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LETTERS

SELECTING TOMORROW'S DOCTORS

Three ways to widen participation

ROB WHITE

I attended a bog standard comprehensive and went straight to university without grade 8 music, Duke of Edinburgh Award, or any voluntary work, neither had I work experience in a hospital. I was fortunate because nowadays not having these "qualifications" would count against me.[1] Yet in my 30 years in the NHS I have never been asked by a patient whether I had grade 8 on the flute or done voluntary work as a teenager.

Why we believe these attainments make people better doctors amazes me. Is it evidence based? As a consultant I have sat through medical school entrance interviews praying for a personal statement that didn't consist of a young person trying to tell us how "empathic" and rounded they were thanks to a couple of weeks as a healthcare assistant or shadowing a doctor in the local NHS hospital. Yet I had no idea if any of these young people had the dexterity required of a surgeon.

To widen participation we need to do three things. Firstly, stop interviews, personal statements, and the need for grade 8 music—they favour the middle class. Secondly, set a competitive common entrance exam for medicine that includes languages and literature as well as the sciences, with scores adjusted by the Carstairs score to take social deprivation into account. And finally, re-establish grammar schools, the abolition of which has reduced social mobility.

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Competing interests: None declared.

1 Greenhalgh T. Widening participation: say no to nepotism. *BMJ* 2010;341:c6130. (3 November.)

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Go back to the future

Stephenson and Stephenson's arguments made me reflect on my experience.[1] I came from an Indian immigrant family that settled in the inner city slums of Glasgow in the 1950s. My parents had four years of primary schooling combined.

I went to Edinburgh University Medical School in 1971 (no interview, no work experience) from state primary and comprehensive schools. My parents emphasised hard work, rather than music lessons, etc. Both my brother and I graduated from medical school. I had no debt, received no money from my parents, and managed with my student grant (about £500 (€580; $800) a year) and occasional holiday jobs.

As a selector for medical admission at the University of Newcastle in the 1990s, I judged that communication abilities heavily influenced selection and that this disadvantaged working class applicants.

Two of my sons applied to medical school with straight A grades, musical qualifications, medical work experience, and other middle class accoutrements. Their admission to medical school was difficult and competitive. They entered the world of student loans, fees, and reliance (to their regret) on parental finances.

I cannot imagine how my brother and I could have applied for and gone through medical school now, especially without full state support. I am grateful to the system that supported me and I lament its withdrawal. Ironically, the country was much poorer in the 1970s than now. Opening up access needs a return to older successful policies.

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Competing interests: None declared.

1 Stephenson L, Stephenson T. Selecting tomorrow's doctors—not a level playing field. *BMJ* 2010;341:c6108. (2 November.)

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Money, motivation, and medicine

Much concern has been expressed, justifiably, about high tuition fees deterring academically able but less well-off students from applying for medicine.[1] As a medical student, I participated in a Yale-Cambridge exchange, which entailed my becoming a Yale medical student for two months. My preconceptions of the superiority of the British system were (at least partly) challenged.

Far from having no will to work hard because their rich parents had paid for their education, American medical students seemed more motivated and engaged with their education than we are here. One reason for the discrepancy was that they study medicine at graduate, not undergraduate level, and are therefore more mature. Another reason, I suspect, is the value attached to a course that has been financed personally: feeling smug about missing lectures, practicals, or clinics is idiotic if you have paid for them.

My short experience probably isn't generalisable, and I might be taking a typically British, self deprecating view of myself and my contemporaries. Nevertheless, although I do not support increased tuition fees, this might be an opportunity to raise the question of how our medical students could attach greater value to their education so that they can achieve their obviously great potential.

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Competing interests: None declared.

1 Stephenson L, Stephenson T. Selecting tomorrow's doctors—not a level playing field. *BMJ* 2010;341:c6108. (2 November.)

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ANTIBIOTIC RESISTANCE

Intractable, and here's why

Although the imprudent use of antibiotics is considered to be a major reason behind the emergence and spread of antibiotic resistance,[1] bacteria isolated from pristine environments show substantial tolerance to antibiotics. For example, bacterial strains from several genera isolated from different samples from the Antarctic (soil, fast ice, cyanobacterial material) and tested at the Centre for Molecular Biology in Hyderabad, India, were resistant to several therapeutically useful antibiotics.[2] The problem is further complicated by the fact that genes that confer resistance to antibiotics and heavy metals occur on the same plasmid. Thus antibiotic resistant bacteria are selected to flourish in a natural environment polluted by heavy metals even in the absence of antibiotics.

