LETTERS

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TWITTER IN EMERGENCIES

Follow our roadmap

GERMAN GARCIA/AFP/GETTY IMAGES

Two fires along the eastern coast of Spain recently destroyed thousands of hectares of forest.[1] We monitored information updates on the catastrophe, mainly via Twitter.

In view of the often chaotic management of information,[2] we have devised a road map for the media and public bodies to follow when using social networks to provide information on unfolding disasters.

1. Official public information needs to come from one distinct place, with a Twitter account. Every tweet (or message on Facebook) must include a link to that site to confirm the veracity of information.
2. The emergencies 112 website should have a complete list of verified Twitter accounts by type of emergency, whether volunteers' organisations, local government, or civil protection. It should also record alerts or incidents; give official emergency warnings; and provide volunteer related news, help, and relevant media reports.
3. Information on road closures, access points to towns, and active fire points should be shown almost in real time on a Google Maps-type map.
4. Because many users uploaded photos of the fire, the media should add information to these images regarding their exact location, time, and date. The images would then not be used to spread panic and distort reality.
5. The media should avoid re-tweeting non-verified information.

The basic principles of information in disasters and emergencies[3]—presence of verified information that is reliable and easy to consult—must be extrapolated to social networks, and should focus on spreading news quickly and denying hoaxes.[4]

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Competing interests: None declared.

1 Baker D. Thousands evacuated in eastern Spain after the country's worst forest fires in a decade rages out of control. *Daily Mail* 2012. www.dailymail.co.uk/news/article-2167508/Thousands-evacuated-Valencia-countrys-worst-forest-fires-decade-rages-control.html.
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HIGH REPRINT ORDERS

Income from reprints creates a conflict of interests

Although the *BMJ* and *Lancet* provided Handel and colleagues access to information on reprint sales,[1] the big US journals were unwilling to share this information. Our experience was similar when we investigated reprint sales.[2]

Much of the previous evidence in this field has been anecdotal, such as the infamous VIGOR trial of rofecoxib, where Merck bought 900 000 reprints from the *New England Journal of Medicine*, at an estimated income for the journal of $700 000 (£446 000; €569 730) to $836 000.[3] However, that trial was published more than 10 years ago, and in the current study one *Lancet* paper that sold a similar number of reprints produced a journal income of around $2.4m.

Handel and colleagues state that "Reprint orders represent a large source of income for the *Lancet* and *BMJ*." Although the *BMJ*'s reprint income is considerable, important differences exist between the two journals. The median number of reprints sold was almost 10 times higher for the *Lancet* than for the *BMJ*,[1] and we found that journal income from reprint sales was 3% of total income for the *BMJ* and 41% for the *Lancet*.[2]

We believe that income from reprints creates conflicts of interest for journals, so editors should disclose this information to readers, just as authors disclose their conflicts of interest.[4] However, disclosure does not eliminate the conflict. Alternatively, trial results could be published on public websites, not in journals, with journals discussing the results.[5] A less radical approach would be to publish trials only in open access journals, where readers can read and print articles for free.

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Competing interests: None declared.

1 Handel AE, Patel SV, Pakpoor J, Ebers GC, Goldacre B, Ramagopalan SV. High reprint orders in medical journals and pharmaceutical industry funding: case-control study. *BMJ* 2012;344:e4212. (28 June.)
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Cite this as: *BMJ* 2012;345:e4970

Time to open up the finances of medical journals

Perhaps the most striking thing about this paper is that the American publishers—all doctors' organisations—refused to provide data. Inevitably, readers will wonder what they are hiding.[1] The answer, I suspect, is the massive profits that they make from selling reprints of research funded by drug companies.

Around a half of drug sales are in North America, and reprints are a major device for promoting drugs. I suggest that the point of reprints is not to provide doctors with scientific data but to link drug company products to prestigious journals. Well over 80% of reprints are probably never read.

