Letters

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New drug treatment for Alzheimer's disease

Doctors want to offer more than sympathy

EDITOR—Yesterday a woman with Alzheimer's disease greeted me by asking spontaneously whether I had recovered from a cold that I had had at her last clinic appointment three months before. A man with the same condition has started to telephone his family again and is now able to go shopping for clothes. The benefits resulting from these two patients' treatment with donepezil are not trivial as Melzer seems to suggest[1]—a clinical trial is scarcely required to show the improvement.

Much is to be learnt from the way in which donepezil has been launched, but, because of the reaction of health authorities hundreds of patients who would by now have benefited from taking donepezil have been denied access to a properly licensed treatment. There are two pieces of subterfuge at work. Firstly, an economic and rationing argument is presented as being a clinical one, with a campaign to raise doubts about the effectiveness of donepezil. The available evidence shows that the drug is as effective as one might expect it to be; it is, after all, only a symptomatic remedy for a progressive disease. Melzer criticises the instruments used in the trials, but the company has followed the methodological requirements of the Food and Drug Administration, so to take exception after the event is unfair. Secondly, contrary to the principles of evidence based medicine and systematic reviews, which emphasise the importance of unpublished data, in the case of donepezil only published trials may be discussed, even though other data have been available all along.

News of new treatments and the enthusiasm accompanying them should not be censored. The representation of the debate among psychiatrists specialising in conditions relating to old age is being distorted. Is it reprehensible for us to wish to offer effective treatments to our patients rather than just sympathy?

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*Tom Dening has been reimbursed by Pfizer for attending a symposium and has submitted a research proposal to the company; neither author has an interest in prescribing donepezil or any other drug for dementia.

1 Melzer D. New drug treatment for Alzheimer's disease: lessons for healthcare policy. *BMJ* 1998;316:762-4. (7 March.)

Effects of drugs can be variable

EDITOR—I agree with Melzer regarding the need for all evidence from trials to be published or made available before a drug is marketed.[1] I take issue with him, however, over the question of effect size and his suggestion that it is too small to warrant using donepezil. He seems to see a small effect in all patients entering trials, whereas the evidence from trials of tacrine,[2,3] velnacrine,[4] donepezil,[5] and other cholinesterase inhibitors suggests that the effect is extremely variable, with large improvements in some patients and none in others.

At the moment we have no foolproof way of distinguishing potential responders from non-responders. When response occurs it does so relatively quickly. The only certain way of proceeding is therefore to use the drug for, say, 12 weeks and to observe the results systematically—surely not an unusual situation in medicine. Why should Alzheimer's disease be treated differently?

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*Competing interests: none declared.

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Drugs should not need to show cost effectiveness to justify their prescription

EDITOR—Melzer's paper is one of many that deal with the launch of donepezil and other future treatments for Alzheimer's disease.[1,2] The number of patients potentially eligible for treatment and their age seem to be the main factors leading to criticism of the cost. No other licence for a new product has been greeted with such fury. The implications for health authority budgets are serious.

The two health authorities served by Wirral and West Cheshire Community NHS Trust—South Cheshire and Wirral—have worked with the elderly mental health directorate, general practitioners, and the local branch of the Alzheimer's Disease Society to develop a measured response, which seems to satisfy most people. Donepezil and future drugs for Alzheimer's disease are prescribed only by the psychiatry of old age services, which has been given funding to provide extra staff and set up a central unit for diagnostic assessment with satellite follow up clinics. Drug treatment is prescribed according to strict guidelines, and the response to the drug is reviewed after three months. If the patient shows no response the treatment is stopped.

A limited budget can thus be directed to where it will be most effective. We save 17.5% of the total costs of the drugs by using prescriptions prescribed by hospital doctors and dispensed by community pharmacists. The cost is lower because VAT is charged on hospital pharmacy supplies.

We use only the 5 mg dose of donepezil as the drug companies have not shown an improvement with the 10 mg dose. Before agreement over protocols was reached and the clinic set up with an audit system in place in November 1997, donepezil was voluntarily not prescribed in our area, which allowed us to negotiate in a spirit of cooperation.

The true effect size, both clinically and economically, will be shown by the use of drugs only in clinical medicine, not in drug trials. Pilot studies for such evidence based medicine should be set up as a matter of course. Perhaps they could run at the same time as the classical double blind phase

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three trials; provided initial phase two work shows safety and some evidence of efficacy.

It takes so long for drugs to reach the market, and the cost of development is so high, that further delays would be counterproductive and lead to a reduction in the number of products that drug companies were willing to research. Why do these drugs need to show cost effectiveness to justify their prescription? Surely improved quality of life and delay in deterioration, such as is expected with, for example, chemotherapy, is sufficient justification.

