Young military veterans show similar help seeking behaviour

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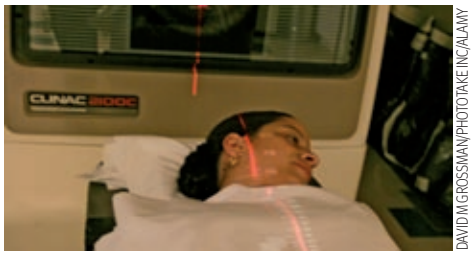
LETTERS



DAVID M GROSSMAN/PHOTOTAKE INC/ALAMY

RADIOTHERAPY HARM

Service delivery should be funded centrally

Donaldson does a considerable disservice to the work of the multidisciplinary members of radiotherapy departments, including radiographers and physicists, and misleads the more general readership of the BMJ, in implying that these errors are not being actively addressed.[1]

Following the incident at the Beatson Oncology Centre, Glasgow, every department in the United Kingdom was asked to evaluate its service in the light of the report.[2] Fourteen separate action points were identified by our team, the first and most important of which is chronic understaffing in the treatment planning section. Even though processes are robust, most of the checking procedures are manual, and rely on staff working efficiently at a reasonable work rate; we compare unfavourably with the Beatson in terms of staff (especially physicists), linear accelerators, and patient ratios.

There are, undoubtedly, process flaws, but they lie less in the processes and standard operating procedures staff use in radiation treatment, and more in the processes involved to secure the funding to redress deficiencies. Most departments in the UK are based in district general hospitals, and any bids for service improvements are considered in direct competition against other services, in an atmosphere of two week cancer waits, and other "must do" performance targets (some of which have associated financial incentives).

While the ultimate accountability for clinical governance sits with provider organisations, the performance management sits with commissioners. However, in the 12 months since our last submission for increased resources in radiotherapy was made, we have become part of a new cancer network; the five main primary care trusts whose patients we treated no longer exist, and nor does the strategic health authority. To whom, therefore, should we be putting forward our business cases? And what are their funding decisions likely to be in these financially challenged times?

Glasgow is a wake up call, not only for individual departments but for the NHS as a whole: this is a national issue, not a local one.

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Competing interests: None declared.

1 Donaldson L. Reducing harm from radiotherapy. *BMJ* 2007;334:272. (10 February.)
2 *Unintended overexposure of patient Lisa Norris during radiotherapy treatment at the Beatson Oncology Centre, Glasgow in January 2006. Report of an investigation for IR(ME)R.*

Culture of secrecy must be tackled

The Royal College of Radiologists welcomes the chief medical officer's editorial on reducing harm from radiotherapy.[1] In the five years to April 2006, only 211 incidents of a dose greater than intended were reported under the IR(ME) regulations.[2] Many of these were correctable by adjusting subsequent treatment. Patient injury is a rare event; this is as it should be for a non-emergency treatment given routinely to patients with an established diagnosis.

In June 2006 the Royal College of Radiologists set up a multidisciplinary working party to identify measures to prevent and mitigate errors in radiotherapy. One of the main obstacles to this work is the culture of secrecy surrounding radiotherapy incidents. The system for reporting radiotherapy incidents in the United Kingdom is dysfunctional: the results of inquiries are secret; there is no dissemination of learning; errors are repeated; and public confidence is eroded.[1] Most of the incidents reported under the IR(ME) regulations remain confidential and can only be identified under the Freedom of Information Act.[2] The full report of the inquiry into the Leeds incident has still not been published despite the fact that it contains a number of recommendations for practice nationally.

Open publication, as in the Glasgow incident, is the exception but should be the rule. This could be facilitated by establishing a website to host anonymised reports of inquiries. At the very least, a confidential system to disseminate learning on the National Confidential Enquiry into Perioperative Deaths (NCEPOD) model should be established. This would involve collaboration between the National Patient Safety Agency, the Health Protection Agency, and the Healthcare Commission. Change in the UK is essential if we are to improve our learning from errors.

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Competing interests: None declared.

1 Donaldson L. Reducing harm from radiotherapy. *BMJ* 2007;334:272. (10 February.)
2 Over 200 hurt or killed by botched radiation. *Sunday Times* 2006 April 30.

RANIBIZUMAB AND BEVACIZUMAB

The cheaper drug, bevacizumab, should be referred to NICE

We think that Chakravarthy and Lim could have said more about the pricing of ranibizumab and bevacizumab.[1] Both drugs are owned by a single company, Roche/Genentech, which has no intention of licensing the cheaper. The US price of ranibizumab is $1950 or roughly £1000 per injection. Monthly injections would cost £12 000 per patient. Bevacizumab, which is licensed for cancer treatment, could cost as little as £17 per injection, as the dosages used for eyes are minute compared with cancer. In the US, off-licence bevacizumab is estimated to cost $17-50 (£8-25) including the costs of splitting up the larger cancer doses. By refusing to license bevacizumab for macular degeneration, Roche/Genentech is raising the price by an unprecedented factor of over 50.

Given the lack of data directly comparing these two drugs, we support the call for a head to head trial (indeed we are part of a team bidding to do such a trial). We wish to make three further points.

