Letters

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Why are doctors so unhappy?

Calibre of people recruited to medicine may be too high for the job

Editor—As an economist who has spent the past 30 years looking at health care all round the world, may I suggest that frustration and perhaps boredom play a part in the anger of doctors and contribute to their unhappiness, as described by Smith in his editorial?[1] This is aside from what I accept are genuine conflicts between levels of public funding and clinical aspirations to help patients. Looking at other professions, I note that people advance through their careers, their work changes, and they build teams and grow their businesses. Some stay in single practice, but many move into management, with changes periodically in their working life.

Similarly, economists like me have a wide range of research and travel as part of our work, and we manage teams on a diversity of projects. I have no idea what I will be doing in September this year, but I am confident that it will be interesting. Contrast these professional lives with those of doctors. General practitioners may have opportunities to develop their management skills but in an environment where the management structures and self employed status of colleagues make this far from easy. And someone has to see the patients each week. Consultants have more of the variety and team building mentioned, but, again, their work plans look very much the same—year in, year out—to the outsider. This leads me to my conclusion.

Might the calibre of people recruited to medicine be too high for the job, not necessarily for the technical elements but for the pattern of work once general practitioner or consultant status is reached? Is a degree of frustration inevitable given doctors' abilities and the relative consistency of the job beyond the age of 30 or 35? Are many years of clinical practice consistent with the job enrichment that able people may want as their career develops?

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

Lack of leadership may be a contributory cause

Editor—Smith in his editorial asks why doctors are so unhappy.[1] He does not mention lack of leadership as a possible explanation. Within the NHS, doctors look for leadership from the chief medical officer working in conjunction with the chief executive under the overall lead of the secretary of state for health. Perhaps particularly in Liverpool—but we suspect elsewhere as well—there is a widespread feeling of dismay that our apparent leaders have allowed themselves to be carried along on a tide of emotional criticism of the profession.

Sixteen Liverpool doctors have been referred to the General Medical Council by the secretary of state himself as a result of the Redfern report into retention of organs removed at postmortem examination at Alder Hey Hospital.[2] Such was the haste to refer them that, apparently, at least one person who is not on the medical register was included. Our NHS leaders have also expressed shock that any tissue is retained as part of a postmortem examination, whereas any doctor trained in the United Kingdom (and, we suspect, any doctor trained in the West) knows that some retention of tissue has been a routine aspect of postmortem examinations. This has exacerbated the public reaction to what has been an extreme variation on postmortem practice that we do not condone.

Any successful organisation, from a multinational company to an army, needs leadership that is capable of inspiring its staff. That is not achieved by public pillory of highly respected clinicians. To many in the medical profession, the NHS seems currently to be drifting rudderless and is in urgent need of inspirational leadership focused on delivery of good quality health care and less driven by political imperative.

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None of the authors is among the 16 referred to the GMC.

1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)
2 Department of Health. *The Royal Liverpool children's inquiry report.* London: Stationery Office, 2001.

Reducing working hours might help

Editor—I find myself surrounded by apparently unhappy doctors whose feelings on the whole I do not share.[1] Sure, I'm worn out from working too hard (having four children at home does not help), but what's new about that?

As doctors we (especially in general practice) have far more control over our working lives than nearly every other occupation I can think of. We have a job for life (an increasingly rare commodity these days) and can switch jobs within the profession comparatively easily from or into clinical practice with a bit of extra training. The constant flow between general practice and public health illustrates this well.

Despite Shipman, butcher gynaecologists, and Alder Hey, we still enjoy high status in society, though not as unquestioned as before. We have to recognise that we are providing a service, like any other, and that 90% of our patients are grateful for our dedication and caring. Patients do not like to see rude or arrogant doctors, of whom there

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are still a fair number (we can all name some, and so can our patients). Patients also do not need overcaring doctors who burn out after 10 years complaining about how their talents are unrecognised and their patients ungrateful.

Doctors need to be balanced, open, and adaptable to change. These traits can be acquired. Perhaps the unhappiest doctors should consider reducing their hours, going without two foreign holidays a year, and maybe sending their children to the usually perfectly good local state school? What about taking a sabbatical? (The government will have to cope with any shortfall in doctors' hours.)

You can enjoy medicine if you focus on the things that really matter in your life. The government is indeed messing us about—but hasn't it always? Threatening to resign is not going to improve our standing in society or make us feel any better about ourselves.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

Are we unhappy?

Editor—Smith claims in his editorial that doctors are unhappy.[1] He does not offer any significant evidence to support this. He then tries to work out why they are unhappy. It would seem unlikely that such an endeavour could prove fruitful, given the lack of time spent on defining the research question or hypotheses.

Is there any evidence that doctors are more unhappy than they were? If so, when did this slide start? If there is evidence that they are more unhappy, are they more unhappy than other public sector workers? Is the level of unhappiness global or is it different for different specialties, different age groups, and the two sexes? Is there any evidence that the levels of unhappiness are associated with policy changes, pay changes, media events, or more global societal changes? Are today's doctors really grappling with different sets of challenges than their predecessors, or have society, medical science, and medical teaching always been in a state of flux that pushes doctors to the limits? Is there really any significant difference in the challenge or does the difference lie in the expectations of doctors?

Surely these are the types of questions that need to be asked and answered with research before we start hypothesising about causal links and what needs to be done about it all?

A quantitative paradigm is implied from the above but qualitative methods may be initially more appropriate.

Of course, there are lots of ways of doing it, but the central point remains. We forget basic scientific principles at our peril. Politicians used to take a few soundings and call it policy. They were rightly criticised for this. The scientific method aims to improve on this. An opinion piece is what I expect to read in *BMA News*, or perhaps in the Education and debate section of the *BMJ*, but not as an editorial in a scientific journal. Am I the only one?

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

It's not all doom and gloom

Editor—I feel privileged to be able to practise medicine.[1] I enjoy my work, which is more than can be said for a large proportion of the population. Through my training I have acquired experience and skills which have enabled me to travel and help those in need. There is nothing more rewarding than treating a sick baby or comforting a family of a dying patient, or more exciting than rescuing a patient from the brink of death.

