LETTERS

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RISKS AND BENEFITS OF DOG OWNERSHIP

Doctors and veterinarians unite on problem of dog bites

Orritt's article highlights the inaccurate use of statistics and reporting of dog bite injuries,[1] yet a serious clinical problem exists.[2]

As a surgeon, one of us (CJM) regularly treats patients with wounds caused by dog bites. Any GP or emergency department doctor is likely to say the same. Increasing numbers of veterinary surgeons are also being bitten and injured.

Clearly, research is needed to establish accurate dog bite incidence rates (and resulting animal euthanasia). The context of the bite injury is also crucial but is often not recorded or investigated.

This is a public health problem for which the medical and veterinary professions could truly demonstrate interprofessional working and collaboration.[3] Moreover, with a recent report noting that "poor areas have most admissions for dog bites,"[4] other agencies, including police, social services, and local authorities, should also be involved.

The lack of a coherent public health policy led us to present our concerns to MPs, including the shadow public health minister, and to the House of Lords.

Through professional collaboration we must:

- Investigate bite injuries that need treatment, documenting specifics of the injury and treatment, as well as information on the animal and the context of the bite
- Develop a "pathway" to provide support to deal with the physical and psychological effects of the incident, as well as the animal's welfare
- Provide education strategies for dog owners, the public, and schoolchildren.
- We are jointly presenting a collaborative perspective of this problem at the meeting of the British Veterinary Behaviour Association and Association of Pet Behaviour Counsellors in Telford (9 October 2014).

The NHS spends vast sums on the treatment of dog bite injuries.[5] With the cooperation of both professions, we should aim to reduce them.

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1 Orritt R. Dog ownership has unknown risks but known health benefits: we need evidence based policy. *BMJ* 2014;349:g4081. (17 July.)
2 Mannion CJ, Mills DS. Injuries sustained by dog bites. *Br J Oral Maxillofac Surg* 2013;51:368-9.
3 Mannion CJ, Shepherd K. One Health approach to dog bite prevention. *Vet Rec* 2014;174:151-2.
4 News in brief. *BMJ* 2014;348:g2991. (30 April.)
5 House of Commons. Responsible dog ownership. 2013. www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130226/halltext/130226h0001.htm.

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GPs AND EMERGENCY CARE

NHS 111: one practice's story

The joint report discussed by Iacobucci says that NHS 111 and equivalent telephone advice services may help to reduce the pressures on the urgent and emergency care system.[1] The general feeling is that the NHS 111 service has only served to increase pressure on already overstretched urgent care services, particularly ambulances and emergency departments.[2-4]

To assess how the service works in our small inner city practice (n=2611), we reviewed all 228 interactions with NHS 111 from July 2013 to May 2014, accessing practice records to identify subsequent management of the problem recorded in the 111 reports.

The mean number of calls per month was 26.8 (remaining stable since inception). Of the 228 calls, 154 were for those aged 19-69, 70 being for those aged 19-29 and only 20 for those aged 70 and over. Of the 228 callers, 130 were advised to seek GP advice and 24 were advised to manage their problem at home. Only 15 callers were advised to attend an emergency department, with a further 26 calls resulting in the dispatch of emergency transport. A total of 24 callers attended the emergency department.

Most callers (174) did as advised; 46 chose not to attend the recommended service, and only three presented to medical services after being advised that this was unnecessary. No evidence suggested that serious conditions were missed, and most of the emergency department attendances seemed appropriate.

Our audit shows that NHS 111 provided a safe, timely service and was particularly used by young people with minor illness. Patients generally followed the given advice, with only a few seeking further services against advice. Most calls were directed towards GP led services, and only 11% ended up in the emergency department (usually appropriately).

We conclude that NHS 111 may prevent large numbers of "worried well" attendances at out-of-hours services rather than simply creating another opportunity for people to be unwell.

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1 Iacobucci G. All emergency departments should include GP staff, say experts. *BMJ* 2014;349:g4654.
2 Turner J, O'Cathain A, Knowles E, Nicholl J. Impact of the urgent care telephone service NHS 111 pilot sites: a controlled before and after study. *BMJ Open* 2013;3:e003451.
3 BMA. Emergency departments veer towards collapse. 22 May 2013. http://bma.org.uk/news-views-analysis/news/2013/may/emergency-departments-veer-towards-collapse.
4 Kaffash J. NHS 111 implodes as GPC withdraws support for urgent care hotline. *Pulse* 22 March 2013.

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EMA AND TECHNOLOGY ASSESSMENT

NICE on technology assessment bodies and the drug industry

We read, with much astonishment, the article by Wise claiming that "selling" scientific advice procedures enables institutional capture by drug companies.[1] The National Institute for Health and Care Excellence (NICE) strongly supports the development of processes for the provision of parallel scientific advice between the European Medicines Agency and Health Technology Assessment (HTA) bodies to the developers of medicinal products.

The provision of scientific advice to drug companies does not threaten the independence of bodies such as NICE. By implying that scientific advice is "unnecessary if scientific data is robust and clinical trials are designed to address legitimate public health needs," the coalition of the European medicines advocates (Health Action International Europe, the International Society of Drug Bulletins, the Medicines in Europe Forum, and the Association Internationale de la

Mutualité) demonstrate a flawed understanding of the scientific advice process and its purpose.

