

The Back Pages

Selling drugs

Two articles in this issue of the *BJGP*, both from the USA, warn against the pharmaceutical industry's campaign to legalise direct-to-consumer advertising (DTCA) throughout the European Union.^{1,2}

Their publication coincides with a conference on the same theme held in Brussels recently,³ which spelt out the potential dangers of the proposed change in law. There is now firm evidence from the US experience that DTCA is very likely to distort expectations, generate unsustainable demand, widen health inequalities, confuse the vulnerable, and divert limited resources from more overtly justifiable causes.^{4,5} If DTCA were legalised, prescribers would, in theory, be able to refuse to authorise a drug that is not indicated, or to recommend a generic or branded alternative. In practice, this will not always happen, especially when the indications for the drug are contestable, the problem complex, the patient particularly resolute, or the physician ill-informed or pressed for time.

The proposal to place more information in the hands of the consumer reflects both the changing power balance between patients and doctors and the changing nature of knowledge itself — which is increasingly ubiquitous and publicly owned. DTCA also represents a metaphorical loss. The prescription pad has long been the symbol of the doctor's control, if not over the illness itself then over the extent and duration of suffering. In the public perception, a doctor can choose to give you an antibiotic, an antacid, or a strong painkiller. Alternatively, and seemingly on whim, they can tell you to pull yourself together or make do with whatever you can get over the counter.

Given the industry's economic strength and political influence, and the prevailing ideological climate (freedom of information, lack of state intervention in the free market), attempts led by the medical profession to stop the DTCA genie emerging from its bottle are likely to be interpreted as a reactionary and ill-judged defence of vested interests. But the industry's claim that DTCA is about consumer rights or patient empowerment is misplaced. There is little if any demand from patients for access to advertising on prescription medicines and, indeed, the campaign against DTCA is predominantly consumer-led.^{6,7}

At the Brussels conference, Leon Wever, Director of Pharmaceutical Affairs at the Dutch Ministry of Health, argued persuasively that there is ample scope within the existing legislative framework for pharmaceutical companies to provide information about their products to those likely to benefit from them.³ Articles and news features in the general media, industry sponsorship of information materials, disease awareness campaigns, links with patient support groups, and similar initiatives are already legal (and undoubtedly already serve as 'quasi-DTCA').

If the industry wins the day, what can be done to minimise the distorting influence of DTCA on consumption patterns of prescription drugs? Regulatory measures should include heavy penalties for telling lies; the insertion of compulsory health warnings (e.g. 'This is a prescription-only medicine. It may not be appropriate in all cases of the condition illustrated. Your doctor will help you decide whether it is the right choice for you.');

an effective and responsive complaints procedure (funded by the industry but entirely independent of it); and perhaps even an independent body with both professional and lay representation to approve all DTCA advertisements before they are released. Furthermore, if debate about the efficacy, effectiveness, and cost-effectiveness of prescription medicines is to be placed in the public domain, decisions by the Medicines Control Agency and the National Institute of Clinical Excellence will — controversially — need to be far more transparent.

Note, however, that the regulation of advertising can never do more than ensure the factual accuracy and restricted distribution of information. Regulatory measures will not help us with moral and ethical decisions on what ought to happen. The demand by the informed consumer for 'health for me', for example, may conflict with the desire by a civilised society to achieve 'health for all'. One potential positive spin-off of the DTCA debate is that professionals are finding it ever more difficult to conflate facts (such as the benefits and harms of medication) with values (such as how best to cut the cake of limited resources) when denying patients the drugs they ask for.

The role of the doctor in society is rapidly changing from expert decision maker to information sifter and conveyor of judgments about how society chooses to levy and allocate public funds. The drive for DTCA is a symptom, not a cause, of this fundamental social change. The industry's inherent tendency to pursue the profit motive needs appropriate counter-measures, but an equally urgent problem is that doctors do not have the training, the time, or the mandate to perform the extended role that is now required of them.

Trisha Greenhalgh

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Conflict of interest

Trisha Greenhalgh is a member of the Appraisals Committee of the UK National Institute of Clinical Excellence. These views are her own and do not necessarily represent those of NICE.

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Clinical Excellence 2001

THE Annual Conference and Exhibition of the National Institute for Clinical Excellence (NICE) took place in December at ExCel, the new convention venue in the Docklands area of London. Hundreds of delegates attended this conference — the largest such gathering of NHS staff involved in clinical governance and quality. There were three streams to the conference within the overall title of ‘Working Together to Understand the National Picture, Deliver Locally and Develop NICE Guidance for the NHS’

The conference opened with a plenary address by the chairman of NICE, Professor Sir Michael Rawlins who presented his analysis of NICE’s work to date. This was followed by presentations from the chief executives of NICE, the Commission for Health Improvement (CHI), and the NHS Modernisation Agency, in a session entitled ‘The Direction of Travel’ — the aim being to present an integrated approach to the NHS quality programme. Peter Homa gave a powerful address and I was struck by a remark he made about the ‘poverty of data’ on clinical performance that CHI have encountered during their clinical governance reviews. Most clinical governance leads would agree with this. Much of the information about current activity in clinical governance is related to process measures as opposed to outcome data. Much more needs to be done to routinely generate clinical audit data.

The NICE conference was also significant for an unusual intervention made by a member of the audience; this particular audience member was the eminent Iain Chalmers, Head of the UK Cochrane Centre, who raised the issue of the extent to which pharmaceutical companies make data available to NICE during a technology appraisal. He raised this question on two separate occasions including the plenary session: should pharmaceutical companies be compelled by legislation to make available to NICE all the data they hold about a technology? I suspect this one will

continue to run.

