

## MEDICINE AND THE MEDIA

# Who are the doctor bloggers and what do they want?

Medical blogs are sometimes seen as just rants about the state of health care, but they have also been credited with spreading public understanding of science and rooting out modern day quacks. **Rebecca Coombes** checks out the medical blogosphere

In “internet time” blogging has been around for almost an eternity. Now, with the possible exception of the odd intransigent high court judge, blogging has achieved household name status since catching the public’s imagination nearly a decade ago.

The medical “blogosphere” is an especially crowded firmament. The opportunity to access raw, unfiltered material, to post instant comments, and to share information with a (often niche) community has become an addictive pastime for many doctors. The field has developed to the extent that devotees rely on their favourite blogs as their first port of call for topical opinion and debate. Taken as a group, the medical bloggers—the popular ones, at least—are overwhelmingly younger men, and many have a typically masculine geeky humour.

But the field is far from just a playground for the young. For example, David Colquhoun, professor of pharmacology at University College London, is 71 and now a celebrated blogger in his field. Professor Colquhoun thinks that a blog’s power lies in its independence. Unlike newspapers, blogs don’t feel bound to present a balanced picture, he says, “which, only too often, means giving equal space to people who believe the earth is flat and those that don’t.”

“On a blog I can just give my view. It’s obviously that—and people can take it or leave it. Also, bloggers often seem to be bet-

ter at investigative journalism than journalists are. All sorts of facts about dodgy practices appear on blogs long before they reach the regular magazines or papers; that is both fun and useful, I think.”

Today annual awards are given for the best medical blogs—including a prize for the best literary medical blog—and competing websites offer rankings of the best blogs. The site [www.edrugsearch.com](http://www.edrugsearch.com) ranks more than 400 of the most popular blogs on health and medicine. It’s hard to gauge just how popular some of these sites are, as top rated bloggers—such as *BMJ* columnist Ben Goldacre, who writes [www.badscience.net](http://www.badscience.net/)—keep this a closely guarded secret. Many of the most quoted and linked-to blogs are by anonymous doctors, who shelter

under fake names to vent opinions on anything from political interference in the NHS to how science is misrepresented in the media.

NHS Blog Doctor (<http://nhsblogdoc.blogspot.com/>), by a general practitioner writing under the pseudonym of Dr

John Crippen, is described as an “extremely depressing” look at the NHS. Dr Rant ([www.drrant.net](http://www.drrant.net)) does what it says on the tin: rant about medicine related topical issues, laced with lots of strong language. These sites examine political interference, root out mod-



**Silver surfer: blogger Professor David Colquhoun**

ern day quacks, correct ignorant journalism, digest interesting stories, or comment on big official reports, for example. Many also use details that would not meet the *BMJ*’s policy on patients’ confidentiality. Dr Crippen, for example, keeps a work diary that details consultations with noteworthy patients.

Ben Goldacre says that blogs are popular because they are more honest than other media: “It is hard to get away with misrepresenting stuff when the original source is but a click away. “I see it as a way of making conversation public—what is good about it is you get unmediated expertise. In the old days, you had to rely on a journalist to tell you what, for example, Iain Chalmers, told them. I think journalists were often really bad at this. On a blog, there he is. In the press it’s hard to know what is true. But with blogs people can link directly to the original source—this never happens in a newspaper.”

He complains that newspapers will also plagiarise blogs without giving credit, whereas blogs will refer and link to a person’s site. And on an online blog people can make instant comments, verifying a story or adding more information, whereas “in newspapers the comment is published a few days after the original article, when everyone else has moved on,” says Dr Goldacre.

## Top five blogs on health and medicine

Ranking by [www.edrugsearch.com](http://www.edrugsearch.com)

1. Random Acts of Reality (Trying to Kill as Few People as Possible . . .) (<http://randomreality.blogware.com/>)
2. Bad Science ([www.badscience.net/](http://www.badscience.net/))
3. MedGadget.com (<http://medgadget.com/>)
4. Kevin MD, Medical Weblog ([www.kevinmd.com/blog/](http://www.kevinmd.com/blog/))
5. NHS Blog Doctor (<http://nhsblogdoc.blogspot.com/>)



and of zero interest to the public. So it's fun to talk about things that do interest the public. It's also fun to be able to influence politicians and vice chancellors, though that is rather harder."

He says that before blogs the ordinary academic had no chance to influence anything much, other than by voting every five years. Now—with a little technical expertise—"they can post stuff for the world to see while sitting in front of the TV or even on a hilltop." Blogs are also easy and cheap to produce—many blog hosts are free.

