me on anything. My time is coming and that will be the end. I'm ready for it and you and the doctors have to be ready for it too."

F Nenner

Correspondence to: F Nenner, Lutheran Medical Center, 150 55 St, Brooklyn, NY 11220, USA; fnenner@LMCMC.com

Informed patient consent was received.

doi: 10.1136/jme.2005.015131

Competing interests: None.

The generic-patent medicine conflict flares up again in The Netherlands

Recently I reported in this journal¹ how it became necessary for a judge to settle a dispute between the pharmaceutical industry and certain Dutch pharmacists. It considered the question of whether a pharmacist is permitted, without prior consultation, to give a patient a (cheaper) generic drug instead of the patent drug mentioned on the prescription.

Another dispute has now arisen after the pharmaceutical industry discovered that healthcare insurers were paying general practitioners (GPs) a bonus if they prescribed generic drugs, such as simvastatin (which reduces cholesterol content) or omeprazole (which reduces the production of gastric acid), instead of the more expensive patent forms (Zocor and Losec, respectively). According to the national newspaper, *Trouw*,^{2,3} Menzis, one of the largest healthcare insurers, offered each of 2300 GPs up to €8000 annually if they switched their patients from patent drugs to the equivalent generic forms. Since the offer was made, more than 160 GPs have agreed to comply with this condition. If most GPs follow this example, Menzis hopes to save more than €3 million each year. GP Geert van Loenen and five other doctors,⁴ however, have rejected the offer and are annoyed that their colleagues "have sold themselves in such a way to the insurer". At the same time four of the leading drug companies; Pfizer, Merck, AstraZeneca and Altana, have taken legal action against Menzis. One of their main arguments was that there existed a code which stated that insurers were not permitted to influence the medical profession on how to treat their patients. On 14 October 2005,⁵ a judge at the law court in Arnhem decided otherwise. He concluded that the competition that exists between insurers since a recent law on health insurance was approved by the Dutch parliament has changed the system. It is in the interest of the insurers to offer their patients the lowest insurance rates. This may entail the payment of a bonus to the GP as long as the patient is not the worse for it. The GP has the right to determine what drug he wishes to prescribe. Furthermore, the code (mentioned above) was not devised for the purpose of protecting the pharmaceutical industry.

According to the newspapers, the Royal Dutch Society of Medicine is surprised at the judicial outcome and a number of patient

organisations are disturbed by the judge's decision. The pharmaceutical companies are now considering whether they should take the issue to a court of appeal.

In my opinion, there exists here a difference between a legal and an ethical solution to the conflict. I believe that it is unethical for a physician to accept a bonus from an insurer. I hereby express my admiration for those GPs who have declined to sign the contract with the insurer, Menzis.

Correspondence to: D O E Gebhardt, Anna van Burenlaan 1, 2341 VE Oegstgeest, The Netherlands; doe.gebhardt@planet.nl

Received 28 September 2005

In revised form 28 September 2005

Accepted for publication 30 September 2005

References

- 1 Gebhardt DOE. The use of generic or patent medicines in The Netherlands. *J Med Ethics* 2005;31:409.
- 2 Bouma J. Menzis before the judge because of bonus to doctors (In Dutch). *Trouw* 20 September, 2005.
- 3 Bouma J. Menzis on the chair of the judge (In Dutch). *Trouw* 4 October, 2005.
- 4 Anon. Bonus for inexpensive doctors (In Dutch). *Volkskrant* 16 October, 2005.
- 5 Anon. Insurer may give bonus to general practitioner (In Dutch) [editorial]. *NRC-Handelsblad* 14 October, 2005.

Consent for anaesthesia in cataract surgery

Cataract surgery has evolved rapidly over the last decade. Previously such cases required admission for prolonged postoperative convalescence. However, currently such procedures are carried out as day cases. An area where significant change has evolved is the role of anaesthesia in cataract surgery.

Recently, a growing number of surgeons have been performing cataract surgery using topical drops to achieve anaesthesia. However, case selection and operator experience impose a limit on the use of topical anaesthesia.¹ Other local techniques for delivering anaesthesia include sub-Tenons and peribulbar block, although a minority of patients might require sedation or even general anaesthesia to achieve anaesthesia.

The consent of such patients is an area of concern. While complications such as retrobulbar haemorrhage, globe perforation, muscle injury, and brainstem anaesthesia occur only rarely, nonetheless the outcome might have serious implications with regard to the visual outcome, or could even be death. In some cases where sedation is necessary during the procedure, formal consent might not have been obtained. Furthermore, appropriate advice—for example, fasting in cases of planned local block—would not, in such circumstances, have been given to the patient.

A survey of 23 ophthalmic surgeons (all grades) who routinely perform cataract surgery (West London ophthalmic units) revealed that up to 80% of surgeons do not obtain formal consent for local anaesthetic procedures and a further 86% do not discuss the options of local anaesthesia with patients. However, about half of the surgeons do mention the option of general anaesthesia during the outpatient visit.

