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The sexual health of boys and men

Commercial advertisements are needed to create a condom culture

EDITOR—Yamey highlighted the need for work on the sexual health of boys and men, and he identified education and service provision as the key factors in increasing condom use, among other outcomes.¹ Both of these factors fail to address the underlying problem, that condoms are unpopular—they are far short of desired items among young men in particular.

A major factor influencing cultural attitudes is not education or services but the media. Global marketing, vast advertising budgets, and sexual imagery are used to sell items as diverse as chocolate bars and sanitary products on television. However, noticeably absent in the United Kingdom is any commercial television advertisement promoting particular condom brands or targeted to the growing market for condoms. Consequently, the promotion of condom use falls largely on public sector bodies. Education and health bodies have already made condoms more available to young people and developed an understanding of their health benefits. However, without a cultural move making condom use popular,

such efforts have limited success as health promotion fights to convince people to use unpopular products. Partly as a result, sexually transmitted infections in young people are increasing in England,² and there are 90 000 teenage conceptions a year.³

Condoms are produced commercially and lend themselves to many images that are used to market other products successfully, so you would predict a deluge of television adverts promoting one brand above another. Antiquated advertising rules may explain why this has not happened. Those governing condom advertisements on UK television expressly forbid companies from showing the product unwrapped, and consequently the image of an unwrapped condom cannot be normalised or promoted.⁴ Advertising limitations also dictate social responsibility in advertisements and prohibit anything promoting promiscuity. How far these other measures limit advertisers seems to be unknown, but such restrictions should be measured against the numerous television hours showing promiscuity without any reference to condoms. Furthermore, these considerable restrictions on condom advertising may prevent movement of new producers into markets and consequently stifle the competition necessary to refine marketing and product development.

The government is pursuing strategies in communicable disease, sexual health, and HIV, as well as reductions in teenage pregnancy.³ Pragmatic revisions to existing rules on the commercial advertising of condoms may allow commercial interests to work with those of health to alter the image of condoms and increase markets (particularly among young people) in order to help reduce sexually transmitted infections and unwanted pregnancies.

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- 1 Yamey G. Sexual and reproductive health: what about boys and men? *BMJ* 1999;319:1315-6. (20 November.)
- 2 Nicoll A, Catchpole M, Cliffe S, Hughes G, Simms I, Thomas A. Sexual health of teenagers in England and Wales: analysis of national data. *BMJ* 1999;318:1321-2.
- 3 Social Exclusion Unit. *Teenage pregnancy*. London: Stationery Office, 1999.
- 4 Independent Television Commission. *Guidelines on the advertising of branded condoms*. 71/87. 1987. (Guidelines available from the Independent Television Commission, 33 Foley Street, London W1P 7LB. Tel: 020 7255 3000; fax: 020 7306 7800; www.itc.org.uk)

Attitudes to adolescent boys' sexual and reproductive health urgently need changing

EDITOR—Yamey questions the appropriateness of ignoring sex differences in sexual and reproductive health, a grave omission in view of the obvious differences in boys' and girls' experiences of their culture, adolescence, and sex.¹ The fact that the focus has been on girls is not surprising because, physically at least, they bear the burden of a pregnancy, delivery, or termination. However, as sex is a joint experience, research and clinical practice should recognise and address this. Last year's *Our Healthier Nation* consultation paper acknowledged the importance of individual differences in behaviour.² Our study of 2018 adolescents confirmed significant differences in self efficacy: girls were more able to say no to sex (61.5%) than boys (38.5%) ($P < 0.0001$).

The media, a powerful source of information, refer more to the consequences of sex for girls than for boys. Although results are divided about the usefulness of sex education, girls unequivocally benefit more than boys from sex education from school and the media.³ Our data show that, although more boys than girls had used contraceptives, paradoxically boys were more willing to have sex without contraceptives and were less unhappy with a pregnancy than were girls. Whether this is through ignorance or boys' unrecognised wish to be involved in the consequences of unsafe sex is not clear.

Yamey urges the nation to change its approach to adolescent sex.¹ By recommending that safe sex services be made "more attractive," he acknowledges that a shift in culture is imminent. Research and government echo this. The question now is: why can't we effectively implement the attitudinal change that is needed? If research continues to fail to have an impact on practice, perhaps the media could redress the covert sexual health equality imbalance for boys in the same way that they, rather than policy or health care, have impacted overtly on the sexual health of girls.

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- 1 Yamey G. Sexual and reproductive health: what about boys and men? *BMJ* 1999;319:1315-6. (20 November.)
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Doctor, help! My child has cancer

Health professionals have the dilemma of how to get it right without getting it wrong

EDITOR—The paired articles by the mother and general practitioner of Antony, a child who died of neuroblastoma, were both exasperating and encouraging.¹ The story highlights a dilemma for health professionals: how to get it right without getting it wrong. Surely I am not alone in thinking that the general practitioner was damned if he did and damned if he didn't visit the family.

Doctors are not mind readers. The general practitioner offered an open door to the family and yet was criticised for not being proactive, for not second guessing the family's needs and the frequency of those needs. Other parents would criticise their general practitioner for coming when they wanted privacy, or for interfering when he or she lacked knowledge of the condition. Antony's mother describes being on "an emotional roller coaster, feelings and tension are high." The consequence is that every action (or lack of action) or phrase (or silence) can be given a meaning far beyond its intention.²

We get the health service we pay for. The general practitioner has a list of, say, 2000 patients. Multiply that by the number of partners in the practice and add the welter of paperwork and administration that he or she faces as a general practitioner and a course organiser; anyone with any experience of general practice will realise that we don't live in Tannochbrae with Dr Finlay popping in for a chat. From the information given by both parties, the general practitioner has nothing to reproach himself for.