What turns off many would be users is the feeling that the blogosphere is a wild west of crackpot opinion-mongers. How do you

determine the relative "value" of a medical blog? Ben Goldacre says that it is easy to sift through the huge choice of medical blogs, building up a bank of trusted sites and following trails to new ones.

He says, "I'm a 33 year old doctor, and I most enjoy reading narrow interest magazines. A *BMJ* editorial is always going to be more interesting to me than a *Times* editorial, a *Nature* article more than a *New Scientist* feature. The <http://science.reddit.com> site [a ranking of science writing that is posted and voted on by users] is consistently brilliant, much better than anything in the newspapers." Blogs also offer users "grand rounds": informal syndication of the best from other blogs. For example, a group of blogs will take it in turns to host a paediatric grand round, rounding up the best of that week's blog entries related to paediatrics.

Professor Colquhoun adds: "Blogs are an enormous step towards real democracy, though the price for that is that every madman and quack can do the same. Indeed, that is what makes it so important for people with knowledge, expertise, and honesty to fight back and draw a line in the sand at the tide of nonsense that engulfs us. The papers don't fulfil that role at all well—and in fact often exacerbate it."

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# Patients' blogs: do doctors have anything to fear?

Blogs written by parents about their sick children's care can be beneficial if handled sensitively.

**Matthew Hurley and Craig Smith** point out the pitfalls

In recent months we have had very different experiences of parents using blogs. One family used a blog simply to update family and friends overseas about their extremely premature baby. It contained a daily record of events, including details of procedures and the names of staff looking after their baby. In another blog the parents of a baby with rare congenital abnormalities used it to keep detailed records of medical care and decisions, including discussions and disagreements with different medical and nursing staff. Both blogs initially caused some concern among staff.

The phenomenon of parents' blogs may have a unique association with paediatric and neonatal practice. It is common practice for parents to take photographs of their babies to log their progress. Electronic dissemination makes sharing these experiences easier, and for many the blog is simply the modern photograph album or memory box. Keeping a blog can be beneficial to parents: it lightens the burden of daily telephone contact and provides written support when others reply to the site. Many parents already publish their experiences on conventional websites in the hope of helping others. Such altruistic blogs include entries on charity affiliated websites, which can be used to publicise a particular illness by attracting the media to an individual's story. This medium may also lend itself to whistleblowing in the public interest.

Blogs can be a useful source of information for patients. Parents go to the internet for information during diagnosis and treatment of their child's illness. Blogs narrate an individual's experience that may not be representative. Parents intent on leading care decisions, in an attempt to achieve the best possible care for

Professor Colquhoun was switched on to the power of blogs after fighting a successful campaign to halt the proposed merger of Imperial College and University College London. "Everyone was unhappy about it but said it was a 'done deal' and could not be stopped. As soon as I started a blog support came flooding in, and it was possible to publish raw, unfiltered information instantly. It took only five weeks after starting the blog to defeat the whole daft idea, and that made me realise the amazing power of the web."

After peace descended on UCL Professor Colquhoun found he was addicted, and he started to publish opinions on quackery and also on politics, religion, and education.

"It slowly dawned on me that all these pages were closely related, [were] just different aspects of 'endarkenment' thinking, and the pages got too big to load quickly, so they are now all supplanted by two proper blogs" (including DC's Improbable Science at <http://dcsience.net/>).

Professor Colquhoun says he still gets an "enormous" amount of enjoyment from blogs. "I think they have really had some success in spreading public understanding of science and even in influencing public affairs (firstly with the merger and more recently with withdrawal of NHS funding for homeopathy). My own research is on the stochastic properties of single ion channels. I love it, but it is specialist



their child, could use their own or other blogs as a novel way of meeting this objective. This information must be viewed with caution, but it can also encourage discussion and learning. At our hospital the parent can take a “prescription” for information from the community paediatrician to the patient information library, where a specialist librarian is available to direct the family to reliable resources.

Reading a family’s experience of an illness and the care given can provide clinicians with a valuable insight into parents’ understanding and help identify elements of the care pathway that need improvement. The temptation to contribute to a patient’s online blog needs careful consideration. Employees who write about their work on blogs have been “doxed”—that is, they have lost their jobs through expressing their views in a blog. Instead, more effort should be taken to improve opportunities of communication and the elements of care under discussion.

