Proposal to abolish resale price maintenance on medicines

Resale price maintenance must continue

EDITOR,—I understand that the chief executive of the supermarket group Asda, Mr Archie Norman, has written to doctors urging them to indicate their support for his campaign for the abolition of resale price maintenance on medicines (whereby retailers cannot sell an item at a price below that recommended by the manufacturer). I trust that, after careful consideration of the implications, doctors will decide to take no such action, or perhaps even to indicate their support for the continuation of resale price maintenance.

Resale price maintenance for medicines exists because the courts decided in 1970 that it was in the public interest. As Mr Norman says, much has changed since 1970: the changes have, however, made resale price maintenance even more a matter of public interest. The key question that doctors should consider is whether it is important for people to treat medicines with respect and as quite different from other items that they buy. If this is so, we must ensure that people are not encouraged to buy more medicines than they need at any one time by promotions such as "three for the price of two" or other slick marketing ploys, all designed to give Asda the target sales turnover that it has set per unit of display space.

Asda recently described paracetamol as a "mundane product," putting it into the same category as detergents and breakfast cereals. This highlighted Asda's approach—one that should sound warning bells for health professionals and parents who want to ensure responsible use of medicines. Thus this battle is not just about prices: it is about the way that medicines should be regarded and offered for sale. Once we allow high pressure promotion of medicines it will be impossible to turn the clock back.

Despite what Mr Norman says, branded non-prescription medicines are 20-30% cheaper in Britain than in every other country in the European Union except Sweden (Proprietary Association of Great Britain, personal communication). Prices in Britain are kept low by competition among manufacturers and by the existence of "own brand" and generic medicines, which are widely available in pharmacies, accompanied by sound advice.

JOHN FERGUSON
Secretary

Royal Pharmaceutical Society of Great Britain,
London SE1 7JN

Asda's reply

EDITOR,—So far, 8000 general practitioners and other health professionals have expressed support for Asda's campaign to end resale price maintenance on well known, widely available health aids, medicines, and vitamins. It is interesting that those who deal daily with the concerns of ordinary people recognise that the price of everyday health care items is an issue.

Asda's purpose in opposing resale price maintenance is straightforward: we want to provide our customers with the products they need at a

price that represents good, honest value. The issue is good, honest value. General practitioners tell us that some patients who are entitled to free prescriptions cannot afford the high prices of branded products that are available over the counter. As a result, these patients go to their doctor for prescriptions and so increase the burden on busy general practitioners, primary health care, and NHS funds. The message from our customers, especially families and older people, is that price matters. Almost one in five buyers of pharmaceutical products in Britain is aged over 65. According to Target Group Index (an industry source), one in seven has a household income of less than £7000 and more than one in three has a household income of under £15 000.

The prices of our own brand products are half or less of those of the branded equivalents, and we still make a reasonable profit. This illustrates the extent to which resale price maintenance has limited competition among manufacturers, allowing profit margins to increase to exploitative levels.

We calculate that the public is paying around £300m a year extra for basic health care products as a result of the outdated legislation concerning resale price maintenance. Furthermore, the benefit of price protection does not accrue to small pharmacies. On many brand name pharmaceuticals we estimate that 50-60% of the retail price is profit for manufacturers and wholesalers. Most of the rest of the spending on such pharmaceuticals goes to the main national retail chains. Neighbourhood pharmacies end up with less than a tenth of the £300m "resale price maintenance tax" on health care.

We are encouraged that the Office of Fair Trading has identified changes in the market for pharmaceuticals since 1970, and we are optimistic that it will announce its intention to review resale price maintenance later this year. The end of price fixing cannot come too soon for those people for whom basic health care products represent an unaffordable luxury.

ARCHIE J NORMAN
Chief executive

Asda Group,
Leeds LS11 5AD

Psychological support for patients having breast cancer surgery

Study had methodological flaws

EDITOR,—June M C McArdle and colleagues' study suggests that support from a breast care nurse can significantly reduce psychological morbidity in women having surgery for breast cancer.¹ We wish to draw attention to several methodological points.

The authors state that psychological morbidity is common in women after surgery for breast cancer and that support from a breast care nurse is the most effective intervention in reducing this morbidity. The women randomised to receive support from the breast care nurse seem, however, to have begun to receive that support before the surgery took place and before any baseline measures were made. This may partly explain why, when the first questionnaires were completed after surgery, the group receiving

support from the breast care nurse alone had lower scores on the general health questionnaire and the hospital anxiety and depression scale than did the other groups. It is unclear why the group receiving support from both the breast care nurse and the voluntary organisation did not have similar scores immediately after surgery to those in the group receiving support from the nurse alone, and no attempt is made to explain this in the discussion. In their analysis the authors simply averaged the scores over all time points and compared them. They did not look at the change in scores, which surely is the more interesting comparison. Without an unequivocal baseline before randomisation the effectiveness of an intervention cannot be estimated.