The *BMJ* is to be praised for publishing both sides of the story—something that I have long advocated, particularly when articles describe a specific incident or a person's course of treatment. Publishing one side of a story (the patient's side) with the author's name and address can cause immense distress to the criticised doctor, who will often recognise himself or herself and probably be recognised by colleagues (R Taylor, personal communication). The *BMJ* does not publish articles written about patients without their consent in case they recognise themselves in the journal or the story is reported by other media (R Smith, personal communication). Not to have given the same protection until now to doctors discussed in articles written by patients is unjust. I hope this heralds a new trend in the right to reply for doctors.

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1 Doctor-patient relationships in primary care: Doctor, help! My child has cancer. *BMJ* 1999;319:554-6. (28 August.)

2 Metcalfe D. Doctors and patients should be fellow travellers. *BMJ* 1998;316:1892-3.

Patients mustn't expect their GP to read their mind

EDITOR—Whenever I see the word "should" in an article or paper these days I immediately expect a complaint to follow. In a recent article the mother of a child who had neuroblastoma says, "Regular contact with us should have been an integral part of his role as our family doctor."¹ Further on in the article there is a statement that the doctor should have initiated the contact.

May I suggest a different approach? In this case the mother had the idea that she would like the family doctor to call. This is a fair idea. What actions could she have taken to bring the doctor to visit the family? The simple approach, and the one most likely to be successful, is to telephone the surgery and speak to the doctor about the case. I cannot imagine a doctor declining such a request. The hardest approach, and the one least likely to be successful, is to keep hoping the doctor will call and then blame him or her for not turning up.

In this case there is no blame on the doctor. He was not asked and could not have known (or guessed) that the family wanted him to call. In all the calls for clear communications in the rest of the article one thing is lost. The message I would love patients to take from this article is that if you want something from your doctor, ask him or her directly and say what your hopes and fears are. If my patients do this I as a doctor can then respond honestly and directly to them. If they want something from me but will not say what it is I cannot give it to them. They may then be disappointed, but I would not be the cause of their disappointment. I would welcome more direct communication between my patients and myself: less guesswork, please.

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Cancer care is team care, and the GP must be included

EDITOR—Traumatic as they may be, the experiences described by the parent and general practitioner of a dying child are not unusual.¹ Alienation, uncertainty, and ambivalence were the frequent experiences of a large proportion of the 85 general practitioners who attended the Royal College of General Practitioners' cancer workshops in 1998 when describing their involvement in the care of patients with cancer—adults as well as children (report in preparation).

Most general practitioners believe that their traditional role in the care of patients with cancer is in recognising the disease, referral, and palliative care, with little involvement in diagnosis, treatment, and follow up. They also believe that they have a role in the management of intercurrent illness, psychosocial care, and advocacy during the treatment phase.

Studies among patients with cancer show a similar ambivalence over the

expected involvement of general practitioners in treatment and follow up. Some patients did expect contact generated by the doctor during treatment but then after remission rejected the idea of follow up being taken over by primary care.²

There is irony too in the Calman/Hine declaration that primary care should be the focus for cancer care.³ The Expert Advisory Group on Cancer's document provided no evidence to support this statement and no practical recommendations beyond improving communications between generalists and specialists. We await further advice on this from the NHS Executive.

The numbers of patients with cancer seen by each general practitioner may be small (5-6 patients a year)⁴—and the numbers of children particularly so (2-3 per lifetime)—but, as this paper shows, such incidents can have an overwhelming effect on the general practitioner and the family. They need to be managed better. The child's mother states that "cancer may no longer be the taboo it once was," but this is only partially true. The workshops provided some illustration of persistent nihilistic behaviour by some general practitioners. A diagnosis of cancer can still be equated with a death sentence.

The answer is not simply better communication. Improved undergraduate teaching and vocational training in cancer must change attitudes. The Macmillan general practitioner facilitator programme will help. But it is not just general practitioners who need to change. The cancer units and centres, particularly those managing the rarer cancers and paediatric cancers, must remove their isolation from primary care and give general practitioners regular updates during treatment of their patients. General practitioners must be enabled to maintain contact with the families with accurate information; such inclusion encourages the continuity that most patients need.

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2 National Cancer Alliance. *Patient centred cancer services? What patients say*. Oxford: NCA, 1996.

3 Expert Advisory Group on Cancer. *A policy framework for commissioning cancer services*. London and Cardiff: Department of Health and Welsh Office, 1995.

4 Summerton N. *Diagnosing cancer in primary care*. Oxford: Radcliffe Medical, 1999.

Relatives are often grateful for GP's presence at patient's death

EDITOR—I was moved by the openly expressed feelings of a general practitioner responding to criticism of his lack of attention to the emotional needs of parents of a sick child.¹ All general practitioners could benefit from careful consideration of the issues so eloquently and sensitively raised.

As a general practitioner with a special interest in terminal care, I was particularly struck by the doctor's observation that he felt that his presence with the family at the time of the child's death was an unhelpful intrusion. I have experienced similar feel-

ings as a general practitioner at such times, but my outlook changed completely at the time of my father's death, when I saw a similar situation from the relative's viewpoint.

My father died in a hospice, in a private room with my mother and three siblings seated around the bed. One of my clearest memories is of the presence of the nurse who had been on duty through the night. She stood quietly in the room, obviously affected by the emotion of the moment. Her presence was an unexpected and quite remarkable comfort at the time—an expression of empathy from the outside world, a feeling that we were allowed to care as much as we did. The reassurance that all was proper in an "official" sense was also important to all the family.

