REALITY CHECK **Ray Moynihan**

Power to the people

Could a new and informed citizens' movement make medicine healthier?

Three decades after John Lennon's death, his ghost made a surprise appearance last month on a most unlikely stage. "Power to the people," proclaimed Gavin Mooney—citing a line from the late Beatle—from the podium of a conference on rural health in faraway Australia. Until recently professor of health economics at Curtin University, Perth, Mooney was outlining a vision of an informed citizenry making health systems accountable to the communities they are supposed to serve. "Now wouldn't that be a revolution?" he concluded, to hearty applause.

As healthcare eats an ever bigger slice of public spending everywhere, calls are growing for the public to take more of an interest in how their money is used. John Menadue, from the Centre for Policy Development in Sydney, told the same conference in March that it's time that an educated and informed community challenged the power of vested interests in medicine, notably doctors' associations, private health insurers, and drug companies. Formerly an ambassador to Japan, a manager within Rupert Murdoch's empire, a chief executive of Qantas, and at one time the top public servant in the nation, Menadue, like many others, is disturbed by the misallocation of so many resources to clinical medicine at the expense of genuine prevention and work on inequity and the social determinants of health.

A concern that too much medicine may actually be harming people is also behind the push for more active engagement of citizens in healthcare decision making. "We're poisoning our old," declared the University of South Australia professor of public health, Robyn McDermott, from the same podium, citing the large numbers of our parents and grandparents admitted to hospital with side effects of treatments. "We're prescribing too many pills for older people for conditions for which they could be much better served by other treatments," she said. Her presentation highlighted how diet or lifestyle change can reduce a person's risk of disease for a fraction of the cost of new drugs, and she emphasised the effectiveness of strategies such as reforming tobacco laws in cutting heart disease. "We're medicalising problems that we can much more effectively deal with with legislation, regulation, and community level activity," she said, echoing calls for more "citizen involvement."

In contrast to the word "consumer," "citizen" carries a deeper democratic resonance, hinting at reciprocal responsibilities between the people and the state. Much of the non-professional voice in medicine in recent years has come from consumer type groups, often advocating for greater attention to their specific disease and celebrating the latest treatments. For obvious reasons powerful vested interests sponsor these patient groups, and it is estimated that perhaps two thirds of all health charities receive funds from drug or device manufacturers. Sometimes sponsorship is negligible; on other occasions the association seems to be little more than "astroturfing"—the practice whereby corporations use fake grassroots organisations to promote their interests. A few years back a star studded outfit called the Boomer Coalition was urging the US public to constantly test their lipid concentrations as one way to fight heart disease. One of the two founding partners of the coalition was Pfizer, the manufacturer of a top selling lipid lowering drug, which had invested millions of dollars in the new group, the *Wall Street Journal* reported.

The confluence of interest between advocacy groups, those who sell treatments, and those who prescribe them makes for a potent cocktail of influence, almost always pushing policy makers in one direction: more tests, more procedures, more beds, more pills. Few groups take a bird's eye view, which would make it painfully clear that overdiagnosis and iatrogenic harm are an increasingly serious threat to human health and the rational use of public resources.

As someone reporting in this field for more than a decade, I sense that what's often missing from the debate is a voice genuinely representing the public interest. Sponsored advocacy groups are quick to celebrate a new treatment or technology but slow to publicly criticise its limited effectiveness, excessive cost, or downright danger. And, like many journalists, politicians tend to be unnecessarily intimidated by senior health professionals and passionate advocates, who too often lend their credibility to marketing campaigns that widen disease definitions and promote the most expensive solutions.

"It's time that an educated and informed community challenged the power of vested interests in medicine, notably doctors' associations, private health insurers, and drug companies"

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The emergence of new citizens' lobbies within healthcare, well versed in the way scientific evidence can be used and misused, may produce a more informed debate about spending priorities. Such citizens' groups could routinely expose misleading marketing in the media and offer the public and policy makers realistic and sophisticated assessments of the risks, benefits, and costs of a much broader range of health strategies. Frightening figures—like the recent estimates of radiation risks from overused computed tomography scans (*BMJ* 2011;342:d947)—would not fall straight from public consciousness but would feature in ongoing campaigns to make healthcare safer and fairer.

Gavin Mooney says that using "citizens' juries" is another way to seek untainted public input into policy making. Randomly selected from electoral rolls, these small groups of around 15 citizens are given the information and the time to deliberate collectively on important questions of health funding, and Mooney says that in his experience with this experiment they invariably argue for more equity rather than for a crude rise in numbers of local hospital beds.

"People care," Mooney says. His desire for more citizen engagement in health debates is part of a wider aim, he says, of enhancing democratic participation and rebuilding a lost sense of community. You may say he's a dreamer, but he's not the only one.

