ 2010;341:c6138

**ASPECTS OF OLD AGE**

We all need help as we age

Richards writes: “Maybe the EU stands to achieve more through its public health programmes aimed at reducing the demand for care. There must also be greater, more transparent, and more through its public health programmes aimed at reducing the demand for care. There must also be greater, more transparent, and more...

What we urgently need, and what Europe can promote, are financial incentives to attract tomorrow’s carers. The job of nursing aide to elderly people is physically and mentally demanding, lowly respected, and poorly paid. At the end of life, such aides are more important than all doctors and specialists combined. We should stop living in denial of old age and give aides the future they deserve and we need—that of the highly respected and well paid person who will guide us in our final journey.

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Competing interests: None declared.

1 Richards T. Who will care for us when we are old? BMJ 2010;341:c1341. (29 September.)

Cite this as: BMJ 2010;341:c6161

**Remedy for guideline fatigue syndrome**

As an academic geriatrician and a long term sufferer from guideline fatigue syndrome—a debilitating condition characterised by irritability and overwhelming lethargy in the presence of guidelines—I have some sympathy for Aylett over the limited relevance of many guidelines to our patients.¹

However, I disagree with her about how to deal with this. We should be encouraging older people to participate in research, not discouraging them, and certainly not undermining their autonomy by misconstruing “protecting” them from research. The solution lies in generating more high quality trials, which embrace the heterogeneity and comorbidity that are inherent in later life, and building an evidence base that is relevant to the core users of healthcare.²

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Competing interests: METMcM is a clinical academic and chair of the UK NIHR-CCRN Agri and Ageing specialty group.

1 Aylett V. Do geriatricians need guidelines? BMJ 2010;341:c1340. (29 September.)

Cite this as: BMJ 2010;341:c6165

**GMC’S GROUP ON CHILD PROTECTION**

Shows how GMC is out of touch

The General Medical Council, in typical arrogant fashion, has ignored the concerns of several paediatric practitioners involved in child protection over its appointment of Penny Mellor to the Expert Group on Child Protection.¹

Professionals who have to deal with child deaths (paediatric pathologists, forensic pathologists, and neuropathologists) also regard this appointment as wholly inappropriate and one that does a disservice to those experts who have been subject to personal abuse and unwarranted criticism from this self appointed advocate of parents who have been accused of causing injury or death to their children.

This is a woman who has been convicted of “conspiring to abduct a child” and who was severely criticised by the trial judge—criticism that the GMC did not read or ignored.

Many paediatric and forensic pathologists decline to conduct autopsies in children where non-accidental injury is suspected. This is hardly surprising in view of the criticism that they have had to deal with from Mrs Mellor and her associates.

Had Mrs Mellor been a registered medical practitioner, her conviction and her campaign against doctors would have resulted in an appearance before a fitness to practise panel. The GMC seems to expect registered practitioners to conform to the principles of good medical practice but allows wholly unacceptable behaviour in people who sit on its expert group.

This is a further example of how the GMC is out of touch with the profession and partly explains why so many practitioners have little confidence in the council.

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Competing interests: JC is a GMC associate who chairs fitness to practise panels. MAG is a member of Professionals Against Child Abuse. PV is a member of GMC Performance Assessment Panel for Forensic Medicine/Pathology. NC and RAR no competing interests.

1 Bridson JM, Samuels M, Speight N, Williams C. Open letter to Professor Peter Rubin, chair of the General Medical Council. BMJ 2010;341:c3884. (21 July.)

Cite this as: BMJ 2010;341:c5999
OPPOSITION TO ASSISTED DYING

Royal Society of Medicine is independent

Kmietowicz’s news report on the new pressure group Health Professionals for Change incorrectly includes the Royal Society of Medicine (RSM) among medical bodies that have “all adopted policies against changing the 1961 Suicide Act.”¹ In fact, the RSM has no policy on this issue: its remit is the education of doctors and health professionals and the promotion of debate, not the making of policy.

In June 2010 the RSM organised a high level public debate on the subject. Legislators, ethicists, and doctors, as well as members of the House of Lords, the clergy, the public, and the health professions, all gave presentations reflecting the commonly opposed views this issue raises. Dr Ann McPherson (who is to chair the new group) was one of the key speakers. We at the RSM believe that our very independence on this and many other issues enabled us to host such a successful conference.

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Competing interests: None declared.

¹Kmietowicz Z. New doctors’ group challenges medical bodies’ opposition to assisted dying. BMJ 2010;341:c5498. (5 October.)

