Letters

Outcomes of screening to prevent cancer

Think of screening as insurance

Editor—Raffle et al provide interesting new data on the outcome of cervical screening.[1] It is particularly useful to be able to tell women that over 20 years of five yearly screening, around 16% will have an abnormal smear test result, 8% will have a biopsy, and 4% will be treated for high grade disease.

The authors also estimate the number of cancers and deaths that might be prevented over 30 years in such a cohort. How they obtained their estimates is unclear, but numbers are surprisingly low. When estimating the number of premature deaths avoided in screened women, they apply the factor 60%, obtained from a population in which approximately one in five eligible women are not screened regularly. In screened women the figure should be closer to 75%, which is more in keeping with the results from case-control studies.[2 3]

Fitting an age cohort model to mortality data from England and Wales for 1950-87 and extrapolating to 2011, we estimate the cumulative number of deaths in an unscreened cohort to be some 50% greater than do Raffle et al. Assuming that 75% of the deaths after 1996 would be prevented in a screened cohort, the number of premature deaths avoided is 2.4 times greater than in the paper. Over the next 30 years, the effect of screening in women born in the early 1960s will be much greater—some 2% of those screened will be prevented from developing cervical cancer.

Describing the benefits of screening in terms of the number needed to be screened to prevent one death equates screening with treatment. Screening is not treatment. It is perhaps better to think of it as insurance. The issue is not how many need to be insured for one person to avoid bankruptcy. It is not even simply a question of whether the cost of an insurance premium is more or less than the expected pay out (it will always be more).

Insurance is put in place to avoid catastrophic consequences of an unlikely event. Women need to be aware of the common negative consequences of regular screening, but they should perhaps think of it as a costly and imperfect insurance policy that may save them from the horrors of invasive cervical cancer.

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Authors' reply

Editor—We agree that screening can be thought of like insurance. It is not the likelihood of a house fire that makes you pay your premiums, it is the seriousness.

We believe numbers screened are valuable. Policy about screening is unsatisfactory in that support for, or dismissal of, the worth of screening programmes is dominated by advocacy rather than scientific debate.[1] Part of the reason this situation persists is that the literature is so hard to understand. It is full of statistical jargon, opaque terminology, and flawed concepts. We need to present complete information about all consequences of screening in an easily understandable way. People understand numbers and explanations in plain English, far better than probabilities, percentages, or sensitivity and specificity.[2]

Sasieni questions our estimates of cases and deaths. Our adjustment for "without screening" is as shown in figures 6.6 and 6.8 of page 51 of the reference we gave.[3] We are happy to share our calculations, and without access to the age breakdown of our cohort we are unsure how alternative estimates can be derived.

We tested varying assumptions for mortality reduction after 1996. Even if 75% of deaths in our study population are prevented after 1996, our conclusion is still that screening is very labour intensive, with 790 women screened for 35 years to prevent one death, involving 6098 tests. We view case-control studies with caution.[4]

We can all hope that future benefits will be substantial, but we cannot let this divert us from the sobering finding that before 1996 there were 57 000 tests and 1955 women with abnormal results for each death prevented. Misguided media campaigns are already causing a repetition of this situation with prostate cancer screening. Invasive investigations and treatments for 2000, in the hope of possibly helping one, will seriously damage men's health.

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Effectiveness of lipid lowering drugs in general practice

Article illustrates major problem

Editor—The article by Hippisley-Cox et al illustrates a major problem of describing a recommended cholesterol concentration as a target value—scatter around a bullseye will always ensure at least 50% of values above the target.[1] What was most interesting about their data was the dispersion of last recorded serum cholesterol concentrations about the means. This was small for simvastatin and atorvastatin, indicating that cholesterol values were close to recommended values even for those >5 mmol/l, and as Marshall has implied,[2] many of these patients may have concentrations $\leqslant 5$ mmol/l on remeasurement.

Although only one trial has compared five statins in a single study,[3] several paired comparisons of the efficacy of the statins[4] and of statins versus fibrates[5] have been undertaken. The data of Hippisley-Cox et al are consistent with these.

