LETTERS

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MANAGING SELF HARM

Is a clinician's "gut feeling" enough to identify self harm?

The guidelines summary recommends against using risk assessment tools to predict future self harm or suicide.[1] Although evidence suggests these scales are poor predictors of risk,[1] can we simply rely on the clinician's subjective judgment and "gut feeling"? Many doctors are experts at this—through years of experience—but no one is psychic; a simple assessment tool provides a basic objective indicator of risk level. Most patients who self harm present to the accident and emergency department and will probably be assessed by junior doctors with limited experience of such problems.[2] The considerable time pressures that most of these doctors face make this a potentially high risk clinical situation.

Furthermore, are doctors receiving adequate formal training on managing self harm? The guidelines suggest that hospitals vary greatly, and most of my peers have received no formal teaching on this subject. Given the potential risk—people who have self harmed have a 50-100 times greater risk of later suicide[3]—shouldn't a more robust training programme on understanding and managing self harm be provided? This could be aimed mainly at junior doctors but would be useful for all healthcare professionals who have contact with these patients, such as triage nurses.

In summary, assessment scales should not be the sole basis for triaging patients but could be used alongside the clinician's judgment to predict overall future risk. The clinician need not be a specialist in psychiatry—all doctors should be able to assess risk to some extent. Serious consideration should be given to improving staff education regarding self harm.

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Competing interests: None declared.

1 Kendall T, Taylor C, Bhatti H, Chan M, Kapur N; on behalf of the Guideline Development Group. Longer term management of self harm: summary of NICE guidance. *BMJ* 2011;343:d7073. (23 November.)
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Difficulties in managing young people who self harm

Junior psychiatry doctors on-call often have to assess and manage young people who have self harmed. National Institute for Health and Clinical Excellence guidelines suggest following the same principles as for adults but also recommend attention to "family, social situation, and child protection issues."[1] This can be difficult, especially out of hours.

Firstly, young people often attend the emergency department with family members or friends whose perspective(s) on the self harm may be specific or partial. Moreover, tensions between the young person and these people may be part of the stressor set precipitating self harm.

Secondly, gaining a clear picture of child protection issues surrounding a young person is difficult out of hours. The young person may not be forthcoming or may not fully appreciate the risks. Parents may be reticent to disclose information they imagine could be "held against them." It isn't possible to liaise with schools or GPs, and reaching a social worker is difficult. Often, this leaves a sense that you may be "missing something."

For under 16s seen out of hours at my trust, the recommended care pathway after self harm is admission to a paediatric ward, one to one nursing via a registered mental health nurse overnight, and a joint review by child and adolescent mental health services and social services the next day. The situation is more complex when the person is 16-17 years or Gillick competent regarding decisions about their overnight care and does not wish to stay in hospital.

I would be grateful if Kendall and colleagues could offer further advice for on-call doctors assessing young people who have self harmed.

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Competing interests: None declared.

1 Kendall T, Taylor C, Bhatti H, Chan M, Kapur N; on behalf of the Guideline Development Group. Longer term management of self harm: summary of NICE guidance. *BMJ* 2011;343:d7073. (23 November.)

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Authors' reply

Ellis and Yates highlight the recommendations on risk scales. A central question is whether healthcare professionals should be able to accurately predict adverse outcomes after self harm. The literature review carried out for the guideline suggests that this is not a realistic aim.[1] After a first self harm episode, most people will not repeat self harm or die by suicide.[2] Identifying those who will have a poor outcome is impossible without unnecessarily labelling a large number of people as "high risk." For example, scales that examined the risk of suicide after self harm had positive predictive values of 1-13%.[1] This means that 87-99% of those rated as at high risk in these studies did not go on to die by suicide.

It could be argued that the notion of risk assessment as prediction is a fallacy. Instead of predicting risk, we should perhaps emphasise the importance of a good quality assessment. The current preoccupation with risk tools might be helpfully redirected to the acquisition of risk skills (skills for the more nuanced assessment of probable risks and the individual's specific psychological needs). Of course, as Ellis observes, tools and scales may help to prompt, add detail, or help structure psychosocial assessments, particularly for more junior staff. We discuss this further in the full guideline.[1]

Education and training for front line staff are crucial for good quality services. We devote individual chapters of the guideline to the service user experience of care as well as training itself.[3] We agree that the

clinical problems raised by self harm in young people are often complex. We were keen that important clinical subgroups were fully integrated into the guideline so did not provide a separate section on young people. However, the specific dilemmas identified by Yates are alluded to in the self harm pathway,[4] which aims to summarise the guidelines on the short term and long term management of self harm in an easily accessible format.

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Competing interests: NK chaired the guideline development group, which TK facilitated. TK, CT, MC, HB were employed by the National Collaborating Centre for Mental Health, which developed the guideline.