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Information from unpublished trials should be made available

EDITOR—Melzer's call to end the secrecy surrounding the licensing of drugs and make available trial data for independent analysis is welcome.[1] I have participated in preparing a systematic review on the effectiveness of drug treatment for scabies.[2] Many important gaps in our knowledge have not been filled, not just about the effectiveness of treatments for scabies but about their side effects. Further unpublished information from drug company trials would provide valuable evidence. Yet although the companies admitted that these data existed, we were unable to obtain them. The Medicines Control Agency was similarly unhelpful. We should not forget that the original Medicines Act 1968, responsible for setting up the Medicines Control Agency to protect the public's health, resulted from secrecy on the side effects of another drug—thalidomide.

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Treatment with metrifonate warrants multicentre trials

EDITOR—Meltzer addressed the problems regarding the treatment of Alzheimer's disease with donepezil.[1] In the absence of published data it is difficult for clinicians to make informed decisions as to whether to treat with donepezil or not, particularly because of the potential financial implications for healthcare providers.

Another cholinesterase inhibitor drug, metrifonate, has been widely used for several years in schistosomiasis. This drug is considerably cheaper than donepezil (the patent has expired) and is well tolerated. Data suggest that the only side effects of note are mild vertigo, lassitude, nausea, and colic.[2] One double blind study compared treatment with metrifonate with placebo in 50 patients with possible Alzheimer's disease over three months.[3] The dose was titrated to achieve 40-60% inhibition of red cell cholinesterase activity, and outcome was measured by the cognitive subscale score of the Alzheimer's disease assessment scale. At the end of three months the scores in the group taking metrifonate were significantly higher than those in the placebo group, by 2.6 points ($P < 0.01$). There was a non-significant improvement in the metrifonate group of 0.75 points ($P = 0.15$), with a significant deterioration in the placebo group of 1.10 points ($P < 0.02$). Significant deterioration in the placebo group was recorded in the mini-mental state examination ($P < 0.03$) and on the global improvement scale ($P < 0.01$). Side effects were uncommon and did not necessitate changes in dose or discontinuation of treatment. Open treatment with metrifonate for up to 18 months showed a deterioration of 1.68 points a year in mini-mental state examination, as opposed to 3 points a year in Alzheimer's disease.[4] Metrifonate is cheap, relatively nontoxic, and it would not place a major financial burden on patient care. This warrants further multicentre trials if it is assumed that restoration of cholinergic transmission would delay deterioration in Alzheimer's disease.

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SMAC's advice on use of donepezil is contradictory

EDITOR—We are surprised by the contradictions between the advice of the Standing Medical Advisory Committee on the use of donepezil for Alzheimer's disease,[1] the committee's principles for giving this advice, and the evidence to support the use of donepezil. The committee states that a principle of its guidance is that "resources should not be diverted to treatments whose . . . cost effectiveness is not yet proven." In its assessment of the effectiveness of donepezil the committee states that "the available evidence is not sufficient to give a clear verdict on the cost-effectiveness of donepezil." We might therefore assume that resources should not be diverted to pay for donepezil, but the guidance to clinicians implies otherwise.

Health authorities work with local clinicians and communities to try to interpret available evidence on the effectiveness and cost effectiveness of treatments so that decision making is clear, open, principled, and fair. The committee's guidance cannot be justified on the basis of the argument it presents and is most unhelpful.

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1 Standing Medical Advisory Committee. *The use of donepezil for Alzheimer's disease.* London: NHS Executive, 1998.

Age is not only criterion for flu vaccine

EDITOR—The Department of Health has announced that influenza vaccine is to be recommended for all people aged 75 and over with effect from the 1998-9 winter season[1]; this represents an extension to the previous policy of targeting people of all ages with high risk conditions.[2] We welcome universal targeting of very elderly people, which offers favourable cost benefit and simpler logistics for those involved in delivering the vaccine, but the attention of primary care professionals must also remain focused on people aged under 75 who have conditions that place them at risk of flu and its complications.

We recently interviewed 232 patients admitted as medical emergencies (all causes) to a large teaching hospital in West Midlands between 2 April and 30 May this year, all of whom had one or more indications for flu vaccine.[2] During the 1997-8 winter season in the same area a local policy existed to offer flu vaccine to all people aged 65 and over. The table shows the vaccine uptake by age group. It is noteworthy that uptake during the 1997-8 season was 61% among patients aged 75 and over with indications for the vaccine, compared with only 27% among those below this age ($\chi^2 = 25.3$, 1 df, $P < 0.05$).

Although based on a sample of patients in hospital, these data nevertheless show that uptake of flu vaccine was considerably lower in people with high risk conditions who were aged under 75. Therefore,

Uptake of influenza vaccine in 1997-8 winter season among 232 patients in hospital with one or more indications for vaccine

	Age group (years)					
	15-44	45-64	65-74	75-84	≥85	Total
Influenza vaccine received:						
Yes	2 (8)	20 (30)	17 (31)	36 (55)	18 (82)	93 (40)
No	22 (92)	46 (70)	37 (69)	30 (45)	4 (18)	139 (60)
Total	24 (100)	66 (100)	54 (100)	66 (100)	22 (100)	232 (100)

$\chi 2$ for trend = 31.64, 1 df, P<0.0001.

although the risks of serious morbidity and mortality due to flu certainly increase with age,[3 4] the new age related guideline issued by the Department of Health must not be interpreted in isolation; primary care professionals must remain committed to active targeting of high risk patients aged under 75.