However, the statement "Statins reduce lipid levels better than fibrates" is at best misleading. Fibrates are often used in diabetic patients and other patients with an atherogenic lipoprotein phenotype (raised triglyceride, low high density lipoprotein, and mildly raised low density lipoprotein cholesterol concentrations), in whom chol-

esterol lowering is not the only consideration. Fibrates are also often used in combination treatment or in patients intolerant or poorly responsive to statins. Hence Marshall may be wrong to dismiss selection bias as a confounding problem. It was unclear whether patients receiving combined treatment were excluded from the analysis, and if included, which starting cholesterol concentrations were chosen. The lack of dosing data also makes it difficult to assess the validity of the statement that a target value of ≤5 mmol/l is unrealistic.

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1 Hippisley-Cox J, Cater R, Pringle M, Coupland C. Cross sectional survey of effectiveness of lipid lowering drugs in reducing serum cholesterol concentration in patients in 17 general practices. *BMJ* 2003;325:689-92. (29 March.)
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Study had two major flaws

EDITOR—The paper by Hippisley-Cox et al is a large study of how prescribed drugs are used in the community and gives a useful picture of the lipid lowering drugs used and their effectiveness.[1] It has two major flaws, however.

The first is the omission to report the characteristics of patients receiving different drugs. The pretreatment cholesterol concentrations in patients prescribed different statins differed, implying non-random selection of drug. In non-randomised studies differences among treatment groups may be systematic, substantial, and consequential. Extreme differences might require matching of subpopulations for comparisons.

The second problem is the omission of drug dosage in the analysis, although the data were collected. The authors probably assumed that the clinician could adjust the dose to achieve target and therefore failure to reach target implied lack of efficacy. Although statins have pertinent differences in potency and efficacy,[2] "recommended dosage" could be another confounding factor. In the *British National Formulary*, the highest recommended daily dose for pravastatin is only 40 mg whereas atorvastatin is licensed for use at 80 mg. The lipid lowering efficacy of 40 mg of the former is equivalent to only 10 mg of the latter.[2]

Under these circumstances, failure to reveal and discuss the dosages of the various drugs in the study seriously undermines the conclusions drawn. A blanket endorsement of atorvastatin and simvastatin as the more effective statins oversimplifies an important subject and might inadvertently provide a pseudoscientific basis for misleading advertisements.

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Authors' reply

EDITOR—Wang et al, and Kumana and Cheung are concerned by the omission of data on drug dosage. We included an analysis of drug dosage in the original paper submitted to the *BMJ* and removed it at the request of the editorial board. Of the 1116 patients whose serum cholesterol value was above 5 mmol/l, 209 (18.7%) were receiving maximum doses compared with 96 (7.1%) of the 1353 patients who did achieve the target range. In addition, in those patients receiving the maximum dose only 32% (96) achieved the target cholesterol value.

The table shows the number of patients taking each drug who reached target cholesterol values according to whether the maximum dose recommended in the *British National Formulary* had been prescribed. However, we have not looked at equivalent doses when these are submaximal for one drug, but maximal for another.

We did not write the statement "Statins reduce lipid levels better than fibrates"—this appeared in This week in the *BMJ* rather than in our paper. The text was different from the version we submitted, and we had no opportunity to comment on it before publication.

Kumana and Cheung raise the issue of differences between patients taking different statins. As we described in our paper, we took account of potential confounders by including the following variables in the multivariate analysis: sex, age, obesity, smoking status, pretreatment cholesterol values, comorbidity (ischaemic heart disease, diabetes, hypertension, and stroke), and registered general practices. We discussed the potential effect on the results in our discussion.

We think that the "dispersion" mentioned by Wang et al refers to the 95% confidence intervals (which are not standard deviations), and naturally these are narrower for atorvastain and simvastatin because of the larger sample sizes in those groups.

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Achievement of serum cholesterol value of ≤5 mmol/l and use of maximum dose of individual lipid agents

Agent	Maximum dosage	No (%) with cholesterol >5mmol/l	No (%) with cholesterol ≤5 mmol/l	Total	P value (χ^2 or Fisher's exact test)
Simvastatin	No	362 (40.7)	528 (59.3)	890	0.233
	Yes	4 (66.7)	2 (33.3)	6	
	Total	366 (40.8)	530 (59.2)	896	
Pravastatin	No	58 (51.8)	54 (48.2)	112	0.18
	Yes	16 (66.7)	8 (33.3)	24	
	Total	74 (54.4)	62 (45.6)	136	
Cerivastatin	No	63 (41.2)	90 (58.8)	153	0.004
	Yes	53 (60.2)	35 (39.8)	88	
	Total	116 (48.1)	125 (51.9)	241	
Fluvastatin	No	36 (61.0)	23 (39.0)	59	0.06
	Yes	6 (100)	0	6	
	Total	42 (64.6)	23 (35.4)	65	
Atorvastatin	No	377 (40.3)	558 (59.7)	935	0.78
	Yes	7 (43.8)	9 (56.3)	16	
	Total	384 (40.4)	567 (59.6)	951	
Fibrates and others	No	11 (73.3)	4 (26.7)	15	0.92
	Yes	123 (74.5)	42 (25.5)	165	
	Total	134 (74.4)	46 (25.6)	180	