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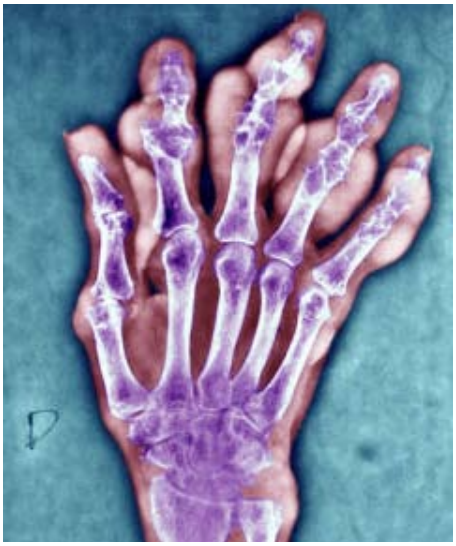
SUBOPTIMAL PRESCRIBING IN GOUT

Patient related factors are also important in treating gout

The treatment of gout remains suboptimal—only 30% of primary care patients take urate lowering drugs.[1] Lipworth and colleagues note that important reasons for this underuse include drug toxicity and poor patient adherence owing to the introduction of these drugs provoking gout attacks.[2]



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However, the views and beliefs of patients about gout and urate lowering drugs also explain this poor uptake. From our experience of treating gout in primary and secondary care, patients are often reluctant to start taking this potentially lifelong treatment if they have access to non-steroidal anti-inflammatory drugs (NSAIDs) or colchicine to treat acute attacks when they arise. This behaviour may stem from a lack of understanding that urate lowering drugs prevent both recurrent attacks and long term irreversible joint damage.[3] Clinicians should explain to patients the impact of these drugs on all aspects of gout, not simply prevention of acute attacks.

Our experience suggests that patients rarely re-consult after an acute attack of gout has been treated. Further acute attacks are often treated with NSAIDs (often purchased over the counter) or colchicine available on repeat prescription. The stigma attached to the condition may also deter patients from re-consultation.[4] GPs may not be aware that patients are having recurrent acute attacks, denying them the opportunity to consider urate lowering drugs, tackle adverse lifestyle factors, and screen for cardiovascular risk factors in these high risk patients.[5] After consultation in primary care with an acute attack of gout, we recommend that a further review is scheduled to consider these matters and explain the rationale for urate lowering treatment.

Irrational prescribing is one factor that leads to suboptimal management of gout but patient related factors should not be overlooked.

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Competing interests: None declared.

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LAUGHTER IN THE DARK

Life goes on for patients with cancer

Joshi's statement: "Adam goes clubbing, something most patients undergoing chemotherapy would not be capable of" is surprising in a review that also mentions how many patients with cancer do not want to feel defined by their diagnosis.[1] Cancer is not one disease, chemotherapy is not one type of treatment, and patients experience both in all sorts of ways. Most people with cancer whom I have met try to make their lives as normal as possible. For many patients work doesn't stop and neither does the school run, looking after a home, doing a degree, having sex, or going to restaurants or clubs. When working with adolescents with cancer, one of the challenges is to stop them from going clubbing when they are neutropenic.

Statements that perpetuate the stereotypical view of the "cancer patient," which patients try so hard to avoid, are not helpful and may cause offence.

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Competing interests: None declared.

1 Joshi PV. Laughter in the dark. *BMJ* 2011;343:d8071. (15 December.)

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SUB-SAHARAN BRAIN DRAIN

Realities of medicine in South Africa lie behind its brain drain

The often stated claims about the huge amounts of money that sub-Saharan countries spend on training doctors only to lose them to "poachers" from developed countries is misleading at best and dishonest at worst.[1]

Tertiary education in South Africa is extremely expensive for students, and medicine is one of the most expensive courses. In most cases the only option is a student loan that you have to start repaying immediately after graduating. Most students are forced to have one or more jobs while studying full time.

Students do 8-12 hour shifts performing duties that would be done by nurses and allied health workers in developed countries, and they face an aggressive and militant unionised nursing workforce that strikes at the drop of a hat with no regard for the effect on patient care.

Then you qualify. As an intern, especially in the smaller hospitals, you are thrown in the deep end, where you could be working 100 hours or more a week with minimal support for two years

MAURO FERMARIELLO/SPL

while earning a pittance (and paying back those loans). This is followed by a further 12 months of community service, during which you work even harder.

The political reality of South Africa is that doctors who are from the previously advantaged groups under apartheid have great difficulty getting into training programmes. Often the only way that you can become the great surgeon you always wanted to be is to do the "chicken run" to the UK or Australia.

Foreign qualified doctors have immense financial and academic hurdles to overcome in the countries they move to, and dealing with the various immigration authorities is no walk in the park either.