It is only natural that doctors feel awkward if they think that their presence is unwanted, but it is unwise to assume that the relatives feel the same way. Over the years I have received feedback from many patients' families acknowledging that my presence or that of a nurse has been a great comfort at the time of a patient's death. As general practitioners we are remarkably privileged to be able to perform a valuable service at such moments.

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Patients get great benefit from their GP visiting them in hospital

EDITOR—I well understand the mother's wish that the general practitioner had taken more of the initiative in offering help during her child's illness.¹ He should have visited the child in hospital, spoken to the medical and nursing staff, and read the notes. He then would have been in a much more favourable position to provide help to both the child and the worried parents.

General practitioners who visit their patients in hospital bestow incalculable benefit on them. The visit eases the fear of the unknown and restores the patients' confidence and sanity in the terrifying world of modern medicine. The general practitioner also benefits. They increase their medical knowledge, establish better relationships with the hospital staff, and, after discharge, can cope with patient and family in a more meaningful way.

I have had some 40 years in general practice and have enjoyed visiting patients in hospital. I believe it to be a worthwhile exercise of value to both doctor and patient.

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1 Doctor-patient relationships in primary care: Doctor, help! My child has cancer. *BMJ* 1999;319:554-6. (28 August.)

Summary of rapid responses

We received 11 electronic responses to this pair of articles on a general practitioner's involvement in the care of a terminally ill

child—eight of which were from general practitioners.¹

W Lewis argues that the publication of the articles illustrates "why today's GP cannot wholeheartedly be the mythical 'friend of the family'.... Can we afford to make friends who then complain about or sue us? Or even write in the *BMJ*?"

M Brimacombe adds: "GPs on the whole have high expectations of themselves which they find difficult to reach. When patients' expectations become so unrealistic and their criticism so sophisticated, finely tuned, and punitive this is destruction indeed."

T Jones points out: "Patients will often relate how close they feel to their doctor, but this intensity of relationship can only, normally, be sustained for the duration of a consultation... this case shows the dividing line between when it is right or wrong to extend the relationship is difficult to gauge."

A Williams admits that he, too, finds it "incredibly difficult to become involved in the care of patients who have unusual illnesses or who are cared for in tertiary centres. Despite holding higher qualifications in medicine it is easy to feel intimidated by specialist centres and specialists with special interests."

R Sloan concludes: "Patients presume all doctors to be trained to a high level in communication skills. With more and more emphasis on the technical aspects of medicine, the reality is that students and practitioners often become de-skilled in areas such as empathy and self-understanding, qualities which they may have had before conditioning and battle-fatigue took over."

Opinion was divided about the usefulness of publishing such articles in the *BMJ*.

"Doctors do need reminding of the human nature of medicine and for looking for covert needs but the article suggests that reasonable steps to identify these were taken. I am no further forward in identifying a hidden plea or comfortable at pursuing the initiative unilaterally. Retrospective analysis is open to bias and [perhaps] should have been acknowledged more clearly" (J Ellerton).

"The pen is mightier than the sword and in this case more damaging. The *BMJ* should have refrained from publishing this one sided and unfair attack" (M Brimacombe).

"I found this article very thought provoking and helpful—I wish there were more in the *BMJ*" (T Jones).

"This article was one of the most thought provoking I have read for some time and an oasis in the desert of 'scientific' medicine" (D Syme).

1 Electronic responses. Doctor-patient relationships in primary care: Doctor, help! My child has cancer. *eBMJ* 1999;319:554 (www.bmj.com/cgi/eletters/319/7209/554). (Accessed 8 December.)

Do you believe in God?

EDITOR—Barracough told an interesting story in his soundings article entitled "Do you believe in God?"¹ No patient in nearly 40 years in general practice ever asked me this directly, although no doubt many

gathered that the answer would have been no, and some I told when it seemed appropriate and helpful. I had not believed in God since my first (and only) confirmation class at school in London in 1932, and I still do not.

In my early years in practice I was struck by how well non-believers faced death. I remember particularly well Sid, a young cockney wideboy who had an inoperable carcinoma of the stomach. Somewhat unusually for those days (the early 1950s) he asked about his illness and I told him the diagnosis and prognosis. I was amazed and humbled by the dignity and serenity he showed when he died in the presence of his young wife and me.

I also remember, at the other end of the age span, a great grandmother dying at the home of her granddaughter. Again I had formed a close relationship with her after I told her that her nightdress was made from the same material as that of my recently born daughter's nightdress. She too had no religious faith. The old woman lay on her side in bed with her granddaughter behind her and murmured, "I know I'm dying." The granddaughter bent down and whispered in her grandmother's ear, "If so you will soon be in Heaven." The old woman, unseen by her granddaughter, gave me a great wink, and soon after died calmly and happily.

As the years slipped by in practice and I developed a better relationship with more of my patients I began to find how courageously and tranquilly the believers also died. It gradually dawned on me that it was not their faith or lack of it which sustained them. But their trust in their doctor surely helped them.

For me it is my lack of dependence on God and my belief in Humanism that has sustained me.

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1 Barracough K. Do you believe in God? *BMJ* 1999;319:929. (2 October.)

Injection with methylprednisolone for carpal tunnel syndrome

Local steroid injections only reduce inflammation temporarily

EDITOR—I am surprised that the *BMJ* has published the article by Dammers et al without a public health warning.¹ As an orthopaedic surgeon, I occasionally use local steroid injection as temporary treatment for the carpal tunnel syndrome when operation cannot be carried out promptly. To suggest that patients should be offered steroid injection as definitive treatment, however, is both wrong and irresponsible. Pressure on the median nerve in the medium term can result in permanent damage to the nerve. Local steroid injections do not reduce the pressure on the nerve in the long term; all they do is reduce inflamma-

tion temporarily—nerve compression almost always returns, recurrence rates of 80% at one year² and 87% at 11 months³ having been reported.

