including those surrounding the NHS and healthcare provision.

There have been informal discussions by some stakeholders, including the Department of Health, the King's Fund and British Medical Association, about whether there should be a health policy centre using the SMC as a model. Time will tell if this happens, or if as the SMC budget and staffing levels increase we expand into these areas.

If you are interested in being on the SMC database and would like to be involved with our work, please contact Claire Bithell on cbithell@ri.ac.uk

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Patient-centred medicine

Editor – I think Lewith is correct (Letters to the Editor *Clin Med* August 2007 pp 416): clinicians currently working at the coalface of clinical practice may be best placed to judge if current health policy is driven primarily by evidence, or by political expediency (that is, what the public wants and is willing to pay for). If it is the latter, the medical profession should be alarmed and ashamed. We have a professional duty to test the efficacy treatments, however confidently we 'know' that they work.

Self-examination may be quite disconcerting, as my own experience has taught me. I obtained the MD degree with a thesis about the metabolic adaptations of severely malnourished children in a Third World country. When I returned to the UK I believed I was particularly well equipped to study the metabolic adaptations of obese adults on severe reducing diets when they mysteriously ceased to lose weight. I thought I 'knew' that, like marasmic infants, they had a severely reduced basal metabolic rate (BMR). Therefore stimulating them with a slightly supra-physiological dose of thyroxin would help them to continue losing fat.

Yes, they lost more weight on thyroxin, so the patients were pleased, and I was keen to prove that my theory was correct. Careful research showed that my theory was doubly wrong. They did not have a severely reduced BMR, and the extra weight loss on thyroid was largely lean tissue rather than fat. So (because BMR is mainly determined by the lean body weight) when the thyroid treatment was stopped they had a lower BMR than they should have done.

I expect many scientifically inclined clinicians have similar stories to tell about beautiful theories that were destroyed by ugly facts. What they 'knew' to be good treatment may prove to be useless or even harmful to patients. I am sorry if Lewith has not had this salutary experience, so he is happy that political expediency should mainly determine his patient care. As he himself states, the practising clinician is best placed to judge the role of evidence in clinical practice. My suggestion to him is: physician, test yourself.

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Patient-centred medicine

Editor – The exchange between Ernst and Lewith (Letters to the Editor *Clin Med* August 2007 pp 416) seems to be at least in part based on semantics. Lewith stated in his original paper that, 'Patients know that CAM (complementary and alternative medicine) works…'.[1] What does he mean by 'works'? If the statement is based on a *post hoc ergo propter hoc* scenario, then it works, and that is an assumption that patients, but I hope not Lewith, will commonly make. By 'works', I suspect that Ernst means 'demonstrated scientifically' – quite a different thing. In addition, it seems to me a misuse of the language to use the word 'know' when 'assume' would be more accurate.

While declaring the possible interest that I am one of the signatories to the letter which Lewith castigates so severely, I cannot agree that one must be a practising clinician to engage in this debate. Yet Lewith implies that those of us with a professional lifetime behind us in generating and evaluating clinical evidence are somehow unable to recognise it. Lewith made much play in the article of the value of non-specific effects, which none of us will deny.

Surely it is important for everyone, especially clinicians and most importantly patients, to know how these can be differentiated from specific effects. How can such knowledge be a bad thing?

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Reference

1 Lewith G. Patient-centred medicine. *Clin Med* 2007;7:250–2.

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Neurologists still have a role in the dementia care pathway

The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) guidance regarding the identification, treatment and care of people with dementia envisages little, if any, role for physicians in general and neurologists in particular in the diagnosis of dementia, anticipating that psychiatrists, particularly old age psychiatrists, will manage the dementia care pathway in its entirety from diagnosis to end-of-life care.[1]

A 'single point of referral' is specified in the guidance. These recommendations apparently ignore the fact that some neurologists and geriatricians have developed significant specialist interests in dementia (the guideline development group lacked the input of a neurologist). Their exclusion from the dementia diagnostic pathway may be premature.

Referral source and diagnostic outcome of all new patients seen by one consultant neurologist in a dedicated cognitive function