Among the parallel sessions I particularly enjoyed the session by Professor David Barnett (Chair of the appraisal committee) and Professor Martin Eccles (Chair of the guidelines committee), both of whom delivered impressive critical analyses of methodological issues. David Barnett also raised the question of whether NICE should generate its own economic models to supplement those submitted by industries — something that I have previously argued for. However, this will be hard to implement because of resource limitations (human, financial, and time).

Alan Milburn was not able to be present, so it fell to the minister Lord Hunt to make the announcement at the conference that Primary Care Trusts would be required to implement NICE technology appraisal guidance. What is believed to be the world’s largest guideline development programme was also launched at this conference, with the establishment of six collaborating centres, including one at the RCGP.

Putting aside the inevitable ‘spin’ associated with such conferences — particularly one themed on ‘modernisation’ — this was nevertheless a significant conference with some major achievements, and the organisers have done well despite some limitations of a venue and site which has yet to mature.

General practice will want NICE to succeed. It is an organisation that is relatively under-resourced and needs to be nurtured. It is taking steps to address concerns about transparency, and independence. The joined-up NHS thinking that emerged from this conference was encouraging, as was the view of NICE as a reflective and learning organisation that is keen to develop itself. In this way, it will be able to connect more fully with GPs.

Mayur Lakhani

Housing, health, homelessness — RCGP conference

IN the six years that I have been working as a general practitioner for the homeless population of Leeds, I have had the privilege of meeting many other health professionals around the country who have a similar interest in the health care of homeless people. Such professionals range from GPs to practice nurses, nurse practitioners, practice managers, commissioning and trust managers, public health physicians, community psychiatric nurses, drugs workers, and client support workers. I have lost count of the number of times I have heard the phrase 'wouldn't it be good if we could have a conference on homelessness'. Of course, the problem has always been how to organise such a conference as well as fulfil the commitments of our sometimes demanding jobs.

It is therefore with a great sense of satisfaction that I am able to write this news article to promote the forthcoming RCGP conference on 'Housing, Health and Homelessness', organised by the RCGP Health Inequalities Standing Group. The conference takes place in Leeds on 7 March 2002 and is targeted at anybody who has an interest in the primary health care of homeless people, including primary care clinicians, users of services, managers and staff of health authorities, PCTs, non-statutory organisations, social services, and housing departments. We would welcome those who are seeking to develop an interest in homeless health care, as well as those who have a long-standing interest. The content of the day includes keynote speeches, participatory workshops from leading clinical experts in the field and non-statutory organisations, as well as a forum to contribute to the updating of the RCGP consensus statement on the topic of homelessness.

Professor Sian Griffiths, President of the faculty of Public Health Medicine will start the day by giving a public health overview of the current demographics of homelessness. This will be followed by a talk by Dr Helen Lester, a Senior Lecturer at Birmingham University, who has 10 years' experience of working with homeless people in a primary care setting. Helen will talk about the evidence base underpinning current and future service provision. These talks will then be followed by workshops where the emphasis will be on clinical and practice development issues. The workshops will cover a wide variety of topics, such as

the management of drug use, alcohol use, the physical problems of homelessness, mental health issues, practice nursing issues, and practice organisation. There will then be a break for lunch (or 'networking' as some would say!). After lunch, Ian Brady, Deputy Director of the Rough Sleepers Unit, will give an address on the work of the Unit. This will cover both aspects of service provision to rough sleepers and current government policy regarding rough sleeping. Following this, it'll be my turn to talk — in my capacity as a GP Consultant and visiting research fellow in Leeds, with six years' experience of working with homeless people. I'll be talking about developments in primary care for homeless people: this will cover examples of local and national primary care developments in homelessness over the past five years. The talk will also seek to prioritise the areas of primary care in need of development, so as to integrate homeless people into our practices. Following this, there are a wide variety of non-statutory organisations that have been invited to participate by leading workshops on areas of their work that are relevant to primary care, including the National Children's Bureau, the Refugee Council and Shelter. It has been exciting to be part of the planning for a conference that covers such a broad agenda. If, like me, you are a little apprehensive as to how it will all turn out, then fear not! We are privileged to have the expertise of Dr Iona Heath, GP and Chair of the RCGP Health Inequalities Standing Group, and Dr Susanna Lawrence OBE, general practitioner and Chair, Leeds Health Authority, who will each chair the morning and afternoon sessions. Knowing each of them personally, I am sure that we can look forward to a lively forum of discussion, debate and problem solving.

By covering clinical, service development and policy issues, it is hoped that delegates will return to their everyday work feeling more supported, both personally and professionally. If, by the end of the conference, homeless people around the country are receiving improved and more accessible primary care and health professionals are collaborating more effectively to deliver such care, then the conference will have served its purpose. It promises to be an exciting day — come and join us, by contacting the Courses and Conferences Unit on 020 7589 1428

Nat Wright

“There is, however, a striking difference between Pharma’s philanthropic claims about ‘putting every disease on the path to extinction’, and its actions.”

Selling drugs to doctors,
Richelle Cooper, Jerome Hoffman,
page 168

“There is great pressure to give the consumer what they want. And they want drugs.”

Selling drugs to consumers
John Frey, page 170

**“We’re not selling out to the Department of Health, we’re ‘adding a dimension of outcome-related incentivisation in social accountability’.
Or something.”**

Behind the lines
Roger Neighbour, page 173

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Selling drugs to doctors

it's marketing, not education

THE pharmaceutical industry (Pharma) is campaigning for direct-to-consumer advertising (DTCA) in the UK. Industry representatives claim DTCA is not merely an educational tool in the fight against disease, but an essential liberty, a matter of 'freedom of speech' needed to protect people 'untreated and in pain' from "government or insurance companies ... (who do not) ... want people to know there is a cure."¹ We have heard similar arguments before. Industry contends that advertisements and marketing materials directed, not at patients, but at physicians, are educational, and 'without distribution of information by pharmaceutical companies ... patients would be deprived of state-of-the-art care.'² Before permitting DTCA in the UK, it is critical to consider if Pharma has lived up to its 'educational' commitment to physicians.