The danger with injections is that the patient feels better, believes that he or she is cured, and does not return to see the doctor for two or three years. Orthopaedic outpatient waiting lists of six months and over in the United Kingdom compound this problem. By this time the thenar muscles may be wasted and numbness of the hand in the distribution of the median nerve may have occurred; at that stage it may not respond to surgical decompression—that is, it is permanent.⁴

Local steroid injections are justified in one specific situation: in the carpal tunnel syndrome associated with pregnancy. These injections are effective in 85% of cases, but in some cases with serious axonal loss surgical release is justified.⁵

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- 1 Dammers JWHH, Veering MM, Vermeulen M. Injection with methylprednisolone proximal to the carpal tunnel: randomised double blind trial. *BMJ* 1999;319:884-6. (2 October.)
- 2 Stahl S, Yarnitsky D, Volpin G, Fried A. Conservative therapy in carpal tunnel syndrome. *Harefuah* 1996;130:241-3.
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- 4 Katz JN, Keller RB, Simmons BP, Rogers WD, Bessette L, Fossel AH, et al. Maine carpal tunnel study: outcomes of operative and nonoperative therapy for carpal tunnel syndrome in a community-based cohort. *J Hand Surg [Am]* 1998;23:697-710.
- 5 Seror P. Carpal tunnel syndrome in pregnancy. *J Gynecol Obstet Biol Reprod (Paris)* 1997;26:148-53. [In French.]

Study does not show long term benefits of injection for the syndrome

EDITOR—Dammers et al's trial shows that, at one month follow up, symptoms of the carpal tunnel syndrome were considerably more likely to have resolved in patients who had received steroid injection than in those injected with a placebo.¹ The study does not, however, provide any evidence to support the suggestion that steroid injection is more effective than placebo after more than three months of follow up. This is because all non-responders were transferred to surgical treatment or steroid injection at either one month or three months' follow up, so we do not know whether their symptoms would have resolved after this.

In the United States DeStefano et al studied 227 patients who were not given surgical treatment (most were treated with splinting and oral analgesics or non-steroidal anti-inflammatory drugs and only six received steroid injection).² They found that at one year symptoms had completely resolved in over half of these patients given conservative management. For many patients, though, the response took several months to occur. The 50% response to steroid injection at one year reported by Dammers et al is therefore probably no different from the response that could be

achieved by using non-invasive forms of conservative management.

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- 1 Dammers JWHH, Veering MM, Vermeulen M. Injection with methylprednisolone proximal to the carpal tunnel: randomised double blind trial. *BMJ* 1999;319:884-6. (2 October.)
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Study is needed to determine best treatment for this syndrome

EDITOR—Dammers et al report that injection of methylprednisolone near the carpal tunnel relieves symptoms of compression.¹ Every general practitioner knows that the carpal tunnel syndrome is a miserable condition that affects many people and may be disabling, so it is a subject well worth studying.

Although the authors mention possible danger from injections into the carpal tunnel itself, they present no evidence that such difficulties are widespread or that such injections are any less effective than other treatments. This was a placebo controlled experiment rather than a trial of different treatments.

Taught from a book, I have been injecting the carpal tunnel to the ulnar side of the palmaris longus tendon at the most distal wrist crease with lignocaine and triamcinolone hexacetonide for over a decade, without difficulty. I have never knowingly caused ill effects and have had apparent long term success in many cases. Our local orthopaedic surgeon seems to use a technique involving an (anecdotally more painful yet no more effective) injection into the hand. Perhaps there are yet other techniques than these three. I do not know whether my injections or those of my orthopaedic colleague do actually go into the carpal tunnel or whether they only go near it.

Practically speaking, those who manage the carpal tunnel syndrome need to know five things:

- which injection site and method are best;
- which preparation (methylprednisolone, hydrocortisone, triamcinolone) and what dose or volume are best;
- whether such procedures are most economically undertaken in general practice, in the orthopaedic clinic, or in neurology outpatient clinics;
- whether clinical diagnosis (as opposed to electrophysiological diagnosis) alone is an adequate basis for injection treatment;
- whether there is any prospective difference (for example, age, underlying cause or precipitant, length of symptomatic period) between patients for whom injections will be curative and patients who will need surgical treatment eventually.

The best site and preparation would have to be decided by reference to the patient's preference, the effectiveness in the short and long term, and the absence or

presence of dangerous or unpleasant side effects. It would also be nice to know the scientific basis for the therapeutic effect of such injections.

Disappointingly, Dammers et al do not really help us on any of these points. Perhaps one day someone will organise a systematic study to elucidate the management of this, perhaps neglected, problem.

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Author's reply

EDITOR—Wallace fears a poor outcome for patients with the carpal tunnel syndrome if they receive injections as in our study. He would even like to see a health warning. Recurrences in our study, when they occurred, were usually seen within three months; nine tenths occurred within six months. In almost all patients these recurrences consisted of sensory symptoms. Wasting of thenar muscles is rare (8%) even in patients with long lasting symptoms. The favourable results of our study are probably explained by relief from pressure and not by anti-inflammatory effects as these are of short duration.

Hayward had expected many more spontaneous recoveries in the placebo group, as has been reported in the literature. In our study patients had had symptoms for at least three months; the average duration was over two years before treatment was started.

Davies wishes to know which injection site and method are best. We gave injections proximal to the carpal tunnel to avoid damage of the nerve as well. Possibly because of this our results are better than those that have been reported for other injection sites. After having read Davies's letter we expect that he will soon start a randomised study comparing different doses of methylprednisolone, injected, as is usual in Alkmaar, proximal to the carpal tunnel.