I have worked in the United Kingdom and New Zealand, and the press is equally ruthless towards the medical profession in both countries. It can be disheartening to have every mistake blazed across the newspapers without a word of all the successes. I guess it is something the profession has to go through until it becomes more open about its fallibility and the public realises that medicine does not have all the answers. The pace of change in the United Kingdom is daunting and unmanageable. A plethora of clinical guidelines, frameworks, and targets to meet is too much when doctors are expected to continue their day to day clinical work.

As much as I enjoy my work, I find myself utterly exhausted with the long hours, the extra management time, the lack of support from senior colleagues, and the battering by the press and politicians. The impact of my work on family life is too often unacceptable.

I concentrate on the positive aspects of my work, which keeps me going, but there is a lot of room for improvement.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

Workload has increased dramatically

Editor—In response to Smith's editorial about unhappy doctors I will describe how workload has increased.[1]

I have now been in my singlehanded general practice for some 14 years. I have roughly the same number of patients with the same range of acute problems, but the energy expended in servicing a practice of this size has increased dramatically. Why? I have no doubt that a little more intrusive administration may be a small factor, but I think that the main factor is an inevitable consequence of the advancement of scientific knowledge and the clinical applications arising therefrom.

Which of us knew much about cholesterol and triglycerides 30 years ago? Now we have a population who know their cholesterol number and television advertisements talking about the low density lipoprotein fraction.

What happened in 1970 when patients presented with angina? They were given glyceryl trinitrate tablets. A few years later they would probably have been given propanolol. A few years later still and atenolol had largely replaced propanolol together with a calcium antagonist. By 1985-90 selected patients would have been referred for an intervention procedure—now much more commonplace.

The result is more letters backwards and forwards to hospital, more blood checks to be done, more repeat prescriptions. This chronic and preventive management has added a second tier to the original job of responding to acute events.

Result—more person hours necessary to service a static population.

Solution—more doctors or more health workers to accomplish this.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

General practitioners need to negotiate new contract

Editor—The demands and stresses of our current way of working in general practice have now become intolerable for most doctors.[1] I am aware from my roles in the local medical committee and the General Medical Council that exhaustion and poor morale are having a deleterious effect on the quality of care we give to our patients. To put it bluntly, the present situation is becoming increasingly unsafe for both doctors and patients alike.

We have mortgages, overdrafts, and offspring to finance so I appreciate many family doctors will experience income separation anxiety at the thought of resigning from the NHS. The reality is that the NHS is desperately short of family doctors, and becoming ever shorter as more and more of us retire early, work part time, or take extended stress related sick leave.

This puts us in a very strong position. We are needed, and the NHS cannot survive without us.

Dentists have successfully cut the umbilical cord between themselves and the NHS, but this has left much of the population without access to affordable dental care. Most doctors, I suspect, would not be happy with such an outcome of any action we might take.

Organising ourselves into geographically based units from which health authorities and primary care organisations could purchase our services would be eminently feasible. With the help of the BMA we could negotiate contracts which clearly define our workload and responsibilities and ensure appropriate remuneration. This would leave us self employed and masters of our own destinies. We have organised ourselves well

to provide care outside working hours so why not during working hours as well?

Another possibility is that future changes to service provision outside working hours as a result of increased involvement of NHS Direct could mean that out of hours general practice cooperatives might consider redefining their role to include provision during working hours as well.

I hope that none of this will be necessary as the government will respond to our genuine and urgent concerns by speedily negotiating a new contract. If, however, the government is foolish enough not to recognise our united anger and determination on this issue, we need to have a plan in place to enable us to provide a safe and satisfactory level of care for the population while remaining in good health ourselves and paying off the mortgage.

We and our patients deserve nothing less.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

Consultant based service is needed

Editor—Smith's editorial is timely.[1] Many doctors in the United Kingdom must have moved from the happy to unhappy category of his survey over the past few years. Except we don't move: we are edged towards this state of poor morale.

I do not think that remuneration is the primary issue: the inadequate support for doctors is inexorably eroding their ability to provide an adequate service. There is a failure of will on the part of the Department of Health to support the establishment of a consultant based service. The pressure is on consultants to deliver all aspects of the service as never before. A pressure not discussed in Smith's article is the impact on consultants of the reduction in junior doctors' hours and the Calman reforms on higher medical training.

In my department (geriatric medicine) we have seven consultants. Over the past six years we have lost one out of three registrars to another trust, as well as the equivalent of a senior house officer to the medical take rota. We have gained a staff grade doctor and a junior house officer, who of course needs supervision. Our trust and indeed many trusts seem to take the view that the appointment of numerous staff grade doctors is an adequate solution to the problem of providing a service. Without wishing to offend any staff grade doctors who might read this, I say it is not. A staff grade doctor cannot and should not be expected to carry the continuing medical, ethical, and legal responsibility for patients.

Lack of funding is an issue. The national service framework for older people does not seem to say much that is new. Also, note that unlike the national service framework for cardiology, there is no new money for the required improvements in stroke care.

Senior house officers have also commented on their concerns about career prospects, and I think that they are right to be concerned. At the moment, highly committed sixth formers still apply to read medicine. But for how long?

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

Medical profession must unite to address problems

Editor—In his editorial on why doctors are so unhappy Smith makes the important point that public belief in the ability of medicine to address social problems fuels expectations which cannot be met.[1] Ultimately this disillusions patients and increases the stress of doctors.

While agreeing, I suggest that it is not just doctors' inability to influence social factors that is stressful but their inability to control the deficiencies in their working environment and its impact on their relationships with medical colleagues.

One of the worst sequelae of this, not mentioned by Smith, is the way that this has set primary care against secondary care. I imagine there have always been scuffles along the primary-secondary care interface, but ever increasing demand in the face of inadequate resources has heightened this beyond measure.

How many general practitioners do not feel some resentment at their colleagues in secondary care for dumping work traditionally undertaken in hospitals on their doorstep without an accompanying shift in resources? How many hospital doctors feel that their colleagues in primary care set their threshold for referral too low? How often do we doctors end up fighting against each other in the battle for those limited additional resources that the government sends our way?