Assisted suicide and euthanasia in Switzerland

Doctors occupy special position

EDITOR—I agree with Hurst and Mauron that the Swiss penal code illustrates how important it is to separate the issue of whether assisting death should be allowed in some circumstances from that of whether doctors should do it.[1] Assistance in dying raises questions that cannot be answered from the perspective of medicine alone.

We should not, however, be misled into denying that doctors inevitably occupy a special position in this issue,[2] and not just

because the barbiturates used in current practice require a medical prescription (there is a movement aiming to make barbiturates for assistance in suicide exempt from prescription). Central to the issue today, in contrast to the age in which the legislation was drawn up, is that assistance in suicide is discussed almost exclusively in the context of a serious and incurable illness.

This means that the treating doctor is the one to negotiate with the patient, relating the wish to die to the medical situation and indicating possible alternatives for treatment or palliative care—assuming that these exist and the patient wants them. As a result, the treating doctor is often the person confronted with the request for assisted suicide. And more and more doctors seem to be willing to meet such requests if they cannot offer any acceptable alternatives, almost always working together with a "right to die" society.

Legal and ethical clarification of the role and responsibility of the doctor in assisted suicide is needed in our country. Ambiguous statements such as "assistance in suicide is not a part of a physician's activity" are not very helpful at this stage.

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Competing interests: None declared.

1 Hurst SA, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. *BMJ* 2003;326:271-3. (1 February.)
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Doctors should keep out of it

EDITOR—Hurst and Mauron debate the role of non-physicians in assisted suicide and euthanasia in Switzerland.[1] There is absolutely no reason why doctors should participate in the mechanics of assisted suicide. Medical input should be limited to providing all available treatment, confirming diagnosis, and counselling patients on the prognosis of their condition. If the patient then decides that he or she wants to die the doctor's role is over. When the underlying reason for the request for release is not related to illness, there would be no reason for any medical involvement at all.

If society decides that it wants this service to be available, then society must set up the apparatus and provide the staffing. Anyone can be trained to administer a lethal injection—hospitals are full of highly competent non-medical phlebotomists—and there is no need to involve doctors.

Of course, politicians will have to devise a watertight consent and authorisation procedure. They will fail, and loopholes will be exploited. If the medical profession is to retain the trust of its patients it must keep its hands clean.

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"Comfort care" needs robust moral framework

EDITOR—The belief of Hurst and Mauron that physician assisted suicide is not entirely contained within the framework of medicine is correct.[1] Physician assisted suicide entails a philosophical value judgment that an individual life is no longer worthy to be lived. The authors do not give us any basis for making these value judgments, but modern bioethics theory creates hierarchies of human worth which are then used to justify medical discrimination.[2]

The authors cite a notional 0.3% rate of assisted suicide in Holland, although the definition of euthanasia in Holland is limited to "the deliberate termination of another's life at his request." This rules out involuntary and non-voluntary euthanasia by definition, but there are several thousand cases yearly in Holland where patients' lives are shortened by deliberate active intervention. This includes infanticide. Twenty per cent of the previously unreported cases of euthanasia in Holland involved ending a life without the patient's consent.[3] The Dutch guidelines have failed. If assisted suicide is a good thing for those who are asking for it, why should it be denied those who are not asking for it? This now happens in Switzerland, where relatives of seriously ill patients have been asked to sanction euthanasia.

The argument that assisted suicide-euthanasia can sit alongside palliative care is unsound. A study of over 1000 doctors, nurses, and social workers at New York's Sloan Kettering Cancer Center showed a negative correlation between willingness to endorse assisted suicide and knowledge of symptom management.[4]

In Oregon the cost of assisted suicide is recognised as a legitimate medical expense in a funding category called "comfort care." Weighed against the cost of care the financial cards are stacked against frail elderly people. This is a reason why many disabled people fear the encroachment of assisted suicide-euthanasia. Without a robust moral framework—based on intrinsic worth, not ascribed worth—and the protection of the law, the culture of death will claim more victims and has already stated its intention. The Zurich declaration of the World Federation of Right to Die Societies in 1998 urged that people suffering severe and enduring distress should be eligible for assisted suicide.[2] The elasticity in this concept is deliberate. It can get around any guidelines or laws.