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Discrepancy remains in pharmaceutical prescriptions in four European countries

EDITOR—Several years ago we reported the drugs that had been most widely sold by value in four countries in Europe (France, Germany, Italy, and the United Kingdom) in 1992.[1] We report here the drug sales in the same countries in 1996.

We firstly established how many of the 50 products that were most widely sold in the four countries did not have appropriate documentation of efficacy. In France, Germany, and Italy the use of useless drugs had fallen considerably; in Italy this was related to the "cultural change" that occurred in 1994 as a result of a law aimed at rationalising drug classification and reimbursement by the national health service.[2] In the United Kingdom the first 50 products by value did not include any drugs considered ineffective. In Italy there was only one drug (a preparation of lactobacilli) in the first 50 whose therapeutic value was unproved, whereas in 1992 there were 10. In Germany there were three products of unproved therapeutic value (six in 1992): ginkgo biloba, naloxone-tilidine, and thioctic acid). In France there were seven such products (10 in 1992), including herbal extracts, ginkgo biloba, and flavonoids.

In addition, the therapeutic classes of the most sold products were strikingly different between the countries, which may partly be explained by therapeutic attitudes and by different means of drug distribution—that is, pharmacies versus hospital. In the United Kingdom, among the first 50 products there were seven (glucocorticoids) for the treatment of asthma, three β adrenergic blockers, and three serotonin reuptake inhibitors. In Italy there were two products containing interferon alfa, two benzodiazepines, and two antiandrogens. In Germany the use of contraceptives (three products) and antibiotics predominated. In France vasodilators (three products), heparin (two), and antibiotics (seven) were popular.

Finally, it is interesting that in 1992 seven of the products among the top 50 in each if the four countries were common to the four countries; in 1996 only five were—captopril, omeprazole, ranitidine, simvastatin, and amlodipine. Amlodipine was not common to the countries in 1992, while aciclovir, enalapril, and nifedipine were not common to the four countries in 1996. Clearly, there is still a long way before harmonisation of drug prescriptions becomes a European reality.

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1 Garattini S, Garattini L. Pharmaceutical prescriptions in four European countries. *Lancet* 1993;342:1191-2.
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Informed consent

Numbers inform the debate

EDITOR—Smith's editorial recognises the complexity of the issue of informed consent and states that the *BMJ* is prepared to relax its absolutism.[1] At the risk of being misunderstood I would like to attempt to construct a decision theory model based on certain explicit assumptions that may allow us to compute numerical values better to inform the debate. At the outset I accept the ethical principle of non-exploitation so beautifully described by Mary Warnock[2]; I also accept the importance of consumers' involvement (I was the founding father of the consumers' advisory group for clinical trials chaired by Mrs Hazel Thornton).

Let us anticipate 150 000 deaths from breast cancer in this country over the next 10 years and let us make the conservative assumption that we already possess a novel therapeutic adjuvant that in absolute terms would reduce the risk of death by 6% over this period—in other words, save 9000 lives.

Next let us assume that the UK Coordinating Committee for Cancer Research has approved three different clinical trials evaluating three promising new agents, any one of which might produce this desired 6% absolute reduction in mortality, which is equivalent to a relative risk reduction of about 25% for patients with an average prognosis. Each trial would need to recruit about 2000 patients to have adequate statistical power to detect this order of relative risk reduction. Let us now suggest that trial A will show no difference between best standard treatment and the new treatment. Trial B will show that the new treatment will produce the desired benefit, and trial C will show that the new treatment is worse by the same order of magnitude. In aggregate 6000 women will have been recruited to these three trials. Altogether 120 will be better off than if they had had best standard treatment, and 120 will be worse off than if they had best standard treatment.

If we have an efficient clinical trials organisation then on past experience we might expect at the best to recruit 1000 patients a year, so whether the trials run in parallel or in sequence the total recruitment time will take six years. So far I have based my assumptions on the experience of using conventional informed consent procedures. Now, for example, let us perturb the model by prerandomising the patients within the trial, seeking consent for the treatment on offer while not discussing the issues of the random allocation of treatment; it is pure speculation as to what extent this will speed up recruitment into the trials. I would guess that a conservative estimate would be doubling the rate of recruitment so that the total sample will have accrued in three years rather than six years. Let us then assume that the results of the trials are implemented rapidly within the country once the results are available. We can then calculate the price of autonomy. A treatment that produces an absolute reduction of 6% a year would save 900 lives a year; the price of autonomy is the cost of 2700 lives lost.

