comment

> The power of consultation means that it is often, in itself, the treatment. Freedom to speak is permissible often only because of an implicit assurance of privacy

NO HOLDS BARRED Margaret McCartney

Breaching trust won't stop FGM

On 31 October new provisions of the Serious Crime Act came into force in England and Wales. This new law compels healthcare professionals, social workers, and teachers to report to the police any cases of female genital mutilation (FGM) in girls or women who appear to have had the procedure before age 18.[1]

The law is one of several interventions that the government has offered to try to reduce such abuse. These include guidance on commissioning new services for women, money for international development, and the ability for courts to charge guardians for failing to protect girls from FGM. And doctors must now take part in the Department of Health's "enhanced data collection" on FGM. This means that we must submit information that identifies patients, which will later be anonymised and published.

Will this stop FGM? As others have pointed out, this approach "has no evidence of benefit, wastes precious clinical time, and will profoundly damage trust in health professionals."[2]

This stipulation is part of a wider malaise of misunderstanding about what doctors and patients say to each other. The broadcaster Nick Ross wrote recently on thebmj.com that, "in socialised medicine," we should follow the example of Norway, which publishes tax returns online: "Why should my medical records be any different? Secrecy is secrecy even when dressed up in the more agreeable word 'privacy.'"[3] Although he said that some conditions such as sexual infections might be worthy of non-publication, "stigma about disease flourishes in the darkness of concealment."

But, behind closed doors, there's the patient's story about stress that ends up being about domestic abuse. Or the request for a sick note that is in fact about the predatory behaviour of a boss. A man has sex with a man while married to his wife. A teenager is wondering about being transgender. A boyfriend is worried about his girlfriend's obsessive-compulsive disorder. A woman with multiple sclerosis and back pain can't afford the bus because her benefits have been stopped.

And a woman has ongoing distress and pain caused by FGM as a child. Will she feel better or worse for having her information disclosed? Will it do her, or the girls and women after her, a favour? Doctors can always do harm, even—and especially—when well intentioned.

I don't expect employees of the Department of Health to understand the land behind the consulting room door. The ground is fragile. The space is precious. The duty of confidentiality means that it is rarely fully described. The power of consultation means that it is often, in itself, the treatment. Patients' freedom to speak is permissible often only because of an implicit assurance of privacy. Socialised medicine means acting for the common good: it does not mean that medical records become common property.

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com
Follow Margaret on Twitter, @mgtmccartney
Cite this as: *BMJ* 2015;351:h5830

LATEST ONLINE COMMENT AND BLOGS

- Read more articles by Margaret McCartney at bmj.co/margaretmccartney
- Read more analysis articles at bmj.co/analysis
- Read more about infectious diseases at bmj.com/specialties/infectious-diseases
- Read more articles by David Oliver at bmj.co/davidoliver

MALCOLM WILLETT

ANALYSIS

Why the drug pipeline is not delivering

Despite the large number of new medicines entering the market every year, few offer important clinical advantages for patients. **Huseyin Naci**, **Alexander Carter**, and **Elias Mossialos** explain the reasons

Many in the pharmaceutical sector think the industry is in crisis. Despite these concerns, US and European regulators granted marketing authorisations to a record number of new medicines in 2014. However, most new medicines offer few clinical advantages over existing alternatives. We discuss how both government and drug company practices contribute to the ongoing innovation deficit in the sector.

WHAT YOU NEED TO KNOW

- The innovation deficit in the pharmaceutical sector arises from a combination of government and industry practices
- A low bar for market entry of new products, stagnating government investment in research, and inconsistency in international regulations discourage innovation
- Industry puts a disproportionate emphasis on marketing versus research and prefers continued investment in established areas to risky research
- Concerted regulatory action is needed at the international level to reward the development of clinically superior medicines

Paucity of clinically superior medicines

Patients and clinicians commonly understand innovation to mean a medicine that has transformed management and treatment,[2] either by providing treatments for conditions with no current (satisfactory) remedies or by offering meaningful improvement over existing options. In recent years, however, industry analysts have adopted other definitions to measure innovation, such as the number of new approvals or number of patents associated with new medicines.[3]