Blogging has legal implications. Healthcare professionals feel vulnerable about the publication of unedited material and opinion in real time. They may also be uneasy about parents who keep online diaries that may be used as

evidence in complaints or legal proceedings. In our experience, many parents already keep a written journal and photographs logging their baby’s journey. An identical electronic version would have no additional legal ramifications.

If difficulties arise during care and the details are published, potential exists for the parent-doctor relationship to be compromised. Blogging, as a form of publishing, is subject to the laws governing defamation, which aim to protect a person or an organisation’s reputation from harm. If you think that you are the subject of an untruthful, unwarranted, or mistaken attack on your reputation, you may have been libelled. Healthcare professionals may feel that a blog misinterprets a sequence of events or, even worse, calls into question their competence or professionalism, publicising this to other parents and staff. Healthcare staff must then decide whether they wish to pursue defamation.

If pursued, the publisher (the internet service provider) may claim “innocent dissemination,” stating that they did not know that any published statement was defamatory. However, the Defamation Act 1996 makes provision for the publisher to make amends, which includes

publishing an apology and paying costs. The internet publisher should have a “notice and take down policy,” whereby offending material may be withdrawn from public access.

There is also a risk that blogs may compromise the right of confidentiality of other patients on the ward or their parents. The legal and ethical protection of confidentiality is underpinned by the Data Protection Act and by the General Medical Council. Parents should be encouraged to write in a way that doesn’t identify individuals. Simple guidance for parents and professionals needs to be developed.

We support the use of blogs by families. Indeed, we aim to provide internet access for families in the near future to facilitate this. However, we recognise the vulnerability of everyone involved and aim to give guidance to parents and staff about parents’ and patients’ blogs.

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## WHAT’S ON BMJ.COM The dangers of attacking disease programmes for developing countries

Roger England has launched yet another broadside attack on programmes for priority diseases in poor countries (*BMJ* 2007;335:565 and 2007;334:344). In his latest Personal View, he claims that “disease specific global programmes [are] not the way to help Africa,” instead that they cause “big problems for recipients,” and that money for HIV/AIDS is “the worst.” He claims that off-budget money leads to distortions; that there are duplications of plans, operations, and monitoring; and that priority disease programmes are neither cost effective nor sustainable.

His evidence that little is being achieved is one statistic: HIV prophylaxis is reaching only 9% (actually it is 11%) of pregnancies of HIV positive women. He blames the warped prioritisation of disease programmes on international lobby groups from rich countries.

England’s prescription for change says that governments must stop funding global programmes that do not go through countries’ planning

and budgeting processes; the Global Fund to Fight AIDS, Tuberculosis, and Malaria must disband and be reconstituted as a global health fund; countries must reform their systems and outsource service provision from the government to the private sector; and everyone should drop the millennium development goals because they are more trouble than they are worth.

The evidence on hand rebuts or at least moderates many of England’s claims and recommendations.

Priority disease programmes have shown considerable progress in a relatively short period of time. Currently, the Global Fund contributes two thirds of international funding for tuberculosis and malaria, and about 20% of global resources for HIV/AIDS, for example. In its short life it has funded programmes that have already saved more than 1.8 million lives; provided antiretroviral treatment to 770 000 people; distributed more than 18 million bed nets; and treated two million new patients with tuberculosis.

Attacking priority diseases programmes and calling for the dismantling of the Global Fund and decommissioning of the millennium development goals is a prescription for returning global health and priority diseases to the backwater of broken promises and failed development.

Instead of criticising the movement and activities that form the leading edge of the driving wedge for global health reform, England, and more particularly planners, donors, and developing countries, should focus on rationalising increasingly robust priority diseases programmes so that they work laterally to strengthen health systems.

By all means, these same policy makers should work much more vigorously to provide sustainable financing for health in quantities sufficient for expanding human resources for health and strengthening the health systems that deliver prevention, treatment, and care for all health needs. We realise that integration of priority diseases programmes in revitalised health

systems in the long term is important. But we also know that suspending these programmes prematurely will sacrifice millions on the altar of a health systems theory that made little progress since Alma Ata until the AIDS movement became the high speed engine on the train of health systems development.

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This is a short version of a rapid response on [bmj.com](http://www.bmj.com/cgi/eletters/335/7619/565#176912). The full version is at [www.bmj.com/cgi/eletters/335/7619/565#176912](http://www.bmj.com/cgi/eletters/335/7619/565#176912).

YANKEE DOODLING **Douglas Kamerow**

# Wham, bam, thank you CAM

Alternative medicine is wildly popular in the United States, but what are we supposed to do about it?

