Letters

Junior doctors' shifts and sleep deprivation

New on-call rotas do not work

Editor—Clearly the editorial by Murray et al on junior doctors' shifts has struck a chord with many, as on-call rotas are something close to many doctors hearts.[1 2] To most it seems the grass is not greener on the other side.

Having worked most rotas, be it a traditional one in four, with full weekends, to partial, hybrid, and full shift patterns, I am in a reasonable position to comment on what I think makes a liveable on-call rota.

I was under the impression that the European Working Time Directive was set out to improve the health and safety of workers, make working conditions better, but also make life away from work better because doctors would be less tired. The directive scores a "no" against all of these. I find myself more tired at work and at home, less enthusiastic, and less motivated by what is becoming a regular chore. Instead of being on call once a week, I find myself doing an on-call shift two or three times a week (on average), being late home more often than not because fewer juniors are around, and spending less time with my young children.

The "old" rota system of a 24 hour on-call, with at least six on a rota, made on-call shifts less frequent, more tolerable, and even enjoyable. It also left plenty of time for training, and so long as there were six or more on rota, it made the annual leave far more flexible and workable. Anaesthetists rarely complained, certainly compared with other specialties' rotas, and everyone knew that however busy, you were always going to go home to a full day off in the morning.

Why not listen to those doing the rota, and affected family members, and respect within reason what the workers want to work.

Nicholas Akerman *specialist registrar in anaesthetics*
Scarborough Hospital, Scarborough YO12 6QL
nik_lucy@hotmail.com

Competing interests: None declared.

bmj.com

Letters appearing here are an edited selection of rapid responses originally posted on bmj.com

We ask for all letters to the editor to be submitted as rapid responses via bmj.com

For advice see: bmj.com/rapidresponses

1 Murray A, Pounder R, Mather H, Black C. Junior doctors' shifts and sleep deprivation. *BMJ* 2005;330:1404 (18 June.)
2 Rapid responses. Junior doctors' shifts and sleep deprivation. http://bmj.bmjjournals.com/cgi/eletters/330/7505/1404 (accessed 3 Aug 2005).

No easy solution exists

Editor—We found the article by Murray et al and the responses interesting.[1 2] The impact of the new shifts is strongest on training, continuity of patient care, and the safety of doctors and patients. In a six month post, three weeks of night shifts (with almost no training) are followed by three weeks off by way of compensation. This means a 1.5 month (25%) loss of training in every six month period.

Solutions can be tricky, statistical, and complex. A single night shift pattern may not help training or continuity of patient care at all. If you do a night on call you are away from day time work for two consecutive days. If you add all the nights you do in a six month period you lose substantial daytime work (for three weeks of nights in total over a six month period, a period of nearly five to six weeks away).

In addition, this pattern will mean more people away from work. The following day after nights is the preceding day before nights for the doctor who goes to nights after you. So, practically, there will be two people missing every day. With commitments to theatres, clinics, and ward work, these random two away days would help create more confusion. At least a week of nights makes covering arrangements easier.

Solutions are two to three nights at a stretch and the old, 24 hour shift pattern (certainly the best). The real problem is applying the European Working Time Directive to training junior doctors. We know it is not an easy task, but a few modifications to the clauses may help preserve safety of workers (us), and also contribute to training and the maintenance of patient care.

Sashidhar Yeluri *senior house officer, basic surgical training scheme*
Harrogate District Hospital, Harrogate HG2 7SA
sashi_yeluri@yahoo.com

Guneesh Dadayal *foundation year 1 trainee*
Pinderfields General Hospital, Wakefield WF1 4EE

Competing interests: None declared.

1 Murray A, Pounder R, Mather H, Black C. Junior doctors' shifts and sleep deprivation. *BMJ* 2005;330:1404. (18 June.)
2 Rapid responses. Junior doctors' shifts and sleep deprivation. http://bmj.bmjjournals.com/cgi/eletters/330/7505/1404 (accessed 3 Aug 2005).

European directive seems not to apply to doctors' hours in rest of European Union

Editor—The editorial by Murray et al on junior doctors' shifts and sleep deprivation had a predictably large response on bmj.com.[1 2] One important point not made there is that in all the noise about the European Working Time Directive not much attention has been paid to how European doctors have coped.

Countries of the European Union have paid little or no attention to the directive's demands when it comes down to doctors' hours. In most countries they are still exempt. In Brussels I have friends still working the old style 24 hour shifts and coming in the next day to work. Some of them are still expected to cover the Saturday morning ward round when not on call. The result is that training is being preserved. Junior doctors in the UK are doing little but service provision.

John J Atkinson *senior house officer, neonatology*
University College Hospital, London WC1E 6DH
john.atkinson@uclh.nhs.uk

Compteting interests: JJA is a surgical trainee.

1 Murray A, Pounder R, Mather H, Black C. Junior doctors' shifts and sleep deprivation. *BMJ* 2005;330:1404. (18 June.)
2 Rapid responses. Junior doctors' shifts and sleep deprivation. http://bmj.bmjjournals.com/cgi/eletters/330/7505/1404 (accessed 3 Aug 2005).