The high number of surgeons failing to obtain consent is despite the recommendations of the Royal College of Ophthalmologists (RCO), which state that surgical assessment should also include discussion of the type of local anaesthetic for each individual patient.²

Currently, it is usual for a tick box system on the consent form to indicate the type of anaesthesia (without indicating the type of local technique) the patient is to receive, with an informal consent being taken verbally by the anaesthetist or the surgeon administering the block.

According to the guidelines of the Royal Colleges of Anaesthetists and Ophthalmologists³ a separate consent sheet is not necessary for the anaesthetic part of the procedure.

However, a separate consent form and a standard method for discussing the options of anaesthesia in the outpatient clinic could avoid unnecessary litigation and ensure that all the appropriate options had been offered to patients in good time before having cataract surgery.

S Kashani

Department of Ophthalmology, Charing Cross Hospital NHS trust, London, UK

P Kinnear, B Porter

Charing Cross Hospital NHS Trust, London, UK

Correspondence to: Shahram Kashani BSc, MRCP, MRCOphth, Ophthalmology Specialist Registrar, Department of Ophthalmology, c/o Eye secretaries, Charing Cross Hospital NHS trust, Fulham Palace Road, W6 8RF, UK; shahdoc@hotmail.com

doi: 10.1136/jme.2005.014969

Received 2 November 2005

Accepted for publication 8 November 2005

References

- 1 Friedman DS, Reeves SW, Bass EB, et al. Patient preferences for anaesthesia management during cataract surgery. *Br J Ophthalmol* 2004;88:333–5.
- 2 Royal College of Ophthalmologists. 2004. <http://www.rcophth.ac.uk/docs/publications/CataractSurgeryGuidelinesMarch2005Updated.pdf> (accessed 30 October 2005).
- 3 Royal College of Anaesthetists and Royal College of Ophthalmologists. Local anaesthesia for intraocular surgery. 2001. <http://www.rcoa.ac.uk/docs/rcarocguidelines.pdf> (accessed 30 October 2005).

BOOK REVIEWS

The Trust Prescription for Healthcare: Building Your Reputation with Consumers

Edited by D A Shore. Health Administration Press, 2005, \$63.00, pp 165. ISBN 1567932401

Taking a phrase from President Clinton's successful presidential campaign in 1992, this book could have just as easily been called *It's About Trust, Stupid*. In his book, David A Shore, PhD, associate dean and founding director of the Trust Initiative at the Harvard School of Public Health, presents

a convincing argument for the importance of trust in healthcare delivery.

Shore is equally convincing in arguing that people have a lack of trust in the healthcare system in the United States. To make this point, he cites studies showing that while many continue to trust doctors and nurses, the trust in healthcare delivery itself has declined at an alarming rate. Confidence in the leaders of medical institutions—for example, declined from 73 per cent in 1966 to 32 per cent in 2004.

A number of factors contribute to this low sense of trust. An overemphasis upon profits and unscrupulous behaviour on the part of such large healthcare players as HealthSouth has certainly had an impact. In addition, the environment of health care is one fraught with difficulties. Newspapers are not sold by reporting that patients are often treated successfully and discharged from hospitals without incident. Nor do television viewers clamour to see reports showing that health insurance companies pay the large majority of claims without question. It is sensationalism that sells. Add this to the bias toward reporting the negative, and it is clear that such stories have an enormous impact upon public perceptions of health care.

One of the strengths of Shore's book, and there are many, is that he spends as much time offering solutions as he does identifying the problems. It may be surprising to some that his remedies focus almost exclusively upon marketing and communications. In fact, nearly half of the book reads like a textbook on such topics as mission/vision, development, and branding. One could almost argue that building trust is simply a marketing ploy were it not for the honesty and good common sense that goes into Shore's recommendations.

Shore argues that healthcare institutions need to focus on both large and small elements to build trust. They must focus on cleanliness in all areas of the hospital, not just the operating room, as part of perception management. Capacity issues should also be managed so that staff/patient ratios stay in line with quality care. Trust building through a patient centred sense of integrity must be seen as being a key part of both the mission and the margin of healthcare facilities.

Shore offers step by step approaches to building trust into the very fibre of an institution. His positive examples include Disney, Coke, and Volvo, as well as Johnson & Johnson and the Mayo Clinic. Each is a leading organisation in its respective field. These companies have a "power brand" that captures their essence in ways that are appealing to customers. Healthcare organisations must include trust as part of their power brand in order to be successful.

Given the importance of the trust factor to health care, it is surprising that more has not been written on the topic. Shore's book is a much needed addition to the field, drawing attention to trust and providing solutions that impact the essence of health care—the relationship between the patient and healthcare provider. His suggestions are both succinct and practical. I would heartily recommend this book as a primary tool for a person looking to become a champion of change and improvement in the healthcare delivery system.