The *Lancet* sold one reprint for more than £1.55m (€2m; £2.4m), and the profit margin on reprints is around 80%, which makes them particularly attractive to publishers. Paper subscriptions are nothing like as profitable. So Elsevier, which owns the *Lancet*, made a profit of more than £1m from this one study. That is one reason why Elsevier's profit margin is over 30%, far higher than in most industries.

The conflict of interest is clearly huge. If Elsevier had to maintain its profit margin by cutting costs rather than publishing that one article it would have to fire about 25 editors

(assuming an average salary plus costs of about £40 000).

Because the American market is so huge and important the American journals, particularly the *New England Journal of Medicine*, may make more from reprints than the *Lancet* does. Doctors who belong to organisations that publish journals should ask to see the journal budgets.[2]

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Competing interests: RS was the editor of the *BMJ* and chief executive of the BMJ Publishing Group. He is a zealot for open access and was from 2004 to 2011 a member of the board of the Public Library of Science.

1 Handel AE, Patel SV, Pakpoor J, Ebers GC, Goldacre B, Ramagopalan SV. High reprint orders in medical journals and pharmaceutical industry funding: case-control study. *BMJ* 2012;344:e4212. (28 June.)
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CONTRACEPTIVE SERVICES

Natural family planning is effective and acceptable

The Guttmacher Institute and United Nations Population Fund study defines women who choose to use any form of family planning except modern contraception as "having unmet need for modern contraceptives" on the basis that alternative methods of family planning "are much more likely to fail."[1 2] Hence the main conclusions of the study depend on two assumptions. Firstly, that efficacy is always the over-riding consideration in choice of method of family planning. Secondly, that modern contraceptives are always much more effective than other methods of family planning.

The first assumption shows no awareness of, or respect for, the values of women in cultures dissimilar to our own who need a form of family planning that is harmonious with their cultural beliefs.

The second assumption is simply wrong. The pill, male condoms, female condoms, and spermicides are all classified as modern contraception, but their typical use failure rates are 8%, 15%, 21%, and a staggering 29%, respectively.[3 4] Contrast this with the typical use failure rate of modern methods of natural family planning, such as the Creighton, Billings, and symptothermal methods, which some studies report as around 3%,[5] similar to Depo-Provera. In fact, the perfect use failure rates of these methods have been reported as 0.5%, 0.5%, and 0.3%, respectively,[4] comparable to those of the pill, female sterilisation, and the copper intrauterine device.[3] It is entirely reasonable, then, to choose natural methods on grounds of efficacy alone.

If we genuinely want to help the poorest of the poor rather than powerful and wealthy drug companies, we should promote effective and culturally acceptable natural family planning in the developing world rather than expensive contraception.

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Competing interests: None declared.

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OSTEOPOROSIS RISK ASSESSMENT

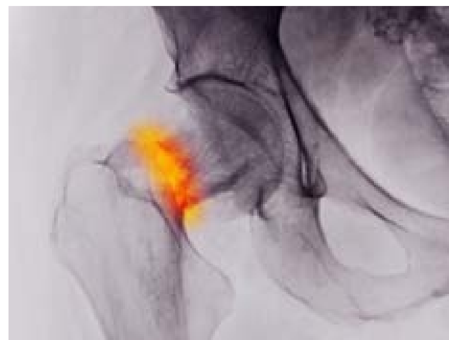
QFracture is better than FRAX in assessing hip fracture risk

Cooper and Harvey's editorial supports the World Health Organization's FRAX tool as better than the QFracture algorithm in identifying osteoporotic fracture risk.[1 2] However, the impact of osteoporosis is dominated by hip fracture, so these tools' ability to predict who will sustain this devastating injury needs to be examined.

We assessed 101 patients (79 women; mean age 82.5 years) admitted with fragility hip fracture on whether the risk of injury could have been identified by FRAX or QFracture assessment. We identified clinical risk factors present before hip fracture, and calculated the 10 year hip fracture risk without reference to bone mineral density.

