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SPL

EMERGENCY OXYGEN USE

Don't forget high flow nasal oxygen delivery

O'Driscoll's comprehensive review of emergency oxygen administration makes no mention of high flow nasal oxygen delivery devices.[1] These devices deliver humidified oxygen at 40-70 L/min, and the achieved fractional inspired oxygen value (around 0.9) is substantially more than that achieved with traditional "high flow" methods (around 0.7), such as non-rebreathing (trauma) masks.[2] They may also provide a small amount of continuous positive airway pressure.

This method of oxygen administration is well tolerated. In patients with severe hypoxaemia, who are not hypercapnic or exhausted, these devices may avoid the need for mechanical ventilation.

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Competing interests: None declared.

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2 Sim MA, Dean P, Kinsella J, Black R, Carter R, Hughes M. Performance of oxygen delivery devices when the breathing pattern of respiratory failure is simulated. *Anaesthesia* 2008;63:938-40.

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UK DRUG POLICY

The medical profession should take the lead

The position of the medical profession is of great importance in the debate on drugs policy.[1] Serial committees regard the lead organisation, the Home Office, as inappropriate. Almost all observers suggest that health should take a bigger part, and many say the Department of Health should take the lead. All want more research into treatments and other health interventions. It is extraordinary that the National Institute for Health and Clinical Excellence has to look to the US, Australia, Norway, and Iran to make recommendations about methadone treatment because no trials have been carried out in the UK.

The medical profession, particularly the NHS and BMA, should take some ownership of these problems. The BMA has challenged international policy before. This led to our unique position on the medical use of diamorphine, which is unavailable in most countries, and our individual approach to drug treatment in the past. The profession seems to have opted out in recent years, despite a changing landscape of increasing medical complications from drug use in an ageing drug using population. The main problem has always been addiction and the main lead branch has been psychiatry. The time may have come for a serious reappraisal. Health should lead from the top, and addictions physicians support psychiatry at secondary and primary care levels. All should be involved with research.

The new drugs policy debate would then be led by information on the hepatitis C epidemic, the pathological consequences of injecting drug use, and the collateral damage to families and communities. This could form the basis of a new policy report with real evidence behind it and some clear direction for policy makers to follow.

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Competing interests: None declared.

1 Iacobucci G. Royal commission should be set up to look at UK drug policy, MPs say. *BMJ* 2012;345:e8403. (10 December.)

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THE "FULL" NHS

Capacity is not sufficient

I would hardly regard a 15% increase in emergency admissions over five years—3% a year—as "soaring."[1] With demographic changes this represents at least a containment, if not a reduction, in admission rate.

Who says 29% of admissions are avoidable? Not patients or their relatives. Who is going to deny the frail elderly admission to hospital if it might improve their condition? Which son or daughter? Recent and much publicised protocols for chest pain and stroke will also have affected admissions. Despite doubling their consultation rate over the past 20 years, GPs are working flat out to prevent admissions. What the NHS needs is a half decent humane hospital service with sufficient capacity to care for those who need it.

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1 Iacobucci G. NHS is "full" owing to rise in emergency admissions and poor discharge procedures, report says. *BMJ* 2012;345:e8245. (4 December.)

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PERSONAL HEALTH BUDGETS

Two key messages overlooked

It was unfortunate that Chinthapalli overlooked the key message of our paper on the Dutch experience with personal health budgets—that their availability is being scaled back radically because of escalating costs and widespread abuse.[1 2]

Another key issue was overlooked. Many view personal health budgets as the beginning of a process, initiated by the Health and Social Care Bill, whereby at some point in the future each of us will be allocated a fixed amount to purchase insurance, with the requirement to top up anything that is not covered. This would be consistent with views expressed previously by various Conservative politicians.[3] What may seem like a good idea could easily become a Trojan horse.

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Competing interests: None declared.

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FEMALE GENITAL MUTILATION

Scotland does not turn a blind eye

I am not sure who in the Scottish NHS said that the author of this feature could not interview doctors or midwives about female genital mutilation.[1]

I am the senior partner in a north Glasgow practice that has more than 3000 patients from an asylum seeking or refugee background. The practice has been involved in the care of this group of patients since 1999. Trained nurses and doctors within the practice are aware of

female genital mutilation and its prevention. We regularly examine and report on cases of female genital mutilation for legal purposes. The Medical Foundation in Glasgow also has high levels of awareness and expertise, as do our consultant colleagues at the Princess Royal Maternity Hospital. We do not think routine examination of female children is an abuse of their human rights, we consider it part of our General Medical Services contract.

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Competing interests: None declared.

