Letters

Empowerment of patients—fact or fiction?

EDITOR—Empowerment of patients is a key element of the *NHS Plan*.[1] However, the current obsession with performance indicators may pressurise managers to interfere with clinical services with little regard to the opinions of patients.

Our unit has a busy orthopaedic outpatient clinic that deals with complex hip problems, many of which are tertiary referrals with patients travelling a considerable distance for their consultations. New patients are routinely given 20 minutes, but some consultations take much longer so that the clinic often runs behind schedule.

Hospital managers asked us to reorganise the clinic to minimise waiting room times and maximise patient throughput. Each patient's consultation was to be strictly limited to the allocated time to improve the "performance" of the clinic. We thought it crucial to survey our patients before the clinic was reorganised. Accordingly, 172 patients were asked which statement represented their views—(*a*) I prefer a clinic that allows me the possibility of a longer consultation, even if this means I may have to wait longer in the waiting room, or (*b*) I prefer a clinic that runs to time, even if this means my consultation is strictly limited to the allocated time.

Sixty eight per cent of patients preferred the present system (option a), whereas 28% preferred the alternative suggestion (option b) and 4% did not know. During the survey only 38% of patients were seen within 30 minutes of their appointment time; the average wait was 55 minutes.

Our survey shows that the desire to influence performance indicators could result in changes that are unpopular with patients. Being slaves to crude measures of performance, such as waiting times, risks a negative effect on what is not measured, such as the quality of the consultation. We as doctors must defend attempts to erode aspects of clinical services that are important to patients but do not feature on hospital league tables. Empowerment of patients, while laudable in principle, seems to be nothing more than politician's hot air when hospital performance stars are at stake.

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1 Secretary of State for Health. *The NHS plan. A plan for investment, a plan for reform.* London: Stationery Office, 2000.

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Men and older people are less likely to use NHS Direct

EDITOR—Last year George discussed the underuse of NHS Direct by certain groups in society.[1] Other investigators have also identified variations in the use and awareness of the service.[2 3] We examined this issue by conducting a survey of people in general practice waiting rooms at two surgeries in Southwark, London. We surveyed 207 people aged 13-90 (a response rate of 79.6%).

A significantly greater proportion of women than men had heard of NHS Direct (P=0.04). Among those aware of the service, we found no sex based difference in use. Use of the service declined significantly with age (P=0.014). Among those aware of the service, however, older people were still less likely to use it (P=0.0021). We found no differences in this study when making comparisons with respect to social class or ethnic group.

We asked participants who had heard of NHS Direct but had never used it their reasons for never having done so. The most commonly cited reason was that the respondent had never needed to. Among those older than 50, however, it was that the respondent would rather see their general practitioner.

These findings indicate that among people attending general practice, sex and age are determining factors in the awareness and use of NHS Direct. The finding of an equivalent level of use among men and women aware of it implies that simply increasing awareness will increase the use of the service among men particularly. With regard to age related differences however, the relative underuse by older people remains even among those aware of NHS Direct. Our results indicate that in older people a significant barrier to the use of the service exists, aside from a lack of awareness, and that this barrier may be a preference for seeing their general practitioner.

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1 George S. NHS Direct audited. *BMJ* 2002;324:560-59.
2 McInerney J, Chillala S, Read C, Evans A. Target communities show poor awareness of NHS Direct. *BMJ* 2000;321:1077.
3 The Comptroller and Auditor General. *NHS Direct in England.* London: Stationery Office, 2002.

Breast self examination

Breast self examination provides entry strategy

EDITOR—Given what is now known about the long subclinical growth phase of human breast cancers, the finding of a recent study from Shanghai, that teaching breast self examination did not detectably improve survival, is not surprising.[1] None the less, Austoker's related editorial, proclaiming the death of breast self examination, should not go unchallenged.[2]

Many studies have reported a reduction in primary tumour size dependent on breast self examination, which may in turn enable more conservative surgery.[3] The editorial's implication that all such end points are rendered illusory by the Shanghai study is overstated; as if to acknowledge this, Austoker concedes that prompt symptomatic presentation ("breast awareness") remains important. But is the timely presentation of breast symptoms—of which palpation of a lump is the commonest—so different from what most people understand by breast self examination?