Firstly, we have modelled how much more effective bevacizumab would have

to be relative to ranibizumab in order to meet the National Institute of Health and Clinical Excellence (NICE) threshold of £30 000/QALY. Using best estimates of current US prices of $1950 and (a high) $50, ranibizumab would need to be 2.5 times more efficacious to meet NICE's threshold. This seems highly unlikely, given the similarity of the two drugs and the observational data that exist on the effectiveness of avastin. Even if ranibizumab's price was reduced to $500, it would have to be more than 5% better than bevacizumab to be cost effective.

Secondly, the review by NICE of ranibizumab versus standard care for patients with the predominantly classic form of macular degeneration, due to report by October 2007, could imperil any head to head trial in the UK. Should NICE find in favour of ranibizumab, then those patients may well prefer to be treated with ranibizumab rather than being randomised. Any UK trial must recruit quickly.

Thirdly, bevacizumab has been excluded from the NICE review because it is unlicensed. Exclusion of unlicensed drugs is normally sensible owing to lack of data. However, given that Roche/Genentech, which owns both drugs, has no plans to license the cheaper, an exception should be considered. Even if a trial were to show bevacizumab to be equivalent to ranibizumab, it would require Department of Health authorisation before bevacizumab could be widely used. The department should urgently consider referring bevacizumab for NICE appraisal.

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Competing interests: Both JR and AL are part of a bid for funding of a head to head comparison of bevacizumab and ranibizumab.

1 Chakravarthy U, Lim JI. New treatments for neovascular acute macular degeneration. *BMJ* 2007;334:269-70. (10 February.)

MENTAL HEALTH OF OFFENDERS

Young military veterans show similar help seeking behaviour

A study undertaken by the King's Centre for Military Health Research had similar findings to those reported by Howerton et al.[1] The study investigated the help seeking paths of young men (n=74) leaving Colchester Military Corrective Training Centre." Young veterans found it difficult to access available resettlement services for a variety of reasons including: previous bad experiences with other services, lack of knowledge of what services were available, and feelings that these services would not be able to help. Additionally, this group had high levels of mental ill health, both before discharge (n=61, 82%) and six months after leaving (n=39, 53%). Only a small minority of those with mental health problems were seeking help for these problems, and most preferred to use informal networks of support, such as friends and family. Six months after leaving, only one participant with a mental health problem reported seeking help for it.

Services need to be better targeted to address the needs of these more vulnerable groups. Further, services based on less formal support networks (such as mentoring) may provide a more successful way to integrate vulnerable groups into resettlement services. In our study population, 82% (n=61) said that they would have found a mentor useful in their transition from military prison into civilian life. This structure could provide "an informal relationship delivered in a formal structure" and so better mimic the chosen support networks of this vulnerable group.

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Competing interests: None declared.

1 Howerton A, Byng R, Campbell J, Hess D, Owens C, Aitken P. Understanding help seeking behaviour among male offenders: qualitative interview study. *BMJ* 334:303-6. (10 February.)

ABORTION

Time to erase the line?

As a longstanding anti-choicer, I commend Gornall on a balanced and informative article on abortion.[1] It got me wondering if the abortion debate isn't all a bit pointless. Pro-choicers and pro-lifers disagree profoundly on whether children can be treated differently depending on whether it's before or after they're born. The "right" answer to this seems to depend on what part of the world you're in. Even within the mainly pro-choice United Kingdom, one nation (Northern Ireland) remains essentially pro-life. This argument will continue for the foreseeable future without a winner.

What if we changed the focus to our main area of agreement: that women and children should be able to lead happy and fulfilling lives?

What if pro-lifers and pro-choicers worked together for a better deal for pregnant women and the parents of young children? Does anyone really want any woman to have an abortion because she can't afford to have a baby or because her job prospects will be wrecked? As a society, are we really doing enough to give women a real choice? How come a 36 year old medical consultant is able to have children with relatively little detrimental impact on finances or career compared with a 25 year old junior doctor or a 36 year old cleaner? What if maternity pay and leave was funded by the government rather than individual companies so that the cost is evenly distributed? What if ...?

The general consensus in Britain is that abortion is a necessary evil. Pro-lifers have spent a lot of time unsuccessfully trying to persuade the public that abortion is too evil to be necessary. It might be time to accept the prevailing view and instead work towards a society where it's unnecessary to be so evil. And perhaps pro-choicers can join us? Then maybe we can all be truly pro-choice.

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Competing interests: None declared.

1 Gornall J. Where do we draw the line? *BMJ* 2007;334:285-9. (10 February.)

NUTRITIONISTS

Give us food sense, not nonsense

For those uncertain of the quality of nutritionists,[1] dietitians have long had an anecdotal way to separate those qualified in nutrition from those not. Avoid the amateur musings of any nutritionist advocating "detox," "superfood" or multiple food group exclusions at first consultation, or who give "candida overgrowth" as a viable clinical diagnosis. For those considering major dietary exclusions as a blunt tool to correct symptoms, I suggest they recall the quote by Fran Lebowitz, with whom registered dietitians would concur, that "Food is an important part of a balanced diet."

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Competing interests: None declared.

1 Goldacre B. Tell us the truth about nutritionists. *BMJ* 2007;334:292. (10 February.)