Large numbers of new drugs have been taken as a proxy for the innovative capacity of the industry. Unfortunately, rather than new breakthroughs, most of the new drugs are relatively minor modifications of existing treatments.[6] Studies evaluating the clinical importance of new drugs over the past decades consistently report a negative trend.[7-11] Regardless of differences in analytical approach and time period, all characterise only a minority of new drugs as clinically superior to existing alternatives.[3]

Despite the paucity of clinically superior drugs, the pharmaceutical market grew by a factor of 2.5 in real terms between 1990 and 2010 (fig 1). Much of the increased expenditure on drugs was the result of increasing industry investment in "me-too" medicines rather than clinically superior medications.[14] Drug companies have remained profitable over this period while the proportion of health spending on drugs has increased and drugs have become less affordable.[16 17]

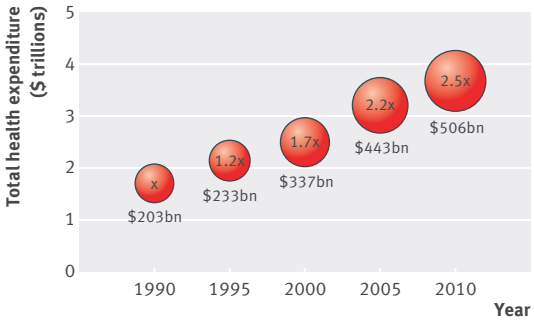


Fig 1 | Growth in total healthcare expenditure and drug expenditure (represented by size of bubbles) in selected countries (Australia, Canada, Finland, Germany, Greece, Iceland, Italy, Netherlands, Sweden, Switzerland, United Kingdom, and United States)[18-22]

Inconsistent and unpredictable government regulation

Much accountability for the innovation deficit in the sector rests with governments. The industry is highly regulated to ensure products entering the market are efficacious and safe. These same regulations should also foster research, development, and access to innovative drugs, yet agencies responsible for approving new medicines such as the US Food and Drug Administration and European Medicines Agency seem reluctant to send the correct signals to drug companies. For example, regulators do not require comparative trials for me-too drugs in classes with multiple effective agents.[23]

Regulators in recent years have in fact progressively lowered their evidence requirements by allowing smaller trials, surrogate endpoints, and placebo comparisons. They have also increasingly adopted

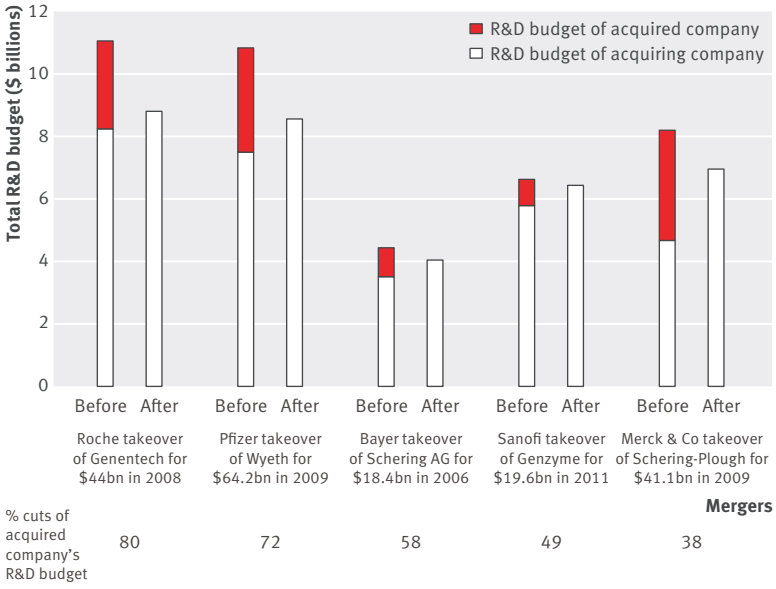


Fig 2 | Reductions in research and development (R&D) budgets after acquisition as percentage of acquired company's R&D budget before acquisition. All costs are in 2010 dollars, adjusted using consumer price index. Source: Thomson Reuters DataStream 5.1.

expedited approvals to get new drugs on to the market more quickly.[24 25] Such rushed approvals had important implications for drug safety.[26 27] Safety warnings and market withdrawals have increased since 1992.

