Letters

NHS national programme for information technology

See Editorial p 1145

Changes must involve clinicians and show the value to patient care

Editor—The resignation of Peter Hutton, from his position as chairman of the National Clinical Advisory Board of the National Programme for Information Technology (NPfIT), has highlighted the lack of clinicians' engagement with this £6bn project.

The advisory board represents a much needed injection of resources to NHS information technology systems, which could bring many benefits to care for patients and clinicians' working practices. The Wanless reports have emphasised the importance of information technology in the future of healthcare in the United Kingdom.[1] A national programme could avoid the problems around interoperability associated with past failures in NHS information technology systems.

However, the secrecy surrounding the procurement phase of the programme has led to an increasing feeling of unease among clinician end users. Anxieties prevail about changes in working practices, usability of systems, training needs, and the possibility that political expediency will overshadow clinical needs.

Aidan Halligan, the deputy chief medical officer, has been charged with ensuring clinical engagement with the programme.[2] The good news for the Department of Health comes from its survey, carried out by Medix, which shows that many doctors are enthusiastic about the potential of the national programme, with three quarters of respondents endorsing it as an important NHS priority.[3]

Only 4% of respondents thought, however, that they had been adequately consulted. The recently announced new Front Line Support Academy aims to correct omissions at the leadership level.[4] But any programme of change management requires the involvement and commitment of all stakeholders. Consultation should not be limited to the select group of doctors with technical skills. The programme requires major changes in the ways all NHS professionals work, and the promised engagement should involve the "average" clinician in the "average" clinic.

SOTIRIS ZAFERIS/SPL

There seem to be few plans to evaluate the programme, yet the required commitment from doctors will depend on showing benefits to patient care and the working lives of professionals. NHS workers "at the coalface" need to be convinced of the added value of electronic booking, electronic prescribing, and a national care records service.

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Competing interests: None declared.

1 Wanless D. *Securing our future health: taking a long-term view.* London: HM Treasury, 2002. www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm (accessed 4 May 2004).
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Programme erodes confidentiality of medical records

Editor—At the same time as the Data Protection Act and the Human Tissue Bill are making life difficult for doctors and researchers in a misguided and unwanted effort to protect patients' rights,[1] the NHS is eroding the confidentiality of medical records.

A process of linking hospital computerised record systems has been going on for a few years. This entails a huge increase in the number of people who are authorised to access sensitive medical data—most obviously pathology data. This obviously reduces the security of the data, but no consultation process has taken place about the wisdom of doing it.

Similarly, and much worse, the national programme for information technology proposes that all medical data including general practice records should be accessible by doctors across the whole of England by linking all medical computer systems. It takes only one corrupt user to access any medical data for anyone on the system, however careful the password system.

What seems to be lacking in the present NHS is common sense and balanced judgment. We risk a situation in which no one will be bothered to do medical research apart from well financed pharmaceutical companies, while patients ask us not to keep computer records for fear they will be made public.

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1 Peto J, Fletcher O, Gilham C. Data protection, informed consent, and research. *BMJ* 2004;328:1029-30. (1 May.)

Internet access is a socioeconomic issue

Editor—The paper by Christensen et al on delivering interventions for depression by using the internet is encouraging.[1] Researchers are starting to probe more deeply into the potential the internet has to offer in medical care. Since the rise and fall of the dotcom bubble over the past few years, much has been promised by this new technology, but the research evidence has been slower to follow.

This paper, however, further confirms my suspicion that use of the internet continues to be socioeconomically determined.[2] Christensen et al show that the people who gained the most from their internet intervention were well educated women in their late 30s. This is particularly worrying as groups well recognised to be particularly affected by mood disorders—namely, old and poor people—do not seem to be represented.

The explanation may be that old and poor people in Australia have a similar pattern of internet access to that of those in the United Kingdom. In the United Kingdom old and poor people have poor internet access. Of those over 65 years of age, only 7% have ever accessed the internet.[3] Of the poorest 10% of the United Kingdom's population, only 12% have ever accessed the internet.[4]

The internet has the potential to offer much, but access to this resource continues to be a problem for those who most need it. Until access issues are addressed, it is hard to imagine that it will ever replace more traditional face to face services, and mental health service providers must resist the temptation to use it as a cut price way of providing their psychological treatments.

