Letters

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Judicial functions of GMC should be abolished

Editor—Attempts are afoot to turn the General Medical Council into an Alan Milburn quango; hence, it has become necessary for doctors to know what they would be deprived of as a consequence.

Currently, the GMC is like a court and is therefore not accountable to ministers or the public. It is a domestic tribunal with the sole purpose of allowing doctors to sit in judgment over other doctors. Therefore, although the Medical Act 1983 makes provision for non-doctors to be on the council, it does not oblige the GMC to give them a judicial role. Also the act ensures that the GMC is fully accountable to doctors.

According to schedule 1 of the act, the GMC must first consult individual doctors before it can change the rules governing elections. According to schedule 4 of the act, the GMC must first consult doctors before making any changes to its judicial functions. The act does not even permit the GMC to go directly to the Privy Council to make changes to the constitution without first obtaining a mandate from doctors. The Privy Council itself cannot make changes without prior consultation with the GMC and its constituent doctors. The GMC is sowing the seeds of its own destruction by moving away from its medical roots.

As an elected member of the GMC I am losing faith in the impartiality of the GMC because its judicial function is becoming less technical and more politicised. As an overseas trained doctor I have no faith in the judicial impartiality of the GMC. The statistics are against me, as confirmed by a recent report prepared by the Policy Studies Institute for the GMC on the handling of complaints by the council. It is not really relevant that some GMC members may claim to be impartial. I can see the world only through my own eyes and not through someone else's.

I also know that I cannot have a fair trial because those sitting in judgment may have neither medical nor basic legal training. The goalposts keep changing because there are no tariffs for offences and punishments, the GMC is always under pressure to convict, and cases are referred to the GMC primarily as a means of exacting retribution.

It should not surprise anyone therefore that I call for the total abolition of the judicial functions of the GMC.

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Inferiority of calcium channel blockers to cheaper drugs

News item was inaccurate on at least two counts

Editor—The news item by Josefson about calcium channel blockers being inferior to cheaper drugs[1] seems to have been taken directly from the press release by the investigators from the Wake Forest University School of Medicine. Nowhere is the lesser incidence of stroke with calcium channel blockers and the equality of total mortality with these and other drugs mentioned. Moreover, the inappropriate inclusion of flawed data in this meta-analysis should be contrasted with the more careful and complete meta-analysis presented by MacMahon and Neal at the International Society of Hypertension on 24 August 2000 and now published in the *Lancet*.[2] Since this study was not hyped by press releases, Josefson was probably unaware of its balanced results.

But Josefson goes further. She states that calcium channel blockers are inferior to other antihypertensive drugs in elderly patients with diabetes and systolic hypertension, referring incorrectly to two papers. The first shows exactly the opposite: calcium channel blockers in the Syst-Eur trial provided better protection than did diuretics in the SHEP trial.[3] The second paper is the SHEP data with ne'er a calcium channel blocker in sight.[4]

The *BMJ* should insist on at least as much accuracy in its news articles as in its papers.

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Competing interests: NMK has been paid honoraria for talks given under the auspices of multiple pharmaceutical companies that market calcium channel blockers, including Bayer, Astra, Merck, and Pfizer.

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Author's reply

Editor—The literature on calcium channel blockers and the optimal pharmacological treatment of hypertension is long and contentious, and a full analysis of the literature is beyond the scope of a regular news piece and this reply. Clearly, antihypertensive treatment is complex and dependent on side effects as well as concurrent disease and lifestyle.

Kaplan should realise that in my role of reporter, I was merely reporting on a study and not necessarily promoting or defending any of its results. Moreover, I have no interest, vested or otherwise, in the study results. Since at the time of my news piece the study from Wake Forest University had not yet been published (it was presented at a meeting) and I lacked a paper to scrutinise, I was limited in my ability to analyse the data and based my report on an interview with Dr Pahor and on the press release.