False positive and false negative "costs" are attached to breast self examination and to any preventive diagnostic interventions. However, an individual who is informed of both the negative randomised data and of the inverse association of tumour stage with survival might still reasonably opt for the potential costs of a biopsy dependent on breast self examination, rather than for the implied comfort of ignorance or uncertainty.

In Asia, where high rates of late presentation persist owing to cultural and economic factors,[4] there seems little reason to

be cheered by the debunking of breast self examination. As one facet of an expanding spectrum of patient empowering initiatives, breast self examination at least provides an entry strategy towards the gradual improvement of cancer awareness and outcomes.

Kline has proposed that the rhetoric of breast self examination should be modified so that healthcare consumers are accurately informed and thus empowered, rather than misled or inadvertently coerced.[5] Surely this is the insight that public health in the 21st century should be striving to attain.

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1 Thomas DB, Gao DL, Ray RM, Wang WW, Allison CJ, Chen FL, et al. Randomized trial of breast self-examination in Shanghai: final results. *J Natl Cancer Inst* 2002;94:1445-57.
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Editorial misses central point

Editor—Instead of clarifying the "confusion of the past decade," Austoker fuels a debate that misses the central point.[1] No single screening procedure is foolproof. Self examination can miss tumours, as can other methods. The issue is not whether breast self examination alone can save lives, but how many lives it can save in conjunction with other screening procedures. Women need to know that screening is multifaceted—that if they are concerned they should not rely on simply one test. Only then can they be assured of detecting breast cancer earlier or eliminating the possibility of having the disease.

Furthermore, Austoker's cited Thomas et al study was a trial of the teaching of breast self examination, not the practice of it.[2] The possible impact of cultural values in the adherence to breast self examination and hence on results is overlooked.[3 4] Instead, Austoker posits that since there is no single agreed method, or it engenders anxiety, breast self examination fails to be effective. Breast cancer survivors can assure women that a positive diagnosis is far more distressing than the trepidation experienced through self examination.

The message is clear. Breast cancer can, and does, induce anxiety in women. However, to discount breast self examination as a detection tool because it results in more biopsies or creates temporary stress, or because guidelines are inconsistent, is unconscionable. Women have been "taught" that early detection of smaller tumours is their best chance for survival. For many women in the trial reported by Thomas et al, breast self examination resulted in the identification of smaller tumours; more in situ cases and 81.9% of tumours were discovered directly through self examination.[2] These figures alone speak volumes about the efficacy and effectiveness of breast self examination as part of an overall, multipronged approach to detecting breast cancer.

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Readability of British and American medical prose

Why are unreadable articles still being written?

Editor—The article by Weeks and Wallace is yet another of many articles over the past 20 years showing that medical information (such as journal articles, informed consent forms) is written in an "unreadable" writing style.[1] Although such articles are interesting, no more research on the topic is needed as any future studies will come to the same conclusion.

The issue that should be studied is why, after so many years of so much readability research, so many articles are still so badly written. Readability findings seem to have no impact on physicians-researchers-writers.

Why are journal articles written at a "very difficult" level on the Flesch reading ease score? Why can't authors write at a more understandable level? How are researchers trained to write—how many and what kind of writing courses did they take in college? Are researchers writing articles that are hard to read because such articles have always been written that way, or because they just don't know how to write any other way?

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Competing interests: None declared.

1 Weeks WB, Wallace AE. Readability of British and American medical prose at the start of the 21st century. *BMJ* 2002;325:1451-2. (21 December.)

Transatlantic writing differences are probably exaggerated

Editor—Weeks and Wallace have come up with an excellent idea, which is to compare texts in *BMJ* and *JAMA* by using two "readability" scores.[1] Unfortunately, the differences between the two journals, while statistically significant, are disappointingly slight when you look at what the tests actually measure.