1 Lloyd-Roberts S. UK's shameful record on female genital mutilation. *BMJ* 2012;345:e8121. (3 December.)

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GMC IMPARTIALITY

Double standards

My complaint about Dr Mullen to the General Medical Council (GMC) originated in the MIST trial.[1-3] He was one of three "responsible authors" of a paper reporting results.[3] Dr Nightingale and I told the other steering committee members that we would not be authors because the paper contained false statements.[4] We were vindicated when *Circulation* published an extensive correction, data supplement, and new version of the paper.[4] Misleading information about the results was also published on the website of the sponsor (NMT Medical) and elsewhere, including the website of the Royal Brompton Hospital—Mullen's employer.[5]

NMT admitted in legal documents that no author had seen the full trial data and that a corporation vice president helped to write the paper. His contribution was not disclosed. Mullen's shareholding in NMT was declared, but shareholdings and NMT's gifts of shares and payments to some other investigators were not.[3 4] Trial data were analysed and misreported by people with financial conflicts, some undisclosed. The GMC decided that it would not consider how these conflicts influenced misreporting of the research at Mullen's hearing.

I believed that I was called as a witness of fact on a restricted and minor matter.[2] The GMC's lawyers admitted that they were taken by surprise when Mullen's lawyers argued that I was also a witness of opinion and that I was not impartial. Of course I was not impartial. Most complainants believe in the guilt of those they accuse. After seven days of legal arguments and the decision to limit my evidence, the GMC offered no evidence.[1]

Mullen and the GMC were right to expect impartiality in those analysing evidence when a doctor's livelihood is at stake but wrong not to expect it when the lives of patients are at risk.

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Competing interests: NMT Medical sued me three times for libel and slander for comments that I made about problems with the MIST trial. The libel claims ended after nearly four years when NMT went into liquidation. Dr Mullen was a shareholder in and a paid consultant to NMT. I asked the GMC to investigate whether he and some other investigators had colluded with NMT to publish misleading information about the MIST trial. GMC investigations are ongoing and a Fitness to Practise Panel hearing of another MIST investigator is scheduled for 2013.

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5 Goldacre B. NMT are suing Dr Wilmshurst. So how trustworthy are this company? Let's look at their website. *Bad Science* 2010. www.badscience.net/2010/12/nmt-are-suing-dr-wilmshurst-so-how-trustworthy-are-they/.

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RESPONSE

Panorama responds to editorial on fMRI for vegetative and minimally conscious states

Turner-Stokes and colleagues' editorial suggests that the Panorama special, *The Mind Reader: Unlocking My Voice*, did not "clearly distinguish" between patients who live in a vegetative state and those in a minimally conscious state.[1] However, the script contained several explanations of these conditions; for example, when referring to one patient undergoing assessment: "Staff here will try to assess whether he is minimally conscious with fragments of understanding or vegetative—with no awareness at all."

Just by viewing this one hour documentary the authors felt able to discern that both the Canadian patients "said to be in a vegetative state" are "probably" minimally conscious.

One of these patients, Scott, has had the same neurologist for more than a decade. Professor Young, who appeared in the film, made it clear that Scott had appeared vegetative in every assessment, including those done after his functional magnetic resonance imaging (fMRI) scan. The fact that these authors took Scott's fleeting movement, shown in the programme, to indicate a purposeful ("minimally conscious") response shows why it is so important that the diagnosis is made in person, by an experienced neurologist, using internationally agreed criteria. In the programme, Professor Young stated that it was only Scott's cognitive responses in the fMRI scanner that had revealed covert awareness.

Indeed, Scott was able to respond in the scanner that he was not in any pain, information that his parents felt was extremely valuable. This was the first time that a patient in a vegetative state had been able to answer a question of clinical relevance while undergoing fMRI.

The programme did not say that the other Canadian patient, Steven, was vegetative. His parents explained on camera that he had a variety of means of physically responding, but that these were inconsistent. This fragmented ability to respond is indicative of the minimally conscious state.

Nevertheless, Steven was also able to respond in the scanner and to show that he is aware that he has a niece, born three years after his brain injury. Irrespective of Steven's formal diagnosis (minimally conscious or vegetative), his physical condition had precluded any such questions being asked, or answered, until he entered the scanner—a moment that was captured for the first time in the film. This was vital information for his parents, who wanted to know whether he could lay down new memories and retain information. The documentary made it clear that the level of the patients' cognitive abilities was unclear.

The authors also say that Professor Owen's assertion that nearly 20% of vegetative patients who he had scanned showed awareness is not supported by the published evidence. Yet the available peer reviewed evidence, including four of 23 (17%) vegetative patients in a study published in the *New England Journal of Medicine* in 2010,[2] bears this out. In a later study of another group of patients, a related technology not featured in the programme (electroencephalography) placed this figure at an even higher 19%.[3 4]

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Competing interests: None declared.

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