None the less, many studies show that calcium channel blockers are inferior to other antihypertensive drugs in preventing some of the cardiovascular complications of hyper-

tension. Moreover, concern has been raised that a financial incentive may be at work because they are heavily promoted above cheaper and arguably equally effective, if not more effective, blood pressure drugs.[1]

Some studies single out short acting calcium channel blockers and dihydropyridine derivatives as the culprits. Most people agree that calcium channel blockers are effective antihypertensives and superior to placebo in reducing blood pressure, and I am not suggesting that patients taking them abandon their treatment. However, many meta-analyses have shown that when compared with other antihypertensive drugs, such as angiotensin converting enzyme inhibitors, β blockers, thiazides, and loop diuretics, calcium channel blockers have a higher relative risk of myocardial infarction and stroke.[2] For example, the ABCD trial compared nisoldipine, a calcium channel blocker, with enalapril, an angiotensin converting enzyme inhibitor, in patients with both non-insulin dependent diabetes and hypertension and also found a greater incidence of myocardial infarction with calcium channel blockers.[3] The MIDAS study suggested that the calcium channel blocker isradapine is associated with more strokes and cardiovascular complications than hydrochlorothiazide.[4]

Finally, while I acknowledge a mix-up with the paper by Tuomilehto et al,[5] I did not mention the SHEP trial by Curb et al. Kaplan seems to have confused this citation with that of the MIDAS trial. Moreover, he does not mention that in the study by Tuomilehto et al nitredipine treatment is not completely segregated from treatment with hydrochlorothiazide and angiotensin converting enzyme inhibitors. Thus many of the patients were taking the calcium channel blocker and enalapril or hydrochlorothiazide, or both, so the results may be confounded.

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Competing interests: None declared.

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Use of long acting calcium channel blockers is not deleterious in elderly hypertensive patients

Editor—We read with concern the news item by Josefson which highlighted the belief that calcium channel blockers may be less effective in elderly patients with diabetes and systolic hypertension.[1] We are worried not only that the article was inaccurate but that it may be misinterpreted by the lay press, leading to widespread concern among patients and sometimes discontinuation of antihypertensive treatment without proper medical supervision and advice, as has happened previously.[2]

Both diabetes and isolated systolic hypertension are associated with a high risk of cardiovascular events. Two recent placebo controlled studies have shown, unequivocally, that reducing blood pressure in elderly patients with isolated systolic hypertension reduces cardiovascular morbidity and mortality. The SHEP study used a diuretic based regimen[3] and the Syst-Eur trial used the long acting dihydropyridine calcium channel blocker nitrendipine.[4] Josefson incorrectly states that calcium channel blockers are less effective in patients with diabetes and systolic hypertension and cites a subgroup analysis of the Syst-Eur study.[4] As the Syst-Eur study was placebo controlled, it is impossible to draw any conclusions about the relative efficacy of calcium channel blockers compared with other agents in older patients with isolated systolic hypertension. Moreover, the subgroup analysis showed a greater reduction in cardiovascular mortality among the 492 diabetic patients included in the trial.[4] Interestingly, a similar observation was also made in the SHEP study, which included 583 diabetic patients, who had a 34% reduction in cardiovascular disease compared with the placebo group.[3]

To date, there have been no comparative studies of antihypertensive treatment in elderly patients with isolated systolic hypertension, with or without diabetes mellitus. However, the STOP-2 trial, which studied a large cohort of elderly patients with hypertension, (systolic pressure >180 mm Hg or diastolic >105 mm Hg, or both), compared a conventional regimen (diuretic or β blocker, or both) with "modern" treatment with an angiotensin converting enzyme inhibitor or a calcium channel blocker.[5] At the end of the study the primary end point of cardiovascular mortality was not significantly different between the two groups.

Therefore, like the authors of the Syst-Eur study,[4] we believe that the current evidence does not support the hypothesis that the use of long acting calcium channel blockers is deleterious in elderly hypertensive patients. We agree, however, that the important issue of potential differences in efficacy between antihypertensive drugs in elderly patients and patients with diabetes deserves specific attention in future large, randomised, controlled trials.

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Testing night vision for driving

Editor—The paper by Currie et al, who conclude that Snellen visual acuity is not necessarily an accurate measure of a person's ability to meet the required visual standard for driving, and the accompanying editorial will be welcomed by those participating in the assessment of a person's visual ability to drive.[1 2] These tests are, however, carried out during daytime only. In October each year in the United Kingdom the clocks go back one hour and the onset of darkness becomes earlier, which should alert us to the necessity of night vision testing as an additional requirement for a licence to drive on the roads. As far as I know, only Germany has this second standard.