The FOG score, for example, creates an index by counting long words and long sentences. When we looked at practice leaflets they ranged from 8.4 (the style of a tabloid newspaper) to 17.2.[2] In the study by Weeks and Wallace, the respective scores are 16.9 and 17.8, a difference of about one point, which can be explained by an extra three words of three syllables per 100 words. This does not seem to be sufficient to warrant a conclusion that one is more readable than the other.

However, this should not detract from the main finding, which is that the prose in both journals is very dense, and we should do something about making it more accessible. In my experience, the problem is that most people who write and edit journals still believe that this is the "proper" way to write.

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1 Weeks WB, Wallace AE. Readability of British and American medical prose at the start of the 21st century. *BMJ* 2002;325:1451-2. (21 December.)
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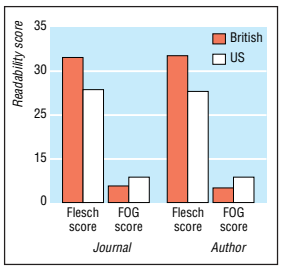
Misclassification, long words, and errors may obscure real differences



Editor—I have three comments on the paper by Weeks and Wallace.[1]

Firstly, an error seems to have crept in as the FOG scores shown in the figure are about half the values of those described in the text. I assume that the text is correct and the figure is wrong, given the authors' conclusions about the poor readability of the articles, but it would be nice if this could be confirmed.

Secondly, I have my doubts about the relevance of the Flesch and FOG scores for grading articles in medical journals. Both scores are influenced by long words, but in medical articles, long words are probably inevitable and do not necessarily make an article hard to read if their meaning is clear. Consider, for example, the challenge of writing a paper about the link between hypercholesterolaemia and atherosclerosis without using any words of more than two syllables. It could undoubtedly be done and would probably end up with a better readability score, but would not necessarily be any more readable than one that used the long words.

Finally, I suspect that they may have underestimated the difference between British and American authors as a result of misclassification of authorship. The analysis by

Weeks and Wallace assumed that the paper was written by the first named author. If a paper has several authors (as most papers do), then the paper was not necessarily written by the first author. Furthermore, many papers are not written by any of the named authors at all, but are ghostwritten by professional medical writers. The assumption that papers with an American first author were written by Americans and that papers with a British first author were written by Britons is not necessarily true. This misclassification will have the effect of obscuring any transatlantic differences, so the real difference may be even greater than that found by Weeks and Wallace.

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1 Weeks WB, Wallace AE. Readability of British and American medical prose at the start of the 21st century. *BMJ* 2002;325:1451-2. (21 December.)

Ultrasound guided central venous access

Ultrasound localisation is likely to become standard practice

Editor—Muhm in his editorial on ultrasound guided central venous access raises many valid points, prompted by recent guidelines from the National Institute for Clinical Excellence (NICE).[1 2]

The evidence for this technology is stronger than for many other medical devices in routine use—for example, pulse oximetry or capnography in anaesthesia, which lack definitive controlled studies on outcome. I question whether is it ethical for practitioners with ultrasound skills and access to devices to revert to blind techniques for controlled trials. Such trials, if measured by numbers of complications, would require operators to persist blindly in difficult cases to the point of complication, rather than give up or use ultrasonography.

The cost of this technology is modest compared with many other medical technologies and the cost of complications. Minor (not to the patient) and major complications are very expensive in clinical, legal, and other costs, such as delayed surgery or discharge. The hidden costs of patients' discomfort, vein damage, thrombosis, and catheter related sepsis have never been measured but must surely relate to multiple punctures even if venous cannulation is eventually successful.

The editorial concludes that ultrasound localisation is a useful backup after failed blind cannulation for patients in whom catheterisation is likely to be difficult and when complications could be serious. Routine use of ultrasonography has the potential to avoid the first scenario, identify and sort out the second, and prevent the third. Currently it is impossible to identify all patients who are likely to have difficult procedures, and there are no patients in whom complications are not unpleasant and potentially serious.