Scientific advice exists because it is essential for companies to understand how to design clinical trials and generate robust scientific data to answer questions about the effectiveness and value of their products. It does not result in "regulatory capture." NICE advice is provided before the initiation of the pivotal clinical trials when it is impossible to know, with precision, the chances of a product's success. Companies pay for the provision of scientific advice to allow agencies to recover costs. Doing otherwise would mean that these costs are covered by taxpayers. The NICE technology appraisal process is separate from our scientific advice processes and our appraisal committee members do not participate in provision of scientific advice.

Scientific advice is an essential tool for enabling constructive and structured dialogue between HTA decision making bodies and industry to ensure that product development plans meet the requirements of decisions makers. In this way, scientific advice can facilitate the development of clinically effective, useful, and affordable medicines for the benefit of patients.

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1 Wise J. European Medicines Agency is attacked over proposal to allow technology assessment bodies to sell advice to drug industry. *BMJ* 2014;349:g4674. (17 July.)

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SCREENING FOR MRSA

Targeted MRSA screening can be as good as universal screening

At the time that the practice pointer on meticillin resistant *Staphylococcus aureus* (MRSA) screening was written, no evidence on the success of the implementation of clinical risk assessment (CRA) based screening in Scotland was available.[1] Recently there has been much debate about whether universal screening should be the preferred method, owing to its perceived ease of implementation and higher compliance than risk based screening.

The evidence outlined in the practice pointer indicated that CRA based screening (three risk based questions and subsequent nasal and perineal swabbing), which had a minimum compliance of 90%, was as effective as universal nasal screening, which had 80-90% compliance (50.4% *v* 53.1% of all MRSA colonised patients identified).[1]

The first results from the Scottish National MRSA screening monitoring system indicated that CRA based MRSA screening was carried out in line with national screening policy in 77.8% of admissions. This level of compliance leads us to question whether a CRA based policy is as effective as universal screening. Interestingly, the Department of Health in England introduced mandatory universal nasal screening in 2009-10 and the English National One Week (NOW) study,[2] which audited MRSA screening, reported that compliance was 65.7%. The percentage of MRSA colonised patients identified using universal nasal screening with this level of compliance is equivalent to CRA based screening with 77.8% compliance (43.6% *v* 43.6%). Consequently, in the clinical setting, CRA based screening performs favourably compared with universal screening because patients can be pre-emptively isolated and the detection rate remains the same. In addition, CRA based screening is more cost effective in low prevalence settings, such as the UK.

These findings provide further evidence that risk based approaches to MRSA screening can be successful in clinical practice and maximise cost effectiveness. The proposed move from universal screening to a targeted risk based approach by the Department of Health in England highlights a policy shift with respect to MRSA screening.[3]

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1 Coia JE, Leanord AT, Reilly JS. Screening for meticillin resistant *Staphylococcus aureus* (MRSA): who, when, and how? *BMJ* 2014;348:g1697.
2 Fuller C, Robotham J, Savage J, Deeny S, Hopkins S, Cookson B, et al. Final report of National One Week prevalence audit of MRSA screening. www.idrn.org/audit.php.
3 Implementation of modified admission MRSA screening guidance for NHS (2014).

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NEW PSYCHOACTIVE SUBSTANCES

New Zealand's innovative drug law is at risk of unravelling

Owing to the increasing availability of new, and legal, psychoactive drugs (NPDs),[1] the New Zealand government enacted ground breaking legislation in May 2013; the Psychoactive Substance Act requires evidence of low risk before NPDs can be legally sold.[2] A transitional period was created until safety testing regimes were finalised. Public outrage, however, grew as adverse effects of "interim approved" drugs placed additional burden on families, police, and healthcare providers, and animal advocates demanded removal of animals from safety testing. Amendments, which banned interim approved drugs and removed animal testing requirements from the act, were incorporated in May 2014.[3] The ban was welcomed, but changes to testing have caused concern.

The act states that new NPDs considered for public sale must be assessed for pharmacological, psychoactive, and toxicological risks to public health, the potential to cause death or create physical or psychological dependence. The amendment states "animals must not be used in trials for the purposes of assessing whether a psychoactive product should be approved." This compromises the standard of proof. Preclinical studies serve two important functions. They help eliminate drugs that are adverse to mammalian species and they provide a basis for starting doses in phase I human clinical trials. In vitro testing has limited value in establishing safety. It does not examine biological endpoints associated with the effect on unborn babies, systemic toxicity, or psychological dependence.

Without adequate preclinical trials, ethical approval to conduct human clinical trials may not be given; consequently, NPDs will fail registration. Alternatively, incomplete data, obtained from approved but limited human trials, will lead to the registration of drugs without full evidence of low risk of harm.

New Zealand's innovative approach to controlling the safety and availability of NPDs is at risk of unravelling because of the public's concern over animal testing.

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1 European Monitoring Centre for Drugs and Drug Addiction. Annual report on the state of the drugs problem in Europe. 2009.
2 Newberry J, Wodak A, Sellman D, Robinson G. New Zealand's regulation of new psychoactive substances. *BMJ* 2014;348:g1534. (13 February.)
3 Psychoactive Substances Amendment Act 2014. www.legislation.govt.nz/act/public/2014/0024/latest/whole.html.

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