The law should be changed to make night vision testing a requirement in obtaining a driving licence. This can be done by using a modification of the Snellen letter chart, the Pelli-Robson chart, which shows letters of decreasing blackness. These charts could easily be available to all outlets currently using the Snellen chart. They are reliable and give readily reproducible results. It would be impractical to ask to patients to assess their own night vision out of doors.

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Registry for torsades de pointes with drug treatment exists

Editor—The editorial by Yap and Camm provided an excellent overview of the subject of medication-induced long QT syndrome and made two important practical recommendations, regarding which we wish to report progress.[1]

They recommended that any adverse event suggestive of cardiac arrhythmias related to drug treatment should be urgently reported to drug safety authorities and drug manufacturers. Since the editorial appeared, an International Registry for Drug-Induced Arrhythmias has been launched, and Camm is a member of the scientific advisory

committee. The aim is to collect, study, and correlate the clinical information, electrocardiograms, and DNA of such cases. The hope is that this will allow development of improved methods for identifying at risk individuals, so that important drugs such as cisapride can continue to be used with greater safety. Practitioners are therefore urged to submit all cases, past or present, of probable torsades de pointes related to drug treatment (associated with any drug, cardiac or non-cardiac) to the registry. To save practitioners from spending time sending information to multiple agencies, the registry will pass on, where appropriate, details of submitted cases to relevant drug safety authorities and manufacturers. We believe that most patients or families who have experienced torsades de pointes will be glad to contribute to the effort of preventing the same thing from happening to others.

Yap and Camm also noted that when prescribing a QT prolonging drug, it is helpful to give the patient a warning card listing precautions, contraindications for co-prescriptions, and risk factors, particularly including other drugs that prolong QT. A regularly updated, searchable and downloadable list of drugs that can prolong QT is available via the registry's internet website at www.qtdrugs.org (alternative direct link www.torsades.org).

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Glucosamine and chondroitin may help in osteoarthritis

Editor—Several recent lay publications enthusiastically promote the benefits of glucosamine and chondroitin preparations in osteoarthritis.[1] This has led to a surge of interest among patients and spectacular success in the marketplace; sales in the United States approach $1bn. The medical community has been reluctant to endorse these products, principally because of concerns about the quality of the evidence available from clinical trials.

Since the completion of our review, there have been several research developments. The issue of trial quality was recently reviewed by McAlindon et al.[2] From 37 identified placebo controlled clinical trials of symptom relief in osteoarthritis with glucosamine and chondroitin preparations, 15 fulfilled predefined quality inclusion criteria for their meta-analysis. It was the authors' overall conclusion that the clinical trials demonstrated substantial effects on symptom relief in osteoarthritis, but that attendant methodological biases were likely to exaggerate the size of these benefits. The chondroprotective properties of glucosamine sulphate have been evaluated in two recent randomised controlled trials.[3 4] The data from each of these are currently available only as abstracts, but both studies show a significant reduction in joint space narrowing among patients receiving 1500 mg of glucosamine sulphate daily, compared with placebo, over three years of follow up. These agents are safe and are readily available to patients in health food shops and by mail order. As a consequence, they have great potential utility in the management of osteoarthritis, even if only modestly effective. Further data on efficacy and cost utility are eagerly awaited.

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Secondary prevention may help intermittent claudication

Editor—We agree with Davies that intermittent claudication is underrecognised as a risk factor for coronary and cerebrovascular events, and that large proportions of patients with claudication are not receiving aspirin or cholesterol management.[1] We have analysed data from the 20 year follow up of the British regional heart study, collected between 1998 and 2000, to investigate the extent to which aspirin is used and blood cholesterol concentration monitored in patients with a reported diagnosis of intermittent claudication.[2]

Among the 4425 men aged 60-79 (74% of survivors completing the questionnaire) 186 men (4.4%) recorded a diagnosis of claudication. Rates of secondary prevention were compared between patients with claudication who did not have other cardiovascular conditions (n=91) and patients with claudication who did (n=95). The results showed that among those who had other cardiovascular conditions (heart attack, angina, or stroke) 71% took daily aspirin, and 68% recalled a blood cholesterol check; among those who did not have other conditions the corresponding figures were 40% and 45%, respectively.

These figures suggest that most patients with intermittent claudication alone are not receiving secondary prevention. Clear guidelines on secondary prevention in patients with peripheral vascular disease are included in the recently published national service framework for coronary heart disease, which may help to improve the situation.[3] The framework advises the prescribing of aspirin and management of cholesterol levels in all patients at high risk of coronary events, which includes those with peripheral vascular disease.

