

Letters to the Editor

Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk]. Letters should be no longer than 300 words and preference will be given to letters responding to articles published in the *JRSM*. Our aim is to publish letters quickly. Not all correspondence will be acknowledged.

Cost to the NHS of Roche oncology treatments

Further to the article in April's *Journal (JRSM 2007;100:166–169)* I would like to clarify the cited costs for Roche oncology treatments. The average cost to the NHS for a year's course of Herceptin for the treatment of early stage HER2-positive cancer is £24 420. When the costs for administration and management of side-effects are added this rises to £28 000, not the £50 000 annual cost quoted by Professor Sikora. The accurate total costs, including administration, are published on the NICE website.

Similarly, the average cost of Tarceva per patient for the second-line treatment of advanced non-small cell lung cancer is £7550 including hospital visits. When discussing drug costs in the context of NHS financial pressures it is far more appropriate to examine the incremental cost of a treatment, as this is the actual extra cost that needs to be funded by the NHS. Tarceva is £6 more costly per day compared to docetaxel. However, Tarceva is likely to save NHS money in terms of avoiding IV administration and side-effect management costs associated with docetaxel. It is therefore misleading to suggest that by using Tarceva, the NHS will incur an additional £65 000 annual cost per patient and we would welcome clarification as to how this figure was calculated.

In addition, the other costs cited inaccurately by Professor Sikora are for Avastin (colorectal cancer) and MabThera (non-Hodgkin's lymphoma). The average costs per patient for these treatments, again including administration, are £18 548 and £11 800—not the £70 000 (Avastin) and £40 000 (MabThera) quoted in the article.

Whilst we applaud Professor Sikora's intention to highlight a growing need for the NHS to review its financial provision for life-saving and life-extending cancer treatments, we feel that (in the interests of future accuracy and balanced reporting) the inflated and non-transparent costs suggested by Professor Sikora warrant a correction. I would be grateful if this were forthcoming in the next issue. For independent validation of the costs provided by Roche, the respective NICE technology appraisals, available at the NICE website, provide an accurate calculation of the actual drug and administration costs.

Competing interests Dr Atkins is Head of Medical Affairs and Code of Practice Assurance at Roche Products Ltd.

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The demise of nursing

I read with interest the thought-provoking article in *JRSM* by two nursing academics, Shields and Watson, entitled *The demise of nursing (JRSM 2007;100:70–74)*.¹ As a junior doctor (Senior House Officer, Registrar and old-style Senior Registrar), consultant surgeon and clinician manager (Clinical Director and Medical Director), I can claim to be a witness to changes in nursing practices in the UK over the last 25 years. Gone are the days when the sister on the ward was the conductor of the orchestra of patient care, who along with his/her staff knew everything about every patient. Yet there was neither a clear promotional structure in the nursing hierarchy nor a financial inducement to retaining this highly committed workforce. With the changes in health care—particularly in the NHS—and expansion in the health care industry, a large number of better remunerated management positions became available; the vast majority of these were taken up by nurses, which left a vacuum on the front line of care.

It may not be politically correct to say that the introduction of 'Modern Matrons' was the last blow, when highly skilled and senior nursing personnel were relieved from front line duties, handed a red uniform, an office, a computer and mountains of paperwork loosely lumped as 'modernization'. It is high time for the nursing strategy to move back to basics, which is the care of the sick by the bedside.

Competing interests None declared.

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The demise of nursing in the UK

In their article (*JRSM* 2007;**100**:70–74)¹ and subsequent reply (*JRSM* 2007;**100**:209–210)² to the ensuing letters of protest, Shields and Watson emphasise their belief that nurses should be *educated*.

I expect linguists, historians, and philosophers to be *educated*. However, I expect pilots, nurses, and doctors to be *trained*. The latter are skills. It matters not a jot to me whether or not a pilot is highly educated: I just want one that is highly competent and skilled.

About Health Care Assistants, Shields and Watson state ‘While these workers may be able to, for example, make the bed of, and feed, a stroke patient, they cannot assess skin condition, or the effects of facial paralysis while they are so doing, nor assess the effects of the person’s illness on the family. A RN does all these, and plans care from this information.’

I spend a lot of time with my patients, and glean a lot more information than these academically-oriented colleagues seem to appreciate. I can’t help feeling that some academics should listen more and lecture less.

Competing interests ND is a Health Care Assistant.

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Redefining quality of care

Defining quality of care is difficult even when considering the outcome from standard surgical procedures.¹ Assessing the outcome of medical emergencies has become more complex since recent political interventions have increased the potential for convoluting the patient journey, thus contributing to a degradation of the overall quality of care.

