LETTERS

We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

BRENT WALKER/FOTOLIA

PAYMENT FOR TREATMENT ADHERENCE

Incentives help vulnerable patients to stay well

In the head to head debate, Shaw says that to pay patients to take medication would create perverse incentives, but in her discussion she dismisses a particularly complex group of patients, with tuberculosis, despite the public health issues involved.[1 2] This is a group of patients for whom payment, or other forms of incentive, are of critical importance, at both the individual and the public health level. For these patients, health is very low on their list of priorities—they tend to be those suffering from social exclusion, often with histories of offending, substance abuse, mental health problems, and homelessness. They require the most complex care and are least likely to complete treatment, particularly when the course of treatment is lengthy.[3]

It is common practice in tuberculosis teams to carry out a standard risk assessment with each patient and to offer incentives to those who would be at high risk of non-completion of treatment. Shaw asserts that even in the case of infectious tuberculosis, the disadvantages of financial incentives outweigh the benefits. However, the reasons she cites for non-compliance with TB medication do not correspond to the attitudes that we find in our high risk patients, for whom the daily business of finding a place to sleep, eat, inject, or sell their bodies comes well before whether to take their medication. Different teams vary in the types of incentive they will offer these patients, and although research shows that money is the incentive proved to be most effective for adherence,[4] other interventions, such as social support, free meals, bus passes, and food tokens, are effective. Unlike in New York, where direct payments of $10.00 are made, financial incentives are not permitted in the NHS. However, through the use of social care incentives, completion rates for TB treatment in this at-risk group of patients are far better than would otherwise be the case.[5]

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Competing interests: None declared.

1 Burns T. Is it acceptable for people to be paid to adhere to medication? Yes. *BMJ* 2007;335:232. (4 August.)
2 Shaw J. Is it acceptable for people to be paid to adhere to medication? No. *BMJ* 2007;335:233. (4 August.)
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4 Volmink J, Garner P. Systematic review of randomized controlled trials of strategies to promote adherence to tuberculosis treatment. *BMJ* 1997;315:1403-6.
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Drug misusers are likely to abuse the system

I am a forensic physician working in the east end of Glasgow, and I write with reference to the debate by Burns and Shaw.[1 2] A high percentage of detainees are on opiate substitution programmes. From my own personal observations, nearly all are using "top-up" heroin.

Additionally, alcohol consumption while receiving methadone treatment is high. It is obvious that a £2 shopping voucher could easily be diverted into paying for two litres of cider to fund a dual addiction.

I also find it ridiculous in a cash strapped NHS service, where we are unable to fund life saving or life extending medications, we are able to pay addicts to "comply" with a treatment that offers no treatment benefit other than to "reduce harm."

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Competing interests: None declared.

1 Burns T. Is it acceptable for people to be paid to adhere to medication? Yes. *BMJ* 2007;335:232. (4 August.)
2 Shaw J. Is it acceptable for people to be paid to adhere to medication? No. *BMJ* 2007;335:233. (4 August.)

RISE OF THE DOCTOR-MANAGER

Management skills need to be systematically learnt

I share Nicholson's belief that NHS organisations will have an improved chance of dealing successfully with the complex challenges they face if led by people who have substantial personal experience of providing clinical care to patients.[1]

However, management skills are not necessarily intuitive. Currently, too many clinicians with management roles rely on innate instinct and gut feeling, honed by variable experience on the job, when dealing with issues and situations that require more than this. Those clinicians who really wish to provide high quality leadership to NHS organisations need to become more familiar with the existing body of management evidence and theory at both operational and strategic levels.

Having been directly involved with healthcare management for the last dozen years, in the United Kingdom and United States, my experience has been that, until becoming formally acquainted with current management thinking by undertaking an MSc in strategic management, my approach was based largely on a set of well intentioned, but vaguely random, principles. Learning systematically from current academic thought in areas such as negotiation, innovation, leadership, marketing, strategic development, and financial management has provided a rigorous and robust platform on which to think and operate.

There are no shortcuts to successful leadership in NHS organisations, as the Gerry Robinson experience showed when the business guru tried to cut waiting lists at an NHS hospital for a recent TV programme. Clearly, not all potential clinician managers need to study management theory to degree level, but by carefully selecting developmental opportunities that make use of the large body of management thinking and evidence currently available, and by targeting these at those clinicians who have the desire to contribute in this way, skilful, clinically experienced and patient focused

leadership could realistically be given the driving seat at the top table of NHS organisations very soon.

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Competing interests: None declared.

1 Day M. The rise of the doctor-manager. *BMJ* 2007;335:230-1. (4 August.)

ABCD OF DIGNIFYING CARE

We need imaginative approaches to training

Chochinov's framework may help health professionals to provide more compassionate and respectful care for our patients.[1] However, great ideas alone don't always lead to better practice, even when supported by training and re-training.