An unintended consequence of government regulations has been a large expansion of the pharmaceutical market. Policies aimed at increasing generic drug use have indirectly contributed to the rise of me-too drugs. Generics now account for a large share of prescriptions, with over $113bn of US sales substituted with generic alternatives between 2010 and 2014.[33] The savings have enabled governments to purchase expensive patented products despite lack of evidence that they are better than older and cheaper alternatives. Indeed, cost reductions achieved by generic use were more than offset by increasing expenditure on branded medications. In Europe, although generics make up almost half of volume sales, they represent less than 20% of value sales.[35]

Industry's disproportionate emphasis on marketing

The industry shares the responsibility for the paucity of clinically superior medicines entering the market. Companies operate in a unique environment shaped by the risky nature of drug discovery; less than a 10th of medicines that enter development receive approval after an average development period of 13.5 years.[36] To minimise risk, industry invests heavily in already established areas and disproportionately emphasises marketing rather than research.

In the short term, companies are under pressure to demonstrate value to their shareholders.[37 38] This encourages research on me-too products, which provide more reliable returns on investment at the potential expense of breakthroughs in other areas. Although multiple drugs may be warranted to allow for individualised, patient centred treatment, the industry's over-reliance on me-too drugs (there are over 15 β blockers and over 30 antidiabetes drugs) cannot always be justified, especially if they do not offer demonstrable benefits to different patient subgroups.

In recent years, several large companies have allocated a disproportionate share of research and development budgets to late stage development of drug candidates.[36 39] These reorganisations led research and development operations away from science driven investigation to process led development (box 2).

High profits in the pharmaceutical sector are not necessarily linked to better products.[47 48] Instead, it is marketing that drives prescriber and patient behaviour and therefore profits.[49] Companies spend almost twice as much on promotion as they do on research and development.[50]

Way forward

Improving the drug development process will require collective, concerted regulatory action to send the correct signals to drug companies. Policy options include identifying priority therapeutic areas and making research in them more economically attractive. This could be through public-private partnerships, advance market commitments, extended marketing exclusivity, or policies to share the risk of financing early stage research. To encourage competition and deter industry-wide consolidation, governments could more closely monitor takeovers.

Finally, pricing and reimbursement policies should reward clinically superior medicines and not me-too drugs.[43] Countries should send a coordinated signal to the industry independently of their differing approaches to regulation. Stricter evidence requirements at the time of market entry and requiring evidence of clinical effectiveness in robust trials would be important first steps.

BOX 2 | HOW MERGERS AND ACQUISITIONS REDUCE INNOVATION

Drug companies are increasingly outsourcing their research and development and creating partnerships to reduce their risks and costs and optimise the clinical trial process.[40] This new business model is focused on identifying, acquiring, and promoting promising medicines created by smaller firms that are often financed by public funds.[36 41]

The pervasive belief that consolidation equates to the development of clinically superior medicines is not backed by theory or evidence.[44] Economic theory suggests that decreasing the number of companies would decrease competition, in turn impeding capacity to develop clinically superior drugs. Cuts in research and development investment after such mergers and acquisitions (fig 2) result in the loss of two essential conditions for breakthroughs: independent research groups (fewer researchers now work in laboratories) and diverse research portfolios.[45] The resulting loss of multiple approaches to the same research question[46] leads to a reduction in the number of breakthrough drugs that reach patients.

Huseyin Naci is assistant professor of health policy, LSE Health, Department of Social Policy, London School of Economics and Political Science

Alexander W Carter is policy fellow, Institute of Global Health Innovation, Imperial College London

Elias Mossialos is professor of health policy, LSE Health

Correspondence to: H Naci h.naci@lse.ac.uk

Cite this as: *BMJ* 2015;351:h5542

PERSONAL VIEW Allen G P Ross

The next global pandemic is imminent

Richer countries should help poorer ones now

The global history of emerging or re-emerging infectious diseases shows that, on average, they have appeared about once a decade since 1940. Recently, however, the time between pandemics has become shorter, as evident from severe acute respiratory syndrome (SARS) in 2003, influenza A H5N1 (bird flu) in 2007, H1N1 (swine flu) in 2009, Middle East respiratory syndrome (MERS) in 2012, and Ebola virus in 2014.[1 2]

The nature of emerging diseases

Emerging infectious diseases are primarily zoonotic (60% of people) and viral, originating in wildlife populations from the tropics (HIV, SARS, Ebola, West Nile virus, Lyme disease).[1-3] In sum, it seems likely that we should expect a viral organism to come from the tropics within the next five years that could potentially cause a global pandemic.

