

OUT OF HOURS Christopher Martyn

Don't give up the ghost

Though medical ghostwriting has had pernicious effects, openly acknowledged ghostwriters may improve medical publishing

Several years before he became president of the United States, John Kennedy published a book, *Profiles in Courage*, that told the stories of a number of US senators who had been brave enough to ignore party lines and public opinion to do what they believed was the right thing. The book was widely acclaimed and won a Pulitzer prize, although it emerged later that it was largely, if not entirely, the work of a man called Theodore Sorensen. Rather more recently Gordon Brown, just before he became prime minister, published a book with a strikingly similar title and structure: *Courage: Eight Portraits*. I've no reason to believe Brown did not write the book himself, and in this regard my view coincides with that of a disabbling reviewer in the *London Review of Books* who assumed that he must have done, observing that no self-respecting ghostwriter could have produced prose of such faultlessly plodding banality.

But, revisionist historians apart, does anyone care whether Brown or Kennedy actually put together the words that these books contain? Indeed, it's a puzzle that men with so much else on their minds thought it worth the time and trouble of writing them. Authorship often matters very little to the reader. Searching a bookshop for a Christmas present for a friend interested in, say, gardening, are you really bothered whether the volume you choose was penned by the celebrity horticulturist whose name appears on the cover? If instead of a gardening book, you pick the autobiography of a football manager or rock star, you can be pretty sure that that it wasn't.

Employing a ghostwriter is clearly the answer if you want your name on the title page of a book but lack the literary skills or the spare time to write it yourself. And, if you're a publisher, it must be hard to resist the temptation to boost sales by creating an illusion that a book was written by someone famous.

Obviously, neither of these practices is entirely honest, but on the other hand it's hard to see where the harm lies. The ghostwriter gets paid. The celebrity makes some money or enhances his or her reputation. The publisher gets rich. Nobody dies.

It's becoming clearer that this sort of thing has infiltrated medical writing too. A case study published in *JAMA* last year alleged that employees of Merck either wrote or commissioned someone to write a large number of articles, mainly single author reviews, on rofecoxib and then recruited and paid external, academically affiliated doctors to be the "authors" of these articles (*JAMA* 2008;299:1800-12). More recently *PLoS Medicine* has constructed an online archive of documents showing that Wyeth did something very similar when trying to create a climate in which large numbers of menopausal women would be prescribed hormone replacement therapy (www.plosmedicine.org/static/ghostwriting.action).

Most commentators have suggested that, regardless of how you might view what goes on with popular books, in medicine this is a serious matter. They argue that authorship of medical publications is central in establishing accountability and responsibility. They are concerned that the practice of seeding the literature with a lot of reviews that emphasise the benefits and play down the risks of a particular treatment leads to bias. *PLoS Medicine* called for reforms to stamp out ghostwriting, the retraction of existing articles in which ghostwriting has been identified, enforceable sanctions, and urgent investigations by institutions whose academics have been involved.

This may be an overreaction. In many ways it would be a good thing if more use was made of professional writers when manuscripts are being prepared. The effect of involving statisticians



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in medical research was not only to improve the individual projects and papers they worked on but to raise standards of trial design and data analysis generally. A greater involvement of professional writers could well have similar benefits in raising standards of presentation, clarity, and completeness of research papers. Of course, the contribution made by the writer ought to be acknowledged. But that's a side issue. What matters fundamentally for the reader, and ultimately the patient, is the quality of the content of the article, not whether credit has been given where it's due.

Here's where the problem lies. These ghost stories show that, despite external peer review and editorial scrutiny in house, journals can't (or don't) reliably evaluate the content. Otherwise the unsatisfactory nature of these guest authored papers would have come to light, and they would have been rejected for failing to give an evenhanded assessment of the new treatment.

It's surely readers rather than journal editors who hold the answer here. *PLoS Medicine* has done a great service by exposing this dubious practice. Now that we're alerted, there's no longer any excuse for being taken in by soft sell review articles that appear under well known names in medical journals. We know now, if we didn't before, that we must always ask whether we're being told the complete story. And when we meet the “author” at a conference we must remember to inquire how much he or she was paid to write it. There's a television interviewer who, when dealing with a politician, is said to ask himself, “Why is this lying bastard lying to me?” We may not have to go so far. Small doses of scepticism and scorn should do the trick.