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1 Christensen H, Griffiths K, Jorm A. Delivering interventions for depression by using the internet: randomised controlled trial. *BMJ* 2004;328:265-8. (31 January.)
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Sustainability of medical imaging

Proposed licensing system and consent procedure are impractical

Editor—It is difficult to argue with Picano's premise that it would be a good thing if the doctors who referred patients for examinations using ionising radiation had a clearer idea of the risks involved.[1] However, Hardingham is right to point out that his suggested solution of a "driving licence" is completely impractical, and is based on a misunderstanding of the current legislation for the protection of patients.[2]

The licensing system he proposes would be bureaucratic and impossible to administer. It is also unnecessary. The legislation makes it quite clear that the referrer's responsibility is to provide the practitioner with sufficient information to decide whether the examination is justified. Whenever possible, that practitioner should be the radiologist (or nuclear medicine doctor) responsible for performing and reporting the examination, who will hopefully have the requisite knowledge of the radiation hazard and will be able to make an informed judgment.

If the licensing were an administrative nightmare then obtaining written consent for every exposure would bring radiology departments to a halt. The concept of counselling all the anxious patients referred for a chest x ray and confused and alarmed by the information that they are about to receive an exposure of 0.02 mSv, which may, or may not, cause cancer in 30 years' time hardly bears thinking about. There may be a case for this with some of the higher dose procedures, but even here we would need to give it careful thought. Simply stating the absolute level of risk (which we don't actually know with any degree of accuracy) without any attempt to put it into the context of the patient's illness and the benefits to be expected, would be unfair on them, and it would be impossible to do this adequately for more than a small minority.

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1 Picano E. Sustainability of medical imaging. *BMJ* 2004;328:578-80. (6 March.)
2 Hardingham C. The radiologist's role in radiation protection. Electronic response to: Sustainability of medical imaging. bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/328/7439/578#52506 (accessed 28 Apr 2004).

To obtain informed consent from everyone is impossible

Editor—Picano asks the impossible in suggesting signed informed consent for radiological examinations.[1] To obtain consent for every x ray examination, you need prepared information sheets and forms and some staff experience. Then consider the factor of time.

Allow half a minute each for introducing the documents to the patient, retrieving and checking the forms, fielding average questions, and filing the paperwork. That's two minutes for uncomplicated, intelligent, unquestioning patients who have remembered their reading glasses. Now multiply this time by two or three to allow for incomprehension, obtuseness, terror, etc.

Who will obtain consent? A receptionist? No, because questions on radiation demand scientific understanding. A radiographer, perhaps? How many radiographers have we to spare (let us not even consider radiologists)?

How many people are needed to take consent? A medium sized district general hospital undertakes 100 000 x ray examinations annually, so at least 200 000 minutes (3300 hours) yearly: that's two whole time equivalent trained radiographers.

Where will consent be obtained? Reception areas are too public. In examination rooms, while equipment lies idle? Or in purpose built rooms in our palatial departments?

Now translate this to mobile breast screening units, where each of about 40 daily examinations is allowed effectively 9 minutes. Uncomplicated consent will snatch about 20% of the time.

Yes, radiation must be limited, but we have no time or staff even to vet requests or check reports now. There are highly intelligent believers in informed consent, but why is our trained, knowledgeable, committed "paternalistic attitude" so despised? Along with "appraisal" and "revalidation," it has become the command of the idealist politician that our skills are so misdirected.

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Use of healthcare resources in the last six months of life

Findings should be approached with caution outside United States

Editor—The article by Wennberg et al on variation in the use of healthcare resources at the end of life raises several questions.[1]

It implies that the frequency of use of services is associated with workforce supply, but other studies contradict this. Supplier induced demand does not explain doctor variability in Norway,[2] and economists have noted the methodological difficulty of making interpretations about supplier induced demand.[3] Variability is still a major phenomenon in countries with centrally planned health systems which have less scope for inducement, such as the NHS in the United Kingdom. There is a fine interpretative line between healthcare activity that is induced by supply and healthcare activity that varies because some patients face inequitable barriers to access. Even if inducement is an issue in the United States, this interpretation may not be generalisable to other countries, given the market orientation of aspects of healthcare there.

The claim that greater use is associated with worse outcomes, making variability a direct risk to patient, requires caution. Given the difficulty, and perhaps even the theoretical impossibility,[4] of establishing a single "correct" population rate of use for a healthcare intervention, it is difficult to interpret doctor variation as inherently bad. If it is not possible to say what the single, best, population rate of treatment should be, why should we expect clinicians not to vary in their practice when observed across populations?

The results presented in this paper are interesting, but their interpretation is very complex and should be treated with caution,[5] especially when trying to generalise to settings outside the United States.