The national health systems of most low and middle income countries would not be able to contain such a viral organism from spilling over and causing a pandemic. The member states of the World Health Organization have agreed to establish international health regulations to support global health security. To meet the core regulations' standards for training—creating the necessary laboratory infrastructure for prompt diagnosis and the technology required for real time reporting of epidemics—poorer countries will need considerably more investment to build capacity in their national health systems.[4 5]

The direct financial cost of the Ebola pandemic was estimated to be close to $6bn, with global economic losses exceeding $15bn

Point of care screening tests for use in the community are increasingly available for rapid diagnosis of emerging pathogens and can shorten the time from presentation to treatment. However, improvements in and more access to diagnostic technologies will need to be supported by the capacity to interpret and act on the findings. Currently, limited healthcare dollars in poorer countries are spent on national tertiary hospitals, and little or nothing is spent on preventive services, disease control, or epidemic preparedness. In reality, these countries see the international regulations as an enormous obligation primarily developed to protect the welfare of developed nations.[6 7]

We should expect a viral organism to come from the tropics within the next five years that could potentially cause a global pandemic

A lack of political will

What can realistically be done, then, to prevent and contain future national epidemics from becoming global pandemics? Building poorer countries' national capacities will take considerable international political will that seems to be lacking at the moment. Instead of allocating huge resources to react to pandemics, funds must be earmarked to prevent them. The direct financial cost of the Ebola pandemic was estimated to be close to $6bn (£3.9bn; €5.6bn), with global economic losses exceeding $15bn.[8]

The World Bank's new Pandemic Emergency Financing Facility does not cover pandemic preparedness or national reconstruction efforts. A total of $1bn is available for all of the 77 poorest countries until June 2017.[9] At the annual World Health Assembly meeting in 2015 the health ministers, who are WHO's decision making body, rejected a proposal by WHO's director general, Margaret Chan, to increase member states' contributions by 5% to prepare for future pandemics.

If funding from WHO and the World Bank can't be used to strengthen national health systems in poorer countries to meet core capabilities required by international regulations, then how can this be achieved?

A multibillion dollar international health system fund has been proposed,[8] but considerable funding from private and public sectors is needed. The G8 group of industrialised nations, the European Union, and philanthropic organisations should contribute. And, ultimately, poorer nations themselves will need to allocate healthcare dollars to epidemic planning and prevention.

For many poorer nations this is not a priority, and they are ill prepared to respond to epidemics on their own soil. Building national capacity is the rate limiting step for global health security. And we must act now if we are to prevent the next global pandemic.

Allen G P Ross is professor, tropical medicine and global health, Griffith University, Gold Coast Campus, Queensland, Australia
a.ross@griffith.edu.au
Cite this as: *BMJ* 2015;351:h6156

ACUTE PERSPECTIVE David Oliver

A fairy tale mandate for the NHS

The health secretary's asks are fantasy

Just after the 2010 UK election, when I was still seconded to the Department of Health, the new English health secretary, Andrew Lansley, came to meet the department's doctors to set out his vision for the NHS. This led to the Health and Social Care Act 2012, now widely regarded as a costly and needless disruption lacking electoral mandate.[1]

Ironically, a different mandate was part of this vision. Lansley stated that the health secretary should have a hands-off relationship with operational management of the NHS, which would no longer be run from Whitehall but through arm's length bodies, notably NHS England. He would simply issue a mandate for the outcomes the service was to achieve and would leave process alone.[2]

Lansley left in 2012, his original vision much altered.[1 3] But the first NHS mandate between the government and NHS England was issued.[4]

The mandate seems more a cosmetic exercise now. Lansley's successor, Jeremy Hunt, has been far from "arm's length," intervening often in the NHS's operations. But the draft mandate for 2016-20 is out for consultation until 23 November.[5] A window into the soul of this government's health team, it prioritises preventing ill health and supporting healthier lives; safety, quality, and seven day services; maintaining both performance and financial balance; making out-of-hospital services more integrated and accessible; and efficiency and productivity.