R S Mathis

Aiming to kill: the ethics of suicide and euthanasia

Authored by Nigel Biggar. Longman and Todd: Published by Darton, 2004, £10.95 (paper back), pp 220. ISBN 0-232-52406-8

The literature on euthanasia and suicide is substantial and ever growing. In his book *Aiming to kill*, Nigel Biggar, a theologian, adds to this something that is hard to come across, in a concise but comprehensive form. His book explores the theological basis of the sanctity of life doctrine: rather than merely asserting what the doctrine demands, simply citing as authority that it is a traditional and fundamental principle, he offers an account of its historical and modern-day rationale.

The book is divided into four unequal parts, whose quality varies. These chapters are designed to provide: firstly, the appropriate sociolegal and ethical context; secondly, an overview and analysis of arguments relating to the value of life; thirdly, an overview and analysis of arguments on the morality of killing; and finally, a section drawn from the conclusions of previous chapters and expounding the threat of the "slippery slope".

Biggar does not claim to come into the debate without prejudices. His standpoint is a conservative one, but he hopes to have taken seriously the concerns of critics of the "traditional position" and does not defend every argument that has been advanced in favour of his standpoint. The whole book is written in clear language. The last three chapters are particularly well presented. Each contains a summary of the position that it is to analyse, followed by a list of the main points to be discussed. Then Biggar takes the points one at a time, responding to critics and assessing the various theological arguments. Finally, he spells out his conclusions. Although he may fail to convert the reader, he does not fail to explain his convictions properly.

The book is strong in its presentation, clear language, breadth of sources and the depth of the author's understanding of the ethical subject matter. Regrettably, it also has its weaknesses. It may be asserted that Biggar does not work from a truly neutral account of matters outside of his expertise. The first chapter begins as a disappointing read and may encourage a reasonably cynical reader to take the rest of the book with an unnecessary pinch of salt. The legal analysis is less than balanced. For example, the sweeping statement that suicide is unlawful is a bold and unsubstantiated claim taken from another work whose author could not plead neutrality. It was not necessary for Biggar to do this to strengthen his argument. And he need not have omitted to mention, for example, Switzerland when describing the Western position. This amounts to a real shame, as the chapter ends well, explaining why the arguments are so relevant now, and noting the secular cynicism of life being given by God and killing being inherently wrong. The references to, and analysis of, theological texts throughout the book are gripping. It is a great pity to see the law misrepresented as it is. It serves to make the reader doubt the strength of other points.

The second and third chapters are what make the book worth reading. Not only is the account interesting, it is more plausible than what we often see in arguments on the

sanctity of life. Biggar's position does not seek doggedly to attach value to human life no matter what. His reasoning is thought provoking and cleverly justified. Ultimately, some of the arguments are less convincing than others. The chapters would have benefited from some longer responses to critics in some cases, but all in all the second and the third chapters are good.

In the final chapter, having argued that the sanctity doctrine does not require an absolute prohibition on intentional killing, but maintaining the great value of intention and not just consequences in moral judgement, Biggar brings his theory back into context by analysing the slippery slope argument. Informed readers who are not already won over by this argument are unlikely to buy into Biggar's account. It is well constructed but, like the first chapter, is too focused on the bits that suit and ignorant of those that do not. For example, no mention is made of the data that are starting to come from Oregon. The focus on just The Netherlands for empirical data are unfortunate and unnecessarily restrictive. Finally, it must be said, Biggar's position on slippery slopes seems to boil down to consequentialist reasoning. The sting is taken out of this apparent irony by his acknowledgement of such potential criticism, but his attempted refutation of it is not really persuasive.

In addition to the four main chapters, the book contains a useful list of basic terms, a handy glossary, and a good further reading list, referencing texts relevant to all the major issues raised throughout the work.

In some respects this book is to be welcomed. For those interested in this debate, the second and third chapters—particularly chapter three—offer fascinating material on the nature and basis of the traditional position. On the other hand, the legal analysis and use of empirical data do diminish the argument's potency and should be considered far from a definitive account of the subject matter. I would recommend this book to a reader who is able to overlook these problems: the ethical analysis is fascinating.

J Coggon

Medical ethics and law—surviving on the wards and passing exams

Edited by Sokol DK, Bergson G. London: Published by Trauma Publishing, 2005, £14.95, pp 293. ISBN 0-95476-571-0

Yet another medical ethics book has been published, but the difference this time is that I actually like it Sokol and Bergson's handbook *Medical ethics and law—surviving on the wards and passing exams* is for medical students and junior doctors preparing for life in medicine and for the inevitable exams. The format of the book closely follows that of the core curriculum for medical ethics and law set out by the BMA in 2004 in *Medical ethics today*. The book covers a diverse range of topics from staples such as consent and confidentiality through to research, genetics and rights.

The authors use humour well to keep the reader's attention and explain ethical concepts. These concepts are often presented as being more simplistic than they are and at times only scrape the surface of moral argument. This, however, is inevitable when trying to squeeze so much into a limited