

Eligibility of non-residents for NHS treatment

Failed asylum seekers should not be denied access to free NHS care

EDITOR—I agree with Pollard and Savulescu that failed asylum seekers should not be denied access to free NHS health care.¹

Firstly, as Williams argues in the previous issue,² evidence shows that failed asylum seekers are desperate and needy from a healthcare point of view. The professional and moral duty of doctors is to assist anyone in such need, regardless of his or her ability to pay.

Secondly, in putting forward the proposals we will not “continue to meet our international obligations.” Article 12 of the UN International Covenant on Economic, Social and Cultural Rights (ratified by the United Kingdom in 1976) guarantees the right of everyone to the highest attainable standard of physical and mental health.

Thirdly, by denying failed asylum seekers access to free health care we will not push them away. There is evidence that most of them remain in the United Kingdom for reasons other than having access to welfare benefits.⁴

Fourthly, the measure will have negative public health and economic consequences, as exposed by Pollard and Savulescu.

Finally, NHS staff are not immigration officers.

The government should issue an urgent clarification statement on all these issues before the proposals are allowed to go any further.

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Competing interests: None declared.

- 1 Pollard AJ, Savulescu J. Eligibility of overseas visitors and people of uncertain residential status for NHS treatment. *BMJ* 2004;329:346-9. (7 August.)
- 2 Williams P. Why failed asylum seekers must not be denied access to the NHS. *BMJ* 2004;329:298. (31 July.)
- 3 Department of Health. *Proposals to exclude overseas visitors from eligibility to free NHS primary medical services. A consultation.* London: DoH, 2004.
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Children of asylum seekers are special case

EDITOR—We share the concerns expressed by Williams about the eligibility of failed asylum seekers to full NHS treatment.¹ In 2002, only 10% of 25 000 children who applied for asylum in the United Kingdom were granted the right to stay.² In our experience, these children often have unmet medical and social needs that may not necessarily be immediately life threatening but have profound long term implications.

We reviewed the children from asylum seeking families referred to a community paediatrician in the central area of Liverpool over a year.³ Children were referred with health problems including cerebral palsy (four), autism (three), behavioural difficulties (two), spina bifida, epilepsy, developmental delay, Down's syndrome, and growth failure. These medical problems had been previously undiagnosed in six children. Most needed further investigations and referrals. A further nine children were referred with social concerns, of whom two were moved to a place of safety and one was placed on the child protection register.

This cohort gives a flavour of the healthcare needs of these children. Continuing care is difficult due to rehousing, deportation, and communication failures. It would be unethical to deny basic medical care to these children irrespective of their asylum status. The UN Convention on the Rights of the Child reminds us that the actions or inactions of governments affect children more strongly than any other group in society.⁴ The amendments to the NHS (charges to overseas visitors) regulation would be detrimental to the long term health of these already vulnerable children.⁵



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- 1 Williams PD. Why failed asylum seekers must not be denied access to the NHS. *BMJ* 2004;329:298. (7 August.)
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- 3 Noglik A, Bassi Z, Snelling S. Medical, social and psychological problems in asylum seeker children in Liverpool: a one year experience. *Arch Dis Child* 2004;89(suppl 1). (Abstract.)
- 4 UN Convention on the Rights of the Child. *Why make a special case for children?* www.unicef.org/crc/specialcase.htm (accessed 12 Aug 2004).
- 5 Department of Health. *Proposed amendments to the National Health Service (charges to overseas visitors) regulation 1989: a consultation.* London: DoH, 2003.

Identity card experience from Slovenia is partly positive

EDITOR—Health politicians in Slovenia introduced an identity health card for almost the same reasons as described in the article by Pollard and Savulescu.¹ Four years later, I have to admit that this has some benefits for the healthcare providers. With a patient's valid identity card you do not ever have problems with billing patients' visits to the insurance fund, because the validity of the card is a guarantee that you will get the money.

On the other hand, a legal or human rights question arises, which should be addressed in addition to ethical questions. Is presentation of a valid card on the occasion of the visit to the practice more important than the insurance status of a cardholder? If patients cannot provide a valid card at the time of the visit they have to pay, despite having valid insurance. Such cases are rare, perhaps one in 100, but nevertheless difficult for general practitioners, who became public insurance servants. The profession and public should be vocal while this instrument is introduced into the NHS because later those who have problems will not be heard. Legal experts and patient representatives should be consulted.