If these internecine difficulties are largely symptomatic of inadequate resources, and the effectivenes of successive governments' divide and rule policies, perhaps we should now accept that resources will never be enough and decide as a profession how to manage within these inadequacies.

This will require the profession to become more united than it currently is and leaders within the profession will have to be conciliatory to the needs of colleagues who work on the other side of the primary-secondary care divide. Unless this can be achieved I do not believe that the question of doctors' happiness at work will ever be resolved.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

Unhappiness will be defeated when doctors accept full social responsibility

Editor—Extending a process started by Margaret Thatcher in 1990, Milburn is developing an industrialised, consumer led NHS. Bureaucracy marches on: as a proportion of spending on health care, administrative costs have doubled from about 6% before the 1990 reform to about 12% now—still behind the United States at about 25%, but we're on course for that target.

Milburn is driven by a vision of the NHS as an industry producing clinical interventions as discrete commodities, episodically consumed by patients. Innovation will depend on subsidised corporate investors. Motives for this electorally unpopular strategy have been explained by Price et al.[1] New Labour's devotion to creeping privatisation of the NHS starts from its apostasy to neoliberal economics and commitment to the general agreement on tariffs, trade, and services, opening all public services to global competition and investment.

The NHS is being parcelled into commodity units, dividing staff from patients and impeding effective care. No market will ever shift corporate investment from where it is most profitable to where it is most needed. Investors will take the profits while the NHS, staff, and patients will take the risks of downsizing and eventual system failure.

If the NHS did not have to provide the most difficult services for the most difficult people, we could just let them pile up in hospital emergency rooms. We could concentrate on high quality care for high quality people, with heroic salvage for the rest. But, according to opinion polls in the *Guardian* on 20 and 21 March, a substantial majority even of Conservative voters still believes in a socialised NHS based on neighbourhoods and devils they know, not on shopping around between competing providers. The industrial model violates continuity, solidarity, and locality, which make work satisfying, and promotes mistrust and £2.6bn of litigation. Like patients, most doctors are loyal to the founding principles of the NHS, but also like patients, their hopes diminish that these principles will be upheld by any party in office. Industrialisers depend on this shared hopelessness.[2]

Smith suggests an honest contract between doctors and patients as equal coproducers.[3] This could indeed provide a material foundation for post-industrial production of socially useful values, beyond, outside, and eventually alternative to either commodity trade for profit, or state paternalism.[4] Clinical medicine is potentially more effective than ever.[5] Affordable delivery depends on continuity, social solidarity, and locality, impeding trade in care as a commodity, but meeting fundamental human needs.[6] Health professionals could understand this better than career politicians, once they see who their real friends and enemies are. Over the past 50

years the *BMJ* has become an increasingly effective dissident press, seeing and saying that the emperors have no clothes. When we dare to accept the full social responsibilities that governments are seeking to evade, we shall gain the initiative and defeat our unhappiness.

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1 Price D, Pollock AM, Shaoul J. How the World Trade Organisation is shaping domestic policies in health care. *Lancet* 1999;354:1889-92.
2 Bosanquet N, Pollard S. *Ready for treatment: popular expectations and the future of health care*. London: Social Market Foundation, 1997:98-103.
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4 Hart JT. Two paths for medical practice. *Lancet* 1992;340:772-5.
5 Bunker J. The role of medical care in contributing to health improvements within societies. *Int J Epidemiol* (in press).
6 Hart JT. Closing gaps between theory and practice, and uselessness of pie charts. *Int J Epidemiol* (in press).

Analysis is timely but blinkered

Editor—Smith's analysis of why doctors are so unhappy is timely but too blinkered.[1] Doctors' despair is not only rooted in an unrealistic relationship with patients and their inordinate demands. The causes lie within social factors that operate globally and have destroyed a contract of goodwill between doctors and the government. After the second world war a generation of doctors accepted the welfare settlement and felt a pride in a service that offered high class medical care to anyone regardless of social status. The comparatively lower salaries mattered less because doctors enjoyed autonomy and esteem. The deal was to accept relative professional failure but enjoy greater freedom from bureaucracy; now doctors are bound by auditors, controllers, and modernisers.

The single doctor dealing with all the problems of the patient, working with minimal equipment, and reliant on his or her personality for comfort has given way to a structure where doctors work in teams underpinned by massive investment in drugs, buildings, and investigative equipment of all sorts. When patients go to the doctor now, they expect their conditions to be investigated and to gain access to the full resources of scientific medicine. The doctor has changed from an authority into a gatekeeper, the patient from a dependant into a consumer. Every doctor who sees a patient commands thousands of pounds of expenditure and every system of medical care has taken steps to regulate costs and bring doctors to heel, a process facilitated by the ease and relative cheapness of modern computers. No longer are the doctor and the NHS perceived as a dependable and caring mother.[2]

These mutually frustrating interactions between patient, doctor, and manager have had more of a dramatic impact in the United Kingdom because the underfunding of the NHS has made dissatisfaction by all visible, newsworthy, and highly political. When the Blair government was driven to announce an increase in funding to bring expenditure up to levels of the European Union he blamed the shortfalls in medical care on the conservatism of the doctors alone. This message triggered a new slump in doctor morale because the need for appreciation was met by contempt and misunderstanding; it reinforced the feeling that doctors live under an occupying power where resistance and survival have become the prime preoccupation. It is time to get back to more honest and less patronising forms of exchange. It is time to get away from the myth that yet another restructuring will usher in the dawn of the perfect NHS. More time and stability are essential now—just as patients need recovery time and support, so do their doctors. If doctors feel like hamsters in a ball, the time has come to let them out rather than increase the rate of spin.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)
2 Wilke G. *How to be a good enough GP: surviving and thriving in the new primary care organisations*. Abingdon: Radcliffe Medical Press, 2001.

