

adickts must rede Bandoleer which is filled with useful info for decishun makers. There logo is an evil-looking bandit with shotgun which mean they aim to hunt down all non-ebm doctors and blow out there cunning vilanous branes. All doctors also now have the red ebm book, and when there turn comes to be kaned by the hospital manger they put the book down there trousers, and it brake the kane which is super.

It is important to take a historical perspektive on this issuhue. All this ruff talk and brusing is normal in the histry of sience. All major discoveries were acompanied by mokery and abuse, viz:

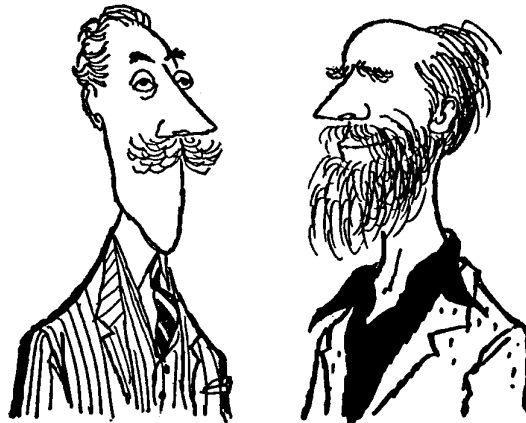
Mr Lister: "I hav discovered that atiseptik practises will prevent zillions of deaths and sicknesses."

Jeering colleeg: "Mark mi words no good will come of it. Now bring me some fresh dung to clean my hands, I am off to see my next pashent."

So you can see the problem is not new. But wot of the future? Wot indeed. Fortunetely we have a plan so everyone can get along together again. Ebm-ers swank much about there hierarky of evidens, from meta-analysis at top to anecdot at bottom, and say Your study is below RCT, so is No Good chiz. The anser cleerly is for non-ebm doctors to hav there own hierarky. It will be similar to the other one but upside down. A Hierarky will also be needed specifikkly for anecdote-based medicine viz:

Level I: Beardy old gent from royal college; *Level II* Doctor with air of credibility and honest face; *Level III:*

Know the Enemy or Masters at a Glance



Some say all EBM-ers are arrogant controvershal and seductive. Others say they are parasites and alchemists. Also many hav beards (my ovservashun). This is called evidence. ©Ronald Searle, 1954

Academic with mad stare; *Level IV:* NHS manager with trust in finanshul crisis

So ther you hav it: EBM in a nutshell. Remember, the futur is brite if you stop squabbling and do not fight like Form 3A when master is out of classroom. (Fothering-Thomas, please spelcheck this and send to top medical journal).

The need for political correctness in scientific writing

James Le Fanu

It is not immediately obvious why political correctness should feature so strongly as sacred cow number two on the hit list of visitors to the *BMJ's* website. Certainly, spouses have become partners lest the unmarried should take offence, and prostitutes have been transformed into sex workers (not that they are likely to be much concerned either way about their job title). But this can be lived with, and there has been nothing in medicine to compare with "Gingerbread Person," "Baa, Baa Green Sheep," or the myriad other absurdities of the politically correct lexicon.

This verbal hygiene is, however, only the outer shell of political correctness. More serious is the censorship of significant facts and observations from scientific writing and which in turn explains why there is such a disparity between the everyday world as experienced by doctors and its bowdlerised, scarcely recognisable, reflection in the medical journals.

Consider, for example, an instructive comparison between Sir James Spence's classic 1954 study *A Thousand Families in Newcastle upon Tyne*¹ and more recent investigations into the links between poverty and health such as the Black report.² Sir James Spence's study found that more than one in 10 houses were "unfit for human habitation," four out of 10 lacked a bath, and one in four had only an outside water closet which was shared with several other families. These appalling, unsanitary, overcrowded living conditions,

he argued, could readily account for the infant death rate of 44 per 1000 live births.

By contrast, the Black report, almost 40 years on, omits to point out that 98% of households have their own bath (and 91% have a colour television set) and that perhaps this might have something to do with why the infant death rate has fallen fourfold in the intervening decades.

Furthermore, Sir James described "the outstanding characteristic" of the families in his study as "the skill with which the majority maintained the health of their children" in these adverse physical circumstances. None the less, there was a minority of "problem families" whose children fared badly, whom he subdivided into "the friendly but incompetent," "the sullen," and "the vicious." He gave illustrative examples of each, including one family living in a condemned and crumbling two roomed tenement flat with no running water and whose water closet was out of order and where "most of the money in the household went on drinking and gambling." The phenomenon of problem families also does not feature in the Black report.