Many emergency patients have already run the gauntlet of NHS Direct and a local Drop-in Centre before arriving in A&E, only to be referred on to the Emergency Assessment Unit (EAU) when the four-hour A&E waiting time target seems likely to be breached. Furthermore, many GP referrals could be avoided if Primary Care spent less time chasing politically generated targets instead of pursuing real medical objectives.

Recently, during two separate Take Days involving a total of 19 hours at work in our EAU, I reviewed 52 patients, of which 27 were discharged. Many of these could have been managed throughout by their GP. A few required urgent referral to other specialties, but in order to comply with regulations either the GP had to re-refer the patient as an outpatient or I had to admit them to hospital. In regard to those patients requiring appropriate admission, many finished up under another consultant, thus delaying their ultimate review for several days.

Today, pass the patient (parcel) seems to be a necessary evil: it generates repetition but not quality. Patients need access to a comprehensive Emergency Service with senior staff available at all phases of the patient journey, not a disjointed collection of staging posts. In our Trust the solution would involve employing more Physicians and building a coordinated Emergency Department. Unfortunately, because health care is driven by managers who lack clinical skills, quantity is encouraged in order to generate income—to the detriment of quality.

Competing interests None declared.

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Informed consent for elective surgery: what is best practice?

Thank you for publishing the review by Andersen & Wearne (*JRSM* 2007;**100**:97–100).¹ It was an informative and interesting article, which communicated the essence of informed consent in a manner that everyone—particularly medical students—would find easy to understand.

The teaching of informed consent, and the seriousness of being able to ensure that a patient is competent to make a decision—either for or against any medical intervention requiring such—has been thoroughly taught to myself and my peers from our first term at medical school. However, the importance of making sure that you are suitably qualified to take informed consent for a procedure that you are seeking consent for (e.g. the authors mention that current guidance state that ‘the person obtaining consent must either (1) be capable of performing the procedure themselves; or (2) have received specialist training in advising patients about the procedure’) is often not communicated enough.

Perhaps such a concern can be best explained by the undeniable fact that often juniors take informed consent, more times than they maybe should, for procedures they

are not experienced enough to conduct themselves. As for the second criterion, some juniors might not have received such specialist training before taking consent.

This is just one sticky point surrounding informed consent that the authors only touch on lightly. Through the mechanistic overhaul of the profession that is MMC, one wonders whether every single surgical procedure is going to be explained, and consent sought, by those who fulfil the above two criteria. It should be for the peace of mind of both doctor and patient.

Competing interests None declared.

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- 1 Anderson OA, Wearne IMJ. Informed consent for elective surgery—what is best practice? *J R Soc Med* 2007;**100**:97–100

Dosage is important when using oxygen for patients with myocardial infarction

In questioning the use of oxygen supplementation for patients with myocardial infarction, Beasley and colleagues¹ failed to discuss the importance of the plasma tension and the relevant science (*JRSM* 2007;**100**:130–133). Cardiac output is tailored to oxygen demand and vascular tone relates to the plasma oxygen tension because it determines the oxygen saturation of haemoglobin. The calibre of vessels is determined by the degree of binding of the vasodilator nitric oxide (NO) by oxygenated haemoglobin in forming S-nitrosohaemoglobin.² In the presence of a coronary artery occlusion, upstream vasoconstriction by oxygen reduces blood flow, limiting the delivery of erythrocytes and hence oxygen availability. However, this only applies over the small range of inspired oxygen concentrations used in oxygen supplementation, because the vasoconstriction is limited by the sites available for NO binding by oxyhaemoglobin. Using 100% oxygen under hyperbaric conditions, plasma oxygen levels may be increased to more

than compensate for the loss of oxygen transport by erythrocytes. Boerema *et al.*³ demonstrated this experimentally in 1960, showing that life is possible without blood when breathing oxygen under hyperbaric conditions.

Higher plasma oxygen concentrations greatly increase the concentration gradient for the transport of oxygen to tissues; at two atmospheres absolute breathing 100% oxygen the concentration gradient is increased ten-fold. This explains the reduction of myocardial infarct size demonstrated experimentally using hyperbaric oxygenation. Beasley *et al.* do not reference the controlled trials of oxygen treatment under hyperbaric conditions. A controlled study of hyperbaric oxygen in myocardial infarction published in 1973⁴ demonstrated benefit, especially in cardiogenic shock, and the paper includes ECG tracings showing abnormalities improving as the patients were pressurized. More recently, a controlled trial has shown the benefit of combining hyperbaric oxygen treatment with thrombolysis.⁵

Competing interests None declared.

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