Exit from eternal triangle of perpetrator-victim-caretaker is needed

Editor—We live in a world where the victim culture predominates. How you are today is seen as the result of someone else's actions. These actions are not intended to help you and probably are an attack on you. You may well be due compensation for your suffering. As part of this culture doctors also see themselves as victims.[1]

A macabre dance is going on in which doctors, patients, regulators, and politicians move round a triangle freely swapping between the roles of perpetrator, victim, and caretaker and often having all three roles at once. So, for example, a politician acting as caretaker for a victim patient may perpetrate an attack on a doctor by calling for the doctor to be struck off. The doctor who perpetrated negligence is now a victim. The politician may be surprised to find himself or herself a victim being attacked for his or her motives in caring for the patient. The victim patient may use the complaint to perpetrate an attack on the doctor and may find himself or herself having to act as caretaker for the politician's actions.

There is a way out of this triangle for doctors, patients, regulators, and politicians. All parties need to realise that their perceptions of the world are at best partial and that if they understood both themselves and each other more they would criticise each other less and accept each other more.

As doctors, we are at present victims of our misperception of the world. If we want enjoyable lives at work we will have to examine our assumptions and prejudices closely. This will be painful: it is so much easier to say our misery is someone else's fault.

Have we the courage to rediscover our own happiness?

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

Doctors have only themselves to blame

Editor—Doctors are unhappy for a myriad of reasons, many of which have been highlighted by Smith.[1] However, we doctors have nobody to blame but ourselves. We may be intelligent but we are neither shrewd nor courageous. For far too long we have let our destiny be determined by others—namely, politicians, bureaucrats, lawyers, journalists, and, oh, I nearly forgot, the public. We kowtow when pressurised from all of the above and seem oblivious to the machinations of politicians, who stealthily move the goalposts sufficiently frequently to achieve their aims.

To turn the tide we should seize control of our working lives. Tearing up all contracts would be a good start. However, I doubt this will ever happen because, let's face it, we are an ineffective, inadequate bunch and both depression and disillusionment are our default mood states.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322: 1073-4. (5 May.)

Doctor support groups can be a lifeline

Editor—Some of the rapid responses to Smith's editorial are judgmental, righteous, and lacking in compassion.[1–3] It is sad to read about the attitude of doctors towards their unhappy fellows—for example, if you're unhappy you must be a lousy doctor, a whiner, bored, so get out.

The lack of compassion so many doctors show towards one another, the competitiveness and paranoia many doctors feel towards one another, is part of the reason many doctors are unhappy. I have facilitated weekly or biweekly doctor support groups in New Hampshire for 18 years and worked with eight such groups over that time. One participant commented that when he came into medicine he expected no support from fellow doctors as he saw them as being aloof and cynical. Consequently, he was not proud to be a doctor and kept his distance. His experience in the support group showed him how to appreciate fellow doctors as compassionate and sensitive, and he consequently felt more pride and security in his role and enjoyed most of his colleagues.

Although these groups are termed physician support groups, the title is superficial since it could imply that the groups are for impaired doctors needing support. In fact, they are for doctors under normal

stress, coping with normal family issues, difficult colleagues and patients, and a sick and impersonal medical system. Such a group provides profound emotional and spiritual support, but additionally could be called a consciousness raising group, an interpersonal skills group, or a physician empowerment group. It is not group therapy, but a successful group is very therapeutic.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322:1073-4. (5 May.)
2 Electronic responses. Survey: Why are doctors so unhappy? bmj.com/cgi/content/short/322/7294/DC2; accessed 23 May.
3 Electronic responses. Why are doctors so unhappy? bmj.com/cgi/content/full/322/7294/1073#responses; accessed 23 May.

Healing and happiness go together

EDITOR—I particularly like the final paragraph and box in Smith's editorial.[1] In my specialty we had first to discover then to accept many of these points. Facing constantly changing reality within a system seems to be a necessary part of growing up—for doctors, nurses, and other professional colleagues, as well as patients, their carers, the government, and the media. I support Smith's view that honesty is the key to making all this less uncomfortable.

Whatever the circumstances, anxiety, bewilderment, doubt, and especially anger characterise resistance to change. They also form the emotional component of an immature response to the threat of some kind of loss. I mean no criticism in using the word immature here. It is simply that the natural process of psychological healing has not yet fully begun to ripen. When it does—with increasing acceptance of the new situation—sorrow is more likely, and this is the more common prelude to renewed happiness, calm, and contentment than those other painful feelings.

This is the essence of grieving, the purpose of which is not to hold on but to let go. The good news is that the process of emotional transition is the route not only to a new equilibrium but also to a more durable equanimity—that is, to permanent personal growth.

Many doctors know all this, but I think that it is something that bears almost endless repetition until the penny drops for everyone. In other words, it is a lesson for doctors not only to learn but to teach.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322:1073-4. (5 May.)

Doctors have conceded their autonomy

EDITOR—As both the results and the design of the survey attached to Smith's editorial clearly show, doctors are unhappy because they have come to believe that their unhappiness is caused by external and uncontrollable forces.[1] In accepting this view doctors have lost the joy that comes from working as a professional, replacing independence and professionalism with the headaches and discontents of being a middle manager. This change is indeed voluntary.

I recently gave a talk about cardiopulmonary resuscitation to surgical residents. "Do we have to ask the patient's permission in order not to perform cardiopulmonary resuscitation?" they asked, seeming distressed at the possibility of having to make a considered and potentially ethical decision themselves, freed from some complex but unwritten set of rules.

My answer to them, somewhat of a surprise to me at the time, can be applied to many areas of doctors' helplessness and angst: "You don't 'have' to do anything. You're a professional. You must make a considered decision, be willing to defend it, and accept responsibility for your actions."

Therein lies the easily overlooked pleasures and joy of medicine.

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1 Smith R. Why are doctors so unhappy? *BMJ* 2001;322:1073-4. (5 May.)

Making mistakes

EDITOR—My intermittent unhappiness[1] is grounded in my inability to come to terms with the fact that I make mistakes, a condition unfortunately shared by my patients, my administrators, and my family.

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Summary of rapid responses

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EDITOR—By 23 May 2001 we had received 65 rapid responses commenting on the *BMJ*'s survey on why doctors are unhappy, as well as 24 rapid responses and three letters commenting on the editor's editorial.[1 2] The results of the survey have already been published and are available on bmj.com,[3 4] but the debate has really only just begun. We have tried here to reflect the breadth of the debate so far, but why not read it in full on bmj.com and contribute to it yourself?

