

Evidence-based medicine

Duncan Neuhauser, Mireya Diaz and Iain Chalmers (*JRSM* 2008;**101**:381–383) are puzzled that one of the great pioneers of clinical trials, Russell LaFayette Cecil, failed to include a chapter on trial methodology when he went on to edit his best-selling *Textbook of Medicine* – but perhaps they are being diplomatic.¹ If Cecil thought most doctors did not need to worry their heads about science he was merely reflecting the profession's long-standing ambivalence to science after two millennia of reliance on Galenic teaching and personal experience. The fact that there are still qualified physicians who endorse Prince Charles' approach to medicine (embrace science when it suits but not when it doesn't) speaks volumes. As Lord Darzi points out in the same edition (*JRSM* 2008;**101**:342–344), the term 'evidence-based medicine' did not enter the medical literature until the 1990s; and there is still a lack of knowledge about fair tests of safety and efficacy² – as I can testify from trying to hand out charitable money to would-be medical researchers, a disconcerting proportion of whom have a poor grasp of design, analysis and statistical power. Things may not be much better in future. Some undergraduates seem to be taught more sociology than methodology; surely a gap in medical education which suggests that the GMC and several deaneries concur with Russell LaFayette Cecil's omissions of generations past.

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DECLARATIONS

Competing interests

None declared

Reference

- 1 Neuhauser D, Diaz M, Chalmers I. A puzzling omission in a great medical textbook edited by a pioneer of controlled trials. *J R Soc Med* 2008;**101**:381–3
- 2 Darzi A. Evidence-based medicine and the NHS: a commentary. *J R Soc Med* 2008;**101**:342–4

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Private practice: Bevan's bogey

Aneurin Bevan's unswerving determination to see a National Health Service established by parliamentary law and Lord Moran's desire to be re-elected as President of the Royal College of Physicians played a significant part in the

evaluation of consultants' remuneration. Previously, consultants had been paid a pittance for their work in the public sector but could make small fortunes from private patients. Who would turn down an offer which greatly enhanced their earnings from the public sector (justified by a probable increase in patient demand) whilst being allowed to continue to make a killing from private practice? Consequently, the NHS was born and Lord Moran was duly re-elected. Furthermore, consultants were given an internally regulated mechanism by which they could negotiate even greater rewards from the public sector by what were described as merit awards. This was intended to compensate teaching hospital consultants and associated university appointees for their diminished exposure to private practice, but quickly became another bonus open to all consultants and unrelated to clinical input. Once this gravy train had been set in motion there was little that could stop it short of a government that would both appeal to the conscience of the medical profession and match that with salaries commensurate with those earned by, for example, lawyers. After working for over 40 years in general medicine I was recently paid at a rate of £52 per hour for an eight-hour shift in our emergency department. A solicitor in the town charges £195 per hour but is unlikely to be exposed to mental or physical abuse or risk of contagion! Do aspiring doctors today see the medical profession as a humanitarian vocation or a means to a potentially substantial income? Inspecting the tables produced by Morris et al.¹ might encourage prospective medics wishing to engage in a lucrative career to see Essex as the county of choice and; those with surgical inclinations might be encouraged to choose orthopaedics, whereas those with a non-surgical leaning and no wish to engage in emergency work might select dermatology (*JRSM* 2008;**101**:372–380). Their paper suggested that working in both the public and private sectors 'might' cause a conflict of interest. Let's not pussyfoot about: it *does* cause a conflict of interest. Doctors must choose between God and Mammon, as recommended by the Parliamentary Select Committee of 2000,² but a full-time NHS commitment would require a level of remuneration which made private practice financially unattractive and illegal.

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DECLARATIONS

Competing interests

None declared

References

- 1 Morris S, Elliott B, Ma A, et al. Analysis of consultants' NHS and private incomes in England in 2003/4. *J R Soc Med* 2008;**101**:372–80
- 2 Parliamentary Select Committee on Health. *Third report: consultants' contracts (HC586)*. London: MHSO; 2000

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Dazed by Darzi

I refer to the article in the July 2008 issue of your journal by 'Professor the Lord Darzi' (your version of the author's name) about evidence-based medicine (EBM) and the NHS (*JRSM* 2008;**101**:342–344). Professor Darzi starts by reminding us that EBM (which used to be the acronym for expressed breast milk) has been around for at least 36 years. And after reading the article six times, I gather that his message is that EBM is a good thing, that everyone involved in healthcare should be aware of its findings, and that there is a need to measure not only the outcomes of treatment but the manner in which it is delivered. All this is good common sense and nowhere near what one might call cutting-edge observations.

What is so desperately disappointing is that it took me six readings to grasp the simple points that Professor Darzi was making. Reading his article made me feel as I do when trying to swat a fly – just when you think you have got it, the beast eludes you. Nowhere in Professor Darzi's article can one find any hard information about how the Darzi message might be applied to everyday clinical practice.