It is not the role of someone like myself or the medical profession as a whole to judge these issues, but we could go back to true representatives of the lay public by way of postal surveys or focus groups to discover what price the public puts on the ethical imperative of self determination.

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1 Smith R. Informed consent: edging forwards (and backwards). *BMJ* 1998;316:949-51. (28 March.)
2 Warnock M. Informed consent—a publisher's duty. *BMJ* 1998;316:1000-5. (28 March.)

"Technical" consent is inevitable in some circumstances

EDITOR—Power argues for better informed consent for patients entering clinical trials and says that this consent is often obtained "technically without any real commitment to its spirit."[1] This problem is common in obtaining consent generally, whether for research or treatment, and a signature on a "consent" form can nearly always be obtained. Under some circumstances, I believe "technical" consent is inevitable. Some years ago, I was the principal investigator in a clinical trial of a novel method of regional analgesia during labour and delivery.[2] Written informed consent was to be obtained from mothers in established labour who had requested regional analgesia. It was not long before I realised that a few minutes was all the time I had to explain the study and obtain consent. Once a uterine contraction occurred in the middle of my explanation, the mother's attention and concentration was lost. After the contraction had passed, many cut off any further explanation and made their decision on what I had already said. To my knowledge, no one read the patient information leaflet until after delivery.

This phenomenon is well known to obstetricians and anaesthetists when obtaining consent for treatment and surgery during labour. The mother is often frightened, in pain, exhausted, and realises there is anxiety in the midwifery and medical staff. The ethical problem of obtaining consent in this situation is different, however; the doctor explains what is thought to be necessary, and the patient trusts the doctor to be acting in her best interests. Many mothers realise that there is an emergency and detailed explanations are wasting time. This is not the case in research; medical uncertainty is a much more complex concept and comes as a surprise to some patients. It is not possible to convey this adequately in a few minutes. My study allowed the mother to choose, after explanation, which type of regional analgesia she would like. If a study is blinded and randomised, the patient has to also understand not only that the doctor does not know what is the best thing to do, but that neither the patient nor the doctor has any choice or knowledge of what treatment the patient will receive.

I do not believe it is possible to obtain informed consent for randomised trials from women in labour, but this is often done.[3 4] Ideally, consent would be obtained before the onset of labour, but this is not currently practical, and it would raise the additional problems of obtaining consent from large numbers of women who would not then enter the trial, and obtaining consent a considerable time in advance of the study. Should all mothers be recruited into all possible trials at their first antenatal visit?

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Consent might have been obtained under duress

Editor—I should like to add a further dimension to the discussion of informed consent,[1-3] that of consent obtained from a subject and which is also informed but was only agreed to by the subject under duress. Examples exist in civil and criminal law: drinking drivers will lose their licence unless they agree to provide a breath or blood sample should this be necessary; a court has a right to assume in a case of disputed paternity where the father refuses to have a blood test that indeed he is the father. In medical care, mentally ill patients may be told that unless they take the drugs they are prescribed they will be subject to one of the detaining orders of the Mental Health Act. Similar examples exist in the field of research and in other areas of medical practice.[5] It would be interesting to know the views of publishers when faced with the dimension of coercion with informed consent.

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2 Doyal L; Tobias JS; Warnock M; Power L; Goodare H. Informed consent in medical research. *BMJ* 1998;316:1000-5. (28 March.)
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Explicit consent is not needed for studies using medical records

Editor—Goodare has failed to acknowledge the practical consequences of her proposal to make explicit informed consent a mandatory requirement for all studies involving the use of medical records.[1]

Many population based studies involving the use of medical records have more in common with public health surveillance activities than with studies involving direct contact with patients. Identifying information is required for a variety of reasons, including the need to avoid duplicate records and the need to link to follow up information, such as date of death, permitting survival analysis. Postcode is used to undertake analyses by area or to gain derived data such as measures of socioeconomic status. Patients have given consent to treatment; the purpose of these studies is to see if they have received appropriate treatment and to inform policy regarding the delivery of care. Data arising from analyses and incorporated in publications are strictly anonymous.

We are unclear why the Scottish breast cancer audit[2] was singled out for criticism. This study extended the cancer registration data set by revisiting medical records, a task performed by data abstractors employed by the same NHS organisation as cancer registry staff and subject to the same stringent regulations on security and confidentiality of data. We are surprised that an advocate for patients with breast cancer would have opposed the publication of two similar studies that have been influential in driving forward improvements in services for patients with breast cancer.[3 4] All of these studies were retrospective and it would not have been possible to obtain consent from more than a proportion of patients because many had died and some would undoubtedly have changed their address, making them difficult to trace.

The crucial value of these studies is precisely that they are population based. Requiring patients to "consent in" would introduce unquantifiable selection bias and undermine the validity of the studies.

The substantial benefits arising from research using medical records have been described[5]—these should not be taken for granted. We think that with tight controls concerning confidentiality, the present system is both ethical and in the best interests of all patients—past, present, and future.

