LETTERS

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UK LAW ON CONSENT

New law shows need for longer consultations

Edozien's editorial describes the evolution of medical negligence, particularly consent case law up till now.[1] Although I agree with Edozien's description of our current formulaic practice in obtaining consent, and the need to impress on the profession the change in the law, I think one of the greatest hurdles will be creating time to have more complex, in depth, conversations with patients.

Several consultations may be needed to allow time to absorb information, including uncertainties, ruminate on it, and come to a decision. This, however, is at odds with our trust's policy of compliance with the 18 week target. This new case law throws the challenge directly at the clinicians' feet: "It is nevertheless necessary to impose legal obligations, so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion which the law requires. This may not be welcomed by some healthcare providers."[2]

Pressure ought to be placed on hospital trusts to encourage and allow for longer consultations. However, there has not been a word about this case from the medical director or chief executive's office. I suspect many trusts will not take adequate steps to inform their staff of this landmark case at this time, let alone make time for the more complex consultations that the law requires, because they have enough to worry about. Bringing a case to court is a lengthy business, so worrying about this new case law will have to wait until tomorrow.

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Full response at: www.bmj.com/content/350/bmj.h2877/rr-4.

1 Edozien LC. UK law on consent finally embraces the prudent patient standard. *BMJ* 2015;350:h2877. (28 May.)

Cite this as: *BMJ* 2015;351:h3484

Authorisation or broad consent for research?

I read Edozien's editorial[1] and the rapid responses with interest, in particular Ilangaratne's quote "the basic principles—and the resulting duty of care—defined in Montgomery are likely to be applied to all aspects of the provision of advice given to patients by medical and nursing staff."[2]

This concern extends beyond direct patient care.

At the recent European Society of Human Genetics conference, Genomics England's 100 000 Genomes Project's chief scientist gave two presentations. In both he gave reassurance that full informed consent would be obtained from participants, even though the website refers to broad consent only. Genomics England's ethics advisory committee finds that "broad consent is possible and acceptable" despite acknowledging that "the detail of future research will be unknown at the time of consent."[3] This is the problem—can the concept of informed consent be applied to such a project in the absence of information regarding future use of the donated material.

A working party convened by the World Medical Association is currently also looking at this problem.[4]

We have a possible solution in Scotland for this difficulty. The Human Tissue (Scotland) Act 2006 requires authorisation rather than consent. This notion was driven by the recommendations of the Scottish Review Group on Retention of Organs at Post-Mortem.[5] It recognised that some parents who consented to a postmortem on their dead child would not wish to receive information regarding the procedure: "Whereas in law a valid consent is generally expected to follow the provision of information, authorisation is not constrained to this requirement."

Authorisation may be more appropriate than broad consent for research when full information on the future use of the donated material is not possible.

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Full response at: www.bmj.com/content/350/bmj.h2877/rr-6.

Cite this as: *BMJ* 2015;351:h3504

CONFLICT OF INTEREST

Diverting attention from financial conflicts of interest

Godlee's comment that "there is little dispute that non-financial conflicts of interest—such as academic passion and personal belief—are just as important [as], if harder to track" than financial conflicts, begs examination for two reasons.[1]

Firstly, personal biases are generally, although not always, multidirectional; some experts might prefer one approach to patient care for personal or philosophical reasons, or may believe fervently in a treatment that is being tested, while others are likely to take a contrary stand. The bias introduced by financial conflicts, by contrast, is almost invariably unidirectional because most clinical research is sponsored by industry, whose fiduciary duty is to sell product. As a result, trial design, analysis, and publication are often biased in the sponsor's favour.

Secondly, industry funds vast networks of lobbyists, patient groups, researchers, lawyers, medical writers, social networking specialists, marketers, and others, all of whom amplify positive results and counter critics. These networks, backed by resources rarely (if ever) available to individual academics or community doctors, make financial conflicts of interest a powerful form of bias associated with breaches of public trust.

Although personal and intellectual bias undoubtedly colour the way individual doctors treat their patients, biased clinical research affects many patients and in aggregate distorts the way clinicians and patients perceive disease and treatment. The impact of financial conflicts is further compounded when claims of "intellectual conflict" (a subjective judgment itself) are used to exclude highly skilled and respected experts without financial conflicts, such as Curt Furberg,[2] Sidney Wolfe,[3] and Jerome Hoffman from serving on guideline[4] and government advisory panels, while keeping people with financial conflicts on those same panels. Financial conflicts can be reduced if not eliminated; failure to take measures against financial conflicts because there are other sources of bias diverts attention from the more serious problem.

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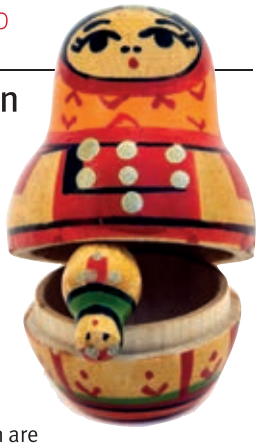
Full response at: www.bmj.com/content/350/bmj.h3176/rr.