For all the above reasons ultrasound localisation is likely to become standard practice in central venous access.

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Competing interests: AB has acted as expert adviser to NICE on recent guidelines in this area but did not write the report.

1 Muhm M, Ultrasound guided central venous access. *BMJ* 2002;325:1373-4. (14 December.)
2 National Institute for Clinical Excellence. *NICE technology appraisal guidance No 49: guidance on the use of ultrasound locating devices for placing central venous catheters*. London: NICE, September 2002. www.nice.org.uk/pdf/ultrasound_49_GUIDANCE.pdf (accessed 11 Feb 2003).

NICE has taken sledgehammer to crack nut

Editor—The editorial by Muhm provides logical guidance on the circumstances in which ultrasound localisation should be used for the placement of central venous catheters.[1] It is distinctly different to the guidance recently issued by the National Institute for Clinical Excellence (NICE).[2] Muhm recommends selective use of ultrasound localisation and emphasises that every anaesthetist should be able to place central venous catheters without it.

In contrast, NICE recommends use of ultrasound localisation for all internal jugular catheterisations, except, perversely, in an emergency, when the landmark method is acceptable.

NICE admits that the landmark method is safe in experienced hands.[2] It has concentrated on the "complication" of inadvertent arterial puncture. Ultrasonography does reduce this risk, but it is usually trivial. Pneumothorax is a significant complication, but there is no evidence to imply that the risk of pneumothorax is reduced by ultrasound localisation.

NICE predicts a cost saving of just £2 per case if ultrasound localisation is used, on the basis of a questionable economic analysis.[3] Thus there is no appreciable safety or cost issue to justify the guidance.

NICE has not recommended that ultrasound guidance be used for all subclavian placements of central lines—only that it be considered. Operators may therefore be tempted to use this route if ultrasonography (or someone trained in its use) is not available. This would be a retrograde step. The renal community understands the importance of preserving the subclavian veins for future fistulas for dialysis. The right internal jugular is without doubt the access of choice.

NICE has taken a sledgehammer to crack a nut. It has tackled an issue that did not require its attention. The guidance is impractical and will be widely ignored. In future NICE should restrict its activity to issues of significant patient welfare or cost. NICE should reconsider this guidance at the earliest opportunity.

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Competing interests: None declared.

1 Muhm M, Ultrasound guided central venous access. *BMJ* 2002;325:1373-4. (14 December.)
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Post-marketing surveillance is needed for off licence use of drugs in children

Editor—Sutcliffe's editorial on the issue of testing pharmaceutical products in children addresses a longstanding problem for which there has been much talk but no solution.[1] Although not likely to produce the quality of data that would come from formal trials in children, an alternative approach is to develop a well structured programme of post-marketing surveillance for drugs that are used off licence in children. This could look at both efficacy and side effects.

Pharmaceutical companies have developed some effective methods of post-marketing surveillance and could be asked to help with the development of such a programme. This could be strengthened by involving pharmaceutical services, which could ensure that prescriptions for specified products dispensed for children are registered with a central registry that could cross check with reports from clinicians.

This approach would be less expensive than the alternative formal trials, and it would resolve many of the ethical issues involved, assuming that a clinician has made the decision that prescription off licence is justified for clinical reasons in a particular child.

Paediatricians have an excellent track record in supporting the British Paediatric Surveillance Unit, and I anticipate that they would give equally strong support to a programme of pharmaceutical surveillance if a similar easy to use approach to data collection were developed.

As the cost for this would be comparatively low, the pharmaceutical industry might be prepared to support establishing such a programme through a supplement to the licensing fees for new preparations.

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Competing interests: None declared.

1 Sutcliffe AG. Testing new pharmaceutical products in children. *BMJ* 2002;326:64-5. (11 January.)

Use of nimesulide in Indian children must be stopped

EDITOR—The continuing use of nimesulide for Indian children is shocking.[1] Numerous studies have established the life threatening hepatotoxic effects of nimesulide.[2 3] Nimesulide is not used in the United States, and many European countries have also banned the drug because of its unacceptable rate of serious adverse reactions.