What drugs do they want to educate us about?

If the goal of advertising were to educate physicians, it should be possible to identify a relationship between advertising and deficiencies in medical practice. Instead what we find is a relationship between marketing and the expense of — and thus potential profits from — the drugs in question. When ciprofloxacin was first approved it was 'indicated' for only a handful of rare conditions, but was nevertheless one of the leading antibiotics in terms of number of prescriptions written and dollars spent, reflecting the intensive marketing of a new and expensive antibiotic.³ Although no authority recommends calcium channel blockers as first-line agents for hypertension, they are extremely big sellers, in a manner that closely mirrors marketing patterns.⁴ Generic medicines, no matter how effective (and inexpensive), are not likely to be advertised. With the recent removal of cervistatin (Lipobay/Baycol©) from the market, a number of full-page advertisements urged patients to see their doctors for an alternate medicine, some offering free coupons; lovastatin, the only generic in this class of drugs, was the only product not featured.⁵ In most instances marketing is concentrated not on pharmaceutical advances, but rather on 'non-innovative drugs in competitive therapeutic categories.'⁶ 'Important new drugs do not need much promotion. Me-too drugs do.'⁷

What is the quality of information in direct to doctor advertisements?

Pharmaceutical advertisements often use images that appear to have nothing to do with the disease in question to evoke strong emotions and circumvent the logical evaluation of products.⁸ Advertisements rarely present research data in sufficient detail for reasoned interpretation,⁹ and when they contain scientific graphs or data tables they often promote numeric distortion — visual underestimation or overestimation of the results — in violation of specific FDA

regulations.¹⁰ Advertisements and materials distributed by drug companies frequently do not provide scientific support for their claims,⁶ have little or no educational value¹¹ and include claims that fail to comply with FDA regulations.^{6, 11-12}

What effect does marketing have on prescribing behaviour?

Maximising profit requires effective marketing, which includes saying whatever is necessary to convince people — whether it be prescribing doctors, or patients who can influence their doctors — to buy one's product. Although industry claims 'physicians, with many years of medical education and experience behind them, are fully capable of evaluating the quality of the information ...'² the literature suggests otherwise. The quality of information provided in drug advertisements is in great part suspect, but nevertheless very effective in influencing prescribing behaviour. Evidence that physician prescribing and formulary requests reflects industry expenditures on marketing more than it does the quality of the drug being sold (whether it be a good, bad, or indifferent choice) is widespread.¹³⁻¹⁵

Why does this situation exist?

The primary goal of the pharmaceutical industry, to maximise profits, is no different than that of other industries. 'The management must generate the highest level of profitability possible to fulfill its fiduciary duty of maximising shareholder value.'¹⁶ Towards this end, Pharma has been enormously successful. Its profits, whether measured in total dollars, net profits or CEO compensation, consistently rank at the top among industries.^{7, 17-18} It provides the public with many important and life-saving medicines, pays for a great deal of pharmaceutical research and sponsors a large percentage of continuing medical education. These important activities are most likely to occur when the products are profitable and of interest to patients who can afford them. There is, however, a striking difference between Pharma's philanthropic claims about 'putting every disease on the path to extinction,'¹⁹ and its actual behaviours. In response to criticisms that it almost completely neglects diseases of the poor — with for example virtually no research or spending on the world's leading killers, such as malaria — in favour of wrinkle creams, baldness treatments, or even anti-anxiety medicines for pets,¹⁹ a defender of Pharma cites the 'fiduciary responsibility' of company executives to shareholders (rather than to patients, or to the public health). He notes 'pharmaceutical companies have to discriminate' (against diseases or conditions whose treatment is unlikely to yield great profits), as 'the decision must be based purely on sales and costs.'¹⁶ Other equally candid expressions from industry representatives, also stand in stark contrast to the nobler sentiments expressed to physicians and to the public. An

Author contact information:
 Richelle J Cooper, MD, MSHS
 UCLA Emergency Medicine Center
 Los Angeles, CA 90024
 USA.
 phone (310) 794-0583
 fax (310) 794-0599
 e-mail: richelle@ucla.edu

industry representative predicts the 'winners in the prescription drug category are not going to be ones with the best products, but those that are best marketers.'²⁰ Profit summaries confirm this prediction; sales of the 50 most heavily advertised drugs to consumers were responsible for nearly half (47.8%) of the \$20.8 billion increase in prescription sales in 1999–2000, compared with the other approximately 9850 drugs that made up the other 52.2%.²¹

Is there any solution?

Skilled marketing contributes greatly to Pharma's profits even when it is unbalanced or inaccurate, and even though it raises health-care costs and leads to non-evidence-based prescribing. As such, it would be foolhardy to expect the industry to change its approach. Similarly, we cannot expect much intervention or oversight from government,²² which is the 'beneficiary' of enormous and lucrative lobbying by Pharma,²³ and which tends to see corporate profitability as a great good, even when it comes at enormous expense to the public.²³⁻²⁴ Although regulations do exist to define and limit what can and cannot be claimed in drug promotions, these are frequently violated in actual advertisements, and at best inconsistently enforced.²⁵⁻²⁷

On the other hand we can, and should, expect better from ourselves — that we honour our special fiduciary responsibility, to patients, and to the public health. Physicians work hard, but we are also well paid. We do not need to rely on 'gifts' and favours. We can buy our own pens and Post-It pads, and refuse to sell ourselves as walking billboards.²⁸ We can choose not to meet pharmaceutical representatives,²⁹ or read marketing materials and advertisements. We need not be beholden to Pharma for our education. '... to rely on the drug companies for unbiased evaluations of their products makes about as much sense as relying on beer companies to teach us about alcoholism.'⁷

In our role as health advocates we need to bring this discussion to the public. Indeed, the influence of industry on physicians is one place where public education is truly wanting, and greatly needed. We should speak out against DTCA, and ask for better enforcement of current regulations on direct-to-doctor advertising. Existing evidence contradicts Pharma's claims that their advertisements to doctors are 'education'. They are in fact marketing, and as such they must not be confused with equitable, impartial, evidence-based information. Perhaps, rather than asking whether Britain should allow DTCA, the more appropriate question is 'why do we continue to allow drug company advertising to physicians?'