Few commentators think that the proposed £22bn NHS savings alluded to in the mandate are deliverable. And even deeper social care cuts are bound to hit NHS performance further

These may seem like goals we could all support, although I'd suggest that seven day services need to start with urgent and emergency care before we start pushing the same staff to provide routine and elective work at all hours.

In the past two weeks the chief executives of the think tanks the Nuffield Trust, the Health Foundation, and the King's Fund signed a letter making it clear that the NHS was under serious financial and performance stress and that urgent services would struggle to cope this winter.[6] NHS England's chief executive, Simon Stevens, also called for the proposed additional £8bn (€11.4bn; $12.2bn) to be released early in the parliament before "the rubber hits the road."[7]

Few commentators think that the proposed £22bn NHS savings alluded to in the mandate are deliverable. And even deeper social care cuts are bound to hit NHS performance further.[8] Public health budgets have been cut, making a mockery of the commitment to prevention.[9] Workforce crises affect nursing,[10] general practice,[11] and emergency medicine.[12]

The draft mandate is but a fairy tale. It asks us to deliver safer, better, more integrated services for more days with inadequate funding and staff numbers, and all before the next election. I hope that the consultation receives some robust feedback before it closes on 23 November.

David Oliver is a consultant physician in geriatric and acute medicine, Reading
David.Oliver.1@city.ac.uk
Follow David on Twitter, @mancunianmedic
Cite this as: *BMJ* 2015;351:h6203

OBITUARIES

J Donald Millar

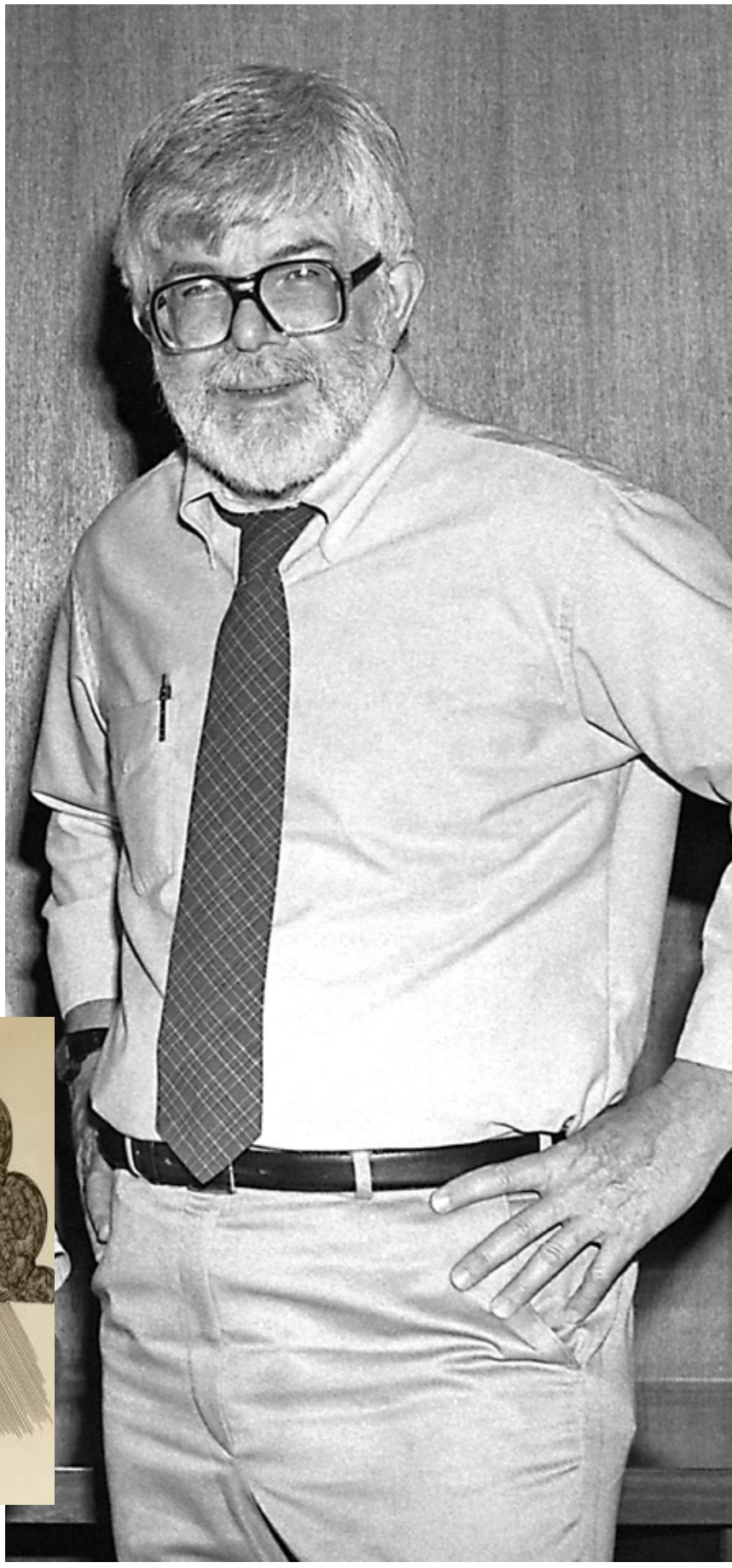
Public health doctor who was crucial to the global eradication of smallpox, and to the improvement of health and safety in the workplace