Sharon Davies *letters editor, BMJ*

1 Electronic responses. Survey: Why are doctors so unhappy? bmj.com/cgi/content/short/322/7294/DC2 (accessed 23 May).
2 Electronic responses. Why are doctors so unhappy? bmj.com/cgi/content/full/322/7294/1073#responses; accessed 23 May.
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Risk of miscarriage in pregnant users of NSAIDs

More information is needed to be able to interpret study's results

EDITOR—Nielsen et al found that the use of non-steroidal anti-inflammatory drugs in early pregnancy was associated with an increased risk of miscarriage but not with congenital abnormality, low birth weight, or preterm delivery.[1] Unfortunately, the study has several deficiencies that make interpretation of the results difficult.

Firstly, the study was based on the Danish birth registry and the prescription database; the clinical information available was limited, and a random sample confirmed the prescription in only 71% of the pregnancies. Although the authors state that the data had high validity, Kristensen et al reported that the birth registry underreported the incidence of preterm delivery by over 50%.[2]

Secondly, in assessing the risk of miscarriage the authors stratified the study group according to the time between the prescription of non-steroidal anti-inflammatory drugs and the date of discharge from hospital after miscarriage. How the control group was stratified is not clear. Without this information, any conclusion about the association between exposure to non-steroidal anti-inflammatory drugs and miscarriage cannot be substantiated.

Thirdly, to establish the association between exposure to non-steroidal anti-inflammatory drugs in the first trimester and the risk of miscarriage the possible confounding factors must be controlled for. Although the prescriptions were "mostly for benign conditions of the muscles and skeleton," the exact frequency and indications for prescription were not clearly stated. A patient with systemic lupus erythematosus is more likely to take up a prescription for these drugs, and carries a higher risk of miscarriage because of the underlying disease. The possibility of confounding by indications for treatment with non-steroidal anti-inflammatory drugs cannot be excluded in this study.

Lastly, the study looked only at the prescription of non-steroidal anti-inflammatory drugs, not at the actual intake of the drugs. No information is given on compliance. Women tend to avoid any drug treatment during pregnancy, so the actual consumption was probably low. The conclusion that use of non-steroidal anti-inflammatory drugs during pregnancy is associated with an increased risk of miscarriage requires further confirmation.

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1 Nielsen GL, Sørensen HT, Larsen H, Pedersen L. Risk of adverse birth outcome and miscarriage in pregnant users of non-steroidal anti-inflammatory drugs: population

based observational study and case-control study. *BMJ* 2001;322:266-70. (3 February.)
2 Kristensen J, Langhoff-Ross J, Skovgaard LT, Kristensen FB. Validation of the Danish birth registration. *J Clin Epidemiol* 1996;49:893-7.

Miscarriages also occur in women intending to have induced abortions

EDITOR—Use of non-steroidal anti-inflammatory drugs is associated with an increased risk of miscarriage, according to Nielsen et al.[1] Their result may be biased because induced abortions were not considered in establishing the study base. It is based on registration of 63 drug prescriptions (1.5%) in 4268 miscarriages being compared with 318 first trimester prescriptions (1.1%) in 29 750 live births. The appropriate comparison should rather be all (or a sample of) pregnancies at risk of miscarriage, including abortions.[2]

Miscarriages may occur in women who had intended to have an abortion. In Denmark in the 1990s this might have been a fifth of the miscarriages, or even more if miscarriage and the intention to have an abortion were associated. Some of the women who had a miscarriage could have been subject to a prescribing practice not influenced by the pregnancy, because they did not intend to continue with the pregnancy.

If a quarter of women with miscarriages intended to have an abortion, of whom 3% had a prescription for a non-steroidal anti-inflammatory drug, this bias could explain the apparent association. This systematic difference between the group who had a miscarriage and the group who had live births could also explain why prescriptions tended to decrease more steeply in the livebirth group than the miscarriage group over the first weeks of pregnancy, as indicated by data provided in table 3 of the paper.

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2 Olsen J. Calculating risk ratios for spontaneous abortions: the problem of induced abortions. *Int J Epidemiol* 1984;13:347-50.

Authors' reply

EDITOR—As we pointed out in our paper, the analyses were based solely on linking of registry data; we did not take into account the indication for which the drugs were used or compliance. The information about exposure and outcome was collected independently; misclassification due to low compliance and use of over the counter preparations was therefore probably similar in the cases and controls and would tend to underestimate our observed risk estimates.

In the discussion of the miscarriages we emphasised that we could not control for confounding by indication. The odds ratio of 6.99, however, is higher than is usually ascribed solely to confounding. The register unfortunately does not include gestational age in cases of miscarriage. As most miscarriages occur in the first trimester, the best available control group comprised women in the first trimester who went on to have live births.

A written confirmation of drug prescription in about 70% of the patients is within the limits most often seen when dealing with pharmacoepidemiology.[1]

We would emphasise our reassuring observation of lack of an association between the taking up of prescriptions of non-steroidal anti-inflammatory drugs and adverse pregnancy outcome. We agree with Chan and Yuen that the association between non-steroidal anti-inflammatory drugs and miscarriage must be confirmed in other studies before definitive conclusions can be drawn.

We deliberately restricted our analysis to pregnancies with spontaneous miscarriage to avoid bias from including women who had chosen to terminate their pregnancies by an induced abortion. Women who choose to terminate their pregnancies may differ from those intending to carry them through in several ways—for example, smoking and alcohol habits. In some cases exposure to non-steroidal anti-inflammatory drugs may have been an additional factor in deciding to have an induced abortion. As the waiting time for getting a legally induced abortion is short, we believe that the number of spontaneous miscarriages while waiting for an abortion is low. We think it unlikely that a change in prescribing habits in this short period will substantially change our risk estimates.

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1 West SL, Strom BL. Validity of pharmacoepidemiology drug and diagnosis data. In: Strom BL, ed. *Pharmacoepidemiology*. Chichester: John Wiley, 1995.