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1 Hurst SA, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. *BMJ* 2003;326:271-3. (1 February.)
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Distinction needs to be made between choice and obligation

EDITOR— I write in response to the article by Hurst and Mauron on assisted suicide.[1] What is a human being? Our view of humankind almost always has consequences in our attitudes as to what is conceived to be right and wrong, how we understand, and how we interact with other people. As we are aware, the view of who a human being really is forms the basis for every question of ethics. We should be very concerned because a time is fast approaching when "right" to die will become "duty" to die.

The contemporary culture of consumerism values functional capacity and productivity, not altruism. Thus acute medicine and patients who can be cured take priority over those who are chronically ill. Society's contemporary intolerance for suffering, has, unfortunately, been fed by the medical profession and backed by the pharmaceutical industry. (The latter now stand silently in the shadows awaiting their cue.)

Is dignity to be assigned to certain conditions? In discussions about physician assisted suicide and euthanasia we fail to notice, at our peril, that there is an important distinction between the "quality" of life and the "value" of life. The common assumption is that if a person's quality of life decreases, then the value of that person's life must decrease proportionally. If we are going to value human beings according to their cognitive or physical functional ability, our humaneness will decrease.

Just what is life about? Not being a nuisance? Conditions for the incurably ill must never be so miserable that death becomes the best solution.

A reminder: in the *BMJ* of 7 December 1996, 50 years after the Nuremberg trial of the Nazi doctors, Hartmut Hanauske-Abel reported an estimate made in 1941:

> The 70 273 futile or terminal patients "disinfected" (murdered) in German killing hospitals up to 1 September 1941 are calculated to free up "4 781 339.72 kg of bread, 19 754 325.27 kg of potatoes" … a total of "33 733 003.40 kg of categories of food," plus "2 124 568 eggs" … Removal of these patients from the wards saved estimated hospital expenses of "254 955.50 Reichsmarks per day."[2]

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1 Hurst SA, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. *BMJ* 2003;326:271-3. (1 February.)
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Authors' reply

EDITOR—There is indeed concern that legalising assisted death without enhancing palliative services could result in low thresholds for giving up on palliative care.[1] This has been central in the decision not to

legalise euthanasia in Switzerland. Even with enhanced palliative services, however, the question of assisted death will remain. In the Swiss debate the importance of palliative care is recognised by all. Disagreements hinge on whether assisted suicide can be acceptable when palliative care fails to relieve suffering sufficiently to make life bearable in the patient's eyes, whether safeguards ensure that assisted suicide is used only as a last resort, and whether doctors should participate in it.

Bosshard and Bury's positions illustrate the difficult question of doctors' participation in assisted suicide. Doctors are likely to receive requests for assisted death. However, this does not mean that they must be directly involved in acts that terminate life. Specific ethical clarification and guidance for doctors are indeed needed as to how best to respond to requests for assisted suicide or euthanasia.

Gardner indicts "modern bioethics" as establishing hierarchies of human worth. This is mistaken. Proponents of assisted suicide argue that respecting each of us as legitimate choosers of our own moral values (as long as we do not harm others) requires that patients be allowed to end their own life if they feel that their life is not worth living. This position may be controversial, but it clearly recognises that all human beings have equal worth. Curtis seems to have misunderstood this also.

Gardner points out that the Dutch guidelines do not prevent the occurrence of life terminating acts without the patient's request. This may be a failure if the intended purpose of these guidelines was to give patients more control over their own death. It seems, however, that this is ambiguous, and that this very ambiguity could be problematic.[2]

Furthermore, without comparative data, the effects of legal frameworks on the frequency of any life terminating acts are unknown. In a survey of European critical care doctors, a higher proportion reported "deliberate administration of medication to speed death" in France and in Belgium, where euthanasia was illegal, than in the Netherlands.[3] Further data on end of life practices in Switzerland would be important in understanding the practical implications of its unique legal situation.

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Competing interests: AM is a member of the Swiss National Advisory Commission on Biomedical Ethics. The views expressed here do not necessarily reflect those of the commission.