Richelle Cooper
Jerome Hoffman

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Selling drugs to the public

Should the UK follow the example of the US?

A DECADE ago, I was complaining to a colleague of mine who was a professor at the school of pharmacy about the sheer volume of pharmaceutical advertising in medical journals. I remember him replying, 'you don't have to worry, they are going to start advertising directly to consumers and bypass you.' One doesn't have to go far to find just how right he was.

Perhaps the worst example — or at least the worst I have seen thus far — of how the pharmaceutical, advertising, and newspaper industries have stretched and then broken the ethical boundaries came, not from a local paper, which could be blamed for not knowing any better, but from the prestigious *New York Times*. Its national edition on Wednesday, 14 November 2001 carried a story written by Dr Lawrence Altman, long-time medical writer for the *New York Times*, about a study presented at the American Heart Association meetings by Dr Rory Collins from the British Heart Protection Study in England and Scotland, on the effects of simvastatin on a large group of patients at risk for heart disease. The study was reported to have shown a reduction in heart disease and stroke — both reported in relative, rather than absolute risk, since relative risk figures are much more impressive to the public. The stroke reduction data were new, as were the data about people not at risk based on their lipid numbers. Dr Collins was quoted as saying that 'statins are the new aspirin', not pointing out of course that aspirin, showing reduction in recurrent heart disease at 2 cents a pill and statins at \$9 a pill, have some very different marketing strategies and financial implications for society.

At the end of the article, Altman reported that '[Collins'] team conducted the study independent of the sponsors. The drug companies had no say in how the money was spent, in the day-to-day running of the study, analysis of the data or the way the findings were reported.' That is on page 14 of the *New York Times*. On page 15, directly facing the article, is a full page advertisement for simvastatin, from Merck, the sponsors of Collins' study.

While Merck may not have had any role in the analysis, it was definitely going to take advantage of the results and couldn't even wait to see the results published, where physicians could read it and draw their own conclusions. The *New York Times* has a

high-end market niche nationally and is more likely to be read by those who consider a cholesterol level of over 5 mmol/l second only to a falling stock portfolio as a threat to one's livelihood. Parenthetically, the *Rio Grande Sun*, the weekly paper from northern New Mexico, one of the poorest states in the United States and the state with the highest uninsured population in the country, has never, to my knowledge, carried a drug company advertisement. Folks in New Mexico will have to just get by on aspirin.

A medical journal, one would hope, would never have accepted the placement of an advertisement in such a blatantly manipulative fashion. The same standards, however, don't hold for the lay press. Newspaper ethics, it seems, do not extend to advertising. The placement of the advertisement next to the story was deliberate and prearranged and was likely bought at a very high price. The cost of the advertisement will be tax deductible to Merck as a part of the 'research costs' of bringing a drug to market. Merck won't pay for the advertisement; the consumer — the target of the advertisement — will.

Direct-to-consumer advertising in the US has reached saturation, with television reruns at off-peak hours having 75% of their advertising for drugs, ranging from antihistamines, to antidepressives. Rather than forcing viewers to listen to all the nasty side-effects and contraindications, which might scare some people away, most TV advertisements carry 'ask your doctor' as the admonition. Since patients are often referred to as 'consumers' in the US, and since patient satisfaction surveys and their annual report to physicians from different Health Maintenance Organisations are becoming a part of the life of practice here, there is great pressure to give the consumer what they want. And they want drugs.

One of my favourite examples of the effect of direct-to-consumer advertising was, not from an overweight patient demanding the latest diet pill, but from an eleven-year-old boy. Most of my patients are not *New York Times* readers but come mainly from the working class of our town. On a busy clinic morning, the boy and his mother came in for a visit and when I walked in the room and asked how I could help, the boy said 'I need Lamisil.' A bit taken aback, I looked to his mother who shook her head and looked at him. I asked why he wanted Lamisil (terbinafine) and he said that he had



Professor Chris Silagy, AO, PhD, FRACGP, FAFPHM: an appreciation

CHRS Silagy, one of the leading lights of academic general practice internationally, died aged 41 on 13 December 2001 leaving a wife, Jane (also a general practitioner) and young sons, Andrew (11), Michael (9), Nicholas (8) and Benjamin (6).

He rather unwillingly conceded his four-year battle against non-Hodgkin's lymphoma, insisting a few weeks ago on travelling to Europe for a conference despite a massive pleural effusion and hosting a Christmas dinner for his department staff less than 24 hours before his final hospital admission. His life force was palpable and infectious. Leon Pitman, Professor of General Practice at Monash, echoes the thoughts of all who knew him by saying 'we have been enriched by our encounter with this great man'.

He was indeed a great man. He came from Monash to Oxford as a Sir Robert Menzies Fellow in 1991. I still have the first letter he sent to me, announcing his impending arrival on flight QF9. After proposing five or six research projects he thought he might initiate on arrival, and detailing the two reviews he intended to write on the journey, he ends with 'and if you have any special tasks you would like me to do on the plane let me know, as 26 hours is a long time'. He was inexhaustible and utterly exhausting. My children nicknamed him 'Tigger'.