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Screening programmes need consent forms

Editor—The recent "Ethical Debate" on informed consent concentrated on consent within the context of medical research.[1] One area of routine medical practice in which there is an urgent need for consensus on the need for informed consent is that of screening programmes, especially cervical and breast cancer screening.

Recent reports into alleged failures at Kent and Canterbury Hospital and other laboratories have highlighted the difficulties in the interpretation of cervical smears.[2] The concept of false negative and false positive reports is a difficult one for the public and even some health professionals to grasp. However, recent guidelines on the information sent to these women barely touch on the subject, as if it were taboo.[3]

Many studies show that, even in the best laboratories, at least 5-15% of abnormal smears may be reported as normal. Women should be given the full facts and invited to sign a consent form before undergoing the test, if only to protect laboratories from litigation when they issue a false negative report. An example of such a consent form maybe found on the internet (http://www.cytopathnet.org).

The present situation is no longer tenable, especially in an era when surgeons are encouraged to explain the exact risks of operations to their patients before undertaking surgery.

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1 Doyal L; Tobias JS; Warnock M; Power L; Goodare H. Informed consent in medical research. *BMJ* 1998;316:1000-5. (28 March.)

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Policy has loopholes

EDITOR—Recently we faced an ethical dilemma regarding notification of the partner of a patient who died just hours after being informed she was HIV seropositive and whose family were unaware of the final diagnosis. The case raised many important ethical issues, particularly the tension between duty of care to the patient and that to the wider community.

We would like to publish salient case details annotated by respected commentators so that colleagues can openly debate these issues. According to the *BMJ's* current policy, "in papers describing recent experiences with patients, consent [for publication] will always be necessary." But how can we obtain consent now that the patient has died? How long is "recent"? It is not unusual for patients with HIV infection to die without the immediate kin being aware of the diagnosis, usually (as in our case) because of late presentation. Such cases commonly appear at clinicopathological conferences or raise ethical issues and in themselves have educational value. In these circumstances, what constitutes valid consent for publication?

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Parents have views on how it should be obtained

EDITOR—Although much has been published about the moral and ethical issues surrounding informed consent, little has been written about the practical aspects of consent.[1-3] To investigate the who, when, and how of obtaining informed consent we interviewed 50 parents after their child's operation.

Who the parents thought should obtain consent (table) is in stark contrast with the reality, in which consent was obtained by the ward doctors from most patients (80% in this series). However, 82% of the parents interviewed had had the operation explained by a consultant. Informed consent therefore has two components: informing the patient or parent about the procedure and signing the consent form. In general, consultants explain the operation at the initial consultation. Is it therefore acceptable to obtain informed consent in clinic many weeks or months before the operation? In our study most parents thought that this was not acceptable (table).

View on informed consent of parents shortly after their child's operation

Question and answers	No of parents (n=50)
Who should obtain informed consent?	
The surgeon who does the operation	29
A surgeon who can do the operation	10
A doctor on the team	6
A nurse on the ward	5
When should informed consent be obtained?	
In clinic	6
On the ward	37
In the theatre	4
No opinion	3

Forty per cent of parents wanted the information to be given by discussion alone, with 56% indicating that an information sheet, in addition, outlining the operation, treatment alternatives, and potential problems would be beneficial. Information sheets would ensure that a minimum standard of information is given. Parents and children would be able to read the information before the discussion with the doctor, and so potential queries could be highlighted.

In this survey 98% of parents thought that potential complications or risks should be explained; 56% wanted to know of complications with an incidence greater than 1% and 90% wanted to know of complications that occurred in more than 10% of operations. This suggests that in obtaining informed consent any complication with a frequency greater than 10% needs to be discussed. Complications with an incidence of 1 in 100 might also need to be explained.

This survey indicates that parents would like consent to be taken, at the time of admission, by the surgeon who is going to, or can, perform the operation. The operation should be explained as a combination of a discussion and an information sheet, which would include a list of complications that occur with an incidence of greater than 1 in 10 operations. With current working practices these results may be difficult to implement.

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1 Alderson P. *Children's consent to surgery.* Milton Keynes: Open University, 1993.
2 Shield JPH, Balm JD. Children's consent to treatment. *BMJ* 1994;308:1182-3.
3 Kohrman A, Clayton EW, Frader JE, et al. Informed consent, parental permission and assent in pediatric practice. *Pediatrics* 1995;95:314-7.

WHO haemoglobin colour scale is modern version of what was used previously

EDITOR—Minerva recently drew attention to the World Health Organisation haemoglobin colour scale for near patient determination of haemoglobin concentrations.[1 2] This apparently elicited response from "a lot of elderly readers" who suggested that it is simply a reinvention of the old Hawksley colour scale. It is, in fact, based on the even earlier "blotting paper" method, which was developed by the Finnish physiologist Theodore Talqvist in 1900, and which has become obsolete and discredited, as have the Hawksley scale and several other similar devices.