J Donald Millar (b 1934; q Medical College of Virginia 1959; MD), died on 30 August 2015 from complications after an earlier car crash.

J Donald Millar was born in the US, of Scottish and English stock, in 1934. When barely in his teens, he spotted Joan Phillips playing a fairy godmother in a grammar school operetta; a few months later they were assigned to the same eighth grade classroom. Joan's mother would not let her date for more than a year, until she turned 15. "We dated for nine years before we married," Joan recently told *The BMJ*. "We had to wait until he finished the first two years of medical school." Millar had thought he wanted to be a lawyer, but playing a doctor in a high school production of Thornton Wilder's *Our Town* changed his mind, she related. "Just being in that play he said, I believe I'd rather be a doctor than a lawyer because I would be saving lives and not destroying lives."

With the CDC

In 1961, as a young doctor, Millar joined the uniformed US Public Health Service Commissioned Corps as a way to fulfil his military commitment. He was assigned to the Centers for Disease Control and Prevention (CDC), intending to stay for two years. He stayed for 32 years and advanced to the rank of rear admiral.



"Millar was very data driven; he sat down and looked at the 10 leading causes of disease and injury in the workplace and used those to drive programme activities"

Millar was honoured twice (in 1983 and 1989) with the distinguished service medal, the highest honour of the US Public Health Service

While working on malaria control in Indonesia, Millar saw his first cases of smallpox—something few Western physicians had ever experienced. He became the CDC's resident expert on the disease.

D A Henderson was dispatched to the World Health Organization (WHO) in 1966 to lead the global effort to eradicate smallpox, and Millar, back with the equivalent of a masters' degree in public health from the London School of Hygiene and Tropical Medicine, took over the CDC's smallpox unit. Soon he was organising a massive measles vaccination and smallpox eradication programme in 20 countries across western and central Africa.

The programme hit a milestone of 100 million vaccinations in 1969. The goal was to end smallpox in the region in five years; it did so in three and a half.[1] Millar and his colleagues created a template that has been used over the past few decades in the fight against AIDS and in millennium development programmes.

New approach to occupational health

Millar was asked to take charge of the National Institute for Occupational Safety and Health (NIOSH) in 1981. NIOSH's activities at the time were governed largely by interests of academic researchers and high profile workplace issues, such as exposure to asbestos.

"Millar was very data driven, he sat down and looked at the 10 leading causes of disease and injury in the workplace and used those to drive programme activities," explains Diane Porter, a senior aide to the admiral at the agency.

"Millar brought all of these public health skills—the development of surveillance systems, epidemiology, analysis, response—to a different problem [in the workplace]," says retired CDC director William Foege. "He was able to do this without being overly concerned with the politics. He followed the science and accepted the political heat from that."