Quality of health information about depression on internet

Study's shortcomings may have affected findings

EDITOR—Griffiths and Christensen evaluated the quality of web based information on the treatment of depression.[1] Although they have tried to scrutinise the quality of a select group of websites, there are shortcomings in their methods that may have affected their findings.

Griffiths and Christensen used just one search engine (DirectHit) and one metasearch engine (MetaCrawler), which limited the comprehensiveness of their search. Although the popularity of search engines changes rapidly, we question the choice of DirectHit over more often used engines such as AltaVista or Google.[2] Therefore, it is difficult to justify the assumption of Griffiths and Christensen that their search method provided the best available approximation to a list of depression sites.

We also question the strategy of using the single search term of "depression," given that over 44% of internet users search using multiple keywords.[3] The extreme narrowness of using a single keyword search was summed up eloquently by Brian Pinkerton, the founder of MetaCrawler, when he said: "Imagine walking up to a librarian and saying, 'travel.' They're going to look at you with a blank face."[4]

Griffiths and Christensen attempt to assess the quality of information found by comparison with a guideline of the Agency for Health Care Policy and Research (AHCPR) guideline. Readers should be aware that tools, such as DISCERN (www.discern.org.uk), are readily available for appraising the quality of patient information. Furthermore, although the AHCPR guidelines were developed using an evidence based method, they were published in 1993 and may not necessarily reflect recent advances, alternative treatments, or local practice.

Smarter search engines such as SumSearch (http://sumsearch.uthscsa.edu/) try to refine and guide users through the literature, yet a global initiative from the World Health Organization may provide further direction for users. The WHO has proposed the creation of ".health" as a new internet top level domain to afford some measure of protection for internet users by identifying the holder of the domain name as one who adheres to known standards.[5] While the feasibility of "dot health" is being debated, national initiatives, such as the National Electronic Library for Health (www.nelh.nhs.uk) are striving to bring together high quality information for patients and health professionals. One of the initial examples of which is information on depression that can be found at http://cebmh.com/depression.html.

Until initiatives such as dot health or high quality web searching tools become available, the onus will remain with users to search effectively and appraise the quality of the sites retrieved.

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1 Griffiths KM, Christensen H. Quality of web based information on treatment of depression: cross sectional survey. *BMJ* 2000;321:1511-5. (16 December.)
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Level of evidence should be gold standard

EDITOR—Several worldwide initiatives have defined criteria for assessing the quality of health information on the internet (box). Over 40 scoring tools are available,[1] and studies examining the quality of health information available on the internet such as that by Griffiths and Christensen have used clinical guidelines as references.[2 3]

The French health ministry and council of physicians have launched an initiative to define a French code of ethics for health oriented internet applications. One of the four working groups created aims to define criteria to assess the quality of the content of health sites on the internet (as distinguished from the quality of the site itself). The group differentiated information on the sites that is sensitive—for example, concerning the efficacy or toxicity of healthcare interventions—from that which is non-sensitive, such as doctors' addresses.

For sensitive information, the group recommended that an indication of the level of evidence for each piece of information should be the main criterion. This recommendation will not be mandatory for all health sites—for example, a website published by a patients' association, with information from patients and their carers, will not need to apply a level of evidence for the information given. None the less, the level of evidence should be indicated in documents, such as clinical guidelines, reports from consensus conferences, teaching materials, and technical reports when the information concerns the efficacy and toxicity of healthcare interventions.

CISMeF was created in 1995 at Rouen University Hospital, France, to catalogue internet health resources in the French language.[4] In December 2000, of the 9600 resources catalogued (1914 documents: 589 clinical guidelines, 111 consensus conferences, 337 technical reports, and 664 teaching resources), only 63 (0.7%) indicated the level of evidence (59 clinical guidelines and four consensus conferences).

These results imply that we need to encourage publishers of sensitive health information to indicate the level of evidence for each piece of information. There is no reference method for evaluating the level of evidence, but this is not an excuse for not tackling the problem. With an increasing number of people accessing an increasing amount of health information on the internet, publishers have an ethical obligation to help their readers (health professionals, but more so, lay people). The conclusions of the French working group were that publishers of sites should be encourage to select a simple method (among the existing methods) for indicating the level of evidence for information on their site until a reference method has been validated.

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1 Jadad AR, Gagliardi A. Rating health information on the internet. Navigating to knowledge or to Babel? *JAMA* 1998;279:611-4.
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3 Impicciatore P, Pandolfini C, Casella N, Bonat M. Reliability of health information for the public on the world wide web: systematic survey of advice on managing fever in children at home. *BMJ* 1997;314:1875-8.
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Initiatives to assess quality of health information

Health on the Net code (www.hon.ch/HONcode/Conduct.html)
Code of ethics of the Internet Healthcare Coalition (www.ihealthcoalition.org/ethics/ethics.html)
Netscoring (www.chu-rouen.fr/netscoring/)
MedCertain (www.medcertain.org), financed by the European Union
American Medical Association, (http://jama.ama-assn.org/issues/v283n12/pdf/jsc00054.pdf)
Hi-Ethics (www.hiethics.com)

Authors' reply

EDITOR—We found that the quality of frequently accessed websites on depression was generally poor, with higher quality evident in sites owned by an organisation or with an editorial board.

Tomlin et al claim that our findings may have been affected by the search engines and search query we used to locate sites. We acknowledge that there are difficulties in being certain of the generality of our findings but doubt that Tomlin et al's suggestions represent improvements in methodology.

The key question is whether the sites we evaluated were representative of sites that are visited by people seeking information on depression. We selected depression sites using both a metasearcher that favoured sites returned by multiple "popular general purpose web search services"[1] and an engine biased towards popularity that favoured sites known to be frequently accessed. Tomlin et al. advocate the use of AltaVista (which we did access via MetaCrawler) and Google. Google had not been launched at the time of our study but, when accessed recently, produced results overlapping substantially with those from our study.

The single word depression is one of the top 500 most frequently submitted search queries (excluding pornographic queries).[1] Multiple word queries related to depression are much less frequently used and are narrower in meaning.[2] (Surprisingly, the single word travel is currently the seventh most popular query.)