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Keeping joint medical and nursing notes at foot of bed

What about confidentiality if notes can be accessed by anybody?

EDITOR—Luke et al's report on the views of patients' families and staff on the placing of notes at the foot of the bed shows some advantages of promoting partnerships in health care.¹ The authors hint at but unfortunately do not address some difficulties with patients' autonomy, confidentiality, and the content of records, all of which require further consideration.

There are substantial differences between patients and within the same patient at different times in terms of attitudes to patient autonomy.^{2,3} A blanket policy of making records available to patients without first inquiring about their wishes or explaining the significance of the options listed in a differential diagnosis or test results would be the opposite of a patient centred approach. Staff often misjudge patients' wishes for information and involvement in decisions,^{2,3} and direct communication between the parties seems the simplest route to reaching agreement.

The question of who else besides the patient might be able to browse through the case notes needs to be considered: should information about termination of pregnancy, psychiatric treatment, or HIV testing be accessible to partners, relatives, and visitors? Patients would need to be fully aware of the contents of their case notes before agreeing to making them potentially available to others.

Patients' access to health records is regulated by the Access to Health Records Act 1990, and refusal to disclose information is possible if the health professional is satisfied that serious physical and mental harm can occur. Whether entries in the case notes and correspondence from third parties should be automatically accessible to patients without the consent of the author of the communication is questionable. As a general hospital psychiatrist, I routinely write in the case notes of patients seen for consultation and correspond with doctors who have referred them; I would wish to be asked before my assessment and management advice were made available to patients. Alternatively, case notes could be screened and third party or potentially harmful communications removed, but this would lead to two sets of records (confidential and super-confidential?), which would defeat the object of the exercise.

New technologies in the form of electronic records and PINs (personal identification numbers) allowing patients access to health records may well provide answers to some of these difficulties and new challenges. They will not, however, do away with the need for healthcare workers to communicate directly with their patients to find out how much they already know or wish to learn about their health, to keep them involved in decisions about treatment, and to ensure that a true partnership develops.

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- 1 Luke SGM, Gallagher A, Lloyd BW. Staff and family attitudes to keeping joint medical and nursing notes at the foot of the bed: questionnaire survey. *BMJ* 1999;319:735. (18 September.)
- 2 Catalan J, Brenner N, Andrews H, Day A, Cullum S, Hooker M, et al. Whose health is it? Views about decision-making and information-seeking from people with HIV infection and their professional carers. *AIDS Care* 1994;6:349-56.
- 3 Carretero MD, Chiswick A, Catalan J. Whose health is it? The views of injecting drug users with HIV and their professional carers. *AIDS Care* 1998;10:323-8.

Authors' reply

EDITOR—We agree with Catalan that the results of our study on a general paediatric ward cannot automatically be generalised to other settings. We would reassure him that families are aware of what is in the notes that are placed at the end of the bed. This is partly because the notes are written in the family's presence and partly because the family can read what has been written. The families are told that the normal practice is to keep the notes at the foot of the bed. Occasionally parents have asked that the notes be kept on the trolley in the ward office.

It is only the notes concerning the current admission that are kept at the foot of the bed. The hospital folder containing the old medical notes are kept in a trolley in the ward office. Any healthcare professional can choose whether the child's interests are best served by them writing their comments in the notes at the foot of the bed or on a sheet in the main hospital folder. It is unusual for professionals, other than healthcare professionals or social workers, to write their notes in the main folder rather than in the folder at the foot of the bed. The main occasions are when there are child protection concerns, when the patient is a disturbed adolescent, or when an adolescent does not wish his or her parents to have access to information shared with medical or nursing staff.

We have found that, because doctors and nurses know that the family is likely to read their notes, they not only think carefully before they write but are also more likely to talk to the family about what they have written. The system of keeping the notes at the foot of the bed on the children's ward continues to evolve at North Middlesex Hospital. The disadvantages seem to be largely theoretical and to be greatly outweighed by the benefits of openness and partnership.

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Prediction of survival for preterm births

Survival table was not easy to understand

EDITOR—The article by Draper et al deserves further comment.¹ The objective of the study was to produce current data on survival of preterm infants, yet theirs was a retrospective study for 1994-7. Since it is now 1999 we believe that their data, albeit useful, are recent rather than current. Antenatal administration of steroids to the mothers was not mentioned as one of the additional factors affecting infants' survival.

As a neonatologist and two mothers of extremely premature babies we do not find the tables described in the paper easy to

understand. Draper et al may be interested in our paper published last month, which describes a table giving outcome for parents of babies at less than 28 weeks of gestation.² This table contains information on survival rates, and also short term complications and treatment of the most recent cohort of such babies. This table could be unit based, updated annually, and be made available to the parents and each member of the perinatal team to promote consistency in the information given to the parents. We also suggest that parents be informed of 11 points, four of which are:

- Outcome for the baby depends on many factors, not all obvious and including infection and maternal and fetal health.
- A reasonably easy to remember guide is that the survival rate is about 40% for all babies born at 24 weeks' gestation, 50% for those born at 25 weeks, 60% for those born at 26 weeks, 70% for those born at 27 weeks, and 80% for those born at 28 weeks.³
- Every baby is an individual, and the parents need to realise that their baby may be different from the average. The table is designed to share with parents risk factors that need to be understood within the unique context of the child and family.
- Babies born at 25 weeks and less are at high risk of death, a long, tortuous journey through life, and disability. Some babies born at 24 and 25 weeks do, however, seem to be developing normally.