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See EDITORIAL, p 775, FEATURE, p 792

MEDICINE AND THE MEDIA

Do proposed libel law reforms go far enough?

The government's draft Defamation Bill meets only half the demands of campaigners. **Clare Dyer** asks whether this is enough to prevent the law's chilling effect on legitimate scientific debate

"We cannot continue to tolerate a culture in which scientists, journalists, and bloggers are afraid to tackle issues of public importance for fear of being sued," declared the United Kingdom's deputy prime minister, Nick Clegg, welcoming his government's keenly awaited draft Defamation Bill. But how far will the bill go to assuage concerns that threats of libel action are chilling scientific debate?

Open for consultation until 10 June, the draft bill may undergo considerable change on the route to enactment, probably in 2012. Two reforms that have been demanded by campaigners—a ban on companies suing for libel, and better protection for web hosts and internet service providers—are not in the bill. Instead, consultees are asked their opinion on how these issues should be taken forward. Should companies be barred altogether, as proposed by the Campaign for Libel Reform, which demands much of the credit for pushing legal reform up the agenda, or should there be some lesser restrictions?

REFORMS IN THE DRAFT BILL

- Deterrence of trivial claims by need to show harm
- Curtailment of "libel tourism"
- More effective and clearer defence of truth (justification)
- Clearer and wider defence of honest opinion (fair comment)
- Extension of qualified privilege to benefit non-governmental organisations and scientific conferences
- Single publication rule with a one year cut-off to stop multiple writs for online publication

Further reforms demanded

- Clearer statutory public interest defence
- End claimants censoring criticism by threatening internet service providers
- Restrict corporations suing to protect reputations
- Change court procedures to reduce time to reach trial and costs

Reform is important for the likes of Peter Wilmshurst, the interventional cardiologist who was a lead investigator in a clinical trial of the STARFlex septal repair device and who is being sued by NMT Medical, its US based manufacturer, over comments he made at a cardiology conference in the United States about the conduct of the trial (*BMJ* 2011;342:d1984).

Coincidentally, less than a week after the bill was published, the maker of another heart device, the Genous stent, announced that it had filed a defamation suit against the cardiologist Pavel Cervinka over the results of a trial on which he was the principal investigator (*BMJ* 2011;342:d2023). OrbusNeich complained that Dr Cervinka had defamed it in presenting the findings of the trial, which the company claimed was flawed, at a US cardiology conference and in a peer reviewed US medical journal. The lawsuit was filed in the Netherlands, not the UK. (The clinical trial took place in the Czech Republic, where Dr Cervinka is based; OrbusNeich is headquartered in Hong Kong, but has operations in the Netherlands, as well as in China and the US.) But as another researcher is sued, concern grows that scientists will be less inclined to publish negative results for fear of facing actions for defamation.

NMT's action against Dr Wilmshurst, launched in 2008, is still rumbling on in 2011. The company last month added a new claim, over an interview Wilmshurst gave on defamation law to a BBC Radio 4 news programme in 2009. He would not have been helped (as someone domiciled in the UK) by measures in the bill to curb libel tourism, or by a requirement for the claimant to show serious harm to reputation, designed to stop trivial claims.

Researchers, it could be argued, have a strong case under the existing common law for claiming that communications about their work are covered by qualified privilege—a defence that protects people who publish defamatory material, even if it later proves to be untrue, as long as they had an honest belief that what they were saying was true. This covers cases where the person who published the information was under a duty to communicate it and the recipient under a duty to receive it, or where publisher and recipient have a common interest in communicating the information. In the 2003 case of Vassiliev *v* Frank Cass and Co, Mr Justice Eady held that "arcane, scholarly and complex" material in a specialist journal was covered by qualified privilege because of the legitimate common interest between the publisher and the likely readers.

The Vassiliev judgment would have featured strongly if the case brought against the Danish radiologist Henrik Thomsen by GE Healthcare over comments at an Oxford conference about its contrast agent Omniscan had gone to trial, says his solicitor, Andrew Stephenson of Carter Ruck. But the case settled early after Dr Thomsen countersued the company (*BMJ* 2009;339:b5615).

Scientists who are sued for libel particularly need a means of getting an early ruling, before costs mount into six figures, as they have in Dr Wilmshurst's case

The bill will replace the common law public interest defence, which has evolved through cases, with a defence of responsible publication on a matter of public interest spelled out in statute. The first factor listed for the court's consideration in deciding whether the public interest applies is "the nature of the publication and its context." Was it, for example, presented at a scientific conference or published in a peer reviewed journal?

The Campaign for Libel Reform, which says the bill has delivered just over half the reforms it was asking for, wants the public interest defence beefed up further. But scientists who are sued for libel particularly need a means of getting an early ruling, before costs mount into six figures, as they have in Dr Wilmshurst's case.