Tomlin et al note that the guidelines of the Agency for Health Care Policy and Research (AHCPR) may not reflect recent advances and alternative treatments. We believe that the guidelines remain valid, although they may need to be supplemented. We have recently produced an evidence based review of the effectiveness of medical, psychological, and alternative treatments written at year 8 reading level for the community.[3] Although there is evidence to support the efficacy of several alternative treatments such as St John's wort and exercise, their inclusion is unlikely to alter substantially our conclusions. Information about alternative treatments on the sites is published elsewhere.[4]

The ACHPR guideline allowed us to directly assess the quality of the content of depression sites. DISCERN and other similar instruments identify criteria that may be indicators of quality. DISCERN and other promising indicators such as the evidence levels proposed by Darmoni et al need to be validated using a content assessment. The next challenge will be to avoid a situation in which authors meet the DISCERN or other criteria but do not provide the best information about effective treatments.

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1 Selberg E, Etzioni O. The MetaCrawler architecture for resource aggregation on the web. *IEEE Expert* 1997;12:8-14.
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Nasal diamorphine in children with clinical fractures

Patients should be told what to do when analgesia wears off

EDITOR—Kendall et al report the advantages of nasal diamorphine.[1] When my 5 year old son was recently admitted to an accident and emergency department with a fractured collarbone, nasal diamorphine was administered with all of the good effects that the authors described. But the effects wear off

quite quickly. In our case, diamorphine was administered at 6 am and my son was supplied with a piece of triangular cotton and discharged home.

By 10 am he was in severe pain, and for the following 12 hours or so he was extremely distressed. The combination of ibuprofen and paracetamol prescribed by the hospital was not adequate. When I rang the general practitioner to request something more effective I was told that she could not help; if we had a problem we should take him back to hospital. Even had I been able to face another six hour wait in the accident and emergency department this was impossible—he screamed when he moved. We persevered at home and worked on distraction.

Nasal diamorphine is evidently effective, safe, and easy to administer. I would appeal to doctors using it for children in accident and emergency departments, however, to make adequate provision for after its effects have worn off.

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1 Kendall JM, Reeves BC, Latter VS. Multicentre randomised controlled trial of nasal diamorphine for analgesia in children and teenagers with clinical fractures. *BMJ* 2001;322:261-5. (3 February.)

Most interesting questions remain unanswered in this study

EDITOR—We question whether intramuscular morphine is indeed the standard treatment for children and teenagers with clinical fractures.[1] We question too the authors' conclusion that "nasal diamorphine spray may be the best way to provide analgesia for young people in different circumstances."

The British Association of Accident and Emergency Medicine has established national guidelines for analgesia in children in the accident and emergency department that do not include intramuscular analgesia of any kind.[2] Americans also avoid using intramuscular drugs for analgesia in children.[3] Intramuscular comparators therefore seem irrelevant to modern practice in emergency medicine. More information could have been gleaned by using oral or intravenous morphine—currently recommended by the British Association of Accident and Emergency Medicine for analgesia in children with moderate or severe pain, respectively. Given that nearly half the patients given diamorphine remained in pain after 20 minutes, it is unlikely that nasal spray will replace intravenous opiates yet.

Other methodological issues also raise concerns: the use of a convenience non-random sample and unblinded raters; lack of data on interobserver agreement; unclear enrolment time frames; unanswered economic questions; use of parametric statistics for non-normal and ordinal data; equating the Wong Baker face pain score to another undefined visual analogue scale; treating toddlers and teenagers as equals (the Glasgow coma scale is unvalidated in toddlers); and lack of follow up data regarding both diagnosis and outcome.

The results seem incomplete. The authors say that "median oxygen saturation was slightly lower in the spray group," but neither the magnitude of difference nor a definition of "slightly" is provided. Altogether 8% in the spray group had an oxygen desaturation event, but who (toddlers or teenagers?) and to what level did the oxygen saturation fall, and for how long? Were supplemental oxygen, naloxone, assisted ventilation, or other measures applied?

The authors report, "Overall, 84 non-serious adverse events occurred; all were mild except for one in the spray group that was considered severe"; they omit relevant safety information. We deduce that 12 more patients in the spray group had adverse events (almost one quarter of patients overall), but greater detail is needed to allow clinicians to judge the gravity of these events for themselves.

This study shows that intramuscular injections hurt and that nasal diamorphine can reduce pain. But the most interesting questions, which might change clinical practice, remain unanswered.

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1 Kendall JM, Reeves BC, Latter VS. Multicentre randomised controlled trial of nasal diamorphine for analgesia in children and teenagers with clinical fractures. *BMJ* 2001;322:261-5. (3 February.)
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Authors' reply

EDITOR—Eva's appeal for adequate provision of analgesia once the effects of nasal diamorphine have worn off usually applies to only a minority of children. Most children in the study, which reflects everyday practice, presented with a fractured radius and ulna. For them the most effective analgesic strategy is immobilisation of the fracture by splinting, although many will require manipulation under general anaesthetic. In these cases analgesia can be given intravenously after immediate analgesia has been achieved with nasal diamorphine.

Immobilisation is not practical for patients with injuries such as a fractured clavicle (like Eva's son). In this situation it is standard practice to support the injured limb in a sling and use a combination of simple analgesia—for example, paracetamol—and a non-steroidal anti-inflammatory drug. Unfortunately, none of the opioids would provide adequate analgesia after discharge from the emergency department, and these agents are not suitable for outpatient use.

Larkin and Leman question three things: the appropriateness of the comparator (intramuscular morphine); aspects of the methods; and the reporting of complications.

Emergency analgesia can be provided by either intramuscular morphine, which is poorly tolerated, or oral morphine, which is inadequate. Giving intramuscular analgesia was still standard practice in many emergency departments at the time that the study was approved (1996-7). The local research ethics committee and the staff in each participating hospital considered that intramuscular morphine was a suitable comparator. The faster onset of analgesia with nasal diamorphine compared with intramuscular morphine shown in the study now makes a comparison with oral morphine difficult to justify.