Obtaining a medical degree never meant losing my liberty professionally or personally.

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Competing interests: None declared.

1 Mills EJ, Kanters S, Hagopian A, Bansback N, Nachega J, Alberton M, et al. The financial cost of doctors emigrating from sub-Saharan Africa: human capital analysis. *BMJ* 2011;343:d7031. (24 November.)

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Tackle root causes of doctors' dissatisfaction to stop drain

Perhaps understandably in a study dealing with numbers and dollars, Mills and colleagues do not consider the reasons for doctors leaving the former colonies of sub-Saharan Africa.[1]

Many such doctors in recent years have given their reasons in the *BMJ* and *Lancet*. My study of 469 South African medical graduates who migrated to Australia showed that almost all were "pushed" from South Africa and that almost nobody was "pulled" to Australia.[2] They had chosen to emigrate. Australia was the destination of choice.

Like most migrants, doctors do not readily leave home and hearth, families and friends, colleagues and careers. What needs to be looked at is why individuals decide to leave. To see that decision as being based on money is to miss the root causes of many decisions to emigrate.[2 3]

No inter-government agreements on migration will solve this imbalance unless the root causes of doctors' dissatisfaction are remedied. To see this migration as poaching is pejorative, ignoring the legitimate concerns of many migrants.

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Competing interests: PCA wrote *A Unique Migration: South African Doctors Fleeing to Australia.*[2]

1 Mills EJ, Kanters S, Hagopian A, Bansback N, Nachega J, Alberton M, et al. The financial cost of doctors emigrating from sub-Saharan Africa: human capital analysis. *BMJ* 2011;343:d7031. (24 November.)
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Cite this as: *BMJ* 2012;344:e190

NEW IMAGE FOR THE DRUG INDUSTRY

Drug industry is now biggest defrauder of US government

Stephen Whitehead, the new head of the Association of the British Pharmaceutical Industry, thinks that the bad press given to the drug industry is largely undeserved.[1] A paragraph heading calls for collaboration. Facts are clear and this call is frightening because in the US laws exist and are implemented.

Public Citizen has made the diagnosis: "While the defense industry used to be the biggest defrauder of the federal government under the False Claims Act, a law enacted in 1863 to prevent military contractor fraud, the pharmaceutical industry has greatly overtaken the defense industry." Settlements for criminal and civil monetary penalties reached a total of $20bn (£12.9bn; €15.4bn) during 1991-2010, with three quarters of the settlements and penalties occurring between 2006 and 2010.[2]

Merck agreed with the US Department of Justice on 22 November 2011 to pay $950m to resolve criminal and civil charges over the promotion and marketing of rofecoxib (Vioxx).[3] A few weeks before, GlaxoSmithKline agreed on $3bn to settle civil and criminal investigations into its sales practices for numerous drugs—its fourth case since April 2008. This payment surpassed the previous record of $2.3bn by Pfizer in 2009.[4]

The Foreign Corrupt Practices Act (FCPA; US Bribery Act) is enforced by the Securities and Exchange Commission and the US Justice Department. Recently they have been looking into drug companies' foreign sales practices. Johnson & Johnson was the first company to pay to resolve FCPA allegations in April 2011 ($70m). Pfizer has just reached agreement in principle to resolve "improper payment" matters outside the US.[5] Eli Lilly is close to a settlement. AstraZeneca is working to reach an agreement. Many others are being questioned.

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Competing interests: None declared.

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NICE NEEDS REFORM

The emperor's NICE new clothes

Spence is right: all doctors should challenge conventional wisdom to secure the best evidence based care for their patients.[1] But attacking the National Institute for Health and Clinical Excellence (NICE) is unlikely to achieve this goal. Far from being an "opaque" bureaucracy, NICE publishes draft consultations of its guidelines—I count 20 on its website currently. In addition, reader friendly versions of its guidance are freely available to the public, patients, and carers.

NICE does not stifle debate—the reverse is true—as can be seen from Welfare's views on prophylaxis against venous thromboembolism in the same issue of the *BMJ* as Spence's article.[2]

Neither is NICE "closed to working clinicians." Even a cursory look at NICE's website will reveal opportunities for frontline staff to suggest future topics, become a member of a new working group, and influence everyday NHS practice by joining the NICE fellows and scholars programme—now moving into its third year.[3]

As for challenging orthodoxy, NICE has, for example, published over 100 "do not do" evidence based recommendations in mental health alone since 2007.[4] Who is wearing the emperor's new clothes now?

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Competing interests: PB is a current "NICE fellow" associated with, but not employed or paid by, NICE.