I got a phone call the other day from a man asking whether I did “alternative” medicine. When I told him that I wasn’t in regular practice, he asked for a referral to someone who could provide this type of care. It made me think.

Complementary and alternative medicine (CAM) comprises a diverse group of treatments, ranging from symptomatic interventions to be used in conjunction with traditional therapies—therapeutic touch or meditation—to unique treatments meant to replace conventional chemotherapy or surgery. CAM includes complex and longstanding fields of study, such as acupuncture, ayurvedic medicine, and homoeopathy, but can also be as straightforward as taking a specific dietary supplement to lower blood pressure or blood lipid concentrations.

Americans love CAM. Over a third of them report having used some form of CAM therapy in the previous 12 months, and the use is increasing every year. Leading CAM therapies include natural products (supplements and herbals medicines and so on), meditation, chiropractic, and massage. Symptoms most commonly treated with CAM therapies include musculoskeletal, respiratory, and psychological symptoms.

It’s a huge business: Americans spend at least \$50bn (£25bn; €36bn) a year on CAM therapies. An increasing amount of this care is covered by US health insurance schemes, although generally this applies only to the more accepted CAM treatments, such as acupuncture and chiropractic. About a third to a half of all spending on CAM is paid out of patients’ pockets, more than we pay directly for hospitalisations.

Despite all this many Americans don’t like to talk to their doctors about the CAM treatments they are using. Only about a third to a half of patients who use CAM report discussing this with their doctor. Their reasons vary from thinking that doctors will not be supportive to saying that it is not important for doctors

to know. That’s a potential problem, given the documented interactions between some natural products and conventional drugs. Surveys in the US find that doctors rarely ask about use of CAM products, even though they admit they need to know more about them.

With all of this activity, it would be nice to know which CAM treatments work and which don’t. A number of Cochrane reviews have looked at CAM treatments, and the US Agency for Healthcare Research and Quality has commissioned around 20 evidence reports—systematic reviews—on CAM therapies. The UK’s National Institute for Health and Clinical Excellence (NICE) has explicitly avoided assessing CAM, however, despite calls for it to do so (*BMJ* 2007;334:506 and *BMJ* 2007:334:507).

In addition, in response to a mandate from Congress, the US National Institutes of Health created the National Center for Complementary and Alternative Medicine in 1999. Its mission is to support rigorous research into CAM and to disseminate its results. This research ranges from large randomised controlled trials of CAM products to basic science research to elucidate physiological explanations for CAM therapies such as acupuncture and ayurvedic medicine. The centre has spent hundreds of millions of dollars investigating CAM products and treatments.

So why don’t we know more than we do about what works and what doesn’t? Part of the explanation is the huge number and heterogeneity of CAM interventions. Only a small number of the most promising treatments have so far been rigorously tested. Part of the problem is the nature of CAM treatments: they can be hard to quantify and hard to specify, and often they don’t lend themselves to standard research techniques such as placebo controlled trials.

Furthermore, once research is done, it is often hard to assess its quality. Paul Shekelle and colleagues have written



“**So many people use alternative treatments and seem to derive benefit, it seems a shame to lump them all together and throw them out**”

about the difficulties of systematically reviewing CAM studies (*Annals of Internal Medicine* 2005;142:1042-7). The challenges include publication, expectation, and other biases; difficulty in locating the literature; treatment variability; variability in use of placebo or sham treatment; and dealing with rare but serious adverse events.

Critics say that CAM doesn’t deserve a place at the table—that enough time has passed and enough research has been done to show whether any of these interventions are safe and effective. The fact that unequivocal success stories are few indicates only that the treatments are placebo and expectation effects masquerading as medicine, they say. And yet so many people use them and seem to derive benefit, it seems a shame to lump them all together and throw them out.

I think a sensible approach is, firstly, for doctors to inquire of patients what non-traditional treatments they are using, both for conditions that the doctor knows about and is treating and for others that have not been dealt with. This will at least allow discussion and investigation of possible adverse interactions. Secondly, doctors should discuss truly complementary symptomatic CAM treatments—for chronic pain, allergies, or the like—so that their scientific basis can be investigated and understood by the patient and the doctor, if possible. Thirdly, for alternative treatments for serious or life threatening diseases such as cancer, doctors should assess the scientific evidence for the treatment and try to understand the range of benefit the patient expects to receive from it.

Although the US seems to lag behind the United Kingdom, we all need to pay more attention to the CAM treatments that our patients are seeking out and are willing to pay for and to the evidence behind their effectiveness.

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