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Vision is needed to address problem of global health information

Editor—If the problem were a new opera house for Sydney, we would hold a competition for architects to show their designs. These designs are visions of the future. Similarly, vision is what we need now to address the problem of global health information.

Pakenham-Walsh notes that international agencies, non-governmental organisations, publishers, libraries, training schools, and others all are seeking to improve access to information for healthcare workers.[1] Collectively they bring a wealth of skills, but their overall effectiveness has been limited by, ironically, lack of communication. Tan-Torres Edejer observes that the long list of initiatives is impressive but asks whether any effort has been been made to get them to work synergistically.[2] That role, she says, is most appropriate for the nations themselves with the cooperation of international organisations and donor agencies.[2] We now need a vision for how these organisations might work together, and to what end. The global health information problem is so complex and formidable—far more so than the Sydney opera house—that providing a focused, realistic vision would make a useful contribution. Without a vision, effective action will be impossible. As the saying goes, "If you don't know where you are going, any wind will take you there." A coherent vision would provide focus for debate, and motivate subsequent concerted action on the part of key players.

Godlee et al identify two key criteria by which such a vision should be judged—sustainability and multidirectionality of information flow (for example, flow not only from developed to developing countries but also from developing to developed countries and perhaps most importantly among developing countries themselves).[3] They are

also right to suggest that the global inequities of health information are part of the problem of global inequities in health, arguably the most important ethical problem in the world.[4] The next step towards a solution is to provide a vision of a global alliance for health information.

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Competing interests: PS is the author of an article containing a vision of a global alliance for health information.

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Data collection barriers can be overcome by schemes such as MEDICS

Editor—McColl and Roland say that a validated method by which practices can obtain and use clinical information is needed in order to meet some of the demands on primary care.[1] This is particularly relevant in the light of the national service framework for coronary heart disease, which requires that general practitioners identify their patients with ischaemic heart disease and create disease registers by April 2001, and of the requirements of clinical governance frameworks, personal medical services contracts, and local health improvement plans.

Such a system is already in place in Northumberland, where MEDICS (Morbidity and Epidemiology Data Interchange and Comparison Scheme) has recently been awarded NHS beacon status. Practices have spent five years working to overcome data collection barriers. Coverage now includes all 53 practices in all four primary care groups in the district, representing a population of almost 314 000 patients. All patients diagnosed with, for example, coronary heart disease are identified. Collectively, we now have over 15 000 patients being monitored. Clinical governance has become a major lever to promote accurate coding for managing chronic disease.

This scheme is one of the first in the country with such a wide coverage, with participants in all but three practices using MIQUEST (Morbidity Information Query and Export Syntax)[2] to extract the data. Altogether 54 clinical indicators are retrieved from each practice, all serving to address the challenges set out in the national service framework, clinical governance targets, and personal medical services contracts. The monitoring for clinical governance does not require any additional work from the practices in order to address these new challenges, as the data are already collected as part of the existing biannual data trawl. Northumberland MEDICS is also piloting the collection of data for diabetes, which will require the addition of several more indicators.

The value of such a tool should not be underestimated. It has an immense impact on the performance of each individual and each practice, encourages systematic and accurate recording of clinical data, helps in the development of a complete disease register for coronary heart disease, enables practices to identify gaps and weaknesses and to remedy them, builds on good practice, compares practice performance, delivers better care, and addresses the challenges of primary care today. The patients benefit directly so this system is supported by clinical staff. Through MEDICS, clinical governance becomes a carrot rather than a stick.

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Hospital accreditation is important

Editor—Essex believes that awards such as the Charter Mark and the King's Fund organisational audit are merely "administrative baubles" and a waste of time.[1] I cannot speak for the Charter Mark award but must point out that the King's Fund organisational audit was reconfigured as the Health Quality Service in 1999; I am chairman of its advisory council.

The Health Quality Service is just that: a service for those who seek to use modern methods to improve the quality of the health care they provide. We lay emphasis on development and education rather than inspection, by providing a thorough review of all aspects of an institution's structure, systems, and processes, with particular emphasis on what patients experience. We support the groundwork that will enable the adoption of more efficient and effective processes, leading in turn to improved outcomes.