At IGB-Neuglobsow (Germany) we recently analysed 66 bacterial isolates from samples taken from waterways in some of the least populated areas of north Germany.[3] We found co-occurrence of resistance to antibiotics (ampicillin, streptomycin, erythromycin, chloramphenicol, oxytetracycline, kanamycin, rifampicin, norfloxacin, ciprofloxacin, trimethoprim, vancomycin) and heavy metal salts (zinc chloride, cadmium chloride, potassium chromate) in various combinations.[3] Ten of the isolates were resistant to five antibiotics and three heavy metals. Surprisingly 13 of the isolates were resistant to chloramphenicol, which is no longer used in clinical practice in Western countries.

Plasmids, which carry genes for both antibiotic and heavy metal resistance, are remarkably stable even in the absence of any selection pressure.[4] The emergence of antibiotic resistance can only be deferred: it cannot be bypassed simply by minimising the use of antibiotics.

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Competing interests: None declared.

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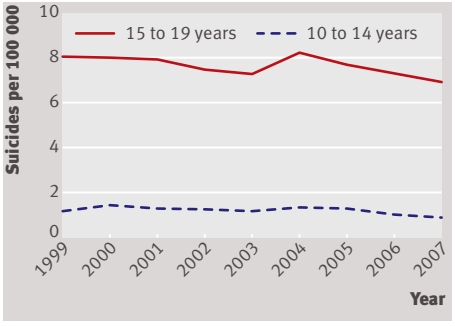
Cite this as: *BMJ* 2010;341:c6848

SUICIDE AND ANTIDEPRESSANTS

Beware extrapolation from ecological data

Identification of an association between antidepressant drugs and suicidal thinking and behaviour in adolescents in 2004, and the regulatory warnings that followed, sparked a debate on the potential for discouraging appropriate use of antidepressant drugs,[1-3] with the unintended consequence of eventually exposing more patients to the suicide risk of untreated depression.[4] These concerns were strengthened by an upturn in 2004 in the US rate of adolescent suicide.[4] Significant falls were also reported in antidepressant drug prescribing for paediatric patients after the regulatory actions.[3-5]

Six years later we present data from the Centers for Disease Control and Prevention on the overall trend in rates of suicide among adolescents showing that the rate of suicide decreased after the unexplained increase of 2004 (figure). In 2007, the most recent year with available data, the rates were the lowest reported in 25 years.



Numbers of suicides per 100 000 in adolescents by year in the United States. Source: Centers for Disease Control and Prevention www.cdc.gov/injury/wisqars/fatal.html

These findings underscore the limitation of using ecological population based approaches and especially of relying on a single year's data to draw strong conclusions and raise what may turn out to be premature concerns. Ecological data could not establish a cause and effect association, neither could such data determine whether the changes in prescribing were due to depression not treated with drugs or to prescription of fewer antidepressants for other conditions. Although being vigilant for unintended consequences of regulatory actions is important, ecological data may not be the best guide to whether drugs are being used appropriately in a given patient population.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c6844

EXTRACORPOREAL LIFE SUPPORT

ECMO patients overestimated

We wish to point out a misinterpretation of our results in an otherwise useful review of extracorporeal life support.[1] The authors suggested that a third of patients admitted to intensive care with severe respiratory failure during the recent H1N1 influenza A pandemic needed extracorporeal membrane oxygenation (ECMO).

They described a cohort of 61 patients in Australia and New Zealand who received ECMO for severe acute respiratory distress syndrome associated with influenza A (53 H1N1, eight not subtyped), with another 133 patients in the same units receiving mechanical ventilation.[2] Although almost a third of the patients who received mechanical ventilation did receive ECMO, this was because the most unwell patients were referred to these 15 higher level centres for consideration of ECMO. As a consequence, the proportion of all patients in intensive care who received ECMO was overestimated. Of the 722 patients admitted to all intensive care units in Australia and New Zealand with confirmed H1N1 influenza A, the 53 treated with ECMO represented 7.3% of all patients and 11.6% of those who were mechanically ventilated.[3] Although acute respiratory distress syndrome from H1N1 influenza A has been a serious problem in the past 18 months, particularly in our region of the world, we wish to correct the assertion that as many as a third of patients admitted to intensive care with severe respiratory failure will need ECMO.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c6847

PRIORITY SETTING IN ISRAEL

Trade-offs have to be made everywhere

Under Israel's National Health Insurance (NHI) system, the government budget includes additional funds for expanding the health services that citizens are entitled to. Demands for new technologies, deliberated on by a public committee, far exceed the budget available. Nonetheless, the committee makes the necessary difficult trade-offs, and its decisions have evolved into an implied set of principles for priority setting.