Joan acknowledges that her husband "was a character, really, sort of crazy in a way. He had a big bullwhip that he kept in his office. And he would take it and go out in the hall and crack this whip. And everybody would come running out of their offices. He would have a megaphone and say, 'Now hear this.'"

One day he cracked the whip and ordered, "'All secretaries immediately to my office.' They came running out down the hall saying, 'What have we done?'," says Joan. "It was Secretary's Day, and he presented each with a long stemmed rose."

Millar was honoured twice (in 1983 and 1989) with the distinguished service medal, the highest honour of the US Public Health Service. He retired from public service in 1993.

He leaves his wife, Joan, and three children.

Bob Roehr, Washington, DC

Cite this as: *BMJ* 2015;351:h5318

Paul Dyson

Consultant clinical oncologist North Cumbria University Hospital NHS Trust (b 1947; q Newcastle 1980; PhD, MRCP, FRCR), died from recurrent lymphoma on 6 June 2015.

Paul Dyson had been treated for cancer as a young trainee doctor, and his disease recurred twice during his professional life. This had required a pneumonectomy (surgical removal of a lung) for diagnosis and was followed by many months of radical treatment, including bone marrow transplantation and cytotoxic chemotherapy. He brought innumerable advances to patients who were diagnosed with cancer during his 25 years as a consultant clinical oncologist in Carlisle. He leaves his wife, Sandra; their three children; and two children from a previous marriage.

Mike Williams

Cite this as: *BMJ* 2015;351:h5025

Hameed Ullah Khan

General practitioner Loughton Health Centre, Essex (b 1947; q Srinagar Medical College, Kashmir, 1971), died suddenly from myocardial infarction on 9 June 2015.

Hameed Ullah Khan came to England in 1973 and did his GP training in Reading. On 1 February 1977 he joined the practice at Loughton Health Centre, where he continued to work until the day of his death. During his 38 years in the practice he was always considering how the practice could develop for the benefit of patients. Aside from medicine, Hameed loved sport, particularly cricket. He leaves his wife, Pari, and two sons.

Pari Khan, Philip Prashner

Cite this as: *BMJ* 2015;351:h5021

Robert William Nicholson

Former consultant surgeon (b 1948; q Manchester 1971; FRCS, MD), died from glioblastoma on 1 May 2015.

Robert William Nicholson was appointed consultant surgeon at what was then the Blackburn Royal Infirmary in 1987. Although he was initially a general surgeon, his practice changed over the years, so he focused on coloproctology and paediatrics. He loved to teach, and those who benefited are now some of today's consultants. Never one to take politics for the game that it is, he preferred to keep away from committees and positions of power. Nevertheless, he made contributions where he could, taking his turn as clinical director for surgery. He leaves his wife, Lorraine; and three children.

Andrew Evans

Cite this as: *BMJ* 2015;351:h5029

Sylvia Madeleine Watkins

Consultant physician and oncologist Lister Hospital, Stevenage (b 1938; q Oxford/London 1961; DM Oxon, FRCP), d 22 March 2015.

Sylvia Madeleine Watkins was appointed consultant physician at the Lister Hospital in Stevenage in 1973, in acute general medicine. After a reorganisation within the hospital, she took over the care of cancer patients, established an oncology unit, and was involved in founding the Garden Hospice in Letchworth. She was appointed as an examiner at Cambridge University and the Royal College of Physicians. Her work was throughout life underpinned by her strong Roman Catholic faith.

John Watkins

Cite this as: *BMJ* 2015;351:h5031

PLACE OF DEATH

Children's preference as to place of death

The problems raised by Pollock (Analysis, 10 October) about preference and place of death also apply to children. Our systematic review found a lack of evidence for the claim that most parents and children would prefer home as the place of death.

In addition, preferences change over the course of illness, some people delay or do not want to express a preference, and some children die without a location having been consciously chosen.

The proportion of seriously ill children who die at home or who attain a preference for place of death is not a useful outcome measure; neither proportion reflects the provision of quality healthcare or a good death. It may be more important to discuss priorities and options for current and future care with children and families than make a particular choice in uncertain and changing circumstances.