Larkin and Leman comment that nasal diamorphine is unlikely to replace intravenous opiates yet. We agree. Intravenous opiates are undoubtedly the gold standard in terms of analgesic efficacy. However, when children present to the emergency department, obtaining intravenous access is difficult and stressful to the child. Fluid resuscitation and emergency anaesthesia are the only absolute indications for immediate intravenous access—hence the exclusion of children needing these.

We discussed Larkin and Leman's second point—the issue of the convenience sample. We reported children's self rated pain scores because these were least likely to be biased, an assertion that is supported by the parallel changes in oxygen saturation. Data on interobserver agreement are not relevant to the study's main objective; data for other observers and other measures are available on request. χ^2 Tests for trend were used for ordinal pain scores; *t* tests were used only to compare the times at which observations were made in the two groups.

Our reporting of complications is in accordance with guidelines on good clinical practice. Additional data on all complications and physiological data are available on request.

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Patient access to records must be acceptable to both parties

EDITOR—Mandl et al think that patients should be able to annotate and challenge interpretations in their records, but in her commentary MacDonald says that this would have British doctors reeling in horror.[1]

The utility of patients auditing and being able to correct their computer held records

has been shown in several studies, including studies of administrative records in hospital[2] and problem and drug lists in diabetes outpatient clinics[3] and general practice.[4] In one study in general practice 24% of patients said that there were mistakes and 30% omissions in their records, including allergies, dates of birth, addresses, current drug treatments and items on the problem list, smoking details, height, weight, alcohol history, and family history.[4]

Other challenges to achieving Mandl et al's aim exist. There may be items on the record that the doctor does not want the patient to see. The desire for such censoring is not always due to paternalism; it may be due to the need for time for discussion with the patient. In the 1980s, when moving from poor quality paper records to computerised records with a copy for the patient, doctors censored many items, apparently without due cause, but probably because they could not be sure that these had yet been discussed with the patient.[5]

Patients may not understand their medical record, and we need to find ways to use it as a gateway to explanations and further information, which may be available on the web. Patients, as well as professionals, need more evidence based discussion about the uses of records so that they can make informed choices about who should have access to their record. The recent study of communication between general medical and general dental practitioners found that at baseline less than half the patients thought that dentists should have full access to their general medical record.[4] The experience of holding their own summary record made them more positive towards the idea.

Mandl et al are American and have problems (such as competition between institutions and reluctance to share information) that are of less concern or have been solved in the United Kingdom. In the United Kingdom, however, we have an important problem—equity of access to information for patients—that they do not mention. We need to investigate different ways of achieving equitable access to medical records which both patients and professionals will find useful and acceptable.

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1 Mandl KD, Szolovits P, Kohane IS. Public standards and patients' control: how to keep electronic medical records accessible but private [commentaries by D Markell, R MacDonald]. *BMJ* 2001;322:283-7. (3 February.)
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Computer use must not affect doctor-patient relationship

EDITOR—Mitchell and Sullivan found no evidence that use of computers in consultations had negative effects on the patient outcomes evaluated, and they concluded that doctors and patients were generally positive about the use of computers.[1]

Use of computers during general practice consultations improves the quality of care in some cases.[2] Benefits have been shown in disease prevention, with an improvement in immunisation rates by up to 18% and in other preventive tasks by up to 50%[3]; in disease management, with more appropriate dosing for drugs with a narrow therapeutic range[4]; and in the management of chronic physical illness for which there is a clear consensus regarding treatment protocols.[5]

Use of computers may, though, have detrimental effects on consultations. Consultation time is increased, and there is no appreciable increase in patient satisfaction.[3] Practitioners' responses and the disclosure of information by the patient are both adversely affected,[4] and many patients are concerned about confidentiality.[5] The current systems are not well suited to the wide variety of undifferentiated problems that present in general practice, and they may prevent the doctor from developing the empathic relationship that is necessary. This makes evaluating the impact of computers in consultations particularly important.

Work is still needed to ensure that computerisation of the consultation is not detrimental to the quality of the doctor-patient relationship during the consultation.

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1 Mitchell E, Sullivan F. A descriptive feast but an evaluative famine: systematic review of published articles on primary care computing during 1980-97. *BMJ* 2001;322:279-82. (3 February.)
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Unlimited consumer demand would destroy NHS

EDITOR—Dixon has written an editorial on the latest review of healthcare funding.[1] Like many, I fear for the future of the NHS. If it is to have any future then some hard political decisions have to be made. The NHS was founded on the principle of "the greatest good for the greatest number." This has served the United Kingdom well, and many countries have been envious of our system. But society has changed, and now the expectation is "the best possible care for every individual." This is an understandable aspiration, but it is not clear if society is willing to bear the necessary cost or accept the concept that health is primarily the responsibility of the individual.

The NHS might be compared to public transport: good value for money and an efficient use of resources but at times uncomfortable and inconvenient. If the population was asked to choose any type of transport at no personal cost then the choices would be diverse. Some public spirited individuals might opt for public transport or even a bicycle; those wishing for greater individual freedom but still recognising the need for cost restraint in a publicly funded system might opt for an old Mini. In a society dominated by consumer values, however, many would want a BMW or Porsche. In addition, some would want an immediate replacement if something went wrong, even if this was due to lack of maintenance or regular abuse. Paradoxically, the evidence is that in large towns with so many cars on the road, travel is most efficient by public transport.

As increasing numbers of patients demand their rights the NHS struggles to meet all these demands. Staff feel that they cannot keep up with rising expectations. In the past the NHS has used covert rationing through waiting lists, limitations on certain types of treatment, and variations in standards of care. The NHS is increasingly centrally driven, and these methods of demand control are now not tolerated.

The choice facing the government and media is stark: either engage in meaningful debate over the scope of the NHS or the organisation will crumple. It will crumple gradually and painfully. If this happens then health insurance will probably have an increasing role in health funding, and the greatest strength of the NHS—free health care for all—will be lost. Those who want the luxury model will be able to afford it, but those who cannot will have a long and painful walk in search of treatment.

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1 Dixon J. Another healthcare funding review. *BMJ* 2001;322:312-3. (10 February.)