This mechanism, although not perfect, puts trade-offs in the centre of public debate in a way that the National Institute for Health and Clinical Excellence (NICE) avoided. The committee is seen as making unavoidable tragic decisions, but not as "penny pinching."[1] The notion that health system resources are limited has found an honoured place in the public debate, alongside principles such as equity, quality, efficiency, and compassion. Our research has shown that the process seems to be accountable and acceptable in the eyes of major stakeholders and the public,[2-4] who have become even more discerning in categorising drugs as "life saving." The process has survived several administrations, both liberal and conservative, and it looks set to stay.

The proposed substitute for NICE decision making, "value based purchasing," exists in Israel in the form of large purchasers negotiating prices with suppliers.[5] But, as the Israeli case indicates, this does not eliminate the need to set priorities. The lesson from Israel is that the NHS will have to re-create NICE, but with a budgetary framework that forces politicians and constituents to face the unavoidable trade-offs.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c6827

DARZI CENTRES

Not "costly duplication," but a complementary service

MARK THOMAS

As the medical director of the first GP led health centre to close, I must reply to the misleading comments given by a primary care trust "spokesman" in your article on the closure of Darzi centres.[1]

I am puzzled by the term "costly duplication"—many patients came to us because it was almost impossible in their practice to be seen on the same day or within 48 hours for an acute problem. Hardly a duplication, more a complementary service.

NHS Stockport announced their decision just days before closure, so patients had little time to complain. We did receive complaints, most vocally from our registered patients, who—in many cases—had experienced their first taste of "continuity of care" and the ability to develop a trusting bond with one doctor. Local GPs also complained about having to register our patients at such short notice.

NHS Stockport did not provide a GP led service for homeless people. They provided a nurse led service, and patients were referred to local practices if necessary. We continue to provide two clinics (three hours long) a week led by a GP at this centre, despite the closure.

Whether such centres created or met a patient demand is immaterial. There is still a widespread belief among patients that access is not as good as we would like to think.

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Competing interests: None declared.

1 Davies P. Darzi centres: an expensive luxury the UK can no longer afford? *BMJ* 2010;341:c6287. (8 November.)

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Flawed assumptions have hampered emergency care

The demise of the polyclinic is predictable given the largely evidence-free nature of this initiative.[1] Much of the pressure to impose these models was predicated on the incorrect assumption that 60% of emergency department attendances are "primary care." The College of Emergency Medicine advised repeatedly that this figure was wrong and expectations fundamentally flawed. This was ignored by strategic health authorities, primary care trusts, and others. The suggestion from Care UK that 40% of patients in the emergency department could be seen in such clinics contrasts with the 15-30% maximum (with minimal cost savings) established by the Primary Care Foundation earlier this year.

Now, after vast wasteful expense, it is acknowledged that associated emergency department attendances have not dropped and continue to rise each year. The funding that could have transformed emergency care has been lost, and emergency departments have not received the investment needed to drive consultant expansion—most departments remain woefully understaffed at senior level.

But all is not lost. The call for a "24/7 urgent care service" reflects an appreciation that the current system is fragmented, confusing, and inconsistent, with major clinical and cost inefficiencies. A model of strengthened local general practice providing improved access at all hours, together with an emergency department providing consultant led emergency care and a colocated primary care service 24/7, tailored to local demand, will ensure the safety, quality, and cost savings required by commissioners in a service the public expects and deserves.

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Competing interests: None declared.

1 Davies P. Darzi centres: an expensive luxury the UK can no longer afford? *BMJ* 2010;341:c6287. (8 November.)

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GP-LED COMMISSIONING

Let the competition begin

If, "There will be a very small number of GPs directly involved in management and leadership, but the bulk of the work will be done by expert lay managers and we hope the very people who are involved in the NHS now will be retained,"[1] why are we going through a disruptive reorganisation of the health services to change very little?

Are the financial costs and the service disruption worth the benefits of "engaging the clinical community more actively in the commissioning process," cited as the gains of the reorganisation? No specific estimates for the benefits of possible reconfigurations of services are given, but could not this "clinical engagement" be achieved in a less disruptive way?