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Telephone consultation requires appropriate training

Editor—In their overview of the role of telephone consultation in primary care Car and Sheikh point out the potential for improving access for patients and reducing general practitioners' workload.[1] We have two important observations from five years of running telephone consultation skills courses with members of primary care teams.

Firstly, all health professionals conducting telephone consultations need to provide a "safety net" for callers—for example, by ensuring that they are given explicit permission and directions to call back if symptoms change or the patient's condition worsens. In our experience, participative professional development courses can both raise awareness of such issues and increase confidence in managing calls.[2]

Secondly, primary care nurses locally report a high rate of telephone contacts, which, if representative, indicates a hitherto undocumented increase in telephone consulting by nurses.[3] However, evidence from participants on our courses indicates that issues of clinical governance for nurses may be more complex and less well explored than the medicolegal issues for general practitioners. Unlike colleagues employed by NHS Direct, who work within explicit clinical governance frameworks,[4] nurses in general practice need to satisfy themselves that they are within the boundaries of their professional competence, be aware of the limitations imposed by lack of visual cues (and develop strategies to minimise them),[5] and be aware of the need to treat all telephone contacts with patients as consultations and have the appropriate professional and organisational support to do so.

Given the likely continued expansion of telephone consulting by all health professionals, appropriate training should be a requirement for general practitioner registrars and primary care nurses. In addition, primary care trusts should provide guidance on appropriate clinical governance frameworks.

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"Author pays" publishing model

Not all authors will gain

Editor—The *BMJ* continues to advocate the "author pays" model, despite its potential to narrow the field of would-be authors.[1] Given that most UK doctors are employed by the NHS, how likely is it that our employer will pay the costs of publication? Those who do not receive any funding from elsewhere will therefore have to bear the cost themselves.

Although attitudes to the "author pays" system may be changing (I was told when a PhD student never to submit work to journals that levied a page charge) the proposals do not make financial sense. For the projected $500-1800 ($825-2970; €720-2580) I could pay for the publication of a medium sized book, or for next to nothing I could post material on my own website—either way my work would be freely available.

The proposed system will benefit researchers at large and well funded institutions that will pay to publish as a form of self advertisement (in some countries such papers were legally required to be labelled as advertisements). However, there will be no place for research by amateurs who write papers because they are interested in a subject and publish them in the hope of interesting others.

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1 Delamothe T, Godlee F, Smith R. Scientific literature's open sesame? *BMJ* 2003;326:945-6. (3 May.)

NHS authors now enjoy free open access publication

Editor—In response to the editorial by Delamothe et al,[1] Bates asks how likely it is that the NHS will pay the publication costs of its employees (letter above).

The NHS recently signed a deal with BioMedCentral such that publication charges will be waived for all NHS researchers. Bates can now publish unlimited papers in BioMedCentral journals at no charge to him (provided that they pass the peer review process) and he will have the advantage of knowing that his papers can be accessed by

anybody connected to the internet. A growing number of institutions worldwide are making similar arrangements with BioMedCentral (see www.biomedcentral.com/inst/).

Just as few researchers pay for laboratory materials, research students, laboratory space, heating, and lighting, etc, out of their own pockets, few would pay for publication charges. Rather, the charges would be included in grants or covered by institutions (using funds saved from reductions in journal subscription). Then all authors would have the benefit of knowing that their papers could be accessed by all interested readers, not just those lucky enough to be somewhere with a subscription.

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Competing interests: DP is director of SPARC Europe, the Scholarly Publishing and Academic Resources Coalition, an alliance for change in scholarly communication (www.sparceurope.org).

1 Delamothe T, Godlee F, Smith R. Scientific literature's open sesame? *BMJ* 2003;326:945-6. (3 May.)

Answering to some objections

Editor—Many readers' responses to the editorial by Delamothe et al are variations on the theme that authors cannot afford to pay to publish their work, especially young scientists and those from developing countries.[1 2]

This is a real problem, but the editorial described three actual or potential developments that would make it unnecessary for authors to pay these fees.

Firstly, the editorial advocated that funding agencies treat the cost of publishing an article as part of the cost of research. Not all research is funded, and not all funding agencies have agreed to this policy. But if this model will work anywhere, it will work in the natural sciences, where most research is funded. Moreover, funding agencies are seriously considering the policy to pay the processing fees charged by open access journals. If this is too speculative, then consider two solutions that already exist.

Secondly, BioMedCentral offers institutional memberships that have the effect of waiving the processing fees for all researchers employed by an institutional member. The editorial listed some notable institutions that have decided to subsidise the fees in this way.