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1 Wennberg JE, Fisher ES, Stukel TA, Skinner JS, Sharp SM, Bronner KK. Use of hospitals, physician visits, and hospice care during the last six months of life among cohorts loyal to highly respected hospitals in the United States. *BMJ* 2004;328:607. (13 March.)
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Paper contains absolutely gorgeous and diverting sentence

Editor—"However, all patients in the last six months of life are quite similar with regard to at least one critical case mix adjuster—they are all dead within six months."[1]

This sounds like something from a Woody Allen film: they just don't write stuff like this any more. We need more such (inadvertent) humour in medical writing.

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How doctors learn may explain results

Editor—Wennberg et al hypothesise that marked variation in use of healthcare resources at the end of life may be explained largely by variations in the supply of doctors and beds.[1] Although this may play an important part, additional explanations are needed.

For example, why does such a large difference exist between New York University Medical Center and Mount Sinai Hospital in the number of intensive care days per decedent if the centres exist in the same city? One clue may be that many of the hospitals that have low numbers of intensive care days per decedent, such as Mount Sinai, University of California San Francisco, and Massachusetts General Hospital, also have active palliative care services with leaders in their field, such as Diane Meier, Steven Pantilat, and Andrew Billings, respectively. Informal social networks are important means by which these palliative care services may have far reaching impacts on the culture of the institutions in which they exist.[2]

In other words, the manner in which doctors learn, and from whom and what they learn, may be an important means of understanding the results of Wennberg et al.

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Author's reply

Editor—Love and Fahey show a fundamental confusion about two distinct questions: whether there is an association between healthcare resources and healthcare use, and why such an association exists.

The validity of the first hypothesis has been understood for many decades in the United States and in countries with central health planning.[1,2] Its original incarnation was "Roemer's law": that a hospital bed, once built, tends to be filled. Our contribution is to note the wide variability of use for similar patients, even in high quality hospitals, and even within the same city. Since occupancy rates tend not to vary across hospitals, the only way hospitals can provide more days in intensive care units to their patients is to maintain relatively more intensive care beds.

The second question is whether these variations in utilisation and resources are because of "supplier induced demand," or because of "demand induced demand": differences across regions in health status, preferences, or access to care. Our empirical results are valid under either explanation. Although it is difficult for us to explain our results in light of demand factors (particularly in light of Fisher et al[3]), readers are free to interpret them as they choose.

We are delighted that Rudolph has noticed our own modest attempt at ironic humour, which is perhaps more familiar to British than American readers. We hope that its use has "increase[d] the effectiveness of a persuasive message."[4]

Finally, we entirely agree with Bernacki. Network and organisational factors in hospitals are strong contenders in explaining hospital specific variations in the United States.

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1 Feldstein MS. Hospital bed scarcity: an analysis of the effects of inter-regional differences. *Economica* 1965;32:393-409.
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Alcohol evidence and policy

Harm reduction strategy is triumph of spin over substance

Editor—Some years ago the Australian health ministers decided on a policy to reduce total alcohol related harm in their communities. One goal was to reduce the average per capita consumption of alcohol, the ministers having accepted that this was an evidence based approach. In 1990 Hawks wrote a most disturbing article on how this process had been hijacked by the alcohol industry and the rest is history.[1] Last year's alcohol summit in New South Wales was a reminder that if governments leave these problems alone they do not go away.

Now, Plant tells us, the same lobby group seems to be at work in the United Kingdom, ensuring that those most dangerous of the mad scientists, those who insist on an evidence base for policy, are put in their place.[2] As Marmot explains, although the evidence supporting a reduction of consumption as a means to reduce harm is solid, education (intergenerational buck passing given a new spin) and better treatment is the government's preferred option.[3] One has to conclude, since the prime minister's committee has seen the same evidence, that this approach has been chosen precisely because it is unlikely to work too well. For the public to accept this approach implies that the dogma of consumer sovereignty and individual responsibility still dazzles and confuses the senses.

The evidence of mounting harm from increasing alcohol use, and of the failure of current interventions, is in the United Kingdom, as in Australia, as obvious (sometimes literally) as a punch in the mouth. This is another triumph of spin over substance.

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1 Hawks D. The watering down of Australia's health policy on alcohol. *Drug Alcohol Rev* 1990;9:91-95
2 Plant M. The alcohol harm reduction strategy for England. *BMJ* 2004;328:905-6. (17 April.)
3 Marmot M. Evidence based policy or policy based evidence? *BMJ* 2004;328:906-7. (17 April.)

Alternative tax strategy is possible

Editor— Plant discussed the alcohol harm reduction strategy for England.[1] Large tax increases may be politically unacceptable, but who could cavil at a progressive application of tax according to the amount of alcohol in the purchased item?

If alcohol were taxed at so many pence per gram (instead of per pint or bottle, as at present), then consumers could choose more readily between inexpensive low alcohol drinks and pricey high alcohol items. The price mechanism, which is known to work, would be used and a modicum of consumer education would take place with every visit to the bar or off-licence.