The views of doctors, nurses, and parents with respect to such information must be sought out. We have just completed a study of 71 perinatologists, 35 neonatal nurses, and 48 parents of extremely premature babies, seeking their views of our outcome table. We found that parents were the most positive and accepting of the table, followed by nurses in second position, and finally by doctors.

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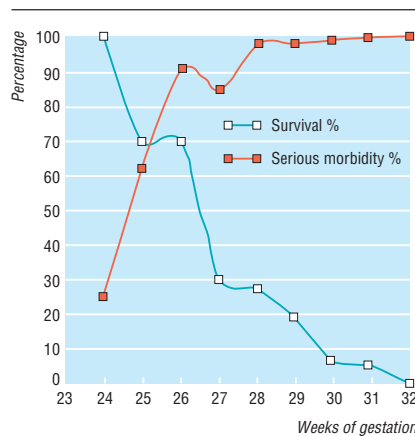
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Curve presents information on survival and morbidity more clearly than tables

EDITOR—We read with great interest the article by Draper et al on prediction of survival of preterm neonates.¹ It provides valuable data on the mortality of preterm infants in the Trent region. However, the tables, although detailed, seem cumbersome to use and do not provide information on morbidity. We have used the data collected on 395 white neonates born at the two main teaching hospitals in Leeds from 1995 to 1997. These data are presented as a mortality/morbidity curve (figure). Morbidity is defined as babies



Survival and morbidity of 395 babies born in Leeds from 1995 to 1997

developing any of the following pathologies: chronic lung disease, periventricular leukomalacia, intraventricular haemorrhage (grade 3/4) or necrotising enterocolitis.

Although the curve does not provide the same degree of accuracy we have found it easy to use as it clearly presents information on survival and significant morbidity, which is paramount for clinicians and parents in the decision making process. The curves are simple for any centre to construct from their own databases, and we hope further to improve our own data by including information on one year survival and morbidity.

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Data on the quality of survival are needed

EDITOR—In their paper Draper et al reported survival rates for infants of <33 weeks born during 1994-7 in the Trent health region.¹ We wish to comment on several aspects of their report.

Their survival rates seem lower than those we found over a similar period, so we have compared their data with reported data from Australia and New Zealand.²⁻⁵ The Australian state of Victoria has about 60 000 births annually, similar to the Trent region. Data are compiled for all births in Victoria from 20 weeks' gestation and linked to data reported on each death.² We collated survival data to hospital discharge for 1994-7 from the Victorian perinatal data collection unit. Survival rates from all three sources were higher than those reported for Europeans by Draper et al, particularly at the lower gestational ages (table).

Survival rates may differ between the regions for the following reasons. The Trent region, with the same number of births as Victoria, has 16 neonatal units compared with four in Victoria. Cohorting preterm infants improves medical and nursing skills, which in turn improves survival rates. The four units in Victoria are staffed predominantly by full time neonatologists and junior medical staff. The nurse-patient ratios are more favourable in Australia than in the United Kingdom. Australia has a policy of transfer in utero to tertiary perinatal centres for infants expected to deliver at <33 weeks. The improving survival rates are reported to obstetricians, who decide whether a preterm infant will be born alive and whether the paediatric team will participate. Survival rates are possibly higher because more extremely preterm infants are actively treated in Victoria than in the Trent region.

If the causes of death were known for infants in the Trent region, other differences between the systems in Australia and the United Kingdom might be identified. We concluded that few preventable causes of death could be identified in preterm infants in 1994-6.⁵ Not only survival data but also data on the quality of survival help decision making.

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Managing doctors and health care

We do not value teamwork in junior doctors

EDITOR—In the editorial by Richard Smith, "Managing the clinical performance of doctors," one of the closing remarks, "We need a culture that ... values teamwork," struck me as particularly true.¹ As I progress through my specialist registrarship in general surgery I am noticing time and again how, as a profession, we are unaware that we are ignoring the value of teamwork.

As the hours of senior house officers and junior house officers are reduced, as more and more "trust" grade doctors are employed to fill in the gaps on middle grade rotas, and as senior house officers are cross covering many specialties during a night on call, it is becoming less common for me as a senior specialist registrar to be on call with the same junior doctors regularly. This can have serious implications for how we perform as an effective unit on call.

I strongly believe that the provision of a general surgery on-call service, in common with many other specialties, is a real "team" game. For any team to operate effectively the individual members must recognise one another's talents and weaknesses, and communicate effectively. With house officers and senior house officers working shifts as short as four hours, I believe that the "team" nature of on-call surgery is being lost for ever. How can you build an effective training rapport with junior members when you rarely work together? How can I train and nurture practical skills in any one senior house officer when I seem to have a different senior house officer working with me every time I am on call? Surgical training is an

Survival rates by gestational age. Data are percentage survival (with 95% confidence intervals)

Source	Gestational age (completed weeks)										
	22	23	24	25	26	27	28	29	30	31	32
Draper et al ¹ :											
Girls	8 (4, 14)	16 (10, 23)	29 (22, 36)	46 (39, 52)	63 (57, 68)	77 (73, 81)	87 (84, 90)	93 (90, 95)	96 (94, 97)	98 (96, 99)	99 (97, 100)
Boys	6 (3, 12)	13 (8, 19)	24 (19, 31)	40 (34, 46)	58 (52, 63)	73 (68, 77)	84 (81, 87)	91 (89, 93)	95 (93, 96)	97 (96, 98)	98 (97, 99)
Data from Australia and New Zealand ²⁻⁵ :											
Victoria*	3 (0, 10)	25 (17, 26)	46 (37, 55)	79 (64, 77)	85 (80, 90)	82 (77, 88)	91 (87, 94)	92 (88, 94)	96 (94, 97)	97 (95, 98)	97 (96, 98)
Australian and New Zealand Neonatal Network†	17 (6, 36)	32 (25, 40)	59 (54, 64)	73 (70, 77)	82 (79, 85)	90 (88, 92)	93 (92, 95)	95 (94, 96)	97 (96, 98)	99 (98, 99)	NA
Royal Women's Hospital‡	NA	38 (21, 58)	59 (41, 75)	79 (64, 90)	86 (75, 93)	89 (77, 96)	96 (89, 99)	98 (93, 100)	97 (92, 99)	100 (98, 100)	100 (99, 100)

NA=not available. *All live births. †Admitted to neonatal units, excluding lethal malformations. ‡All live births, excluding lethal malformations.

apprenticeship, and in any apprenticeship there is a teacher and a trainee. The relationship between teacher and trainee is becoming fragmented.