To provide this service we have the help of staff in the institution being surveyed. It is true that these staff may be away from other duties for a time, but the alternative is to allow healthcare institutions to continue to struggle without the benefit of modern methods of quality improvement.

I must also disabuse Essex that the King's Fund organisational audit and Health Quality Service were thought up by "an administrative mindset." The first such scheme was initiated by Dr Ernest Codman in the United States in 1910 and led to the founding of the American College of Surgeons in 1913 and the Hospital Standardization Program in 1917. This programme sought to ensure that "those institutions having the highest ideals may have proper recognition before the profession, and that those of inferior equipment and standard should be stimulated to raise the quality of their work."

The Health Quality Service does not seek to control as Essex suggests; on the contrary, we seek to coach. A plaque is on offer for those institutions that are accredited, but it need not be used—nor need the fact of accreditation be announced. Many hospitals are proud of gaining accreditation and use the opportunity to encourage their staff to do better still.

There is a long history of cynicism about the value of hospital accreditation, but after 90 years it is clearly here to stay. We are encouraged that the government has initiated the Commission for Health Improvement, which will have a statutory responsibility to ensure that NHS hospitals are properly engaged in modern quality improvement.

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1 Essex C. Baubles are a waste of time. *BMJ* 2000;321:905. (7 October.)

Insulin-like growth factor-I can be helpful towards end of life

Editor—In their editorial Smith et al review the literature relating high circulating concentrations of insulin-like growth factor-I to the risk of developing certain malignancies.[1] They warn of the dangers of the use of exogenous insulin-like growth factor-I by athletes, in whom the additional lifetime risk of developing an associated cancer may be increased. Towards the end of life, however, maybe the anabolic anti-apoptotic properties of insulin-like growth factor-I be should be considered in a different light.

Cardiac cachexia is a devastating phenotype of chronic heart failure associated with high morbidity and reduced survival.[2] High concentrations of growth hormone and inappropriately low concentrations of insulin-like growth factor-I are recognised features of this syndrome and suggest that a state of growth hormone resistance pervades.[3] The finding that skeletal muscle bulk also correlates inversely with concentrations of insulin-like growth factor-I hints at a pathophysiological link between these findings.[4] Furthermore, in dogs with heart failure, which have a high incidence of cachexia, those with raised concentrations of circulating insulin-like growth factor-I actually show an advantage in survival.[5] These findings perhaps reflect the possible advantages of higher concentrations of insulin-like growth factor-I in chronic disease alluded to by Smith et al.[1]

In patients with chronic wasting diseases approaching the end of life, when the

theoretical risk of treatment associated malignancy can reasonably be ignored, higher concentrations of insulin-like growth factor-I may be beneficial. There is, therefore, a valid argument for the use of exogenous, anabolic, anti-apoptotic compounds, such as insulin-like growth factor-I, in catabolic states where mortality is high and even short term benefits are elusive. Such new approaches to the treatment of a crippling syndrome such as cardiac cachexia would be most welcomed.

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Drug development means economics in the end

Editor—Garattini and Liberati state, "Millions of people suffer from tropical diseases (malaria, leprosy, schistosomiasis), and yet no one designs realistic strategies to tackle them."[1] But surely the authors are being either naive or disingenuous if they think that the cure for this is to take the responsibility for drug development from those who answer to Wall Street to those who answer to Brussels. Would we not still see breast cancer, heart disease, diabetes, asthma, Alzheimer's disease, etc as being the diseases attracting funding rather than bilharzia?

Similarly, the authors state, "The use of treatments should not be extended by analogy from one group of patients to another without randomised controlled trials." I disagree. We make such extensions all the time, from people treated in 1992-4, when the trial was run, to those being treated in the third millennium; from Protestants to Catholics; and even, and justifiably on occasion, from men to women. If you find a useful treatment in lung cancer you will have done so using a majority of male patients. If you insist on repeating your study in only women you are being neither ethical nor economical.

Whatever distortions brought about current economic arrangements, everyone who works in drug development will have to face economics in the end. In any case, the notion of generalisability depending on the representative nature of the patients studied is hopeless and wrong. The typical meta-analyst agonises about whether patients with moderate and severe hypertension can be pooled but places all β blockers together in one pot without even noting unit doses and dose schedules. But anybody who has worked in the pharmaceutical industry knows that even a change in the formulation of a drug can alter its potency.