Cite this as: BMJ 2010;341:c5982

RCA clarifies its position

Counter to the inference in Kmietowicz’s article,² the Royal College of Anaesthetists (RCA) has debated assisted dying many times and fully considered all aspects of the issue. The royal college also has not “adopted policies against changing the 1961 Suicide Act.”³ It has previously received requests to support amendments to Lord Joffe’s assisted dying bill; but the council maintains that “it is not for a professional body to tell individual clinicians how they should approach the issue of assisted dying” (council minute CID/87/2008).

We at the RCA express our sincere sympathies to Dr Ann McPherson for the extreme health issue she faces. We will continue to encourage fellows and members to contribute to this important debate, but as individuals whose personal views will be respected.

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Competing interests: None declared.

²Kmietowicz Z. New doctors’ group challenges medical bodies’ opposition to assisted dying. BMJ 2010;341:c5498. (5 October.)

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BRITISH MEDICAL JOURNAL

BREAST CANCER AWARENESS MONTH

Still awaiting screening facts

On 19 February 2009 we wrote a letter in the Times calling for the leaflet, Breast Screening: the Facts, to be rewritten because none of the invitations for screening told the truth about its harms and benefits.¹ Two days later the Times reported that the national cancer director, Professor Mike Richards, had stated that a formal review of the guidance on screening had already begun, and that a new leaflet would be issued in autumn 2009.² The promised leaflet is still unavailable. Since then, three million more women have been deprived of the means of making a proper decision regarding screening.

The issue is now even graver, as shown by recent analysis of the impact of screening in Norway.³ The accompanying editorial summed up the negative findings of that paper as follows: “If you screen 2500 women over the age of 50 for 10 years, then one breast cancer death might be avoided at the cost of 1000 false alarms and between five and 15 women being over-diagnosed and treated needlessly with surgery, radiotherapy, and chemotherapy.”⁴

A recent independent review of the evidence of benefits and harms of screening for breast cancer came to similar conclusions and asked for breast cancer screening to be independently reviewed by the National Institute for Health and Clinical Excellence.⁵

How much longer do we have to wait for action?

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Competing interests: None declared.

²Kmietowicz Z. New doctors’ group challenges medical bodies’ opposition to assisted dying. BMJ 2009;339:b5089. (5 October.)
³Cite this as: BMJ 2010;341:c6152

ORAL REHYDRATION SOLUTION RISK

Link with hypernatraemic dehydration in gastroenteritis

Each year many small children fall ill with viral gastroenteritis, most often caused by rotavirus. Hypernatraemic dehydration (serum sodium ≥150 mmol/l) may ensue, which can cause hypovolaemic shock, seizures, and death. Oral or enteral fluid rehydration, or both, with a balanced sodium-glucose oral rehydration solution is recommended firstline treatment of gastroenteritis at home and in hospital.¹²

In January 2010 we observed that several initially normonatraemic infants developed increased stool losses and hypernatraemic dehydration during ongoing enteral (naso gastric tube) fluid treatment. Two children required treatment for shock and intensive care. The number of children with hypernatraemia at admission also increased (table).

DNA sequences of 15 available rotavirus strains were similar in children with hypernatraemic dehydration and normonatraemic children admitted at the same time. The number of infants requiring admission has remained stable for several years. Thus neither changed viral virulence nor prevalence of gastroenteritis could explain the increase in incidence of hypernatraemic dehydration (table).

However, a new oral rehydration solution was launched by Nestlé in October 2009 in Sweden (Resorb Junior Plus; Alhydrate in other European countries). It replaced a balanced solution (Semper) that had been used at home and in hospitals for more than two decades. The sodium content of the new solution was the same as the old but a glucose polymer (maltodextrin) replaced glucose at more

Numbers of children admitted for viral gastroenteritis and numbers with hypernatraemic dehydration* from 18 January to 30 April each year

<table>
<thead>
<tr>
<th>Year</th>
<th>Total admitted</th>
<th>Total</th>
<th>At admission</th>
<th>During rehydration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>127</td>
<td>25</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>2009</td>
<td>125</td>
<td>7</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>2008</td>
<td>133</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>2007</td>
<td>110</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

*Serum sodium ≥150 mmol/l

³P<0.0001 in χ² test for all categories of hypernatraemic dehydration comparing 2007-9 and 2010.
than four times the amount. Intestinal hydrolysis of the glucose polymer may result in hyperosmolar diarrhoea and hypernatraemic dehydr ation, an adverse effect observed three decades ago. The parents of 14 of the 15 children (one not available) who developed hypernatraemic dehydration at home were interviewed. Twelve of them had used Resorb Junior Plus. During four weeks after a balanced glucose-sodium oral rehydration was reintroduced none of the 81 infants admitted to hospital developed hypernatraemic dehydration during enteral rehydration.