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RECONFIGURING HEALTHCARE

Keep any reconfiguration small and personal

Smallwood calls for rationalisation of providers within the NHS and specifically the development of large polyclinics for primary care.[1] After 35 years as a general practitioner and latterly several as a patient, I have great respect for the skill and knowledge of consultant colleagues and agree that further centralisation of specialist skills will bring safer and more efficient secondary and tertiary care. However, the large organisations that have been built up to support these services have yet to become patient friendly and seem to be fairly unhappy places to work in. I suspect that the answer to both these problems is to have small units within large organisations, each with passionate clinical leaders and an environment that enables them to set the tone for patient care and organisational morale alike.

Until this is achieved, please do not thrust yet another huge organisation on to us in primary care. Never has a friendly face to help patients navigate the complex and often impersonal maze of modern secondary care been so much needed, and I firmly believe that this is much easier to achieve within a small general practice and personal lists than in the impersonal labyrinth of a polyclinic.

I agree with the call for collaboration between primary and secondary care. Ironically, the ownership that is a natural consequence of smaller organisations should enable this to flourish.

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Competing interests: PM is a retired general practitioner.

1 Smallwood JA. We must reconfigure healthcare providers. *BMJ* 2011;343:d6997. (14 December.)

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NEW: FOLLOW-UP RATIO TARGETS

Time to act on these nonsensical targets

A year ago I wrote about imposed targets for outpatient new:follow-up ratios and their impact on chronic disease management,[1] receiving many supportive comments in both medical circles and the lay press.

I hoped that common sense would prevail and that this damaging target would be abandoned. I was therefore appalled to learn from a colleague that quite the opposite was true: every month his trust exceeded the ratio it was to be fined by the local primary care trust (or clinical commissioning group). Furthermore, his clinical decisions on patient review were to be over-ruled by managers controlling follow-up bookings so that the target would not be breached.

Such dangerous processes make it impossible to fulfil specialty guidelines on disease management. Things are made worse if new patient numbers are pegged by the imposition of referral quotas on GPs—requiring even larger cuts in follow-up. A service could spiral inexorably downwards. Seeing the dangers, some clinicians are resorting to gaming to hold things under partial control—for example, by insisting that, if follow-up needs to be advanced as an emergency the patient is rebooked as a new patient. Some clinicians are deliberately manipulating their new lists to include larger numbers of "one-stop" patients, many of whom may not need to see a specialist: their GP could manage osteoporosis if they get a DEXA scan result, or a physiotherapist could take first shot at patients with back pain.

The NHS is now concerned primarily with making money and only secondarily with providing a clinically appropriate service. I am depressed by how many colleagues say that they can do nothing because they will be pressurised or harassed by their managers—"anything for a quiet life." We are sleepwalking to catastrophe. Time to wake up, and rise up.

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Competing interests: ANB has taken early retirement from NHS practice.

1 Bamji A. Outpatient follow-up ratio targets make no sense. *BMJ* 2011;342:c7373.

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HONORARY AND GHOST AUTHORSHIP

Let's simply scrap authorship and move to contributorship

Why do science journals stick to authorship rather than moving wholesale to contributorship?[1]

These days science is rarely undertaken by individuals. Most research is conducted by teams, often large teams with people with very different skills. A binary division into authors and non-authors is bound to be arbitrary and to cause problems, as a recent systematic review shows.[2] It makes more sense to treat research papers like films rather than novels and to use credits or contributorship rather than authorship.

Rennie and colleagues identified the serious problems with authorship in 1997 and made a convincing case for contributorship, but 15 years later we are still floundering around with authorship.[3] Why can't journals be bolder and scrap authorship forever?

As the Cassandra of scientific publishing, I was irritated by the editorial saying, "Editors are unlikely to have sufficient resources to validate all authorship claims or conflicts of interest." My bet is that *Neurology*, the journal that the author of the editorial edits, makes about a 35% gross margin, way above that achieved in most businesses. They do have resources. How enraged they would be if—with similar waywardness—a drug company said, "We don't have the resources to follow up all reports of adverse effects of our drugs."

As Stephen Lock, my predecessor as editor of the *BMJ*, wrote more than 15 years ago, it's time for medical journals to move beyond their amateur ways.[4]

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Competing interests: RS is a former editor of the *BMJ* and chief executive of the BMJ Publishing Group.

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Why not switch to movie-style credits for research papers?

Movie-style credits could solve the longstanding problem of honorary and ghost authorship in high impact biomedical journals.[1]

The research group lead would be the producer and the principal investigator would be the director.

Ghosts could be credited as scriptwriters. Patients would be cast. The helpful medical student could be "best boy/girl", and the professor would, of course, be the "gaffer."

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Competing interests: None declared.

1 Wislar JS, Flanagin A, Fontanarosa PB, DeAngelis CD. Honorary and ghost authorship in high impact biomedical journals: a cross sectional survey. *BMJ* 2011;343:d6128. (25 October.)

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