Pendulum is still swinging

Editor—The editorial by Murray et al on junior doctors' shifts and sleep deprivation shows just how far the pendulum of reduced hours for junior doctors continues to swing.[1] How many of our nursing colleagues, who often work a stretch of seven nights, expect to go for a sleep for two hours during their shift while asking a senior colleague to cover? What other industry pays their workforce to sleep on their night shifts?

Although research on the adverse effects of shift patterns is very welcome, it does not justify special measures solely for the medical profession. It is also disappointing that no mention is made of the impact that reducing rosters to a single night shift would have on the numbers of senior house officers. This proposal results in one less junior doctor at each level every day of the week. What would the impact of this be on patient care?

Andrew Short *consultant paediatrician*
Worcester Royal Infirmary, Worcester WR5 1HN
andrew.short@worcsacute.wmids.nhs.uk

Competing interests: None declared.

1 Murray A, Pounder R, Mather H, Black C. Junior doctors' shifts and sleep deprivation. *BMJ* 2005;330:1404. (18 June.)

"Weeks of nights" give the illusion of working fewer hours

EDITOR—Murray et al present a good argument against the current practice of weeks of nights.[1] However, many managers (and doctors) ask why doctors find even four nights in a row too difficult whereas nurses have managed quite well with a rota that entails a set of consecutive nights. There are two main reasons.

Firstly, nurses have a job with a far more restricted range of activities, even if they are more physically demanding. That is easier to maintain than the more mentally demanding and diverse role of a doctor.

Secondly, most nurses (and some doctors who work shifts in intensive care units, paediatric units, etc) deal with patients in a defined location (one or a few wards) and can therefore familiarise themselves better with the layout, facilities, and colleagues. More importantly, they are more likely to follow up on the same patients that they have seen on previous occasions.

This rota with a week of nights is merely the NHS's way of getting the same work done by the same people to make it look as if they are working fewer hours, a completely illogical concept. It means that at least three junior doctors are missing from their day duties on every weekday except the Friday (when there are six missing) in every hospital in the country. But we plod on.

I hope that those who manage the medical workforce will look carefully at Murray et al's well supported arguments and use them to make the NHS safer for patients and doctors.

Arvindan Veiraiah *specialist registrar clinical pharmacology*
Llandough Hospital, Penarth CF64 2XX
dr_veiraiah@hotmail.com

Competing interests: None declared.

1 Murray A, Pounder R, Mather H, Black C. Junior doctors' shifts and sleep deprivation. *BMJ* 2005;330:1404 (18 June.)

Please make on-call rooms available to doctors at night

EDITOR—The editorial by Murray et al reassured me that senior members of the Royal College of Physicians have concerns for and appreciate junior doctors' hard work.[1 2]

I recently worked nights as a medical registrar at a university hospital in this region and was shocked to see the notice on the door to the on-call rooms, saying that on-call rooms are not provided any more. I had to review every patient seen by the senior house officer and house officer on the medical admissions unit and authorise and endorse transfer of some of these patients to outlier wards (owing to bed crises), therefore taking responsibility for the transfer as well. I also had to drive more than a mile in between outlier wards, at least thrice to the emergency admissions unit, to attend to ill patients and also see the referrals from other specialties. All this was happening amid the couple of resuscitation decisions that were urgently needed on patients in other medical wards.

After everything had been sorted out, at around 5 am, just when I was thinking of taking a 30 minute nap (which has always helped me charge myself up for the next five hours of the 12.5 hour shift), I saw the notice that on-call rooms had been closed.

Might NHS policy makers be persuaded to give doctors a room for half an hour to help us to freshen up? How can I convincingly persuade my juniors to take up general medicine as a career full of variety and challenges? No wonder general medicine has slipped down the priority list in favour of specialist interests, despite remaining in the front line.[2]

George I Varughese *research fellow*
ASCOT Centre, Department of Medicine, University of Birmingham, Birmingham B18 7QH
georgeiv@doctors.org.uk

Competing interests: GIV is a specialist registrar specialist registrar in endocrinology, West Midlands Deanery.

1 Murray A, Pounder R, Mather H, Black C. Junior doctors' shifts and sleep deprivation. *BMJ* 2005;330:1404. (18 June.)
2 Vallance P. A post-take ward round. *J R Soc Med* 2005;98: 191-2.

Hospital formularies restrict evidence based practice

EDITOR—I agree with Maxwell that evidence based prescribing is complex and requires clinical experience, common sense, and some knowledge of clinical pharmacology.[1] The drugs that I can prescribe are governed primarily by a strict hospital formulary and, in some cases, the primary care trust formulary. The formulary often has a limited number of drugs (often only one) that can be prescribed for each class, and the choice is often determined not by evidence but cost per tablet (and not even longer term cost effectiveness). This kind of restriction is often defended by policymakers using the "class effect" argument. The hospital's necessity to slash the drug budget has led to some good drugs being excluded from the formulary, despite their use being supported by class A evidence and national clinical guidelines.