Although some studies have indicated that nimesulide may be chosen for osteoarthritis in selected patients with associated gastric problems, other non-steroidal anti-inflammatory drugs such as acetaminophen (paracetamol) are far better choices as antipyretics or analgesics, especially for children.[4] No rationale exists for selecting nimesulide as the first drug of choice for fever or pain. Published studies from India indicate rampant abuse of nimesulide.[5] At least 12 paediatric preparations of nimesulide are available in India, which affirms the widespread use of the drug in children.[5]

Hardly any dependable post-marketing surveillance for adverse drug reactions is undertaken in India. Moreover, unlike in the West, Indian doctors are not under any real supervision and therefore do not necessarily keep up with the rapidly changing information about adverse effects.[5] Patients receiving nimesulide should be closely monitored for evolving hepatic failure. Indian patients may not follow necessary guidelines, for simple economic reasons. Even if the Indian drug control agencies are reluctant to impose a total ban on nimesulide, they should immediately forbid its use for treatment of fever or pain.

A plethora of scientific data show that nimesulide should not be used as the primary mode of treatment as an antipyretic or analgesic, especially in children, for whom much better and safer choices are available. It will be unfortunate if the Indian government waits for another "committee" report before stopping the use of nimesulide, even for the treatment of pain or fever, and lets more innocent patients suffer needlessly.

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Competing interests: None declared.

1 Kumar S. Drug linked to child death is still available in India. *BMJ* 2003;326:70. (11 January.)
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Artificially giving nutrition and fluids is not one action

EDITOR—The and colleagues' description of decision making for patients with severe dementia who have difficulties in eating and drinking, raises several troubling issues.[1]

Firstly, they implicitly consider tube feeding to be life sustaining. In fact, no credible data show that tube feeding prolongs life in advanced dementia.[2–5] An honest summary of the data is, "We have no good evidence that tube feeding will prolong life, and chances are good your loved one will die soon if we put in a tube." To offer, "We could put in a tube or you can let your loved one starve" is inaccurate and often hurtful.

Secondly, administering nutrition and fluids is treated as a single intervention, one all or nothing decision. Acute, self limited illnesses can stop fluid intake, causing death in days. Providing fluids can prolong life. Unlike dehydration, poor intake of nutrients rarely threatens life acutely, usually occurring in chronic illness. Furthermore, fluids may be replaced orally, subcutaneously, intravenously, or enterally, whereas long term parenteral and enteral nutrition may impose substantial burdens. Nutrition and hydration are very different decisions.

Finally, The et al refer twice to prolonging life "unnecessarily" and twice say that to prolong life would not be beneficial. If an incapacitated patient is allowed to die without life sustaining treatment, something serious and extremely complex has occurred. To say "unnecessary" or "not beneficial" conceals volumes. The true purport is to say the patient would be better off dead. Perhaps The et al used these terms as shorthand, or perhaps doctors and family members are the ones using this shorthand.

Patients nearing death or their carers must often choose between a future that offers longer survival with intensified suffering, or an alternative where comfort and dignity are emphasised instead. Tube feeding in advanced dementia is not such a decision; it neither prolongs survival nor enhances comfort and dignity.

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1 The AM, Pasman R, Onwuteaka-Philipsen B, Ribbe M, van der Wal G. Withholding the artificial administration of fluids and food from elderly patients with dementia: ethnographic study. *BMJ* 2002;325:1326-30. (7 December.)
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Intensivists are becoming gatekeepers to intensive care

EDITOR—Way et al present a brief overview of the major topic of end of life care in intensive care units.[1] The main impact of this review might be to bring the issue to the attention of the general medical community, which may be unaware of the mode of death of most patients in intensive care.