Although some GPs are enthusiastic for the reorganisation, they are divided over whether the reorganisation will be beneficial. There is little evidence that it will be. With funding becoming more difficult, surely there is a need not to be wasteful and reckless but to move carefully and not take big risks. Why not an incremental, experimental approach?

There has been some progress with improving commissioning, but there are problems with the current method. Some GP consortiums might improve commissioning; why not let patients decide which method of commissioning is best?[2 3]

Allow patients to choose the commissioners they prefer. If they believe that a GP consortium is better at commissioning their care than their primary care trust then let them transfer (using the current capitation payment formula) to the GP consortium.

Continue with trusts and let the public decide which commissioners they want to look after their care.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c6833

ACADEMIC SPONSORSHIP

Time to treat as independent

In response to the rosiglitazone affair, Steinbrook and Kassirer suggest that more trials should be sponsored, funded, and conducted by organisations independent of industry.[1] We agree. We operate close to that model with two studies requested by the European Medicines Agency. Academics wrote the protocols, collaborators are academic, and the study data are owned by the steering committees (on which industry has no say), which also control analyses and publications. A university is the sponsor. Funding is from industry, which has no role in study conduct, data collection, or data interpretation.

So is everything rosy? Unfortunately not.

In the UK many primary care practices regard these studies as commercial and will not participate. The Danish Board of Medicines also classifies them as "commercial" and requires participating practices to register this interest, which results in practices withdrawing from the studies. This threatens the viability of doing studies in Denmark to the detriment of everyone.

We have sought to do research at "arm's length" from industry. Applied widely, our model would obviate many of the problems with industry sponsored research. This would be in the public interest.

Our concern is that academic sponsorship is not treated as "independent" but seen as commercial. The Danish Medicines Board's decision will have no good outcome. It is retrogressive and against the public interest.

We hope that others view academic ownership and sponsorship more positively. There will be no hiding of results by us.

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Competing interests: The three authors form the executive of a trial originally requested by the European Medicines Agency that is funded by Pfizer.

1 Steinbrook R, Kassirer JP. Data availability for industry sponsored trials: what should medical journals require? *BMJ* 2010;341:c5391. (12 October.)

Cite this as: *BMJ* 2010;341:c6837

OPEN ACCESS CITATIONS

Still robust after three years

Critics of our randomised controlled study of open access publishing, article downloads, and citations said that we were too eager to report our findings and should have waited two to three years.[1] Now, after three years, we report that our initial findings were robust: articles receiving the open access treatment received more article downloads but no more citations.[2]

During the first year of publication, open access articles received more than double the number of full text downloads (119%, 95% confidence interval 100% to 140%) and 61% more PDF downloads (48% to 74%) from a third more unique visitors (32%, 24% to 41%). Abstract views were reduced by nearly a third (−29%, −34% to −24%), indicating that readers preferred to read the full article when available.

Thirty six months after publication, open access articles were cited no more frequently than articles in the control group. Open access articles received, on average, 10.6 citations (9.2 to 12.0) compared with 10.7 (9.6 to 11.8) for the control group. No significant citation differences were detected at 12, 18, 24, and 30 months after publication.

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Competing interests: None declared.

1 Davis PM, Lewenstein BV, Simon DH, Booth JG, Connolly MJL. Open access publishing, article downloads, and citations: randomised controlled trial. *BMJ* 2008;337:a568. (31 July.)
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Cite this as: *BMJ* 2010;341:c6854

UK EXPORT OF DEATH ROW DRUG

Like rope to England, or steel to France

The lobby opposing the export of the British anaesthetic thiopental for use as a lethal injection during execution has missed the point.[1]

Any intravenous anaesthetic agent would serve the purpose as the effect is dose dependent. The commonest agent used to induce anaesthesia in the world is propofol. All such agents require use by highly trained specialist doctors (anaesthetists) or administration could be lethal—hence its implicated contribution to the death of Michael Jackson.

It would have been ludicrous to oppose the importation of rope to England or the export of steel to France as a means of preventing hanging or guillotining. The opponents of capital punishment should focus on the practice itself rather than on an anaesthetic or any other agent.

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Competing interests: None declared.

1 Dyer C. High Court to review UK's failure to stop export of death row drug. *BMJ* 2010;341:c6301. (5 November.)

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