Identity cards are not a panacea for the financial problems of healthcare systems. They are more or less a cosmetic attempt rather than some breakthrough innovation in how to collect enough money to deliver quality services.

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1 Pollard AJ, Savulescu J. Eligibility of overseas visitors and people of uncertain residential status for NHS treatment. *BMJ* 2004;329:346-9. (7 August.)

Duty of easy rescue has become clouded

EDITOR—The duty of easy rescue described in the article by Pollard and Savulescu seems to have become more cloudy since the negligence lawyers got involved.¹

Once upon a time people would not have hesitated to act, but now most people, especially professionals, will reflect and consider whether they might expose themselves to legal action. If I pass a road crash I will do the minimum necessary to sustain life and check that adequate resources are available and then slip away as soon as any competent formal professionals arrive. I am not worried about getting my shoes wet or other inconvenience to myself. I am worried about being sued for large sums of money when I try my inadequate best to offer assistance. It is not clear that the lawyers have benefited anyone.

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Eligibility for HIV treatment needs special consideration

EDITOR—We agree with Pollard and Savulescu that the new guidelines directed towards recovering costs for HIV from overseas visitors are not only unethical but also could lead to an escalation of new cases in the United Kingdom by failing to treat highly infectious cases with advanced immunosuppression.¹

In this hospital most new HIV cases present with low CD4 cell counts and medical complications that usually require urgent treatment. These patients invariably have minimal financial resources. Pre-test HIV discussion with these people at high risk includes treatment issues and the likelihood that highly active antiretroviral treatment (HAART) will be recommended, if not immediately then in the near future. If the guidelines are to be implemented this discussion will have to include the information that the government will seek to recover medical costs from patients who may be extremely ill with conditions causing respiratory distress, such as *Pneumocystis carinii* pneumonia and tuberculosis, or Cytomegalovirus retinitis, which may result in irreversible blindness. We believe that the psychological distress that this will cause both patients and those involved in pre-test discussion will be considerable.

In the mid-1980s, before antiretroviral drugs were available, many people were counselled that there was little point in getting tested if bad news was the most likely outcome. Surely we cannot go back to this

era? People with advanced immunosuppression are more likely to have high viral loads, rendering them highly infectious compared with others diagnosed early on or taking HAART. By not offering free treatment to this group who cannot afford HAART, the risk of new infections is likely to be increased considerably. In addition to the human rights issues, the public health aspects of the new guidelines seem to have been glossed over and require urgent attention by HIV commissioning groups.

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Dispersed HIV positive asylum seekers need care throughout UK

EDITOR—I strongly agree with Creighton et al that inappropriate dispersal of asylum seekers with HIV may lead to increased medical and psychosocial problems.¹ They also point out that the national asylum support service should seek specialist advice and consider the impact on infrastructure and staffing at the receiving centre. Although the study reported by Creighton et al was conducted in England, similar problems exist in Wales, where the enforced dispersal of non-indigenous people to areas where there was previously little ethnic diversity can further stigmatise an already vulnerable group.

I am a single handed HIV doctor in Swansea and provide daily cover for 170 HIV positive patients, of whom 54 are non-indigenous, mainly asylum seekers, 46 of them women. These women are of particular concern since many have been raped and may be separated from their families, further adding to the emotional and physical trauma of being HIV positive. Most have been dispersed from London, where they had social and cultural support from their families and friends within a comparatively larger ethnic group.

Patients are often given very little notice of their imminent dispersal, such that they cannot obtain adequate supplies of drug treatment. Others have been transferred with such complex medical problems and no medical case notes that lives are put at risk. The additional strain on local service provision also seems overlooked when dispersal is decided.

Enforced dispersal of young heterosexual HIV positive patients may have unknown effects on the long term epidemiology of HIV in areas where there was previously a comparatively low

incidence of HIV in the heterosexual population.