Professor Darzi seems, instead, to have fallen into the trap of espousing the obscurantist smoke screen of 'management speak'. Example: 'We can use an evidence base to better understand the structural enablers for driving forward multidimensional quality improvement agendas in a contemporary NHS'. If Lord Darzi and his advisers want to see changes for the better in the NHS, I would urge them to abandon management waffle, to resort to plain, basic English (preferably avoiding Americanisms like 'incentivize') and to give us concrete examples (rather than nebulous dissertations) on what they envisage for the future.

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DECLARATIONS

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References

- 1 Darzi A. Evidence-based medicine and the NHS: a commentary. *J R Soc Med* 2008;**101**:342–4

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The NHS at 60

Your editorial, based largely on benign misunderstandings and wishful thinking in the style of one Rowan Atkinson, urges clinicians [especially those over 40 and fed up] to engage in the debate – presumably with management and politicians (*JRSM* 2008;**101**:327). This is dangerous. During the first 20 years of the NHS most clinicians did engage and co-operate with a tiny number of mostly very able administrators and agents of the Ministry of Health, resulting in a very happy NHS indeed becoming the 'Envy of the World'.

The 'COGWHEEL' reorganization in 1974 heralded the imposition of an ever increasing management structure, the poor managers more and more burdened by often hasty and reactive schemes, plans, structures, initiatives, targets and the rest, running to millions of words, introduced by a succession of Health ministers, few of whom were long in post and many of whom seemed to have little understanding of health generally or the NHS, and little ability to formulate and think through workable plans.

A sensible strengthening of management clearly was needed – first to organize the increasingly complex and expensive technology available; second to try to contain the huge increases in costs by real increases in efficiency; and third to introduce rationing. It all went wrong, for many reasons, most caused by poorly worked out and poorly drafted plans and dictats from the politicians. The abject fear of feeble politicians of association with the idea of rationing of health care in the public mind has led to blundering cuts and devolution of responsibility to the often powerless managers, rather than to the rational economies and sensible rationing that could have followed an open debate.

It is quite wrong, and most regrettable, to suggest that clinicians have so far failed to engage. A large proportion have at

times done so, but most of these have found it a bruising and unsatisfactory experience, while many of those who have persisted seem to have adopted management values, making them unfit to represent patients, doctors and other health professionals.

Before engaging, therefore, doctors should be well aware of the natural aims and aspirations of those on the other side of the table. Politicians, both local and national, always aware of their need of popularity for re-election, will rarely be concerned beyond the short term. To a Minister, health is a portfolio to be held for just long enough to impress sufficiently for promotion in the next reshuffle. It is much easier to make cuts in services, often deviously disguised, than to achieve economies by real efficiency. A good manager is ambitious and aware that advancement will require loyalty to the organization as his overriding priority. This may be strengthened by bonus payments, sometimes for questionable successes. Altruism is unlikely to appear until the manager or official is very senior, and even then is likely to fail in competition with the Honours system. Whilst recognizing that the managers have a tough and sometimes thankless task running the service as the politicians direct, we must never forget that the patients' ultimate safeguard lies in the independence of the medical profession – and, almost as importantly, that our integrity depends on us fighting against any erosion of that responsibility. We should be involved but we must not be assimilated.

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DECLARATIONS

Competing interests

None declared

Reference

- 1 Abbasi K. The NHS at 60: vulnerable but full of ideas. *J R Soc Med* 2008;**101**:342–4

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Errors in text

It is curious that a respected medical journal would publish this discussion of GM food and other GM products (*JRSM* 2008;**101**:290–298) without at least some oversight related to the validity of the content.¹ I view the promotion of GM food as directly analogous to the

promotion of a new pharmaceutical product without any testing for safety. The only difference is that GM food could alter the health of a much larger population, and without any element of product choice. I will address three specific errors of fact and logic – there are many more.

- (1) 'GM plants undergo extensive safety testing'. This is absolutely false. In the US, while the GM food plants must go through the FDA for approval, there is NO REQUIRED safety testing: it is up to the producer, and if anything is done it is minimal. There has been essentially no long term animal toxicology on any GM product, something the medical community should be concerned about.^{2,3}
- (2) 'GM crops consumed... with no reported ill effects' – therefore they are safe. This statement is illogical and the conclusion is not valid. There is no assay and there is no epidemiology. If any GM food product did cause harm it would be impossible to pick up within the constant background of disease, particularly since in the USA, the biggest consumer, there are no labelling requirements. For an example of the necessary data to make a conclusion of harm, see Schubert.⁴
- (3) 'Increased yields': there have been none with the current GM crops.⁵

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DECLARATIONS

Competing interests

None declared

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- 2 Domingo JL. Toxicity studies of genetically modified plants: a review of the published literature. *Crit Rev Food Sci Nutr* 2007;**47**:721–33
- 3 Freese W, Schubert D. Safety testing and regulation of genetically engineered foods. *Biotechnol Genet Eng* 2004;**21**:299–324
- 4 Schubert D. Two views of the emperor's new clones. *Nat Biotechnol* 2007;**25**:282–3
- 5 Union of Concerned Scientists. http://www.ucsusa.org/food_and_environment/genetic_engineering/

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