We need a global system to help identify new uses for existing drugs

A centralised, worldwide system, similar to the existing “yellow cards” collected for adverse drug events, could amass the huge numbers of data needed, writes Ricardo Borges

Identifying new uses is usually a serendipitous process, and most are the fruit of observations by isolated physicians who rarely communicate them to the scientific community in a patient receiving treatment for another condition, or about an unknown or unreported potential use of a drug.

This would be especially valuable for rare diseases, given the high cost of research and development and the smaller markets for commercial exploration that may discourage drug companies’ investment.

Moreover, reaching a consensus about new treatments using established drugs can be difficult and requires a huge number of individual reports. The potential clinical benefits could be attained only via a system that centralises such communications.

Centralisation would also facilitate and encourage the sharing of such information. The system would have to take into account some legal considerations, such as intellectual property rights, because a doctor might claim discovery of a new application of a drug.

A system similar to the yellow card system but which collects adverse effects could help amass the data necessary to identify other potential uses of currently marketed drugs. Such a system might give a necessary boost to the industry’s waning drug discovery programmes; hopefully it would also benefit patients, by increasing the clinical drug armoury.

Ricardo Borges is professor of pharmacology and head of the pharmacology unit, University of La Laguna Medical School, The Unit of Pharmacology, E-38071 La Laguna, Tenerife, Spain rborges@ull.es

Competing interests: None declared.

Provenance and peer review: Not commissioned; not externally peer reviewed.

References are in the version on bmj.com.

Cite this as: BMJ 2014;348:g1806
The lives of others

Doctors are good students. We get used to people telling us how clever we are. At university we are considered an elite group. And because many medical students are privileged we do not need to work in lowly positions, as many other young people do. When we graduate our career path is secure and distinct. We marry within the profession. Then come more exams, titles, and gongs to puff up our status. Doctors’ experience of life is different and separate. This is our professional curse. It’s no one’s fault; it’s just the way it is and always has been.

But it means that we lose perspective and have a creeping sense of entitlement, and what we might consider professional confidence may seem like arrogance to others. And then there develops a schism between the expectation of a medical career and its reality. This separation can eventually lead to a landslide of professional unhappiness.

In addition, in clinical practice we make errors, things go wrong, and bad things happen. Scars and regret live with us forever and wake us at night. Complaints always come, however bright, careful, and educated we might be. Doctors are blamed, and patients feel anger towards us. Medicine is not easy on any level. And time is the great leveler—sneaking up behind us, covering our heads with a hood, knocking the living daylights out of our confidence, and bleeding out all of that youthful certainty. The closed and isolated nature of our profession compounds this pain and fuels complaints. Medicine seems a lonely and unhappy profession for many. Being good students does not make us good doctors.

I have a good piece of advice passed down through generations of doctors which, if we all followed it, would open the profession and make us happier too: “Treat others as you would want to be treated yourself. Remember that the patient is someone’s son, daughter, sister, brother, father, or mother.”

In modern medical jargon this might be called empathy. But it is more than that—more than a clumsy tick on a consultation scoring sheet. We have to consider how we would feel, what we would want, how we would wish be spoken to; and we should strive to understand and gain insight from others, irrespective of race, creed, sex, or status. Medicine is not science; it is a well crafted art.

All of this would make our apologies for mistakes more convincing, heartfelt, and accepted. If we all followed this advice the NHS would have far fewer complaints, and Mid Staffordshire might well have never happened.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk

Competing interests: I have read and understood the BMJ Group policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; externally peer reviewed.

Cite this as: BMJ/2014;348:g2209

Labour’s recommendations on integrated care and social reform

Labour’s independent commission on health policy has made some welcome recommendations on integrated care and system reform, but could create conflict between the NHS and local government.

It calls for the Payment by Results system to be reformed to stop rewarding episodic care in hospitals, and advocates outcome based commissioning. This would typically be achieved through a prime contractor, where one organisation is responsible for the delivery and coordination of services to achieve specific outcomes.

On reconfiguring services it wants a “national conversation,” to be completed by 2016, on the future of health and social care. If this means ministers will provide clear political leadership for reforming services then it has the potential to give renewed impetus to service improvements while encouraging a more realistic debate about what the state can afford.

Virtually the entire NHS will welcome the proposal to scrap the coalition’s competition laws—although aspects of the NHS such as autonomous and competing foundation trusts mean there will still be a role for the market.

Oldham’s proposals create two potential areas of conflict between the NHS and local government. First, Oldham proposes that the health and wellbeing boards overseen by councils would become the “system leaders” for integrated care, focusing on developing a coordinated commissioning plan for long term conditions, disabilities, and frailty.

Bringing health and social care together at the boards was always the intention, but specifically identifying them as system leaders would mean that a GP membership organisation—the clinical commissioning group—would be accountable to a body led by councillors. Alongside this is a recommendation to strengthen provider representation on the boards. Taking all this together it is easy to imagine local hospitals feeling threatened by clinical commissioning groups’ plans to move care into the community lining up with councillors in opposition.

The second recommendation is giving NHS England—renamed Care England—overall responsibility for whole person care. While Labour is attempting to overcome the separation of NHS and social care, which has baffled and frustrated generations of service users, this sounds benign, it would entail giving the organisation influence over social care spending, local government’s biggest and most difficult budget. Local democratic decisions balancing out social care need against the huge diversity of competing demands which councils face do not lend themselves to central oversight, and local government would fiercely resist it.

Labour is attempting to overcome the separation of NHS and social care, which has baffled and frustrated generations of service users. In doing so it is pursuing the care equivalent of nuclear fusion—trying to do something which offers limitless possibilities in theory but is always elusive in practice.

Richard Vize is a journalist and communications consultant specialising in health and local government. He was the editor of the HSJ 2007-2010.