1 Godlee F. Conflict of interest: forward not backward. *BMJ* 2015;350:h3176. (11 June.)

Cite this as: *BMJ* 2015;351:h3505

CAESAREANS AND CHILD HEALTH

Misinformation about caesarean sections



The caesarean section rate remains an issue for polarised debate. If Blustein and Liu are right,[1] women are choosing to give birth by a more risky route. However, this debate usually comes with a fair dose of misinformation and opinion. These authors do not disappoint.

Firstly, women with a previous caesarean do not have to decide between a caesarean and a vaginal delivery but between a planned caesarean and a planned vaginal delivery. A planned vaginal delivery carries up to a 63% risk of emergency caesarean.[2] This subtle but key difference is at the centre of antenatal misinformation.

Secondly, the authors discuss examples of acute risks of vaginal delivery and caesarean. For caesarean, they appropriately cite admission to the neonatal intensive care unit. For vaginal delivery, they cite an increased likelihood of cephalohaematoma. I have never heard this risk discussed with any woman. More appropriate risks are uterine rupture (22-74/10 000[3]), intrapartum stillbirth (1/1000[4]), and cerebral palsy.

The notion that knowledge about chronic disease risk could affect decision making in non-essential caesarean is fanciful. As an obstetrician and parent, I would rather deliver 1000 healthy babies who later develop asthma than deal with one stillbirth. Furthermore, no caesareans are non-essential. When an obstetrician decides that a caesarean is needed, it becomes essential, even though others might have safely achieved a vaginal delivery. When a woman decides that she wants a caesarean, the procedure becomes essential.

The key to reducing caesarean rates does not lie in attacking maternal choice or warning about risks. The key is preventing that first traumatic birth—realistic antenatal education, one to one midwifery care, and appropriately trained obstetricians so that interventions are not recommended "at the drop of a hat."

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Full response at: www.bmj.com/content/350/bmj.h2410/rr.

1 Blustein J, Liu J. Time to consider the risks of caesarean delivery for long term child health. *BMJ* 2015;350:h2410. (10 June.)

Cite this as: *BMJ* 2015;351:h3489

PEOPLE AND EXERCISE

Seismic shift in policy needed to increase physical activity

We agree that there is now considerable evidence that exercise can maintain and promote health.[1] However, Kamerow's suggestions for promoting exercise seem narrow compared with the size and importance of this public health challenge.[2] We need a seismic shift in public health activity and an approach that is in line with the Ottawa Charter for Health Promotion.[3]

Many professional groups could help promote physical activity, and doctors, especially GPs, could play a pivotal role.[1] They could use their many interactions with individual patients to encourage physical activity, and as community leaders they could advocate for change. However, these roles may not be easy to undertake in parts of the country with severe GP shortages.[4] Resources will be needed.

Schools are important settings for promoting health, and they should work with pupils and parents in this area. They should encourage pupils to participate in a range of physical activities and help them understand how such activities are beneficial to health.

The social and physical environment can have an important impact on physical activity. Barriers that prevent people from being active need to be removed so that the healthier option will be the easier one. For example, transport and housing policies should support physical activity and active travel.[5]

A multi-sectoral approach will be required to increase physical activity in the population, and national plans will need to target individuals and create supportive environments.[3] Government commitment will be necessary to energise all sectors. And because of the scale of this public health issue a dramatic increase in action is urgently needed.

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Full response at: www.bmj.com/content/350/bmj.h3024/rr-2.

2 Kamerow D. Why don't people exercise, even a little? *BMJ* 2015;350:h3024. (4 June.)

Cite this as: *BMJ* 2015;351:h3486

NON-NHS PROVIDERS

Private companies behave differently from NHS providers

Appleby states that "if rates of [average?] growth . . . continue over the next 20 years . . . non-NHS providers could account for one in five of all outpatient attendances."[1] This is a surprising interpretation of the data. If the trend as shown continues, non-NHS providers would account for 20% of the total within five, not 20, years.

Would this matter? It would be interesting to know the health and transactional costs to patients and to the NHS from a recent "unmitigated disaster": the Nottingham privatisation experiment. After the hospital's renowned dermatology unit was privatised, emergency, outpatient, and inpatient services were fragmented, and the whole service—together with education, training, and research at the hospital—has collapsed, with considerable disruption and displacement of patients. "Destructive innovation" or just destruction?

Elsewhere, Serco, Circle, Vanguard, Concordia, Carillion, Clinicenta, Harmoni, and BUPA have all undergone early termination of contracts. Five of these cases included seriously substandard levels of care or staffing; death, harm, or threats to patient safety; extremely high rates of surgical complications; or fraudulent behaviour—all since 2012.

Public debate over privatisation has been evaded and obfuscated. The implications and consequences of deregulation and contracting out need to be accounted for: costs, instability, and manipulation of the non-free health (external) market; perverse incentives of private healthcare; commercial secrecy; the major differences between a private contractor providing audiology services or taking over a hospital; influences on medical knowledge, education, training, and research.

Private companies manifestly do not behave the same as NHS providers and the argument that GPs provide "non-NHS" services is spurious. Aside from contractual differences—such as paying their own indemnity insurance and not having a final salary pension scheme—GPs are every bit NHS and always have been.

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Full response at: www.bmj.com/content/350/bmj.h3109/rr-2.

1 Appleby J. Paid for by the NHS, treated privately. *BMJ* 2015;350:h3109. (10 June.)

Cite this as: *BMJ* 2015;351:h3490