By all means let us have criticism of the pharmaceutical industry. But any alternative approach to drug development will have to work within the priorities of the society that funds it and will have to take a realistic approach to costs and needs. You can try and take profits out of drugs if you want, but you can't do without economics.

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Competing interests: SS is a consultant to the pharmaceutical industry.

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When response rates do matter

Editor—I read Minerva's contribution about the importance of achieving a 55% response rate in general practitioner surveys.[1] There is evidence to suggest that much higher response rates are necessary and that the traditional requirement of a 70% response rate is inadequate. In our survey of general practitioners in a commissioning group, we achieved a 100% response rate.[2] The initial response was 74% and the remainder were persuaded to respond after direct visiting or telephone contact. We noted a significant difference in replies of the prompt responders compared to the reluctant responders—whose replies would have been missed in more traditional surveys. The reluctant responders were less committed to the commissioning group and less likely to think that it would be successful.

Their prescribing characteristics also differed. Reluctant responders were less likely to think that their prescribing was high quality and less likely to be happy to let others view their prescribing data. These results point to the importance of eliciting the full range of opinion in any survey of attitudes among general practitioners. By accepting 70% response rates, the results may be biased toward a more optimistic conclusion than is justified. Non-responders already feel less sense of belonging and by ignoring their opinions may end up further marginalised. Primary care organisations have a responsibility to represent all their general practitioner members and not just those who answer questionnaires.

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Census of availability of neonatal intensive care should have used different denominator

Editor—Parmanum et al documented the number of maternal and neonatal transfers occurring from referral centres in the United Kingdom during a specified three month period.[1] They attempt to give some epidemiological perspective to the observed numbers, but the denominator that they used to calculate the rate per 1000 deliveries, at least in Wessex, is the total number of deliveries in the whole region rather than the number occurring in Southampton, which was the centre involved in the study.

The university hospital in Southampton provides several tertiary services relating to neonates, but the neonatal medical unit is not funded as a regional referral centre. Most of the neonatal intensive care within Wessex takes place in the nine district general hospitals in the region, all of which offer level 1 neonatal intensive care.

A more representative denominator, therefore, would be the number of deliveries taking place within Southampton—4837 during the year of the study. The rate of transfers out then becomes 11.6 per 1000 deliveries, rather than 1.4 per 1000, and it becomes more apparent that this represents a substantial proportion of the district's at risk delivery population.

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1 Parmanum J, Field D, Rennie J, Steer P. National census of availability of neonatal intensive care. *BMJ* 2000;321: 727-9. (23 September.)

Drugs may have reduced effect of falls intervention

Editor—Van Haastregt et al's study of the effects of a programme of multifactorial home visits on falls did not mention the drug history of the people who received the programme.[1] The authors also did not mention whether there was any intervention with psychotropic drugs that are associated with falls.[2]

Interventional studies in elderly people receiving long term care have found that psychotropic drugs contribute to 85% of falls; reducing doses or stopping the drugs altogether and giving buspirone instead of other conventional psychotropics may reduce falls by up to 75% over one year.[3] The rate of falls and admissions to hospital because of falls has been directly correlated with the number of psychotropic drugs used

long term (Cooper JW, Horner MR, American Society of Health-System Pharmacists mid-year clinical meeting, Las Vegas, December 2000; abstract P-511E). A recent study of withdrawing treatment with psychotropic drugs and using a home based exercise programme reduced the risk of falls by two thirds over 44 weeks.[4]

Readers could understand better why an 18 month multifactorial interventional programme had no effect on falls if there was a record of drugs taken over that period.

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Tampons could be used to diagnose sexually transmitted diseases

Editor—Gottlieb in his news item reported that tampons could be used to diagnose sexually transmitted diseases.[1] This report relates to work performed and recently delivered at a meeting in Toronto, Canada, by Dr Patrick Sturm of the University of Natal in South Africa. In a population of 1030 asymptomatic women it was found that a sample collected on a tampon, when used to detect sexually transmitted infections by polymerase chain reaction (PCR) technology, was more sensitive than conventional diagnostic methods.[1]

We would like to underscore the findings of the value of self collected specimens. We introduced and validated the use of tampons as specimens collected by patients, initially as a sensitive method for the detection of human papillomavirus by PCR, when we were examining the role of sexual transmission in the epidemiology of the virus.[2 3] This was a suitable, yet unintrusive method of collecting genital samples from a virginal population.[3] We then showed the value of this method for detection of *Chlamydia trachomatis* by PCR.[4] By increasing our menu of pathogens to include *Neisseria gonorrhoeae*, *Trichomonas vaginalis*, and herpes simplex virus, we showed that, in contrast to traditional culture techniques, this method is more accurate and avoids the need for endocervical sampling and stringent criteria for transport.