Two interlinked issues were not covered by Way et al. The first is conflict over withdrawing treatment between attending or primary specialists or surgeons (who want "everything done" for "their" patient) and the intensivist. Here, the concept of "futility" has proved to be of little use in decision making. In general, when consensus cannot be achieved full treatment is continued. The message being communicated to the family must be consistent, and there are clear risks of one party trying to manipulate family members to their cause. We insist that the intensivist is present at family interviews with primary specialists and that an agreed approach is used involving clear explanation of the implication of continuing treatment when possible.

The second issue is the increasing use of intensivists as gatekeepers to intensive care, expectedly refusing admission to a patient with clearly no hope of survival whatever is done. More and more frequently we find doctors and surgeons reluctant to deal with the difficult subject of withholding and withdrawing treatment, with their patients and relatives. The intensivist is called and expected to manage the process while the primary specialist retreats to his or her rooms.

The life of the intensivist is at risk of becoming more and more that of a palliative care doctor. This is not the reason most of us entered the specialty. A real need exists in this age of "everything is possible," high technology medicine for all practitioners to engage their patients in meaningful discussions about their expectations for treatment, desired outcomes in terms of quality of life, and wishes in the event they require life sustaining treatment. Once a bed is pushed through the doors of an intensive care unit it is probably too late.

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1 Way J, Back AL, Curtis JR. Withdrawing life support and resolution of conflict with families. *BMJ* 2002;325:1342-5. (7 December.)

Academic boycott of Israel

Academic boycott of Israel is the least we can do

EDITOR—The *BMJ* "deplores" the call to boycott Israeli institutions.[1] I believe that it is a mistake to reject a legitimate means of exerting influence on that state's racist and unlawful treatment of the Palestinian people. Sanctions—economic, sporting, and

academic—were part of the pressure that finally ended the apartheid regime in South Africa. The fragmentation of the West Bank by Israeli settlements is reminiscent of that regime's Bantustan policy and has been condemned as such by veterans of the anti-apartheid struggle, including Desmond Tutu and Ronnie Kasrils.

The *BMJ* has been diligent in reporting from Palestine; the denial of clean water supplies; the doubling of cases of child malnutrition in Gaza because of the Israeli blockade; the World Medical Association's condemnation of harassment of health workers in West Bank and Gaza.[2] The UN has had to call for an end to Israeli "beating and killing" of its staff.[3] Israel's policy of collective punishment and targeting of civilians contravenes the fourth protocol to the Geneva Convention.

What price, then, "the universality of science" when the reality of academic life in the occupied territories is of students and professors being shot at, beaten, and humiliated at roadblocks? In addition, the occupiers have closed the universities[4] and there is documented involvement of Israeli doctors in torture.[5]

Those, including Israeli academics and peace campaigners, who support the academic boycott do not do so on the basis of "citizenship, gender, religion, or colour," as you say; the boycott is specifically focused on official Israeli institutions and those affiliated to them. The arguments used in the *BMJ* are those used in the 1980s to undermine the anti-apartheid boycott of South Africa. They were wrong then, and they are wrong now.

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Competing interests: None declared.

1 Editor's choice. Some politics: against academic boycotts and for cheap drugs. *BMJ* 2003;326:0. (4 January.)
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"No" should not mean indifference

EDITOR—I support the *BMJ* 's position of not supporting an academic boycott of Israel.[1] An academic boycott is an extreme instrument that is justified only in crimes against humanity and when the collusion of the scientific or medical community is clear. South Africa's apartheid system met this test.

The organised medical fraternity was not only silent but even sought to whitewash the participation by doctors in human rights violations such as the murder of Steve Biko. Many scientific journals around the world refused to accept submissions from South Africa, and international academics refused cooperation with South African institutions. The academic boycott undoubtedly contributed to the ultimate demise of apartheid. Deplorable as they are, the Israeli actions have not reached this threshold.

Nevertheless, the *BMJ* 's rejection of the boycott should not translate into indifference about the goings on in the Middle East or the lot of the Palestinians. I do not believe that the *BMJ* should ignore or be studiously silent on political conflicts in the Middle East or elsewhere around the world that portend dire implications for the health of the affected populations.