We are all taught good practices as students but usually conform with the habits of colleagues and bosses once we enter the "real world" of work. Unfortunately bad habits contribute to the culture of our parent organisations and are engrained and very hard to change. Replacing a bad culture with a better one requires will, leadership, and good strategic planning, but, as is often said in business circles, "culture eats strategy for breakfast."[2]

So how might we persuade people to adopt new and better habits? An interesting approach is suggested by Fred Lee in his book, *If Disney Ran Your Hospital*.[3] He explains how exercises in imagination are crucially important components of staff training at Disney (world leaders in customer satisfaction). Lee adapted Disney's technique to training healthcare workers. He reports the case of a surly radiology department receptionist with bad interpersonal skills. Lee persuaded her to imagine that a patient was not a stranger but instead was her favourite aunt. The receptionist's behaviour became far more compassionate and caring and—most importantly—the changes persisted. Lee's book abounds with similar examples and he explains why these methods beat many traditional approaches to staff motivation and training.

Chochinov has described a better world, but real work is needed to get us there. New habits will overcome bad cultures only if better ways of learning are accepted.

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Competing interests: None declared.

1 Chochinov HM. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *BMJ* 2007;335:184-7. (28 July.)
2 McCracken J. "Way forward" requires culture shift at Ford. *Wall Street J* 2006; 23 January.
3 Lee, F. *If Disney ran your hospital: 9½ things you would do differently*. Bozeman MT: Second River Healthcare Press. 2004.

MEDICINES FUNDINGE

Value for money is nothing new

Pursuing value for money in medicines funding is neither tough nor new.[1]

PHARMAC (New Zealand's funder) has focused strongly on it for 14 years. We are mindful of funding trade-offs through explicit use of a fixed budget—a desirable and powerful incentive to ensure that value for money remains paramount.[2]

PHARMAC has used the tools referred to by Jack for several years, including reference pricing, tendering, rebates, and risk sharing arrangements.[3 4] Built around a strong core of independent clinical[5] and economic assessment, the strategies have successfully improved value for money, freeing up resources for funding of other medicines or health services.

The idea of an individual refund for ineffective treatments is interesting, but one PHARMAC hasn't implemented because of definitional and monitoring concerns. The mechanism is an attempt to deal with a fundamental mismatch between pricing and value (health outcomes) to populations—an issue that can generally be more cost effectively managed in other ways.

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Competing interests: None declared.

1 Jack A. No cure, no cost. *BMJ* 2007;335:122-3. (21 July.)
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4 Davies A, Metcalfe S, Moodie P, McNee W. PHARMAC responds to Stewart Mann on dihydropyridine calcium channel antagonists. *N Z Med J* 2005;118:U1621.
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UVULA ANGIO-OEDEMA

ENT form of Saturday night palsy

Davidson et al present a case of uvula angio-oedema associated with the recreational drug ecstasy.[1] Referrals of patients to our ENT unit in Scotland with isolated uvula angio-oedema are not uncommon. However, on occasion the aetiology seems to differ from the causative factors which the authors discuss.

Many of these patients give a history of alcohol ingestion and heavy snoring thereafter (often corroborated by their partner). Most quickly settle with no intervention and do not receive steroids or antihistamines. It has been postulated that the snoring itself is responsible, worsened by the sedative and desensitising effects of the alcohol, and relative dehydration. The anaesthesia literature includes reports of uvula oedema after deep sedation and heavy snoring.

Clearly it is important to consider the other aetiologies that the authors discuss, and in severe cases follow the management plan that their case necessitated. Quincke's oedema is an important differential diagnosis.

However, we write to highlight a subgroup of patients who may simply be manifesting a relatively innocuous ENT equivalent of the "Saturday night palsy" and will settle with reassurance, oral rehydration, and no further intervention.

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Competing interests: None declared.

1 Davidson JA, Patel SB, Emin A, Bennett AMD. Minerva *BMJ* 2007; 335:216. (28 July.)

THE PROFESSION'S FUTURE

Is the *BMJ* fit for purpose?

Where is the evidence for Jones's statement that the Shipman, Bristol, and Alder Hey inquiries, and a litany of errors, shook the foundations of public trust and professional confidence?[1] My attempts to elicit such evidence from him have so far been unsuccessful. I am aware, however, of a MORI poll that suggested that confidence in the medical profession had not been dented.[2]

In this evidence based age, the journal's editor should ensure that her editorialists provide evidence for their assertions. False premises make for unreliable conclusions.

One basis for stating that Shipman has dented patient confidence is that the government wants it to be so, because this serves to promote the wasteful non-starter called revalidation.

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Competing interests: ORD has received a warning from the GMC and therefore is considered fit to practise.

1 Jones R. The future of the medical profession. *BMJ* 2007;335:53. (14 July.)
2 Medical scandals leave trust in doctors unshaken. http://society.guardian.co.uk/nhsperformance/story/0,487612,00.html