As a tool for screening of sexually transmitted infections and for surveillance purposes, particularly in populations that are difficult to reach or in groups that do not readily access medical services, we found self collected sampling, together with PCR detection, not only highly sensitive but associated with high patient compliance.[4] In one study of women living in remote communities in northern Australia, detection of *N gonorrhoeae* , *C trachomatis* , and *T vaginalis* by PCR on self collected tampons was 11%, 5% , and 16%, respectively, yet by conventional methods detection of these pathogens was 1%, 3%, and 9%, respectively.[4] The method was also found acceptable when determining the prevalence of sexually transmitted infections in female attendees of an outpatient clinic in Ulaanbaatar, Mongolia, in a population of homeless youths, and in sex workers.[5]

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Putting patients first will help interprofessional education

Editor—We read Finch's paper on interprofessional education with interest but were surprised that there was little reference to the needs of patients.[1] We too struggle with the definition and true meaning of interprofessional and with the logistical barriers to getting learners, both before and after qualification, together. The regional collaborative of the NHS Executive South West recently defined interprofessional learning and development as a process in which two or more professional groups come together and learn from and about each other in order to develop collaborative practice and achieve health improvements.[2]

Finch continues the traditional divide between higher education and those providing the service, but there is a need to take a systemic view and see interprofesssional working as the way we work together, not just something we teach students. When interprofessional teams work together with a focus on developing or redesigning a service to improve the way they meet the needs of their patients, much significant learning happens. If our learners put meeting the needs of their patients or clients at the heart of their drive for improvement, they will naturally work interprofessionally, with different professionals complementing and supporting each other.[3]

By guiding teams to reflect on this process of working together—for example, by using the methods of continuous quality improvement—the different professionals in the team become aware of the roles and underpinning values and models of both their own profession and those with which they are working. Nurses, doctors, or social workers will understand more about their professional identity, as well as learning about the strengths, perspectives, and skills of their fellow professionals. The true interprofessional team is not a seamless garment of nondescript khaki but a colourful patchwork with strong seams holding the whole together, as advocated by Heath.[4]

Our challenge is to give learners the opportunity to work in vibrant and effective interprofessional teams, actively improving the service patients receive, and also to give them space and guidance to reflect and learn from the experience. Our experience so far shows us that overcoming the logistical barriers is worth while for the learners recognise the relevance of learning where the driver and integrator is continuously improving the match between what they provide and the needs of those who depend on them.[5]

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It is time to dismiss calls to ban DDT

Editor—In his commentary in the ethical debate on banning DDT (dichlorodiphenyltrichloromethane) Liroff hides behind a veneer of reason in arguing to reduce its use carefully, but the final sentence exposes the essence of his priorities.[1] He writes that we need "protection from both malaria and DDT," which effectively equates a plague that has ravaged human populations throughout history[2] with the theoretical risks touted by environmental organisations.

DDT is the king of chemical benefactors, with its stunning success against typhus in the second world war, its association with a Nobel prize, and the increase in food

production when it is used as an agricultural pesticide. Reputations are made by killing heroes, and environmentalist groups made their reputations by lobbying to have DDT banned in the United States; they have a large stake in suppressing the good news about DDT and magnifying theoretical risks. Through the years, when one accusation was disproved they unabashedly moved on to other accusations: from animal populations to cancer to the latest theory that DDT is an endocrine disrupter.

The first clarion came from Rachel Carson's *Silent Spring*, telling of declining bird populations and rivers filled with dead fish. No one ever questioned her implied comparison of DDT's benefit to humans against her charges of its harm to avian and piscine populations, but they needn't bother. Her lyrical paean to nature, wrong on so many points, was wrong on those as well.[3]

There were charges of a link with breast cancer, refuted several times.[4 5] In 1997 the *New England Journal of Medicine* published an editorial that railed against sensationalism and called for "scientists, the media, legislators, and regulators to distinguish between scientific evidence and hypothesis, and not allow a 'paparazzi science' approach to [resolving] these problems."[4]

Affluent nations can afford the folly of overspending in order to prevent imagined risks; demanding that poorer nations engage in such quixotic adventures is arrogance. It is time to dismiss these calls to ban DDT.