Chris established the Australian Cochrane Centre when he returned to the chair of general practice at Flinders in 1993. His passion was to see the best scientific evidence applied to clinical decisions in everyday general practice. He led by example. His warmth and humanity were legend. In his self-written obituary he ends with: 'his battle with lymphoma was lost, but his vision and legacy will hopefully live on'. It will — in the UK, in Australia, and across the primary care world.

David Mant
Oxford, 8 January 2002

John Frey

fingernails that needed treatment.

I asked him why Lamisil and he said that he had seen an advertisement on TV for a condition that looked just like his fingernails. The advertisement had indicated a toll-free telephone number to call for more information and when he did, they sent this eleven-year-old boy a videocassette with more information about the perils of onychomycosis and said 'ask your doctor for Lamisil'. So he did. His mother kept looking at me and rolling her eyes.

He was a very bright young boy and his mother was obviously proud of his ingenuity. I told her that Lamisil was not a covered drug in their insurance plan and that I could prescribe it but it was going to be very expensive. I could prescribe a less expensive medication which was generic. She looked at her son and his obvious disappointment. A small amount of onychomycosis was the least of this young man's worries and I would not be inclined to prescribe anything but I was cornered, just as his mother was, by the TV advertisement and the boy's initiative. So they left with a prescription they probably didn't need with the boy sensing that both I and his mother had let him down. I am glad that his mother, rather than he, fills out the annual physician satisfaction survey.

The argument that direct-to-consumer advertising is a form of education is so specious as to not deserve serious consideration, except that is how such advertising is pitched to the public. Doctors in the UK are still overwhelmed with the amount of information on new drugs in journals, direct advertising and the omnipresent pharmaceutical representative. We are hardly above reproach, with increasing attention being paid in the press to the solicitation of practicing doctors by drug companies which offer fancy dinners, free family holidays matched with big speaker fees to academics who 'educate' doctors about new drugs. But Aldous Huxley would have been stretched to conjure up a world where reminders of allergy-free, pain-free, worry-free, slim and sexually uninhibited eternal life were more in evidence than the US media today. Soma in *Brave New World* was nothing compared with Zocor, Viagra, Clarityn, Lamisil, and all the other keys to a happy future.

Thinking about patients
David Misselbrook
Petroc Press 2001
PB, 203 pp, £29.95 (1 90060349 7)

'THE continuous evolutionary struggle for control of medicine is in a pivotal phase. How shall we define medicine's future gaze? Who is to control the practice of medicine?'

David Misselbrook's book, *Thinking about patients*, is a major contribution — perhaps the best so far — to the accumulating literature of sophisticated, postmodern medicine. He has demonstrated that a 'busy' frontline GP, involved in medical education, given great intellectual gifts and possessed of a deep and eclectic knowledge of the literature, is the best person to guide us into a better understanding of what medicine is, or should be, about. I hope and believe his book will be widely read and discussed, particularly by managers and politicians active in the medical field, and for many of whom, if they read it with an open mind, it will be a life-changing revelation.

Misselbrook begins with a quote by Paracelsus: 'Every physician must be rich in knowledge, and not only of that which is written in books; his patients should be his book, they will never mislead him.'

And this is no platitude; Misselbrook is entirely genuine in his respect for the patient's very different view. Here he is dealing with that patronising word, 'compliance':

'Thus the issue is not one of compliance (will the patient do what I tell him?), but of concordance (have I understood the patient's health beliefs and negotiated a course of action that both of us are happy with?) Remember that concordance is only a meaningful model if its outcome is allowed to differ from the compliance model. It is not a sneaky way of getting the patient to do what we want. It is a way of negotiating between two different but equally valid perspectives, accepting that the patient makes the ultimate treatment decision.'

It is very difficult and subtle stuff, which Misselbrook expresses with outstanding clarity. He uses every trick in the book to do so: chapter summaries and introductory quotes, clear, simple diagrams, clear sub-headings, excellent abstracts of key papers, apposite case reports, exhaustive references at the end of each chapter, an index and — wonderfully — no less than 12 blank pages at the end for notes. He expects us to 'think about patients' too. The book costs about as

much as two full price CDs, and it is worth every penny.

His discussion of paternalism, to take another key example, should give pause to anyone who thinks the matter has been 'finally sorted out'. The word 'paternalism' hasn't yet been banned, as the *BMJ* notoriously banned the word 'accident' recently, but the idea is certainly non-PC. Misselbrook is devastating in his logic:

We may find paternalism problematic, but it won't go away. Patients sometimes want us to be paternalistic. We are cast into a role within society which in other cultures would be filled by a shaman.

Using the case report of a young visitor from South America who wants him to give her the injection of metoclopramide that her doctor at home always gives her for her dysmennorrhoea, he demonstrates unimpeachable, evidence-based credentials. But he also expresses the ambivalence of the experienced doctor perfectly, and the true complexity of this human situation. In this, and in his highlighting of our culture's deep ambivalence to Authority itself he comes close to defining what has gone so mysteriously wrong in modern medicine. He shows that taking one 'side' or the other in this argument will no longer do — we are looking for balance, and he demonstrates the extent to which balance is the GP's special area of expertise.

'Is there not a tension between our shamanistic role and our goal of patient autonomy? Yes, certainly. But we manage many tensions in the practice of medicine, and this is one that we will manage best if we acknowledge it and reflect on how it works.'

'We need to consider how we can respond to people's need for a shaman whilst retaining the benefits of the Western medical system and also our respect for autonomy.'

We are indeed at a pivotal phase and a book of this intellectual weight and moral courage is exactly what was needed.

James Willis

All quotes, unless otherwise stated, are from the book. They are out of sequence.