We conclude that the increase in hypernatraemic dehydration was caused by the high glucose content. We propose an update of current European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) recommendations on oral rehydration solutions and withdrawal of Nestlé’s oral rehydration solution from all European markets. Marketing and trade of oral rehydration solutions should also be scrutinised by medical authorities.

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Competing interests: None declared.

1 Guarnino A, Albano F, Ashkenazi S, Gendrel D, Hoekstra JH, Shami R, et al; European Society for Paediatric Gastroenterology, Hepatology, and Nutrition; European Society for Paediatric Infectious Diseases.


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RESPONSE

Nestlé’s response to concerns about oral rehydration solution

A Nestlé maltodextrin based oral rehydration solution (ORS) has been sold under various trade names in several European countries. In all of these countries and for two decades this product has proved safe and efficacious as an ORS for treatment of diarrhoea and acute gastroenteritis. The product was introduced under the brand name Resorb Junior Plus in Sweden in 2009. In April 2010 Nestlé decided to withdraw the product from the Swedish market because of reports of a few unexpected cases of worsening dehydration and hypernatremia during treatment of young children. (See also previous letter from Lidefelt and colleagues.)

After a meeting between the Nestlé Nutrition Institute and Karolinska Hospital, a collaboration was established to find the cause of the unexpected adverse reactions. A review of the case by Professor Henia Sajewszka, University of Warsaw, Poland, an independent paediatric ORS expert, could not identify a cause for the complications that had occurred in some children during diarrhoeal treatment with the product in Sweden. The Karolinska Hospital provided the correct dosage of Resorb Junior Plus according to WHO and ESPGHAN recommendations. Furthermore, the possibility of an error in the manufacturing process and reconstitution of the product was ruled out.

The ORS literature is controversial, particularly in relation to the carbohydrate content and composition of ORS solutions. Several randomised controlled trials have shown that maltodextrin based ORS formulations (30-80 g/l, predominantly 50 g/l) and the WHO standard ORS are generally equivalent in their effects on either total stool output or the duration of diarrhoea in children with acute non-cholera gastroenteritis. None of the investigators in these trials reported an increased risk of hypernatremia.

In light of the recent observations at Karolinska Hospital, one randomised controlled trial from 1996 is interesting. The effect of sugar malabsorption on the efficacy of treatment with the WHO standard ORS or a reduced-osmolality maltodextrin based ORS was assessed in 90 boys aged 3 to 24 months with acute non-cholera diarrhoea. Almost half of the children (46%), irrespective of the administered ORS, had an increased stool output owing to transient sugar malabsorption. This was associated with a longer duration of diarrhoea, a raised serum sodium concentration, and the need for unscheduled intravenous rehydration. The researchers hypothesised that, like the standard ORS, the reduced osmolality maltodextrin based ORS may be associated with sugar malabsorption. This can increase the effective intraluminal osmolality to equal or exceed that of the standard ORS. Both sugar malabsorption and intraluminal hypertonicity could contribute to a net flow of water from extracellular fluid into the gut, an increased serum sodium concentration, increased thirst leading to greater intake of ORS, ORS treatment failure, an increase in stool output, and an increase in duration of diarrhoea.

A cause and effect relation between the administration of the product and the development of cases of hypernatremia in children with acute gastroenteritis could not be firmly established in the cases at Karolinska Hospital. Publication of full details of the cases in a peer reviewed journal would be an important contribution to the ORS literature. In all markets except Sweden, where sales of Resorb Junior Plus were completely stopped in April 2010, instructions were given on 26 April to stop ordering the product from the manufacturing factory. Action was not taken to recall product from the market—for example, on shop shelves or in warehouses—in countries other than Sweden because there have been no adverse reports associated with the use of the product in these countries over the past 20 years since its first use. The product will be replaced by an ORS in accordance with the latest recommendations.

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Competing interests: Nestlé Nutrition Institute (www.nestle-nutrition-institute.org) is a non-profit making separate legal entity. All its activities are in the field of scientific communication.

1 http://takvit.lakartidningen.se/artNo37979.


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