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1 Creighton S, Sethi G, Edwards SG, Miller R. Dispersal of HIV positive asylum seekers: national survey of UK healthcare providers. *BMJ* 2004;329:322-3. (7 August.)

Offending in psychiatric patients after discharge from medium secure units

Conviction rate may be misleading

EDITOR—Offending by psychiatric patients is of great public concern, and offending by former patients in medium secure units who are, or should be, receiving psychiatric supervision in the community is particularly interesting. The paper by Maden et al, although a welcome addition to the literature, obscures important aspects of the issue by its brevity.¹

Previous studies have reported only a quarter of discharges from medium secure units as being directly into the community.²⁻³ The commonest discharge location was non-secure psychiatric wards, and about a third of patients were discharged to prison or other secure psychiatric units. The opportunities for offending and the likelihood of violence leading to a conviction vary widely between these settings, with those in the community more likely to gain convictions. This makes an overall rate of conviction difficult to interpret.

Conviction data from the offenders' index also need to be used with caution. Previous studies have reported 20% discrepancies between these data and clinical records.^{4,5} The use of multiple data sources including the offenders' index, clinical records, and national computer records from the police is recommended.⁴

The two year rate of conviction for violent offences among former patients from medium secure units in the community is likely to be higher than the 6% implied. This is because of greater opportunities to offend, more likelihood of offending resulting in conviction, and underestimates of offending because a single data source is being used. This has implications for both risk management and allaying public concern.

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1 Maden A, Scott F, Burnett G, Lewis GH, Skapinakis P. Offending in psychiatric patients after discharge from medium secure units: prospective national cohort study. *BMJ* 2004;328:534. (26 June.)

2 Maden A, Rutter S, McClintock T, Friendship C, Gunn J. Outcome of admission to a medium secure psychiatric

- unit: I. short- and long-term outcome. *Br J Psychiatry* 1999;175:313-6.
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- 4 Jamieson E, Taylor PJ. Follow-up of serious offender patients in the community: multiple methods of tracing. *Int J Methods Psychiatr Res* 2002;11:112-24.
- 5 Edwards J, Steed P, Murray K. Clinical and forensic outcome 2 years and 5 years after admission to a medium secure unit. *J Forensic Psychiatry* 2002;13(1):68-87.

Language used to describe results is misleading

EDITOR—The study by Maden et al adds to limited knowledge on the risk of further offending in patients discharged from medium secure units,¹ but the results are reported in a misleading way.

Maden et al claim that only 6% of discharged patients commit a violent offence in the two years after discharge. This is not supported by the results. What the study shows is that only 6% of patients are convicted of a violent offence in this time. Many barriers must be crossed before an individual is convicted: the police must be informed and be willing to attend, the victim must be willing to press charges, the police must be willing to investigate, the Crown Prosecution Service must be willing to proceed, and the individual must plead guilty or be found guilty by the court. It is also unclear if warnings or cautions were picked up as well as convictions.

The 6% figure therefore represents the tip of the iceberg of violent acts committed by this population and could easily lead to complacency on the part of clinicians and managers.

I suspect that most of these people were not discharged into the community but to conditions of lower security, where they were supervised by qualified staff and their liberty was restricted. In my experience in hospitals, most violence does not result in police involvement.

I am amazed that a professor of forensic psychiatry has not pointed out these weaknesses himself, and I consider that this paper would not have been accepted in this form in a psychiatric journal.

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Author's reply

EDITOR—Back seat drivers are the worst critics. Yes, we could have used additional measures of violent offending. The Macarthur study (cited in the paper) did that but cost \$8m (£4.4m; €6.5m) for a similar sample size and 50% less follow up. I have offered to do the same thing over here for half the price but have had no takers so far.

Reconviction is not the whole story, but it is an important part of it. Medium secure

units usually admit patients after they have been convicted of an offence, and we should know how many are reconvicted. It is a good measure of serious violence, which is the public's main concern in relation to psychiatric services.

The authors debated whether to report results only for patients discharged to the community but decided this would be more misleading. We may not like to trumpet this fact, but one of our main tools in violence risk management is the further detention of patients who are considered too dangerous for an immediate return to the community. The patients who stayed in were not chosen at random, and to omit them would ignore this function of the service.