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ETHICS MAN Daniel K Sokol

The unpalatable truth about ethics committees

Clinical ethics committees are ill suited to resolving the individual ethical problems of clinicians at the coalface

My pathological inability to say “no” has carried a high price. I sit on 10 committees, including clinical ethics committees (CECs). In 2005 the Royal College of Physicians noted that “wherever healthcare is provided we believe that there will be a need for formal ethics support which is both timely and informed.”¹ The United Kingdom now has more than 70 CECs. Their role varies from institution to institution, but most of them review hospital policies and provide advice on ethically problematic cases. The idea is wonderful; the reality quite different.

After anecdotal reports of inactivity, some colleagues and I recently published a study in the *Postgraduate Medical Journal* on the case consultation activities of CECs in the UK.² We sent an anonymous questionnaire to chairpersons of 70 CECs. Thirty completed the questionnaire. The results were worrying: although all the respondents said that their committee welcomed individual cases, 10% had not considered a single active (or “live”) case in the past 12 months, 43% had considered between one and three cases, 30% had considered between four and six, 13% between seven and nine, and 3% (one committee) between 10 and 15. There was no correlation between the age of the committee and the number of active cases considered. Our main conclusion was brief: “At the moment, the stark reality about CECs in the UK is that clinicians are not using them.”

It is rarely wise to bite the hand that feeds you, but I wish to nibble it nevertheless. Part of the problem is that the hand feeds no one. CEC members are not paid for their work on the committee. Coupled with the lack of activity, this can affect morale and attendance. Inadequate financial support by the trust sends a negative message to the CEC. In the United States

bioethics departments produce pens, stickers, and leaflets that they hand out to staff, patients, and relatives. In the UK we struggle to let hospital staff know that a CEC exists at all. Lack of pay may also affect the perception of the committee by prospective users, who may see the CEC as little more than a meeting of enthusiastic amateurs.

Related to the perception of the committee is the issue of recruitment. It is unclear how CECs recruit their members. Inviting friends, however, is not good enough, and clinical seniority is no indication of ethical perspicacity. Depending on the individual, a powerful figure can intimidate other members and impede fruitful discussions. This is the kiss of death for a CEC. Careful selection is vital, because it is extremely difficult to get rid of a member once in post.

As in clinical medicine, it is difficult to acquire expertise in ethics when presented with a handful of cases a year. It would take years before members could reach the stage when their first reaction to a new referral would be “we had a very similar case recently and this is what we suggested.” CEC members should, in my view, undergo training in medical ethics that extends beyond the few lectures on the annual “away day.” This is one way to convince clinicians that we are qualified to help them resolve their ethical problem. Many committees do not use a formal method of case analysis. An unstructured, free for all analysis runs the risk of omitting ethical issues and producing a skewed recommendation.

Another problem is that many ethical problems are acute and need a response within hours. Most CECs meet once a month. Some CECs have developed “rapid response” teams—at St George’s, for example, a CEC member checks a telephone answering service once a day—but our survey showed that these are seldom used.



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As I mentioned above, CECs can be intimidating, graced with consultants, senior nurses, lawyers, medical directors, and the occasional ethicist. We are not terribly approachable, and I doubt that the average junior doctor or nurse would feel comfortable sitting at the end of our boardroom table. The truth about CECs is that they are ill suited to resolving the individual ethical problems of clinicians at the coalface. They are too clumsy an instrument. CECs, however, are valuable for reviewing and developing hospitals’ policies. In my experience, the ideal situation is a mixed model of ethics support made up of a CEC, for the macro issues, and individual ethics consultants, for the micro issues.

It is wrong to lay the blame on clinicians who do not refer cases or on the CEC members. The problem lies with the model itself. A sole committee model for case consultation is condemned to near certain failure, with only a trickle of cases reaching the CEC. In Washington Hospital Center, in Washington, DC, the ethicists have 400 formal consultations a year. In Providence St Vincent, in Portland, Oregon, the hospital ethicist conducts around 160 consultations a year. More than half of the CECs in our survey did not consider more than three cases in the previous year. I doubt this is because ethical dilemmas are more prevalent in the US than in the UK.

There is a need for “timely and informed” ethics support in the UK, but it must be accessible, professional, and non-threatening. CECs have an important role in improving the ethical climate of an institution, but alone they are not the answer to the day to day dilemmas faced by clinicians.

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References are in the version on bmj.com