to have allowed counterarguments to be made to help prescribers make up their minds. Just because an agency is not sponsored by a pharmaceutical company does not mean that the concerns that Richard Smith has highlighted¹ cannot arise. May readers assume that when the *BMJ* identifies sources of funding in the future it will identify not only private but also public funding?

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- 1 Smith R. Conflict of interest and the *BMJ*. *BMJ* 1994;308:4-5. (1 January.)
- 2 Song F, Freemantle N, Sheldon TA, House A, Watson P, Long A, et al. Selective serotonin reuptake inhibitors: meta-analysis of efficacy and acceptability. *BMJ* 1993;306:683-7.

Authors of letters should also disclose interests

EDITOR,—We were disappointed that Richard Smith's editorial on conflict of interest and the *BMJ* made only passing reference to the problem of undisclosed conflict of interest in the correspondence pages of medical journals.¹ The pharmaceutical industry watches medical journals carefully, and letters in reply to potentially influential articles are often written by people who reveal links with the industry. For example, we recently published a meta-analysis in the *BMJ* comparing the efficacy and tolerability of antidepressants; of the eight letters published in response,² two were from people who had financial links with the pharmaceutical industry (those from R A Foulds and Joanna Nakielny).

While such correspondence may be legitimate, it sometimes seems like campaigning. After a recent article on changes in bronchial epithelium in smokers the *Journal of the American Medical Association* received four critical letters, all from authors with links with the tobacco industry.³ Two of the correspondents had had at least 20 letters on the topic published.

The *Journal of the American Medical Association* is not alone in making editorial comment. A recent letter in the *New England Journal of Medicine* on lipid lowering diets was followed by a note by the editor on the links between one of the authors and a commercial company.⁴

In an effort to curtail manipulation of the medical literature the net should not be cast too wide. There may well be non-financial sources of conflict—personal, political, religious, academic, and so on—but they are harder to define reliably. There is a danger of encouraging personalisation of the debate about contentious issues if every utterance has to be accompanied by a defence of personal integrity as well as careful intellectual argument. A reasonable start would be to place journals' correspondents under the same obligation as authors of peer reviewed papers.

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- 1 Smith R. Conflict of interest and the *BMJ*. *BMJ* 1994;308:4-5. (1 January.)
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Openness is not the only answer

EDITOR,—Richard Smith's editorial on conflicts of interest in publication is important.¹ My experience of establishing a software company while working as a professor of geriatric medicine high-

lights the problem. A colleague and I had developed a new method of measuring bed use,² but companies we approached showed little interest. Accordingly, with the permission of the medical school, my son established an independent company, Millard Associates (UK), to develop and market the software. Openness is necessary but is not the sole answer. Though the company's name was chosen to ensure openness, colleagues thought that I was trying to make a profit from them; potential collaborators in research balked at the idea of paying; and organisations that award grants asked for advice on contracting, copyright, and patents.

If new products are to be brought to the market someone has to risk losing money. Whether the loss is personal or not is irrelevant. Markets work on the principle that a product brings benefit to the user. If the product is not beneficial there is no market, so it is not in the interest of a company to publish false facts. Thus academic departments tread a fine line when they market products that they believe to be beneficial to those who will buy them. To varying degrees our papers, seminars, teaching days, workshops, conferences, and research groups are all involved with the product. In the long term a company may bring profit, yet we must believe in its benefits for if we did not we would not risk our money and the job of those we employ.

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- 1 Smith R. Conflict of interest and the *BMJ*. *BMJ* 1994;308:4-5. (1 January.)
- 2 Harrison GW, Millard PH. Balancing acute and long-term care: the mathematics of throughput in departments of geriatric medicine. *Methods Inf Med* 1991;30:221-8.

Sharp advertising

EDITOR,—As our cherished NHS slips gradually between our fingers we in Britain should be reassured that we are not as far down the road to market as New Zealand. Auckland Hospital, which dominates the city's skyline and is not a pretty sight at the best of times, is now topped with a huge illuminated advertisement for Sharp Electronics (figure). Exactly how much the hospital gained by such a brutish descent into bad taste I don't know, but perhaps our managers here could pick up the idea. The best place to start must be the politically so visible St Thomas's Hospital, but others in prominent positions could soon follow.

Advertisement on top of Auckland Hospital, New Zealand

The *BMJ* could then run an annual competition for the most vulgar example of this new advertising opportunity or—if it could find out—the one earning the most revenue.

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Genetic testing and insurance

Complicated by polygenic diseases

EDITOR,—We commend the recent attempt to address the issue of genetic testing and insurance.¹ Given the differences between the health care systems in the United States and Britain, however, we believe that the editorial should have had British authors. Though the situation for life insurance may be similar on both sides of the Atlantic, that for health insurance is very different as in Britain health care is available to all through the NHS regardless of any additional insurance a person may hold.

Too little mention was made of the complex issues of polygenic and multifactorial diseases. Perhaps these were beyond the scope of such a short editorial, but, because of the speed of recent technological advances, particularly in cancer genetics, this subject warrants further discussion. In the near future it will be possible to identify people who carry a gene or genes predisposing them to various types of cancer. These people might then behave in a way that alters their risk—for example, they might undergo prophylactic surgery. This should be taken into account by insurance companies when they assess premiums.

There are many more questions than answers with regard to generic testing and insurance. If the medical profession does not address them urgently the commercial considerations of the insurance companies will overtake us. Thus until more concrete guidelines are in place we support the call for a moratorium on the results of genetic testing, as set out by the Nuffield Council on Bioethics.²

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- 1 Alper JS, Natowicz MR. Genetic testing and insurance. *BMJ* 1993;307:1506-7. (11 December.)
- 2 Nuffield Council on Bioethics. *Genetic screening: ethical issues*. London: NCB, 1993:65-74.

Withholding test results sidesteps ethical problems

EDITOR,—Joseph S Alper and Marvin R Natowicz assert in their editorial that "a strong case can be made for forbidding the use of tests for monogenic conditions" and later wish to extend this ban to "all forms of insurance in which underwriting is based on medical risk."¹ But how should it be based? Their obvious implication is that all insurance should be given on equal terms, regardless of risk. This answer to their supposed "irreconcilable dilemma in underwriting" is no answer at all. The insurance companies choose to rate premiums in accordance with risk, and the client can choose the policy with the best terms.

The authors are concerned with the difficulties of the high risk group, who may not be able to afford policies. The response to this problem depends on one's attitude to equity, justice, and autonomy; the fundamental issue is how far the whole community should assist its disadvantaged members. This is a political question, not a medical one, but should not be lost in the discussion. No serious objections to the use of medical data in underwriting had been raised until geneticists realised they were potentially jeopardising their clients' insurance prospects. Instead of dealing with the ethical issues raised by the enormous advances in genetic technology, they attack the generally accepted right to underwrite. If their ideas are upheld, premium rates will rise for all,