The reporting was not misleading, as our measure of offending was clearly defined. Outside the scientific arena, a propaganda war is taking place about violence by psychiatric patients, and we make no apology for pointing out that one part of mental health services is working well, according to one crucial measure. We are not complacent, and we end with suggestions for better identification of high risk patients. We could have discussed our limitations at greater length but correspondents should remember that their letters amounted to more than 750 words,¹ whereas our description of a three year study took 500.

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Sharing workload in group practices

Personal lists work well

EDITOR—Branson and Armstrong studied general practitioners' perceptions of sharing workload in group practice.¹ The thorny issue they mention of who might not be doing their fair share of work is not an issue for my colleagues and me as we work with strict personal lists, list sizes being adjusted to allow for less than full time commitment. This means that we all have the same potential workload, and if some of us are less efficient at managing it there is no spillover on to other colleagues.

Having a clearly identified doctor of prime concern means that each patient is "sorted out" by one partner rather than being passed around like a baton in a dysfunctional relay race, with the assumption that somebody else will be the one crossing the finishing line. It also enables us

to deal with clinical governance issues much more easily as the audit trail is easier to follow. Knowing your patients can save a lot of time during consultations, and it is my experience that patients are less likely to lodge a complaint against a general practitioner with whom they have a longstanding relationship than with one whom they have only seen a handful of times.

Many believe that the personal list system is an anachronism. I beg to differ. I believe it is the formula that can ensure that primary care can deliver personalised continuity of care while maintaining high levels of job satisfaction for those of us occupying the hot seat.

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1 Branson R, Armstrong D. General practitioners' perceptions of sharing workload in group practice: qualitative study. *BMJ* 2004;329:381. (14 August)

Unfairness and early experience colour perception of inequality

EDITOR—Branson and Armstrong's study shows that perceived inequality remains an issue for general practitioners.¹ Some years ago, when I was conducting a follow up study of my 1983 cohort, I found that depression in senior general practitioners was best predicted by perceived envious sibling relationships when young, as measured when they were students.² Almost all had siblings.

This suggested to me that perhaps one reason that doctors enter the family milieu of general practice is to recreate earlier family life, the good or the bad. Those with a poor early experience may perceive the inevitable inequalities of working life rather faster and more negatively than others.

If such a finding held good in other studies, then it may be quite difficult to "cure" the current workplace problem in any simple manner.

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1 Branson R, Armstrong D. General practitioners' perceptions of sharing workload in group practice: qualitative study. *BMJ* 2004;329:381. (14 August)

2 Firth-Cozens, J. Individual and organizational predictors of depression in general practitioners. *British Journal of General Practice* 1998;48:1647-51.

The grass is always greener

EDITOR—With reference to the paper by Branson and Armstrong on general practitioners' perceptions of sharing workload in group practice,¹ it is part of human nature to think the grass is greener on the other side.

Sometimes it is, and sometimes it isn't, but in the complex work of general practice I remember a remark made by an experienced colleague: "If you don't think you are



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working harder than your partners then you're not working hard enough."

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What is intermediate care?

Nothing new

EDITOR—The editorial by Melis et al focuses on the difficulties the confusing terminology of intermediate care causes for researchers, opening with the statement that intermediate care is an emerging concept.¹ The definitions quoted include terms such as transition from illness to recovery, chronic impairment, restoration of health, and complex needs, primarily with reference to elderly patients.

Intermediate care is nothing new. An amalgam of these definitions describes comprehensive multidisciplinary assessment and management of complex medical and functional problems. This is "good old fashioned" geriatric medicine, and intermediate care when properly funded and organised is indistinguishable from it.

To navel gaze about the definition of intermediate care and the nuances of comparing research in this area is essentially to ignore the real issue. The real issue is ensuring adequately resourced multidisciplinary care led by appropriately trained doctors, and as such the editorial misses an opportunity to make a bold statement about core clinical services for elderly people.

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1 Melis R, Olde Rikkert M, Parker SG, van Eijken M. What is intermediate care? *BMJ* 2004;329:360-1. (14 August.)