But that is where the similarity with our device ends. We identified a particular type of chromatography paper to be the test strip matrix so as to ensure even spread of the blood with constant drying. The spectral characteristics of the colours produced by blood from a set of haemoglobin standards were identified by a computerised analytic spectrometer. These specifications were reproduced in light-resistant printing inks prepared from the three primary colours and a neutral diluent; advanced technology pigments were used to obtain a high level of light fastness. The colour shades were printed at a defined ink density on a specialist paper that was chemically neutral, unbleached, and chlorine-free to avoid premature ageing or yellowing that could affect the ink colour. The colour strips were then mounted on a neutral grey surround with a rigid white polyvinyl chloride backing so as to avoid interference from reflected light.

These specifications resulted in the device, which the laboratory based evaluation reported in our article showed to be a reliable screening method.[3] This evaluation has recently been followed by an international validation study with 6400 tests at several primary health clinics, antenatal clinics, and blood transfusion donor sessions. The results (to be published) have shown an accuracy of over 90% in detecting anaemia (haemoglobin <120 g/l) and a reliability of 80-90% in distinguishing the severity of anaemia.

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1 Minerva. *BMJ* 1998;316:638. (21 February.)
2 Minerva. *BMJ* 1998;316:1030. (28 March.)
3 Lewis SM, Stott GJ, Wynn KJ. An inexpensive and reliable new haemoglobin colour scale for assessing anaemia. *J Clin Pathol* 1998;51:21-4.

Protecting breast feeding from breast milk substitutes

Royal college supports promotion of breast feeding

EDITOR—In its submission to the Acheson inquiry on poverty and health (the findings of which are expected to be published in autumn 1998) the Royal College of Paediatrics and Child Health proposed interventions to increase the number of women breast feeding their babies. At the college's 1998 annual general meeting Unicef accepted an invitation to set up a stand at the trade exhibition to provide information on its baby friendly initiative, which was designed to help establish breast feeding and was launched in 1991. Also at that meeting members and fellows reaffirmed

their unequivocal support for the practice and promotion of breast feeding in a policy statement. This was policy states that "women should be encouraged to practice exclusive breastfeeding for the first 4-6 months of their infant's life. Thereafter, infants should be enabled to breastfeed while receiving appropriate and adequate weaning food for as long as this meets with their mothers' wishes and convenience."[1]

Therefore, we were surprised and disappointed to read some of the sentiments expressed in the editorial by Costello and Sachdev on encouraging breast feeding which reminded doctors that manufacturers of infant milk substitutes may attempt to seek "endorsement by association" or "passivity towards their products."[2] They cited as examples the failure of the Royal College of Paediatrics and Child Health to join the interagency group on monitoring breast feeding and the fact that the college accepts research funds from manufacturers of breast milk substitutes. In fact, the college declined to join the group not because it was opposed to its aims but because of legitimate concerns about the proposed research methodology.

The college takes the issue of commercial sponsorship seriously, not only in the area of breast milk substitutes. At the 1997 annual general meeting the college's ethics committee was asked to investigate the marketing of breast milk substitutes and provide recommendations for action. Its report will be ready later this year. In the meantime no further research funding or donations have been or will be accepted from manufacturers of infant formula.

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1 Royal College of Paediatrics and Child Health. *Policy statement, June 1998.* London: RCPCH, 1998.
2 Costello A, Sachdev HS. Protecting breast feeding from breast milk substitutes. *BMJ* 1998;316:1103-4. (11 April.)

Authors' reply

EDITOR—It is disappointing, but perhaps predictable, that Jacobs and Bronner,[1] representing the Infant and Dietetic Foods Association and the International Association of Infant Food Manufacturers respectively, responded negatively to the report of widespread violations of the World Health Organisation's international code of marketing of substitutes for breast milk.[2] They suggest that the peer reviewed interagency study has been "severely criticised," but provide no details or published peer reviewed references to validate this criticism. Although they suggest that the code does not apply to follow on formulas, the code states that any product marketed "as being suitable for the partial or total replacement of breast milk" is covered by its recommendations.[2] Jacobs and Bronner also use an old industry strategy of avoiding their responsibilities to honour the code by suggesting that "local regulations and codes" are crucial. In many countries not all of the components of the code are established in national legislation, and readers should be reminded that the industry agreed to abide fully by the code when it was first drawn up in 1981.

We are delighted that Marcovitch et al emphasise that the Royal College of Paediatrics and Child Health will take stronger measures to support breast feeding, and that they do not plan to accept further donations from manufacturers of infant formula until they receive a report from their ethics committee. Their refusal to join the study done by the interagency group because of "legitimate concerns" about the research methodology raises two points. Firstly, the college's policy is to fully support the code so surely it would have been better to join the interagency group and help develop the methodology. Secondly, the research unit at the college that commented on the methodology was funded by a donation from Nestlé; this seems to represent a conflict of interest. We would argue that the college has been weakened by its financial link with the manufacturers of infant formula because its pronouncements on these important and sensitive issues must be seen to be fully independent.