Furthermore, the mean scores for these questionnaires were frequently well below the thresholds that indicate that clinically important emotional distress is likely. The authors state that their scores were skewed, but not in which direction. Thus it is impossible to know how many women were actually "cases" of emotional disorder in the first place. In addition, it is unclear from the paper who administered the general health questionnaire and the hospital anxiety and depression scale, but we assume that it was the breast care nurse. We recognise that blinding is often not feasible, particularly in evaluating psychological treatments, but it is not advisable for the person who provides the support or treatment to administer the assessments as well. The nurse may have influenced patients' response on the self report questionnaires.

Although we are aware of the enormous difficulties involved in conducting and reporting ran-

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the *BMJ* article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.

domised controlled trials of psychological interventions, the results of this trial seem to be inconclusive.

KARIN FRIEDLI
Research fellow
MICHAEL KING
Professor

University Department of Psychiatry,
Royal Free Hospital School of Medicine,
London NW3 2PF

1 McArdle JMC, George WD, McArdle CS, Smith DC, Moodie AR, Hughson AVM, *et al.* Psychological support for patients undergoing breast cancer surgery: a randomised study. *BMJ* 1996;312:813-7. [With commentary by C Foster.] (30 March.)

Support groups whose members have themselves had breast cancer are helpful

EDITOR,—Although all support groups have a useful role, it is a pity that the support group used in June M C McArdle and colleagues' study was not one whose members have all had breast cancer themselves and are specifically dedicated to supporting patients with breast cancer.¹ Members of such support groups can therefore truly empathise with the patients and also have the added advantage of being able to talk to patients not only about the feelings involved but also about the day to day practical problems experienced after leaving hospital.

In Edinburgh the breast care nurses quite often refer patients to our support group, Reach for Recovery, and value the reassurance and help that we can provide. We have been given the use of a room in the breast clinic, where nursing staff can bring patients immediately after they have received their diagnosis, while they are waiting to see the breast care nurses. This allows them to have a cup of coffee, a chat, and a quiet weep away from the public waiting area, and they are in a calmer and therefore more receptive frame of mind by the time they see the nurse counsellors. In addition, on a Wednesday morning we have a drop in centre, where patients can talk about their worries and concerns; this helps them to put everything into perspective. We are also allowed to visit patients in the breast cancer ward every Friday morning. This has been greatly appreciated by patients, and many long term contacts have been formed as a result of this short, informal, chat.

Feedback from patients indicates that they find our services helpful and a useful supplement to the medical team. They also find it reassuring to meet former patients who look both fit and "normal."

HELEN CAULTON
Coordinator

Reach for Recovery,
Edinburgh Breast Unit,
Western General Hospital,
Edinburgh EH4 2XU

1 McArdle JMC, George WD, McArdle CS, Smith DC, Moodie AR, Hughson AVM, *et al.* Psychological support for patients undergoing breast cancer surgery: a randomised study. *BMJ* 1996;312:813-7. [With commentary by C Foster.] (30 March.)

Patients' consent should have been sought

EDITOR,—It is ironic that a study in which informed consent was not sought¹ should be published in the same issue as an editorial by Richard Smith calling for action on misconduct in research.² The study falls well short of good clinical research practice, which is a requirement in trials sponsored by the pharmaceutical industry.³ The hospital ethics committee was surely at fault in allowing the research to proceed in contravention of the Nuremberg Code.

In her commentary Claire Foster addresses some, but not all, of the issues of informed con-

sent raised by the study.¹ Women, unlike rats in cages, move around and communicate with each other. In the 1980s Evelyn Thomas, a lecturer in biology with the Open University who fully understood the principles of randomised controlled trials, found to her distress that she had been included in a trial of counselling versus no counselling after her mastectomy. Her case, which led to a formal complaint and was well publicised at the time, should have been a warning to future researchers.

The study raises further problems. It is imprudent for the lead researcher also to be the lead therapist. As Watson pointed out: "This is a major methodological flaw, as it is difficult to eliminate bias from a study where there is an obvious vested interest in the outcome."⁴ The fact that two members of the same family are co-researchers should also give cause for concern. It is, moreover, a serious drawback that the voluntary organisation involved in the study, Tak Tent, was not functioning in its usual fashion; this in itself invalidates any conclusions.

A common complaint from cancer support groups is that hospitals act as gatekeepers, often not informing people of the groups' existence.⁵ Patients should be free to refer themselves at any stage of their cancer journey, according to individual need. It is untrue that the effect of community based support organisations has not been evaluated: the reference that the authors give is out of date.