Although many of the reasons why this occurs—for example, reduction of junior doctors' hours—seem to be insurmountable problems, I do not believe that they are. It may save money to multiskill and adopt cross covering regimens for junior staff—but this comes at a cost. And the cost is the loss of working as an effective team. We desperately need a culture that values teamwork at all grades in the profession.

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Health service monitoring in Britain and the United States

EDITOR—Smith's editorial¹ comes when Britain's chief medical officer, Professor Liam Donaldson, has proposed external clinical audit and annual appraisals for all doctors working in the NHS. Earlier, Prime Minister Tony Blair launched the Commission on Health Improvement to oversee health services in England and Wales and to respond to problems it identifies.

These system-wide changes almost coincide with the recent report in the United States of an expert panel from the Institute of Medicine, part of the National Academy of Sciences.² The panel found that medical errors kill from 44 000 to 98 000 Americans each year.³

The National Academy of Sciences, in condemning the fragmented healthcare system in the United States, said, "The majority of medical errors do not result from individual recklessness, but from basic flaws in the way the healthcare system is organized." It said that a crucial strategy in reducing errors was shifting the focus "from blaming individuals for past errors, to a focus on preventing future errors by designing safety in the system."

One example was the panel's finding that 7000 Americans die each year as a result of "medication errors." It pointed out that pharmacists often have difficulty in deciphering the illegible handwriting of doctors who prescribe drugs. In a case of damages awarded against a cardiologist for an illegible prescription thought to have caused the death of a patient, the doctor's lawyer said, "This jury clearly questioned why in the electronic age ... we're still using this antiquated system based on a 3½ by 5 [inch] piece of paper."⁴ The Institute of Medicine panel recommended a unified federal system of reporting serious medical errors, and periodic re-examination and certification of doctors and nurses by each state. With the goal of reducing medical errors by 50% in the next five years, the panel said Congress should create a new federal agency—a Center for Patient Safety—in the Department of Health and Human Services, costing \$100m (£63m) a

year—about 1% of the \$8.8bn a year in healthcare costs that can be attributed to preventable medical injuries.

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Menorrhagia and hypothyroidism

Evidence supports association between hypothyroidism and menorrhagia

EDITOR—Prentice in his review of menorrhagia states that there is little evidence to link hypothyroidism with excessive menstrual loss.¹ He supports this with reference to a retrospective analysis of the records of 50 patients with myxoedema.² In this cohort 28 women (56%) complained of menstrual disturbance, with the most common complaint being menorrhagia (occurring in 18 (36%) of the women). The acid test of causation is, however, whether treatment of the condition corrects the menstrual dysfunction. In this study (which reported the women's perceived loss) and more recent studies in which the menstrual loss was measured³ treatment of hypothyroidism with thyroxine decreased menstrual blood loss.

Hypothyroidism may be greatly underdiagnosed as a cause of menorrhagia. Wilansky tested for thyrotrophin releasing hormone in 67 women with menorrhagia who had normal concentrations of thyroxine and thyroid stimulating hormone.⁴ Fifteen (22%) had abnormal tests and were treated with thyroxine. Twenty four of the total cohort (who had not had surgery and remained without a definitive diagnosis) were followed up one to three years later. Of these, eight had been treated with thyroxine for an abnormal test result for thyrotrophin releasing hormone, and all considered their menstrual loss to have returned to normal. Of the remaining 16 (whose test results were normal) nine (56%) still complained of menorrhagia. These findings were later replicated in a study of women who had menorrhagia associated with intrauterine contraceptive devices.⁵

All the available evidence supports a causative association between hypothyroidism and excessive menstrual loss. Some of the study methods are weak by modern standards, but in the absence of evidence to the contrary the conclusion must be that hypothyroidism is a correctable cause of menorrhagia. Prentice asserts that routine thyroid function tests are of no value in the investigation of women with menorrhagia. Maybe we are just conducting the wrong test of thyroid function, however, and all women

with unexplained menorrhagia should be tested for thyrotrophin releasing hormone.

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- 1 Prentice A. Medical management of menorrhagia. *BMJ* 1999;319:1343-5. (27 November.)
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Author's reply

EDITOR—It is interesting how different people interpret the published literature. Weeks, in responding to my article, believes that the literature supports the concept that hypothyroidism is a significant cause of menorrhagia and consequently we should be assessing thyroid function in all women. This view is at odds with the guidance from the Royal College of Obstetricians and Gynaecologists. The advice given in the college's *Evidence Based Clinical Guidelines*, where the same evidence was considered, is that thyroid function tests do not need to be routinely performed in the evaluation of menorrhagia.¹ The reasons given were that in the studies examined menstrual blood loss was not objectively measured and the diagnosis of hypothyroidism relied on a test for thyrotrophin releasing hormone in patients with normal concentrations of thyroid stimulating hormone and thyroxine.^{2,3}