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1 Jacobs S, Bronner A. Marketing of breast milk substitutes [letter]. *BMJ* 1998;317:350. (1 August.)
2 World Health Organisation. *International code of marketing of breastmilk substitutes.* Geneva: WHO, 1981.

Health workers must be protected from conflicts of interest

EDITOR—The editorial by Costello and Sachdev on breast feeding and breast milk substitutes illuminates one of the methods manufacturers of formulas and food for infants are increasingly using as a marketing tool: association with "prestigious national bodies."[1] Last year the National Childbirth Trust charity was torn apart by conflict after it accepted short term sponsorship from a supermarket in the United Kingdom that sells its own brand of infant formula. Some volunteers who provide support to women who are breast feeding argued that accepting the sponsorship implied endorsement of the infant formula and compromised volunteers' ability to give, and to be seen to give, impartial information to women.

In September 1997 the Breastfeeding Network was launched as a home for the volunteers who support breast feeding, who wanted to continue to work to promote breast feeding, and who had left the trust as a result of the sponsorship. As a new organisation, we are committed to remaining independent, and to not profiting from the choices women make about how to feed their babies. We welcome the editorial's call for "financial support for advocacy groups" such as ours. Without this support, we will inevitably find it difficult to accomplish all that we otherwise could.

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1 Costello A, Sachdev HS. Protecting breast feeding from breast milk substitutes. *BMJ* 1998;316:1103-4. (11 April.)

Study about marketing of substitutes was not correctly designed

EDITOR—The article and editorial about the marketing of breast milk substitutes may illustrate the importance of declaring all competing interests rather than just financial ones.[1 2] I was asked by the Infant and Dietetic Foods Association to investigate whether the report and protocol on which these were based could support the conclusions drawn.

I formed the view that these documents, especially the interpretation of the results, were not ones likely to be produced by a truly independent and objective research organisation. On a more even handed interpretation, the results suggested that companies were not, as had been suggested, systematically breaking the World Health Organisation's code. The Interagency Group on Breastfeeding Monitoring has seen and not contradicted my reasoning. Taylor's article takes account of some of my criticisms[1] but contains incorrect statements not in the original report. Some examples follow.

The protocol showed partiality by stating the research aim as "To obtain objective evidence of violations of the International Code of Marketing of Breastmilk Substitutes." This was not some accident of wording. A later note states "It should be noted that while the aim of this research is to provide objective evidence of violations, should it not find such evidence, it cannot be concluded that violations do not exist."

The report claimed that "many companies are taking action which violates the Code, and in a systematic … manner." The data showed that only 1.1% of the women interviewed said that they had received "negative information" from companies. For free samples the proportion was 0.8%. The pattern varied unsystematically between countries and companies.

Under "sampling procedure" Taylor's article claimed "A sample of 800 women would give a 95% power to observe at least one reported violation if the true prevalence was 2%." In fact, the chance is considerably greater than 99.9%.

The editorial claimed that the study had internal consistency since "the country with legislation had the least free samples and that with no code had suffered the most violations." There was no such relation for free samples or gifts to women or to health facilities.

I agree that surveys can assist in monitoring compliance. As with all research, however, they must be correctly designed and con-

ducted and interpreted fairly. An outline protocol to achieve this was sent to the Interagency Group on Breastfeeding Monitoring, but the group has refused to discuss it or to cooperate in its implementation.

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1 Taylor A. Violations of the international code of marketing of breast milk substitutes: prevalence in four countries. *BMJ* 1998;316:1117-22. (11 April.)
2 Costello A, Sachdev HS. Protecting breast feeding from breast milk substitutes. *BMJ* 1998;316:1103-4. (11 April.)

Doctors and patients should sign prescriptions ◑

Editor—Patients often fail to adhere to prescribed drug regimens, and efforts to improve compliance have not had sustained success.[1 2] A therapeutic alliance between patient and doctor, albeit at higher cost, may show the way forward. The adoption of this concordance model for the relationship between patient and prescriber should ensure that decisions on prescribing are made jointly, with both parties in agreement and with responsibility shared.[3 4] To signify that such an agreement has been struck we suggest that the prescription should be signed jointly both by the doctor (or dentist or nurse) and by the patient.

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1 Marinker M. Writing prescriptions is easy. *BMJ* 1997;314:747-8.
2 Milburn HJ, Cochrane GM. Treating the patient as a decision maker is not always appropriate. *BMJ* 1998;314:1906. (28 June.)
3 Mullen PD. Compliance becomes concordance. *BMJ* 1997;314:691-2.
4 Marinker M. Compliance is not all. *BMJ* 1998;316:151. (10 January.)

◑This letter was first posted on the BMJ's website on 5 August.