The *BMJ* should be willing to take political risks and address the health issues of specific (and invariably poor) populations who are victims of political conflict. It should welcome and perhaps even solicit articles on the consequences of the Israeli occupation of the West Bank, the demolition of homes, and the disruption of health services for the health of the Palestinians. Similarly, we should see articles on the effects of other regional conflicts.

The *BMJ* needs to ensure that it is not used as a vehicle for propaganda for whichever side, but it should not shrink from addressing health related ethical issues arising from political conflict, in the Middle East or elsewhere.

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Competing interests: DJN is the editor of the *South African Medical Journal*, serves on the *BMJ* editorial board, and has ties with Israel through family.

1 Editor's choice. Some politics: against academic boycotts and for cheap drugs. *BMJ* 2003;326:0. (4 January.)

Threshold for academic boycotts of apartheid South Africa and apartheid Israel needs clarification

EDITOR—I did not join the academic boycott of Israel while I was director of the UK Cochrane Centre because this would have been inconsistent with my explicit offer of support for people in Israel who want to contribute to the Cochrane Collaboration. When I read editor's choice, however, I thought that the brief reference to the *BMJ* 's rejection of an academic boycott of Israel would be a trailer for a more substantial discussion later in the journal.[1]

I hope that the *BMJ* will actively solicit contributions from the Israelis (Jews and non-Jews) who support an academic boycott of Israel so that readers can understand why these people are prepared to run the considerable personal risks that result from their explicit support of an academic boycott. These contributions are likely to be considerably more enlightening than the cheap and predictable charges of anti-Semitism (reflected in some of the responses you have received[2]) against anyone who calls on the Israeli state to observe its responsibilities as a signatory of the fourth Geneva Convention.

Because Israel is an avowedly Jewish state, it inevitably has apartheid laws and other regulations that discriminate against non-Jews, within the pre-1967 borders, as well as in the territories illegally occupied by Israel. During the apartheid era in South Africa I respected the call from anti-apartheid groups in that country to support an academic boycott and declined repeated invitations to attend meetings there. Some years later Daniel Ncayiyana told me that the academic boycott of South Africa had contributed to the ending of apartheid.

In his letter above Ncayiyana confirms that he is prepared to support academic boycotts in some circumstances, but he judges Israel's actions against the Palestinians not yet to have reached the threshold at which a boycott is justified. Given Nelson Mandela's and Desmond Tutu's public statements on the situation of the Palestinians, I urge Ncayiyana to clarify what more needs to happen to them before he would regard that threshold to have been reached.

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Competing interests: None declared.

1 Editor's choice. Some politics: against academic boycotts and for cheap drugs. *BMJ* 2003;326:0. (4 January.)
2 Electronic responses. Some politics: against academic boycotts and for cheap drugs. bmj.com 2003. bmj.com/cgi/content/full/326/7379/0/g#responses (accessed 11 Mar 2003).

Bureaucracy hinders prompt care

EDITOR—At least one anomaly still exists in the NHS (there may be others). It results from a bureaucratic requirement to follow strict communication pathways. That these are detrimental is shown by the example of an elderly woman who developed sight problems from a detached retina.

She first saw an optician. Immediate treatment was recommended. She was told that a letter would be sent to her general practitioner so that this could be done. An appointment to see an eye specialist was eventually (because of omissions and other factors) arranged and took place nine months later. The patient, aware of long hospital waiting times, accepted the wait philosophically, which partly added to the delay.

It is absurd that trained opticians cannot communicate directly with an eye clinic. If they could the eye would have been treated immediately. A general practitioner receiving an optician's request for further referral is not likely to refuse to make the arrangement. In addition, provided that information flows both ways, the general practitioner will be aware of what is happening if a duplicate of the optician's referral request is added to the patient's notes.

Since the patient is going to be seen at a hospital clinic anyway, it does not alter the clinical load. Delays in treatment do, as well as causing unnecessary suffering and sight loss. The system requires change, and freeing up.

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