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Proposals for preventing community violence are naive

EDITOR—The issues that Shepherd et al raise in their editorial on using injury data for violence prevention should be more widely debated,[1] particularly because the government has suggested that its plans to tackle violence will be based partly on injury data derived from accident and emergency departments.[2]

Shepherd et al suggest that accident and emergency departments should give the police assault data on a regular basis. They note something that the accident and emergency community knows well: many assaulted people who present to these departments never inform the police, so police statistics are inadequate.

The authors say that particular licensed premises are hotspots for violence, and they claim that a reduction in violence will occur if police activity concentrates on them. As a professor of maxillofacial surgery, Shepherd does not have the responsibility for ensuring that the community perceives the hospital, and particularly the accident and emergency department, as independent from the police. If people realise that the department is going to provide data to the police they may assume that these data can be traced to them personally. If they are arrested and released on bail they might well vent their anger about the arrest on the accident and emergency staff. Far too much violence is directed at accident and emergency staff already, without this additional hazard.

Injury data are indeed more complete than police data, but this is not new. Teanby even found that the police were unaware of some pedestrian deaths.[3] Even if Cardiff Police's data were incomplete, statistically they should still be distributed in the same way. The data would be equally bad about everywhere, so the same hotspots would appear.

Some aspects of Shepherd et al's editorial, such as the suggestion of having police hotlines in accident and emergency departments, deserve our support. But I remain uneasy. Firstly, this solution to the problem is simplistic and fraught with risk, including to our staff and to us. Secondly, and possibly more worryingly, is it the thin end of the wedge? Once the accident and emergency community has accepted that these data are passed, will requirements on other potential crimes follow? Surely patient confidentiality is one of the bedrocks on which good medical practice is based. These proposals risk eroding that part of the doctor-patient relationship unacceptably.

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Is this the end of the line for flu vaccine as we know it?

EDITOR—Last autumn money was mobilised to try to prevent flu becoming one of the many winter pressures in the United Kingdom, whereas flu in the southern hemisphere was negligible. Lacking in the process was any consideration of previous years' vaccine uptake, the efficacy of flu vaccine in preventing flu in elderly people, and whether bribery was likely to achieve any further uptake. Little was done to consider the management of flu in those who might refuse vaccination (or in those in whom vaccination was less effective).

In 2000 in East Sussex (where a large proportion of the population is elderly) the uptake of flu vaccine was 62% among those aged over 65 compared with 57% in 1999. To achieve this general practitioners were paid £591 000, a cost per additional person vaccinated of £81. The best rate of effectiveness for induction of immunity in elderly people is only 58% of those vaccinated, so the cost per additional person immunised rises to £140. If the circulating flu had a rate of infectivity of 10% the cost becomes £1400 per patient protected.

To raise immunity to levels sufficient to make vaccination cost effective among elderly people requires a considerable amount of effort and enthusiasm. Despite multiple reminder letters and a range of opportunities, a hard core of patients, representing 20% of those aged over 65, remained unvaccinated in this practice.

Flu vaccine is considered to be the first line of defence against influenza on the assumption that the circulating influenza strain is that predicted by the World Health Organization. The WHO receives little information from countries where the density of population is high and the economic status low, countries where influenza can replicate and recode undetected. Vaccination is useless as the only means of defence, and it takes weeks, if not months to develop a vaccine against a newly emergent strain.

Attempting to raise vaccination rates by item of service payments has done little to increase immunity among elderly people in the United Kingdom. Vaccine may have been diverted away from other patients at risk who did not attract a payment but who would have developed better immunity through being younger. Education about correct self diagnosis and the need for early treatment in those at high risk should be a national priority. Facilitating telephone hotlines and cooperation between practitioners should be encouraged locally to decrease impact on primary care teams. There should be better understanding of the roles of antiviral agents that inhibit flu virus activity at an early stage before respiratory tract damage occurs.

Further funds should now be mobilised to develop policies to manage flu.

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