The only case report in which objective measurement was performed included only one subject, which is not the implication in Weeks's letter. Hypothyroidism is a common clinical condition, and women are affected six times more commonly than men. It would not be surprising if in a proportion of women with menorrhagia hypothyroidism, clinical or subclinical, coexisted. The routine screening for thyroid disease is not recommended in asymptomatic adults,⁴ and the treatment of subclinical hypothyroidism is controversial.⁵ Weeks is advocating an expensive screening programme of unproved value. It is only reasonable routinely to test thyroid function in women with menorrhagia as part of a prospective study designed to address this specific question. Until that time we should follow national guidelines.²

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Revalidation in the United Kingdom

Practicality and cost of revalidation plans must be assessed

EDITOR—Scanning the contents of the *BMJ* for 30 October 1999, I thought I detected an editorial masterstroke. The education and debate section contained five articles on revalidation,¹ followed by—here's the flash of inspiration—an article on the problems of medical staffing in our hospitals.²

Sadly, this seems to have been pure serendipity. Far from "debate," the authors all seemed blissfully unaware of any link. Article followed article on revalidation, describing teams of doctors, busily revalidating teams of doctors. In apparent isolation, the last article discussed the staffing crisis without mention of the workload to be imposed by revalidation.

I do not question the need for revalidation, but I do question the practicality of implementing these plans without new resources and more staff. There was not even an assessment of the cost, let alone a cost benefit analysis.

Would it not be a good idea, in a section labelled "debate," to have at least one author who questions the dogma?

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2 Dowie R, Langman R. Staffing of hospitals: future needs, future provision. *BMJ* 1999;319:1193-5. (30 October.)

Supportive culture must accompany revalidation

EDITOR—On any aircraft flight I am comforted by the knowledge that the pilots are regularly subjected to simulator exercises and medical checks to establish fitness. It is this last point that I wish to emphasise in the context of revalidation.¹ It is frankly scandalous that the largest employer in Europe has no formal mechanisms for looking after both those whom it employs and those who are in effectively monopolistic contracts to provide its services.

We must deal with this issue in as supportive a fashion as possible. The evidence now is that almost a fifth of general practitioners are as depressed as their patients, or more so. The ability to provide continuity of care in an environment of protected time and space is being constantly eroded. We will have to wait and see whether NHS Direct alleviates need or merely serves further to fuel the demands and expectations of an increasingly stressed and unhappy population acting out their distresses via the more acceptable medical model.

I suggest that an essential part of revalidation should be an annual quality medical and psychological check up for all health professionals; it should be provided by an independent occupational health service within the NHS (which would also

treat any of the acute needs of its employees). Many doctors start off caring and being in touch with their essential humanity at the outset of their training or career. Systematic brutalisation, exhaustion, unremitting public demand, and constant organisational change are taking their toll; the word retirement is on the lips of many. Tony Blair likes to parade his stripes, but they are painted on with stage paint and would wash off easily when bathed by a spin doctor.

There is far greater opportunity for praise and valuing those who work so hard in the NHS than exists at present. I heartily support the need for revalidation, but as part of a supportive culture that nurtures and provides mentors for its own.

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Prevalence of antibodies to HTLV in blood donors in north London

EDITOR—We note with interest the observation by Donati et al in their study investigating the prevalence of antibody to human T cell leukaemia or lymphoma virus in women attending antenatal clinic that infection with this virus was not limited to women who described themselves as black African or black Caribbean.¹

In an extensive study of 100 000 blood donors in north London we detected five donors who tested positive for antibodies to human T cell leukaemia or lymphoma virus.² One, an Afro-Caribbean man, was confirmed positive for antibodies to HTLV-II and had a history of intravenous drug use. The remaining four were white women with histories of sexual exposure to partners at risk of infection with human T cell leukaemia or lymphoma virus. In this situation, although we have detected antibodies in Afro-Caribbean blood donors in other studies, selective screening would have proved inadequate.

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Centres of excellence are needed for clinical forensic medicine

EDITOR—In their editorial Norfolk and Stark express concern about the privatisation of clinical forensic medical services.¹ Certainly, if this is poorly implemented without suitable safeguards, particularly for the doctors, it can greatly reduce the quality and independence of the medical service to the detriment of all concerned. On the other hand, privatisation can be beneficial.

Irrespective of how clinical forensic medical services are provided, procedures must be in place to ensure the competence and independence of the doctor and that the medical service is provided in a professional manner. As with any medical service, it must be of a high quality. No one would expect a recent medical graduate or practising doctor not trained in the field to perform complex surgery on patients regularly. So too it is inappropriate for doctors untrained in clinical forensic medicine to practise in this field.

As Norfolk and Stark point out, training for clinical forensic medicine requires far more than a two day course. Clinical forensic medicine requires, in addition to an extensive knowledge of general medicine, a detailed knowledge of forensic principles and their limitations and an understanding of ethics and the law well beyond that encountered in general medical courses and specialised medical fields. In addition, it requires a knowledge of the custodial system and of how to medically manage detainees in that system, and a self confidence to ensure that the principles of medical ethics and the law are upheld. To achieve this, the doctor must receive appropriate supervised training and accreditation and engage in ongoing education and peer review.

It is surprising that in the United Kingdom, which has a well established system of police surgeons of high quality, the state has failed to understand the need for fully funded centres of excellence (academic departments) in clinical forensic medicine. No one would doubt the value of university departments of medicine, surgery, forensic pathology, etc, to maintain and extend practitioners' knowledge in these fields. Clinical forensic medicine isn't any different. The courts are becoming more demanding of doctors and of forensic practitioners in particular. Failure to introduce an academic department or departments of clinical forensic medicine will eventually result in a decline in the quality and knowledge of forensic services and become an injustice to all.

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Rapid responses



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