Analogous arguments apply to energy taxation policy—if energy were uniformly taxed at so many pence per kwh contained (whether the fuel be solid, liquid, gaseous, or electric current) then the true cost of our energy exploiting lives would become apparent and behaviour would change—rapidly.

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Decimalise measure of alcohol

Editor—With respect to Plant's editorial on the alcohol harm reduction strategy for England,[1] the "unit of alcohol" was really intended to suit imperial measure, but it is far too complex and vague to be of any practical use to people on an evening out, or even in.

Most people could manage the concept of actual millilitres of alcohol in each glass and keep a running total. It would be ideal to provide a simple pharmacokinetic chart linking millilitres consumed, body mass index, and liver function to failing the breathalyser test, but it would be a useless defence in court.

In short: no units, just millilitres.

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Beliefs and evidence: asking question might help

Editor—Marmot's editorial on alcohol evidence and policy illustrates a common human trait: people's willingness to take action influences their view of the (scientific) evidence.[1] This trait is evident in us all—but in some more than others.

If you are in the business of trying to influence policy and/or win hearts and minds, it is wise to be aware of this and to what degree the individual or group has this trait. Individuals or groups form very strong views or beliefs about something as they go through life and may have compelling reasons to stick with that view, despite good evidence that they may be wrong or misguided. Asking the question "What would it take to change your mind about this?" can at least guide us to where our efforts at change can be best targeted.

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Evidence base: rock of certainty or shifting sands?

Where is the evidence for "evidence based"?

Editor—Like Dewhurst,[1] I am uncertain of the newly popular term "evidence based" for it implies, without directly stating, that past practices in mental health were not evidence based. They were. The evidence base was, however, limited and often basely false.

When a term garners acceptance as swiftly as "evidence based" has done, one would be wise to examine it closely.

How many people are using it simply to mirror a popular language use, and how many intellectually apply it with a concerted degree of integrity? Certainly past practices travelled in the same manner, and their equally broad acceptance was taken as an indication of evidence.

Where is the evidence for evidence based?

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Not a rock of certainty—but stepping stones?

Editor—In his personal view Dewhurst discussed his problems with evidence based medicine.[1] I spend most of each day accessing, appraising, and synthesising research evidence to answer a range of clinical questions, but no one would suggest that—lacking, as I am, in both a medical degree and clinical experience—I should undertake to treat patients based on the information I collect.

Evidence based practice is not practice directed by research evidence. Evidence based practice is the judicious use of research evidence, based on a clinician's expertise and experience, in light of the patient's preferences. Research evidence does not supersede the challenging role of the doctor in clinical decision making, but it can support it. Just as diagnostic tests provide additional, helpful information but don't dictate patient management, research evidence provides further, hopefully useful information, but can't and shouldn't dictate practice. As both a patient and an evidence based practice researcher, I fervently hope that doctors still observe and think.

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1 Dewhurst J. The evidence base: rock of certainty or shifting sands? *BMJ* 2004;328:963. (17 April.)

Universal consent form might help

Editor—I wrote the "universal consent form" below a few years ago, but it now seems germane in view of the editorial by Furness and Sullivan on the new human tissue bill.[1]

"By signing this I agree that my doctor is a reasonable person, applying common sense and trying to do his or her best in circumstances for which society takes collective responsibility. My doctor will attempt to do the best possible, but I accept that nobody is perfect and human beings are only human. In particular, any effective treatment is not without side effects and all tests are fallible; in an attempt to reduce risks to a minimum, I understand drugs and procedures may have been tested on animals first. I accept that my doctor may not mention every possible side effect or complication because life is too short and he or she understandably wishes not to worry me unnecessarily.

"My doctors or their delegate(s) can access and make available to others anything of use to me, my situation, my family, or other humans or animals. For medical science to progress I accept clinical trials are necessary, but I will not complain if my case cannot be included in a clinical trial or study. Any tissue, gas, liquid, or solid removed, expelled, exhaled, evaporated, or derived from my body ceases to be my property; I understand that my body is no different from any other organism, in that ultimately all its components will be recycled in, for example, the carbon and nitrogen cycles.

"I agree to a postmortem examination of my body, given that that is the only way of finding out what really went wrong in the end, and that it will benefit society as a whole, if not my nearest and dearest as well. All this does not affect my right to sue for damages in case of, for example, negligence, but I take responsibility that the overall cost of thus disaffecting the system may ultimately be to mine and everyone else's disadvantage."[3]

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1 Furness P, Sullivan R. The human tissue bill. *BMJ* 2004;328:533-4. (6 March.)

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