Myra Bluebond-Langner (bluebond@ucl.ac.uk)
Emma Beecham
Bridget Candy
Richard Langner
Louise Jones

Cite this as: *BMJ* 2015;351:h6123

FAECAL TRANSPLANTS

Establishing an NHS faecal transplant programme

Despite the UK's relatively permissive regulatory framework, we encountered considerable obstacles when establishing an NHS faecal transplantation programme (Editorial, 24 October). These included the expense of donor screening, governance issues, infection control implications, and administrative problems.

Such difficulties may result in faecal transplantation not being available to patients who might benefit greatly. Regional networks could be one solution, with a "hub" centre to coordinate donors and transplant preparation and "spoke" centres that have agreed protocols with the hub centre on delivery.

The exact mechanisms by which faecal transplantation works remain unclear. Because it treats *Clostridium difficile* infection so effectively in most cases, analysis of the few donors whose stool does not induce remission may be particularly useful. Researchers therefore need access to donors for sample analysis and robust clinical records of faecal transplantation outcomes for each donor; this should be borne in mind as "stool banks" become established.

Benjamin H Mullish (b.mullish@imperial.ac.uk)
Horace R T Williams

Cite this as: *BMJ* 2015;351:h6043

LETTER OF THE WEEK

England must debate opt-out organ donation

Sharif (Personal View, 24 October) warns that introducing an opt-out system for organ donation will not be a panacea. But supporters have never claimed that it will be.

Opt-out systems are associated with increased organ donation. In the UK in 2014 the deceased donor rate was 20.6 per million of the population, compared with 35.7 in Spain, 35.1 in Croatia, 27.3 in Portugal, and 26.9 in Belgium, which all have opt-out systems.

We need to harness public support for both organ donation and changing to an opt-out system to dispel the current apathy in which only around three in 10 people are on the organ donor register.

The Organ Donation Taskforce recommended against introducing an opt-out system in the UK seven years ago. The target of increasing organ donation by 50% by 2013 was met, but there is still a yawning chasm between the number of people on the waiting list and the number of donors. In 2014-15 the number of people waiting for a donor heart increased by 8%, but the number of heart transplantations decreased by 9%.

Wales introduces an opt-out system on 1 December. It is encouraging to see Scotland and Northern Ireland now starting the debate. It's time for England to join them.

Mike Hobday (hobdaym@bhf.org.uk)

Cite this as: *BMJ* 2015;351:h6140

Clarifying treatment of *Clostridium difficile*

Spector and Knight (Editorial, 24 October) state that metronidazole or vancomycin is the standard treatment for *C difficile*, with or without bowel lavage or probiotics, but do not mention fidaxomicin, which is non-inferior to vancomycin and prevents recurrence more effectively. Multinational guidelines limit colonic lavage to a few clinical scenarios, and evidence to support the use of probiotics in *C difficile* infection is insufficient.

Spector and Knight state that faecal transplantation is used in the whole spectrum of *C difficile* infection, but the systematic review cited identified only seven patients who received it as initial treatment. It was mainly performed in patients with recurrent infection and is endorsed only for that indication.

Damian P Mawer (damian.mawer@nhs.net)
Mark H Wilcox

Cite this as: *BMJ* 2015;351:h6130

Authors' reply

Mawer and Wilcox point out that newer antibiotics may be superior to vancomycin for treating recurrent *Clostridium difficile* infection. However, the gulf in efficacy between these treatments and faecal transplantation is so large that transplantation will remain the treatment of choice, especially when it is much cheaper and does not risk further antibiotic related problems and drug resistance.

Tim Spector (tim.spector@kcl.ac.uk)
Rob Knight

Cite this as: *BMJ* 2015;351:h6132

REDESIGNED PRINT *BMJ*

Low priority given to original research

Is it time that *The BMJ* stopped pretending to publish a print academic journal (Editor's Choice, 24 October)? Your preference for magazine style controversy over research content was clear in the new look "clinical research" print edition of 24 October 2015. Six pages were devoted to NHS contractual issues, whereas there were only three original research articles, all abridged. More space was given to a report documenting the difficulties in accessing material for research. Without an electronic device to hand, I think I understand how the authors might have felt.

John Savill (john.savill@headoffice.mrc.ac.uk)

Cite this as: *BMJ* 2015;351:h6126