More than a health service term

EDITOR—Any search for clarity or consensus on the meaning of intermediate care, as discussed by Melis et al,¹ is doomed to end in disagreement and disappointment. Much of the confusion stems from misunderstanding it as a medical intervention.

Intermediate care is a function or form of assessment and care and case management that challenges the one size fits all approach in favour of individually tailored efforts to meet needs, promote independence, and prevent further disability and distress. These tasks are not simply targets for health services. Intermediate care exposes the interdependency between health and social care (as well as housing, voluntary, and family support systems). If a definition is still needed, all these should help to shape the term.

The voices of older people also need to influence such debates. In our experience the term intermediate care is rather meaningless to most people receiving it, but they

do recognise a helpful, joined up, and reliable service if they are lucky enough to meet one. They do not mind whether the system is a trailblazer or troubleshooter, but they are affected if it is inaccessible and potential referrers are not sure of its criteria. So definitions matter.

Older people often wonder why services only last up to a maximum of six weeks, but that's another definitional problem.

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1 Melis R, Olde Rikkert M, Parker SG, van Eijken M. What is intermediate care? *BMJ* 2004;329:360-1. (14 August.)

A flawed substitute for rehabilitation in the United Kingdom

EDITOR—In asking what is intermediate care Melis et al point out one major conceptual error in the United Kingdom's version: it aims at relieving an administrative problem—namely, excessive bed occupancy.¹ They did not deal with the patient's perspective. To achieve change four issues need to be addressed, in sequence. What is needed? How can that need be met? Who can meet it? Who pays?

Patients' needs relate partly to the underlying pathological process.² Some are born with disabilities or acquire them early. Acquired illness in adult life may have expectations of improvement (for example, trauma), progression (for example, motor neurone disease), or relapse and remission (for example, rheumatoid arthritis).³ Recovering patients may require intensive or slow rehabilitation as inpatients to facilitate returning home. For patients with deteriorating conditions, community based teams, which work in the patient's own home and liaise closely with community agencies (educational, social, vocational), are more appropriate. Hospital and community teams can together ensure a patient's (re)integration into the community.

Not all people with disabilities are elderly. The UK government pays incapacity benefits to about 2.7m people of working age.⁴ Ultimately, the taxes paid by the working population facilitate the health services needed by all. We cannot neglect the rehabilitation of those of working age.⁵ Neither can we ignore the generic support services needed by disabled people of all ages—for example, wheelchair services.

The Department of Health, the British Geriatrics Society, and the British Society of Rehabilitation Medicine should jointly devise a strategy to meet the needs of Britain's disabled population.

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1 Melis R, Olde Rikkert M, Parker SG, van Eijken M. What is intermediate care? *BMJ* 2004;329:360-1. (14 August.)
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Beyond conflict of interest: maybe wrong questions are being asked

EDITOR—Lenzer reports that scandals have eroded the US public's confidence in the drug industry.¹ Although we should be shocked over the tangled fiduciary relations between the cholesterol guideline authors and Big Pharma, we should also examine how the underlying research was funded. Beyond the overt conflicts of interest among eight of nine authors of the guidelines, what of the funding sources for the studies upon which they were based? We need to ask if drug companies are driving not merely the conclusions but the questions to be researched.

The ATP III update recommendations were based on five major studies on the effects of three statins in lowering cholesterol concentrations. In all cases a majority of principal investigators had received money from pharmaceutical manufacturers through consultancies, lecture fees, or outright employment.

More importantly, all five studies were directly funded by the statin manufacturer(s). So before the conclusions were reached and the guidelines issued, the matter of what to investigate had apparently been determined by the funders.

There's little question that statins reduce cholesterol; tougher questions addressing causes of high cholesterol go unfunded. How many other good research questions will never be addressed because they are not expected to rapidly yield a profitable drug?

As we come to expect some fiduciary relations between clinical researchers and drug manufacturers, our healthy sense of outrage becomes numbed. Let's remember to direct what remains less toward the pipers and more toward those who call the tune.

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Competing interests: JD is a medical librarian and therefore has an indirect relationship with publishers of medical journals, but with no personal fiduciary interests other than job security.

1 Lenzer J. Scandals have eroded US public's confidence in drug industry. *BMJ* 2004;329:247. (31 July.)