Although not part of the bill, one of the most important reforms suggested in the consultation is a new court procedure to allow early rulings on preliminary issues before the costs pile up. This might have allowed the court to decide at an early stage not only whether Dr Wilmshurst was speaking on a matter of public interest, but also (along with other reforms in the bill) whether science writer Simon Singh's *Guardian* article that accused the British Chiropractic Association of happily promoting bogus treatments was comment or a statement of fact—before he incurred £200 000 costs (*BMJ* 2010;340:c2086).

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- Editorial: Libel law in the UK (*BMJ* 2009;339:b2759)
- A C Grayling on libel law (*BMJ* 2010;340:c339)

LOBBY WATCH **Jane Cassidy**

Office of Health Economics

What is it?

Perhaps best known for producing an annual compendium of health statistics encompassing population, morbidity, mortality, UK healthcare expenditure, and NHS costs, the Office of Health Economics is currently carrying out a commission on the role of competition in the NHS. The idea is to investigate which health services would benefit from competition and which would be harmed by it.

By collecting evidence it says that it hopes to cut through extreme positions for and against that are unlikely to represent the most socially beneficial outcome.

Chaired by the Oxford economics professor James Malcomson, the commission expects to complete its work and issue a report before the end of the year. It will then make recommendations on:

- The characteristics of publicly funded healthcare services that determine whether competition or contest is likely to be beneficial
- Non-price and price competition, and
- How competition and contest, where potentially beneficial, might be enabled, promoted, and regulated.

What agenda does it have?

It aims to provide independent research and advisory and consultancy services on policy implications and economic issues in the pharmaceutical, healthcare, and biotechnology sectors.

Founded in 1962, the Office of Health Economics is currently headed by Adrian Towse, a specialist in the economics of the health and pharmaceutical industries.

Responding to the Department of Health for England's consultation on a new value based approach to the pricing of branded drugs (*BMJ* 2010;341:c7296), which closed on 17 March, the organisation says that the government's proposals overlook some key aspects. These include the role of pricing in promoting a strong and productive pharmaceutical industry and the UK's responsibility as one of the world's richest economies to share a reasonable burden of developing new drugs of global benefit.

The government insists that there must be a much closer link between the price the NHS pays for a drug and the value that it delivers. It is calling for a common pricing policy across the country that is more stable and transparent, to give patients and clinicians access to effective and innovative medicines.

Recognising and rewarding innovation is central to the proposed new system, which the government wants in place by 2013. However, the Office of Health Economics argues that because it's not possible to attribute the costs of research and development to one market, individual countries can seek a free ride by driving prices down. This may lead to more affordable prices in the short term but can have a negative effect on investment in research and development and may lead to less innovation.

It also argues that innovation in drug development is a cumulative activity. This means that small advances are important too and that there are damaging consequences for not rewarding incremental innovation.

What does the government think of it?

The Department of Health is a client. A department representative, Bob Ricketts, director of provider policy, sits on the competition commission panel.

Where does it get its money from?

Commercial clients include the Association of the British Pharmaceutical Industry. Support also comes from research grants and consultancy fees from a number of sources, including the Department of Health's policy research programme, the National Institute of Health Research, the Medical Research Council, and the EuroQol Foundation.

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See NEWS, p 784

FROM BMJ BLOGS

Angry bird medicine

David Kerr

"I want this company to be bigger than Sanofi-Aventis in ten years' time," was the opening line from a (successful) entrepreneur I met the other day. He might be right, given the resources being poured into creating technology for the healthcare market here in Silicon Valley these days.

The concept is straightforward—choose a disease and bring all evidence based medicine into one place, invariably on a mobile phone platform app, and translate the data to make it understandable to the user—that is, patients.

Secondly, create new technologies for self monitoring as many relevant physiological variables (including multiple biomarkers).

Thirdly, link the two using software based on the approach used successfully for online games and other "verticals" of this genre (angry bird medicine?).

Finally, launch the new app and connect with patients through social networks. Companies like this are very supportive of the notion that there is a need for "free, reliable, and independent health information." The best health decisions take into account personal data, unbiased expert knowledge, and community insights.

They may be successful, at least in some situations, but, as a colleague quipped, "Six years of medical school and 10 years of training can now be put on to an app and sold for a few dollars—where did I go wrong?"

Elsewhere, a group of technology developers have created a new San Francisco incubator focusing specifically on health apps. The idea is to offer entrepreneurs with early stage ideas operational and strategic guidance, including office space, mentorship, and money.

The budding entrepreneurs are offered a $20 000 start up grant with the potential access to more substantial capital as well as support from a major US clinical centre and hospital. Unsurprisingly this is a hot topic on Twitter (@RockHealthFund).

Would the NHS ever embrace this approach?

David Kerr is the managing editor of the *Journal of Diabetes Science and Technology*

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