FRAX and QFracture risk estimates showed significant correlation (r=0.72, P<0.01), but QFracture scores were higher in patients with a history of falls, reflecting its sensitivity to this important risk factor.

With FRAX only 24 patients met the National Osteoporosis Guideline Group criteria for osteoporosis treatment, 43 would have needed referral for bone mineral density measurement to guide treatment choice, and 34 would have been falsely reassured by their assessment.


SCOTT CAMAZINE/SPL

In contrast, 97 met QFracture's proposed treatment threshold (the highest tenth of 10 year risk). These patients could have been considered for preventive measures without requiring bone mineral density measurement, avoiding an assessment that often poses practical problems and is of limited clinical relevance in frail elderly people.

A population strategy based on FRAX would have had limited success in identifying the need for preventive treatment in these patients with hip fracture. Care of hip fracture dominates the cost of osteoporosis, which clearly limits the cost effectiveness of FRAX. By contrast, a strategy of targeting the top tenth of risk with QFracture would have identified most of these patients before they developed hip fracture.

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Competing interests: None declared.

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Cite this as: *BMJ* 2012;345:e4988

MENTAL AND NEUROLOGICAL DIVIDE

Authors' reply to letters

We argued that psychiatric and neurological conditions should be classified together because they are both essentially disorders of the nervous system.[1] However, we also argued that psychological and social considerations are vitally important throughout medicine. We therefore agree with Holmes that "many 'brain diseases' result from . . . environmental and developmental processes."[2] But we disagree that "only psychiatry can encompass the 'social brain.'"[2] Indeed, every doctor should pay attention to how social (and psychological) factors affect their patients and their illnesses. We do not foresee that psychiatrists will lose their unique skills. Instead, we propose a change in every doctor's understanding of disorders of the brain, however they were previously labelled.[1]

The views expressed by the five senior officers of the Royal College of Psychiatrists were disappointing,[3] not least when a previous college president shared our concerns.[4] Bailey's solution of dual classification is liable to sow confusion, as we exemplified in our article,[1] and to delay an overdue shift in attitudes to disorders of mind and brain. We believe that the reintegration of psychiatry into medicine, symbolised by the changes in classification we suggest, would benefit patients within

psychiatry and medicine more generally. The resulting change in professional attitudes, more frequent interchange of students and trainees between mental health and medicine, and the wider adoption of a biopsychosocial model of illness would enhance the quality of care provided by all healthcare professionals. It would be a step towards ending the worldwide scandal whereby most people with mental illnesses receive no treatment.[5] Our proposal is not "premature" but long overdue.

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Competing interests: HR and AZJZ have no competing interests. PDW has provided consultancy to the UK government and a re-insurance company.

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AVASTIN VERSUS LUCENTIS

Approve bevacizumab in eye disease in cash strapped times

We agree with Godlee that the "miracle" of anti-VEGF (vascular endothelial growth factor) treatment has been overshadowed by the bevacizumab (Avastin) versus ranibuzimab (Lucentis) dispute.[1]

However, in our opinion, the anti-VEGF treatment versus no treatment debate is even more important. During this economic crisis, many of our patients with age related macular degeneration or diabetic retinopathy are unemployed, uninsured, or immigrants (sometimes illegal); these patients need treatment with an anti-VEGF drug but cannot afford monthly injections of ranibuzimab.

What should be done with these patients? Because current evidence is that bevacizumab is as safe as ranibuzimab, should these people be given the option of the cheaper drug or left untreated? What is ethical for a doctor to do? Use an off-label treatment or give no treatment at all?

In Greece, ranibuzimab can be prescribed only for age related macular degeneration, diabetic macular oedema, and vein occlusion. What should be done with patients who need treatment for another condition, such as choroidal neovascularisation secondary to myopia, angioid streaks, or diabetic vitreous haemorrhage? Should these patients receive bevacizumab or should their disease be left to run its natural course?