The upshot of this comparison is that, whereas Sir James's lively sympathetic study is readily recognisable as reflecting the real world of the 1950s, the omission by the Black report of the particularities of the circumstances and competence of "the poor" results in a quite

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unrecognisable picture of the relation between poverty and health in the 1980s.

At the heart of this comparison lie the two essential characteristics of political correctness. Firstly, society is perceived as consisting of many different minority groups, such as "the poor," each of which is a victim of an unfair and inegalitarian system. Secondly, moral judgment is suspended to avoid the charge of appearing "judgmental." Thus it is not permissible to even hint at the possibility that perhaps social incompetence might have something to do with the health problems associated with poverty.

The lifestyle theory of disease is similarly permeated by the same dead hand of political correctness. The public once again is a victim, but this time of the powerful alcohol and food industry. The politically approved "healthy diet" anathematises private pleasure, and even if it were true that drinking skimmed milk or eating

vegetables five times a day protected against cancer, few doctors have the time or inclination to cajole their patients into making substantial changes to what they eat. These practical difficulties that loom large in everyday practice are scarcely touched on in the thousands of articles on the alleged relation between diet and disease published over the past 10 years.

Political correctness is an idealist philosophy that seeks to make the world a better place by wishing it to be so. Medicine, on the other hand, is a practical business that must deal in the warts and all of reality. They are incompatible and, as the visitors to the *BMJ*'s website insist, it is time for political correctness to meet its nemesis in the abattoir.

1 Spence J. *A thousand families in Newcastle upon Tyne*. Oxford: Oxford University Press, 1954.

2 Townsend P, Davidson N, eds. *Inequalities in health: the Black report and the health divide*. Harmondsworth: Penguin, 1982.

Double bandaging of sprained ankles

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The healthcare establishment generally ignores mundane important issues, preferring to consider popular (sexy) topics. Who wants to assess the cost effectiveness of different management strategies for sprained ankles when you could be introducing a new technology (toys for the boys)? Most of the contacts patients have with the NHS relate to non-life threatening conditions, and their management does not require state of the art technology. However, if the NHS is to operate in the most effective and efficient manner all aspects of health care must be appropriately evaluated. This short paper uses the management of sprained ankles as an example.

The problem

Ankle injuries are common (estimated at 600 000 attendances at accident and emergency departments per year in the United Kingdom), and 30% of patients may have continuing symptoms.¹ Traditional teaching states that the treatment is RICE (rest, ice, compression, elevation). Many accident and emergency departments use a cylindrical elasticised bandage for the compression, many centres using double layer bandaging. An

adult would be expected to need at least 50 cm of tubular bandage, which becomes 300 km of bandage per year for ankle sprains in the United Kingdom, or double that if two layers are applied. This equates to a bandage reaching from London to Berwick upon Tweed if it were used double (without stretching it) and a cost for the bandages alone of £654 000.² These estimates exclude people who treat themselves or are treated by their general practitioner. We aimed to examine the evidence for the use of tubular bandages.

The evidence

We conducted a Medline search (1963-98) to identify all trials of treatment for ankle sprains, using combinations of the keywords sprain, ankle, compression, Tubigrip, and trial. We reviewed the abstracts of the 148 articles obtained to determine their relevance. Only 12 trials studied compression for the treatment of ankle sprains. The results are summarised in the table.

The results of these studies suggest that early movement gives the best result. The method of least restricting the ankle may be to apply no bandage and

Outcome of trials investigating different compression treatments for ankle sprains

Reference No	Interventions compared	Preferred intervention
3	Nottingham ankle support v Tubigrip v eversion strapping	New support
4	Compression bandage + early movement v elastic bandage + limited weight bearing	Early movement
5	Ace bandage v compression bandage	No difference
6	Plaster of Paris v tubular bandage	Tubular bandage
7	Aircast splint v plaster of Paris	Aircast
8	Plaster cast v air stirrup v elastic wrap	Elastic wrap was equivalent to air cast; both better than cast
9	Elastic wrap v plaster splint	Elastic wrap
10	Air stirrup v compression	Air stirrup
11	Layer bandage v adhesive tape	No difference
12	Operation v plaster of Paris v strapping	Operation
13	Operation v early movement with support	Early movement
14	Minimal bandage v Tubigrip v plaster of Paris v early physiotherapy	Early physiotherapy