Breast care nurses do a valuable job; they have no need to compete with self help groups but should cooperate with them. They have limited time and rarely hold qualifications in counselling. They may therefore not pick up, or not be able to deal with, psychological morbidity. If as a result of this study they dismiss the work of voluntary groups and fail to inform patients of other sources of support, the study will have done harm rather than good.

HEATHER GOODARE
Counsellor in private practice

1 Heron Way,
Horsham,
West Sussex RH13 6DF

1 McArdle JMC, George WD, McArdle CS, Smith DC, Moodie AR, Hughson AVM, *et al.* Psychological support for patients undergoing breast cancer surgery: a randomised study. *BMJ* 1996;312:813-7. [With commentary by C Foster.] (30 March.)

2 Smith R. Time to face up to research misconduct. *BMJ* 1996;312:789-90. (30 March.)

3 Official statements: good clinical trial practice. *Bull Med Ethics* 1996;114:10-1.

4 Watson M. Psychosocial intervention with cancer patients: a review. *Psychol Med* 1983;13:839-46.

5 Iveson P. A life turned upside down. *IJSM Network* 1995;2(24):4.

Data may not have been summarised appropriately

EDITOR,—June M C McArdle and colleagues end their paper by saying that "the failure to reduce morbidity in the combined approach [routine care plus support from a breast care nurse and a voluntary organisation] is difficult to explain."¹ This logic is not supported by the data presented.

An overconcentration on P values at the expense of descriptive trends seems to have led the authors to conclude that "scores were consistently lower in patients offered support from [a] breast care nurse alone compared with the other groups, which were similar to each other." My interpretation of their data is that the poor showing of the combined approach is explained simply by two opposing effects, one larger than the other. Take, for example, their results for anxiety at 12 months. The means were 4.8 (routine care), 4.4 (routine care plus nurse only), 6.3 (routine care plus voluntary organisation only), and 5.8 (routine care plus

nurse and voluntary organisation combined). The effect of the nurse can be measured as $4.4 - 4.8 = -0.4$ and as $5.8 - 6.3 = -0.5$. The effect of the voluntary organisation can be measured as $6.3 - 4.8 = 1.5$ and as $5.8 - 4.4 = 1.4$. These effects combine to give more morbidity than if routine care alone is given. Similar conclusions can be drawn for most other measures reported at 12 months or averaged over four postoperative visits.

I recognise the dilemma in using parametric methods to summarise skewed distributions, with the resulting mismatch between presentation and results of statistical testing. Consequently, readers are presented with an inferior description of the trends. But how inferior? Is my manipulation of means justified? I have merely used my skills to interpret differently those means that the authors themselves regard as less than appropriate. My gut answer to my own questions is that means of skewed distributions do often characterise the appropriate message, but I would qualify this by saying that a more appropriate description should also have been given. In my experience, the main difficulty lies not in being able to summarise data more appropriately but in being able to do so within the confines of the space allowed.

A final point relates to inequality of loss to follow up in the study. At 12 months the loss was 24% for the routine care group compared with 6% (nurse only), 8% (voluntary organisation only), and 16% (combined). The psychological morbidity of those lost to follow up and of those who remained could have been different. This point should have been discussed in relation to the results.

DEREK LOWE
Medical statistician

Fazakerley Hospital,
Liverpool L9 7AL

1 McArdle JMC, George WD, McArdle CS, Smith DC, Moodie AR, Hughson AVM, *et al.* Psychological support for patients undergoing breast cancer surgery: a randomised study. *BMJ* 1996;312:813-7. [With commentary by C Foster.] (30 March.)

Authors' reply

EDITOR,—We note Karin Friedli and Michael King's concern about baseline values. The large numbers and the randomisation process in our study make important differences in baseline self rating scales to the patients; thereafter it was often a member of the clinical team who did this. We agree that the person providing the support should not undertake a subjective assessment of the intervention. We felt, however, that self rating scales would circumvent this problem. We would have expected that, if the nurse had influenced the scores, the scores in the group who received support from both the nurse and the voluntary organisation would be similarly influenced, but they were not.

We agree with Helen Caulton that many women seem to benefit from support from a self help group whether the group consists of fellow sufferers or not. We would encourage self help groups, offering different approaches, to participate in randomised clinical trials. It is only by doing so that we will be in a position to define the best approach.

We note Heather Goodare's comments about the juxtaposition of our paper and the editorial by Richard Smith. We are not clear what she is implying. Is she suggesting that our results were falsified? At the time that this study was initiated (1987) there were no established breast care nurses in the west of Scotland. The ethics committee, the Cancer Research Campaign, and other respected authorities considered that informed consent was not necessary. Further-