Thirdly, as the editorial noted, open access journals tend to waive processing charges in cases of financial hardship. This is the express policy of both BioMedCentral and the Public Library of Science.

While the editorial offered these three answers to the objection, it should have avoided the unfortunate and inaccurate phrase "author pays" to describe this business model. The open access business model is that someone at the author's end of the transaction should pay the costs of publication, rather than someone at the reader's end of the transaction (such as the reader or the reader's library). If the costs of dissemination are fully covered by the author's sponsor, then readers will need no sponsor of their own and can enjoy free access to this body of literature. But the charges needn't be paid by authors themselves and will usually be paid by the author's employer, research grant, or government.

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Competing interests: PS has published articles defending the idea discussed in the editorial, but this may be a credential rather than a competing interest.

1 Delamothe T, Godlee F, Smith R. Scientific literature's open sesame? *BMJ* 2003;326:945-6. (3 May.)
2 Electronic responses. Scientific literature's open sesame? bmj.com 2003. www.bmj.com/cgi/eletters/326/7396/945 (accessed 27 June.)

Strategy is needed to get from A to B

Editor—With reference to the editorial by Delamothe et al,[1] last year my library paid €2.8m (£1.9m; $3.2m) for subscriptions to refereed journals. We could have saved this amount in a completely open access world, as all articles would be freely available on the internet.

Also, we had to pay for the refereeing, editing, and posting on the internet of the articles that my university published. It concerned 1413 articles. To the amount of €500 each, this makes €706 500. So for me there is no debate about the question in which world scholarly communication is cheaper. Moreover, the ultimate result is far more accessible in the open access world than in the subscription world.

The point is, however: how do we get from A to B? We cannot do away with the old journals before we have the new ones in place, with their impact factors and brands. In the meantime we have to pay in both worlds. The transfer is further impeded by the recent licensing contracts with the big commercial publishers. Any strategic ideas for this journey?

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Competing interests: LJMW is the librarian of Wageningen University and Research Centre.

1 Delamothe T, Godlee F, Smith R. Scientific literature's open sesame? *BMJ* 2003;326:945-6. (3 May.)

Model is concerned with vanity and profit

Editor—Delamothe et al assert that in the "author pays" world of medical publishing, peer review would occur exactly as it does now—the "author pays" model would not become a form of vanity publishing.[1] They also say that submission fees are likely to become routine parts of the process.

But consider this. All editors receive and reject many papers that are competent and methodologically acceptable, but highly unlikely to be of any interest to many other than those who have worked on the paper. Experience teaches editors which sort of papers are uncitable.

For example, our journal, *Tobacco Control*, could easily sink under the weight of parochial smoking prevalence studies. We receive an unending stream of these, and reject most not because they are poorly done but because we know that they are relatively unimportant, dull, and a poor use of expensive publishing space.

But if the cost factor is removed via an "author pays" system, should we now accept such papers? The many authors of such papers would certainly agree, but would our readers see this as progress? While editors who cherish the "feel" and overall quality of their journals are likely to argue that "author pays" should not compromise quality, how long would it take for their profit conscious publishers to begin urging them to relax a little?

As an editor, I can often tell from a title and abstract whether a paper will be rejected before review. An author's submission fee will certainly encourage expectations in authors that their work should be reviewed rather than immediately rejected. Will such expectations be passed on to already overloaded reliable peer reviewers? Or will submission fees be a cynical little impost on authors naive to the concerns of editors to produce journals with papers that people want to read?

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Competing interests: None declared.

1 Delamothe T, Godlee F, Smith R. Scientific literature's open sesame? *BMJ* 2003;326:945-6. (3 May.)

Only "bad" authors should pay

Editor—When he first published *A la recherche du temps perdu*, Marcel Proust had to pay because André Gide, who reviewed his manuscript, did not understand how good it was. Except for a few other notable exceptions like this one, in literature, the authors who are charged are not considered to be the most gifted ones.

Isn't this system a good one, even if imperfect?[1] Shouldn't biomedical publishing try to imitate this system? If yes, it is the peer review process that should probably change. In particular, reviewers should be paid and should not remain anonymous.

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Competing interests: JCW is a bad author and appreciates being published free of charge.

1 Delamothe T, Godlee F, Smith R. Scientific literature's open sesame? *BMJ* 2003;326:945-6. (3 May.)