So these days the dilemma of bevacizumab versus ranibuzimab seems to be a theoretical one—a dilemma of prosperity.

In many cases bevacizumab is the only affordable solution for the patient, with impressive results in saving vision. We strongly believe that bevacizumab should be approved for use, despite the resistance of the drug companies.

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Competing interests: None declared.

1 Godlee F. Avastin versus Lucentis [Editor's Choice]. *BMJ* 2012;344:e3162. (2 May.)

Cite this as: *BMJ* 2012;345:e4806

SALE OF BABY MILK

Expensive monopoly in Greece

Despite recent market reforms, rulings of the Hellenic Competition Commission, and European Community legislation,[1] the sale of baby formula milk in Greece is once again restricted to pharmacies, which charge high prices.[2]

Apparently, pharmaceutical lobbying in Greece is so powerful that it can cancel established market reforms that benefit parents.[3-5] The line of defence is that pharmacists can explain mixing procedures to parents better than supermarket employees, even though detailed instructions are included in the package.

Doctors can explain side effects and drug interactions to patients better than pharmacists, so should doctors be the only ones certified to sell drugs in Greece? Would pharmacists accept this?

In the meantime, Greek parents are forced to buy baby milk at more than double the price in the UK.[3 5]

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Competing interests: None declared.

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BAD MEDICINE: CHEST EXAMINATION

Reliable clinical examination

JOHN THYS/REPORTERS/SPL

We echo Spence's sentiments that the clinical examination could be improved.[1] In our experience, doctors teach and assess in a traditional rather than evidence based manner. Reliability is the agreement between doctors that a clinical sign can be independently elicited in the same patient when it is present.

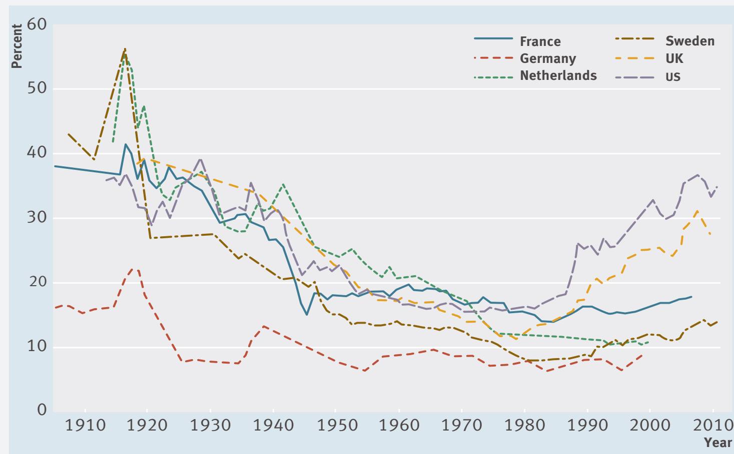
When learning and applying the respiratory examination, doctors should know the reliability of the different elements; studies have identified these based on kappa coefficient values (–1 very unreliable, 1 very reliable). On this scale, percussion note has a reliability of 0.52 whereas tactile vocal fremitus has a value of only 0.01 (wheeze 0.51, crackles 0.41, chest expansion 0.38, whispering pectoriloquy 0.11, tracheal position 0.01, tactile vocal fremitus 0.01).[2]

Furthermore, clinical examination can be refined to specific clinical presentations such as suspected pneumonia or pleural effusion.[3 4] Interestingly, clinicians naturally perform the more reliable elements of the respiratory examination, and students have good knowledge of the reliability, an effect enhanced by experience.[5]

We disagree that chest examination is largely redundant. However, examination must be adapted to suit the situation and accept the limitations. In an age of rapidly advancing investigations, chest examination still has a role in refining or altering a working diagnosis based on symptoms. Further studies are required to guide evidence based stratification and diagnosis. We agree that we need to move towards an evidence based approach to performing, teaching, and assessing chest examination rather than stay with the traditional regimen.