UNDER normal circumstances I'd even read the *BJGP* before any garbage about dwarves, magic swords and suspiciously androgenous elves. And as for wizards, my Christmas wish was that Harry Potter be hunted down by wild dogs.

So all my instincts rebelled against liking *The Lord of the Rings*, from the forelock-tugging hobbits to Aragorn, who possesses all the qualities of the noble horse, to Frodo, who is always depressed and has a paranoid fear that Someone Is Out To Get Him. In this book there is no reality; no-one ever takes a dump or has heaving sweaty sex. The elves in particular are real lucky sods. They live forever, they look gorgeous despite never using the bathroom, they are seriously cool, their lifestyle is sumptuous and they are dead clever; they never seem to do an honest day's work ... maybe they sell drugs.

But I admit I loved the book. It's a rattling good story, you come to care about the characters, there is a real sense of overwhelming evil and the futility of resistance, the fantasy universe is credible within its own rules and the sheer breadth of imagination is stunning. And it's much more believable than the Bible, though I suppose that isn't hard.

Because I liked the book I was uncertain about seeing the film and about how the director's vision would conflict with my own perverse imagination. But again, I was pleasantly surprised. The film is magnificent, with very high production values, and the many different races and characters and locations are superbly realised. Just as in any cinematic adaptation, even one 190 minutes long, there is some abbreviation and a few characters are omitted or adapted. But these don't spoil the plot in any way and help to keep the pace up.

I'd be interested to read a review by someone who hasn't read the book; to them the ending might be too downbeat and the plot confusing. But in summary it is a great cinematic event, certainly worth seeing, and parts two and three are due to be released at Christmas 2002 and 2003, respectively.

Finally, a little tip: there is a parody book called *Bored of the Rings*, published by the Harvard Lampoon series. I first read it about 20 years ago, but I see that it has cunningly been re-issued, and it is really very funny and highly recommended.

Liam Farrell

CHRISTMAS in the Scottish Borders. The clouds have broken their promise of snow and let down only a Presbyterian drizzle. In Dumfries and Galloway, finally free of foot and mouth disease, sheep are once more in evidence. The grass is lusher than usual, last season's growth left only half-nibbled by their slaughtered predecessors, of which the stench of burning carcasses the air no longer reeks.

On the hillside above Langholm a small flock is grazing. And they have blue bottoms. The sheep's bottoms are — well, there's only one word for it — blue. Bright blue. My hostess is a former sex therapist with Relate and therefore qualified to advise on such intimate mysteries. It's only the ewes who have blue bottoms, she points out. The rams have had their tummies painted blue. She taps her nose knowingly, and the penny drops. During this, the rutting season, the farmer has devised a contact-tracing strategy at whose effective simplicity the staff of every GUM clinic can only gasp in admiration. A blue bottom means 'recently serviced'.

On closer inspection, not all the ewes are equally committed to the cause of cerulean fundamentalism. A few appear to have signed a pledge of purity and still have their nethers undyed. These are the sheepish virgins, the Ann Widdecombes of the ovine world. On others, by contrast, the blue badge of congress is so vivid as to mark them out as ewes of easy virtue or Playram centrefolds. So far, no ram looks to be sullied *a posteriori* with the tell-tale stain, but these are liberal times ...

Outraged, I feel an ethical protest is called for. To have one's sexual status colour coded and flaunted for all to titter at makes a mockery of every principle of confidentiality. It's a disgraceful breach of the shepherd–sheep relationship, beside which all the recent hoo-hah about the public's right to know if the Prime Minister's youngest has had his MMR vaccine seems small beer.

Whether Leo Blair is jabbed or unjabbed matters less than his father's frantic attempts to avoid telling us which. The 'whether to vaccinate' decision is a private matter between Leo's parents and doctor, doubtless made after the fullest consideration of the facts and circumstances. But the 'whether to disclose' decision is another matter entirely, with genuine public repercussions. A College spokesman was quick off the blocks, harrumphing predictably about threats to the doctor–patient relationship, but addressing the wrong question. Whatever may have been threatened on this occasion — mainly a politician's inalienable right to conceal hypocrisy — it certainly wasn't the sanctity of the consulting room. As I recall, indeed, no member of the press had even considered the Blairs' GP as a potential mole or whistle-blower.

Mind you, I can't for the life of me think why not, given the ease with which some supposedly impregnable bastions of our ethical creed have crumpled in the face of the Government's secret weapon — cash.

I suspect someone in Whitehall is employed to maintain a current price list for the medical profession's principles. Do you doubt it? Then think of Aneurin Bevan stopping the consultants' mouths with gold; remember Ken Clarke observing how GPs feel nervously for their wallets at the mention of reform. Recall how, more recently and more insidiously, we GPs have been systematically bribed into becoming enforcers of central policy. Fundholding, PMS, prescribing incentive schemes, new patient checks, smear and immunisation targets — what are these if not backhanders to encourage us, when push comes to shove, to overrule patient autonomy and renege on our advocacy of individual patients in favour of politically imposed priorities? Oh sure, Government usually offers us a get-out clause, one of their range of Newspeak slogans, so that we can betray loyalties without too great a sense of guilt. We're not selling out to the Department of Health, we're 'adding a dimension of outcome-related incentivisation in social accountability'. Or something.

Bullshit. An increasing proportion of our income is tainted money, and it shouldn't be. But fear not: I have (like Jonathan Swift of old) a modest proposal to restore moral consistency to our profession.

Patients who are up to date with their immunisations and smears, who maintain a cholesterol of less than 5 on diet alone, who promise not to join any waiting list longer than three months, and who keep the cost of their prescribed medication in the bottom quartile for their age, will be designated 'beacon patients'. GPs who release the names of their beacon patients to the press, where they will be held up for public acclaim as an encouragement to others, will be paid £500 per patient.