Planning the United Kingdom's medical workforce

Editor—Planning the medical workforce has recently been the subject of headline news in both the medical and the lay press.[1–3] The third report of the Medical Workforce Standing Advisory Committee recommended increasing the intake of medical schools by about 1000 students a year.[4] The health secretary, Frank Dobson, confirmed plans to phase this increase to help create the "extra" 7000 doctors necessary to staff the NHS. I hope that these extra doctors are not solely juniors, otherwise it will only create further problems.

There is no contention that more doctors are needed. This need has many reasons, including the reductions in junior doctors' hours, the Calman reforms, the fact that more women are in medicine, and increasingly high expectations on the patient's part.[1] We can increase the number of juniors only if we increase the number of job opportunities at the other end (general practitioners or consultants).

At present planning of the medical workforce in the United Kingdom fails. In my specialty of obstetrics and gynaecology fully trained doctors (on the specialist register) are unable to find appointments as consultants. There are two reasons for this—the Calman reforms and inaccurate workforce planning. Currently the specialty has 150 such registered doctors, some facing redundancy in the near future when the 18 month extension after they have gained their certificate of completion of specialist training expires. On average (in this specialty) 70-80 consultant positions have been available annually over the past few years. Roughly half of these are new posts (created with task force money), and half are the result of retirements or deaths. In reality rates of consultant expansion are now slowing (3.1% in 1997, currently 2% this year, predicted to be more than 6.5% for the next five years), and output is increasing.

If further home produced junior doctors enter the equation the situation will worsen. Even more than the fifth of doctors who currently leave in their first 10 years[5] will be lost, at vast expense to the taxpayer and to the profession. So in times of increasing clinical throughput and patient expectations, with developing demands for clinical governance and a consultant based service, surely Mr Dobson and colleagues must first think of increasing the numbers of consultants and retaining more doctors in training before increasing the number of medical students, who will soon become disillusioned with their prospects.

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1 Goldacre M. Planning the United Kingdom's medical workforce. *BMJ* 1998; 316:1846-7. (18 June.)
2 Klein R. A generous birthday present to the NHS. *BMJ* 1998;316: 224-5. (25 July.)
3 Wilson E. Why can't we train enough doctors? *Daily Mail* 1998 July 24:1.
4 Medical Workforce Standing Advisory Committee. *Planning the medical workforce. Third report.* London: Department of Health, 1997.
5 Lambert TW, Goldacre MJ, Parkhouse J, Edwards C. Career destinations in 1994 of United Kingdom medical graduates of 1983: results of a questionnaire survey. *BMJ* 1996;312:893-7.

New Labour's new maths is hype

Editor—In his editorial Klein got it wrong: the figure of £21 billion extra for the NHS in the United Kingdom over the next three years is an example of the Labour government's new maths rather than its new generosity.[1] According to figures for England, for example, next year the NHS will receive an extra £3.1 billion; the year after, an extra £2.8 billion; and the year after that (2001-2), £2.8 billion.

In conventional, if boring, accountancy, this adds up to an increase over three years of £8.7 billion—not, as the Department of Health's press release stated, £17.7 billion (the equivalent figure for the British NHS is the much headlined £21 billion).[2]

The government has effectively counted next year's increase three times, the second year's twice and the third year's once to arrive at the inflated total. If the same accounting is applied to all the increases the NHS has received since 1948 we would expect this year's budget to top £602 billion—about 70% of the country's gross domestic product. Similar mathematics were used to present all the spending plans announced by the chancellor.

The actual increases are not too bad, which makes the triple helping of hype hard to swallow. After allowance is made for inflation as experienced by the NHS, the impact of the minimum wage, paying off trusts' debts, etc, the increases each year until 2001-2 will probably work out at an average of 3%.

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1 Klein R. A generous birthday present to the NHS. *BMJ* 1998;317:224-5. (25 July.)
2 Department of Health. *£20 billion boost for the NHS.* London: DOH, 1988. (Press release, 14 July.)

Standardisation for age certainly changes proportions of doctors holding merit awards

Editor—Surely there is an arithmetical error in Dudley's letter about racial discrimination in distinction awards[1]; 61 out of 221 white neurologists with merit awards is indeed 27.6%, but 1 out of 18 non-white ones is not 0.06% but 5.6%.

It is essential that, as Williams states,[2] rates of award are standardised by age when both non-white and women consultants are being considered. About 12 years ago I noted the ages of all doctors in Scotland who held merit awards; at that time, if my memory serves right, awards were held by about 35% of the consultants. The number of award holders under the age of 40 was minimal. By contrast, of the consultants due to retire that year, 68% had awards. Is the situation still the same?

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1 Dudley N. Racial discrimination in distinction awards. *BMJ* 1998;316:1979. (27 June.)
2 Williams K. Racial discrimination in distinction awards. *BMJ* 1998;316:1978. (27 June.)

Correction

The hot air on passive smoking

An error occurred in the table accompanying this letter by Nemery et al (1 August 1998). The row of figures relating to J R Idle should have read 159, 12, 12, and 4 (not 159, 12, 1, and 24, as published).