THE CRUSADE FOR HEALTH EQUITY

Let's be clear about capitalism



Top 1% share of national income by country and year[5]

Richards says that Marmot "does not endorse the view that capitalism is the root of all evil."[1] Of course it isn't, but unrestrained social injustice and the poisonous inequalities that result are evil. Marmot himself, Wilkinson and Pickett,[2] and Dorling[3] have done much to show this.

We have to remember that certain political choices make far greater differences than almost any health intervention possibly could. I urge readers to look at the graph (figure), which shows how six leading economies have chosen their paths during the 20th and early 21st centuries.[4 5]

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Competing interests: None declared.

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Cite this as: *BMJ* 2012;345:e4979

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Competing interests: None declared.

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Not useful in modern healthcare

I completely agree with Spence.[1] He raised an issue that many find controversial although it is as clear as water.

Physical signs are unreliable and usually have very high interobserver variability, which makes them useless in terms of changing the patient's management.

We need to reassess all physical signs and techniques in the light of new tests and develop a guideline on their usefulness. They may be useful where tests are not available, but in a modern healthcare facility they are mostly a waste of time.

I still remember my MRCP cases, where on one case I had a clear pass (4) from one examiner and a clear fail (1) from another. This meant that two out of the three of us were wrong. Unfortunately, I was the one who had to take the test again.

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Competing interests: None declared.

1 Spence D. Bad medicine: chest examination. *BMJ* 2012;345:e4569. (4 July.)

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HEALTH WORKER FLU VACCINATION

What about other care workers?

This editorial focuses on an important preventive issue,[1] but I wonder how many colleagues realise and would approve of government policy, which fails to fund flu vaccination for non-NHS (and non-social services) professional carers—that is, those employed by the voluntary or private sector, by far the majority?

These low paid carers must pay for vaccination themselves because their employers rarely do; the result is they are mostly left unprotected in the case of an epidemic, free to spread flu to thousands of vulnerable people, or else stay off sick in great numbers with dire consequences to their clients. Can we exert pressure on the Department of Health to change the rules?

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Competing interests: None declared.

1 Nair H, Holmes A, Rudan I, Car J. Influenza vaccination in healthcare professionals. *BMJ* 2012;344:e2217. (28 March.)

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INQUIRY INTO MATERNAL DEATHS

Look for heart disease in at risk women at antenatal check

Heart disease has been identified as a leading cause of maternal death,[1] so why is there no prompt to perform a cardiological examination among the numerous checks and tests in the National Institute for Health and Clinical Excellence guidance for antenatal care unless heart disease has previously been identified?

Because rates of rheumatic heart disease are rising across parts of Africa, Asia, and the Orient (with current prevalence rates of rheumatic heart disease as high as 100/100 000), and national demographic patterns are changing as a result of immigration, should we start to look actively for valvular heart disease in patient groups at risk?

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Competing interests: None declared.

1 Shennan A, Bewley S. What has happened to the UK Confidential Enquiry into Maternal Deaths? *BMJ* 2012;344:e4147. (21 June.)

Cite this as: *BMJ* 2012;345:e4965

THE NHS MUST CHANGE OR DIE

Is community care any cheaper?

I see that Hawkes has come out with the usual stuff about the NHS having to change (never backed up by any reasoned argument except that the government has decided it's not prepared to go on paying for it) and that this must involve fewer staff and beds (again light on evidence).[1]

This opinion piece has two major flaws. Firstly, where is the evidence that community care is any cheaper? Or is "community care" really a euphemism for "no care," which I guess is cheaper in the short term? Secondly, if community care is to mean anything, it has to be put in place before we decommission hospital care. The two systems will have to run in tandem at least for a short time, if patients aren't to fall between the cracks. That would be expensive, so I'm guessing that the chances of it happening are approaching zero.

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Competing interests: None declared.

1 Hawkes N. The NHS must change or die. *BMJ* 2012;345:e4478. (4 July.)

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