Paid £500, and have their bottoms painted blue.

roger.neighbour@dial.pipex.com

E-epilepsy: the National Society for Epilepsy web page

FULL credit should go to the National Society for Epilepsy (NSE) for the production of this new resource for the medical profession on epilepsy (www.E-epilepsy.org.uk). For the busy GP it provides on-screen, a wealth of information, ranging from frequently asked questions on areas such as pregnancy issues, to more specific questions such as, 'Can a child with epilepsy use a computer?' This is all quickly and readily available and I can imagine would be quite possible to use during a consultation.

The parent page (www.epilepsynse.org.uk) is also available to the general public and provides further help for anyone with questions relating to epilepsy arising later after a consultation. The NSE has a long history of working with the medical profession; for example, the epilepsy assessment centre in Chalfont, Buckinghamshire, is run by the NSE and is also allied to the NHS; functioning as a sister site to The National Hospital for Neurology and Neurosurgery, Queens Square. I find it reassuring that this site has strong credibility and has a broad base of medical authors that contribute to it.

The range of detail available at the site is wide. This is the place to look for those who wish to look up epilepsy-related matters in more detail; for example, there are articles explaining the current theories of aetiology of epilepsy and others offering the lowdown on the newer therapies, both medical and surgical. The authors who contribute to the various sections are named and each is well referenced, which enhances further the site's authoritative, yet friendly feel. There is also a section that informs you of new developments and also of forthcoming conferences in epilepsy. On the other hand, some of the articles are basic and ideal for brief reference on the rudiments of epilepsy.

The site also features a service that allows you to e-mail a question to the NSE on epilepsy; this is generated within the page and you don't have to wait for your standard e-mail facility to be opened up. There are no Java scripts either, which means navigation between the pages is quick and easy — the website is clearly designed to be informative and not entertaining.

In summary; all in all a comprehensive and well thought out site, and in my opinion is well worth bookmarking.

Greg Rogers

**RCGP Members
honoured in the
New Year Honours List
January 2002**

Knights Bachelor
**Professor Graeme Robertson
Dawson Catto** — for services to
Medicine and to Medical Education

Professor Liam Joseph Donaldson
— Chief Medical Officer for
England, Department of Health

Officer (OBE)
Professor Richard Baker —
Director, Clinical Governance
Research and Development Unit,
University of Leicester. For services
to clinical audit in health care

Prasanta Ranjan Bhowmik —
General Medical Practitioner,
Newham, London. For services to
health care

George Geddes Shirriffs —
General Medical Practitioner,
Aberdeen. For services to the
Scottish Council for Postgraduate
Medical and Dental Education

Denis Simpson White — RCGP
Northern Ireland Committee
representative. For services to
medicine

Member (MBE)
Jyotindra Keshavlal Pandya —
General Medical Practitioner,
Tottenham London. For services to
health care

William Humphrey Watson —
Life Member, MC. For services to
medicine in developing countries
and to the community in Shropshire

GMCnews

The annual retention fee to the GMC is up from £170 to £290. This — most important — piece of GMC news was detailed in a letter accompanying the December issue of *GMCnews*, which I discovered in an unopened pile of mail that became lost in the Christmas tidy-up. The increase was not deemed important enough to feature in the actual pages of *GMCnews*, though the proposed increase had been covered in the August issue. We were treated to outgoing president Sir Donald Irvine's view of incoming president Professor Graeme Catto: 'I am pleased that Professor Catto has been appointed as my successor, and I hope that he finds his term as President as fulfilling as I have done'. Well, he was unlikely to say that he had preferred one of the other candidates, and that the whole shebang was a poisoned chalice. Catto was equally sycophantic about Irvine.

My hope is that not a penny of the retention fee helps pay for *GMCnews*, yet another unnecessary publication piling onto doctors' doormats. Perhaps we can hope that the plentiful advertising reduces the retention fee. Locum agencies feature heavily, followed closely by firms offering crafted office furniture. There's a box advert of car registration numbers for sale, though none of them seem especially appealing to doctors — there's no BMJ, PCT, ECG, or even GMC. RIL 37 costs £8000 because it is a RILEY lookalike. LIL 37 costs £1800 because it is a LILEY lookalike, which has me somewhat puzzled because I don't know what a LILEY is. If someone could find NIC 3, they could buy it for Sir Michael Rawlins.

But on the back page there are free classified ads. There are houses and apartments for sale or rent in Devon, Provence and Mexico. There are practices for sale and people offering themselves as locums. There are medical instruments, medical textbooks and literary collections for sale. There are a number of cars and some camera equipment, and someone is selling sailing clothes. Someone wants an 'adjustable double bed for doctor and wife with oesophageal problems'. Do they both have oesophageal problems? Or just the wife?

And then, sinisterly, someone is selling a cement mixer. I can understand boats, cars, and houses. They are the currency of being a doctor. They're what we talk about. Many of us do the odd bit of DIY; I even remember painting window frames until I could afford to pay someone to paint them for me. But I am wary about a cement mixer, even if it is purportedly in 'ex cond'. I've seen too many crime movies, and worry too much about body parts.

Nev.W.Goodman@bris.ac.uk

Was Andrew Manson your role model . . . ?

A J Cronin's *The Citadel* is an unforgettable depiction of primary care before the NHS. The Welsh RCGP are organising a study day to reflect on this iconic tale of medical practice in the South Wales Valleys, in Harley Street and even before the GMC. If Andrew Manson's idealism has inspired you or irritated you, charmed you or choked you, please let us know. If the book, the film or the TV series of *The Citadel* had an effect on your career, write it down in 500 words or less. If you can explain why Christine had a fondness for cheese, don't keep it to yourself. We are looking for personal responses for our poster exhibition, and possibly to publish in *Adventures in General Practice*, a celebration of Cronin's Welsh writings.

'Don't you remember how you used to speak of life, that it was an attack on the unknown, an assault uphill — as though you had to take some castle that you knew was there, but couldn't see...' Aberalaw awaits your reply.

Please send your personal response by 3 May to: Wayne Lewis, Carreg Wen Surgery, Church Road, Blaenavon, Pontypool NP4 9AE; **wayne@drlewis.freereserve.co.uk**

Mud on the road: tackling the symptom

Is writing about your travels as bad as forcing your holiday snaps on friends? Perhaps, but good travel writing serves to enrich the reader and invoke a sense of place and time. Moreover, as befits a medical journal of this calibre, I can present my holiday experience as a metaphor for medical practice.

The triangular road sign depicts a landslide. The pole is half-buried in a fresh fall of earth that has been churned into mud by intermittent traffic in the past few hours. In the mud a truck is floundering up to its axles. The revving of its engine produces little forward movement but sends gobbets of clay onto the fascinated audience sitting by the road.

Our bus, en route from Veng Vei to Luang Prabang, the ancient capital of Laos, slithers to a halt. The audience of about 20 Lao men sitting by the road contemplates our arrival. We get off the bus. At first this is a welcome relief — time to stretch legs and unbend backs. Our late arrival that morning at the bus station meant that the two of us had been allocated the last seats: a pair of unsecured plastic stools at the front among the excess luggage.

Our fellow passengers are predominantly tourists, of the subgroup 'backpacker' following the road north from Vientiane. While the fare is only 40 000 kip (about £3.50) for the eight-hour, 156 kilometre journey this is prohibitively expensive for the majority of the local populace. Vehicles run infrequently on the narrow winding road that gradually ascends the mountains. However, after an hour a queue is beginning to form on either side of the marooned lorry. A crowd of farangs and natives gathers in the road; the sun beating down seems to have no effect on the mud, which is still wet and extremely sticky.

One of the farangs (OK, it was my husband) picks up the only spade in evidence and starts to shift mud from the road, hoping that his example will stir the others into action.

Everyone (Lao, French, American, Australian, other British) stands around and watches.

Sometime later, when a bucketful of mud has been transposed from one part of the carriageway to another, a loud noise heralds the arrival of a digger complete with front loaded plough and exceptionally large wheels. Unfortunately, its tyres are completely bald.

After a lot of negotiation it is decided that the digger will pull the truck out of the mud. And by some miracle this is achieved, both vehicles sliding across the road and lurching frighteningly close to the observers, few of whom move from their grandstand positions. The truck is freed but has been pulled to the wrong side of the obstacle and still cannot get away.

The digger scoops a small amount of mud off the road and retires for a rest. Three vehicles coming south will wait no longer. They set off down the hill in gut-wrenching slow motion, practically moving perpendicular to the desired direction of travel. But they are through.

The truck driver decides it is now his turn. He negotiates the first 30 metres or so and then ... he is stuck again.

And again the digger pulls him out. And retires.

By now the mud on the road has become even more treacherous. Clear the mud, we think, and suggest, and mime. But first here comes another bus, swaying from side to side, trying its luck. But fortune does not smile and the bus slithers to a stop a few feet away from the precipitous drop down into the valley.

The digger is recalled. The digger gets stuck.

Two heavy lorries with the words 'highly inflammable' etched on their sides are pressed into service and free the digger, which then frees the truck. This has taken over two hours. 'Clear the mud!' we cry in unison.

Eventually the digger clears the mud, but not before two trucks have gone head-to-head on the road with neither being prepared to let the other pass without protracted negotiations and threats. As the rain starts to fall our bus finally gets through and we are off.

And the metaphor? Well, I spend a lot of my time treating symptoms without trying to tackle the underlying problem. This takes time and money. Would someone please keep reminding me to clear the mud first?

our contributors

Richelle J Cooper is Adjunct Assistant Professor *sic* (Department of Medicine, division of Emergency Medicine), UCLA Emergency Medicine Center, UCLA School of Medicine, Los Angeles, California. Richelle@ucla.edu

Liam Farrell's new medical magazine, *HealthCheck*, can be seen every Thursday at 19.30 for the next six months. But only on Ulster TV — everyone else gets the UEFA Cup, poor things

John Frey is Professor and Chair, Department of Family Medicine, University of Wisconsin; he was assistant in General Practice, Glyncothrog Health Centre, West Glamorgan, Wales, 1979–1980; he practises at Wingra Family Practice among 'the increasing ethnically diverse population of patients that is becoming the norm in the US these days, thankfully.' jfrey@dfmp1.fammed.wisc.edu

Neville Goodman spends weekends with repaired aortic aneurysms in Bristol operating theatres while waiting for intensive care beds to unblock. But is he down-hearted? Well, Yes, now you ask.

Trisha Greenhalgh is professor of primary health care at University College London. Her inaugural lecture, *Harry Potter and the number needed to treat*, was delivered to wild acclaim a week ago. Cate Blanchett plays Trish in the forthcoming film

Jerome R Hoffman is professor of medicine and emergency medicine at UCLA School of Medicine in Los Angeles. jrh@ucla.edu

David Mant is Reader in General Practice at the University of Oxford

Roger Neighbour knows more about sheep than any previous ex-Convenor of the MRCGP. Curious readers are directed to page 740 of the *The Concise Scots Dictionary* (Aberdeen University Press, 0-08-028491-4)

James Willis's magisterial George Swift Lecture to the Wessex Faculty of the RCGP can be supped at <http://www.friendsinlowplaces.co.uk/GSLecture.htm>

Nat Wright is a GP Consultant in Homelessness and Substance Misuse, NFA Health Centre for homeless people, Leeds

All our contributors can be contacted via the Journal office, at journal@rcgp.org.uk