As clinicians, we are encouraged to practice evidence based medicine, and many of us spend hours every week familiarising ourselves with the latest research evidence in our specialties. What is the point of doing this without the power to prescribe the drug that we believe to be the best choice for our patients? Furthermore, why should pharmaceutical companies spend millions of pounds in supporting research and developing new and better drugs when the NHS urges drug formularies to include only those drugs which are the cheapest and not primarily those which are supported by good evidence? What will happen to clinical and prescribing autonomy as medical practice in the United Kingdom moves further towards being purely protocol driven?

If evidence based practice is to thrive or even survive in the NHS, I urge policy makers to reconsider the impact of their ever increasingly restrictive prescribing policy.

Joseph Kwan *specialist registrar in geriatric medicine*
Elderly Care Research Unit, Southampton General Hospital, Southampton SO16 6YD
jk@1to1.org

Competing interests: None declared.

1 Maxwell SRJ. Evidence based prescribing. *BMJ* 2005;331: 247-8. (30 July.)

Withdrawal of co-proxamol

Drug was useful in gastroenterology as well as rheumatology . . .

EDITOR—In his personal view Vaughan describes the loss to rheumatology of the withdrawal of co-proxamol.[1] Gastroenterology is another discipline where the withdrawal will have a negative impact. Patients with functional gastrointestinal disorders, particularly of the constipation predominant variety, are restricted in their choice of analgesic because of the constipating effects of most agents. Even non-steroidal anti-inflammatory drugs are not suitable for this group of patients as they often significantly exacerbate their symptoms. For patients with more severe painful disease co-proxamol was a life line which has often now been replaced by a stronger analgesic.

Co-proxamol was unique in not upsetting the gut. It will be greatly missed by gastroenterologist specialising in abdominal pain.

Peter J Whorwell *professor of medicine and gastroenterology*
Wythenshawe Hospital, Manchester M23 9LT
peter.whorwell@smuht.nwest.nhs.uk

Competing interests: None declared.

1 Vaughan M. The ivory towers are as resilient as ever. *BMJ* 2005;331:299. (30 July.)

. . . and its withdrawal is illogical

EDITOR—Vaughan highlights the impact of withdrawal of co-proxamol on patients with rheumatoid arthritis.[1]

Co-proxamol has been withdrawn because it was the parasuicide drug of choice. As a rheumatologist, I cannot recall any of my patients with arthritis taking overdoses of it: most of them are stoical people who bear their disease with great fortitude and take what little help is available where they can. Co-proxamol was one such helpful agent—not a sexy, modern, or expensive drug but something that helped the pain and was easier to tolerate than the more potent agents.

As a general physician participating in the general medical take in a busy district general hospital, I am also familiar with the stream of distressed, young patients who have taken an overdose of co-proxamol. The contrast between the two groups of patients could not be more striking.

How am I to explain to my older patients with arthritis that a useful painkiller

they have used for years is to be withdrawn because younger folk irresponsibly overdose on it?

I expect that co-codamol or co-dydramol will now become the parasuicide drugs of choice. Both are more dangerous in overdose as they contain 500 mg paracetamol per tablet against co-proxamol's 325 mg. Forty co-codamol tablets is 20 g paracetamol, 40 co-proxamol only 13 g. An overdose of 40 co-codamol tablets is clearly more dangerous.

So not only is this measure being taken against the best interests of the patients for whom the drug is indicated (and supposedly in the interests of a group who don't need it) but it may increase the accidental fatality rate from analgesic overdoses in future.

I fail to see the logic.

Matthew L Grove *consultant rheumatologist*
Tyneside General Hospital, North Shields
NE29 8NH
matthew.grove@northumbria-healthcare.nhs.uk

Competing interests: None declared.

1 Vaughan M. The ivory towers are as resilient as ever. *BMJ* 2005;331:299. (30 July.)

Challenges to implementing NPfIT

Nothing counts except what is in front of the clinician to use

Editor—The clue to the difficulties being encountered in implementing the national programme for information technology (NPfIT) is given in the participants section of the abstract of Hendy et al's article.[1] No mention of the actual users of the system, just assorted panjandrums of greater and lesser degrees of titular magnificence.

The whole edifice teeters on the usability and acceptability of the user interface. The users have got to want to use the system because it is easy and helpful.

The grandness of the vision, the vastness of the expenditure, the shininess of the machines, the detail of the planning, the complexity of the systems, the rightness of the cause, the necessity of modernisation, the face of the sponsoring politicians—none of these things signify if the users' requirements are not met ahead of all other considerations.

Existing paper records are no longer ideal for many reasons, but they did evolve into their present broad form for sound reasons. Heed should be taken of that evolutionary process when devising a digital replacement. The end product should, in appearance and functionality, generally mimic the old familiar systems.

Among the first changes that need to be wrought to NPfIT is the ability to operate the whole system without keyboards. Many clinicians are one or two finger typists, myself among them, and the time taken correcting the spelling, punctuation, grammar, and capitalisation of notes occupies precious minutes. I shudder to think what a court would make of some of the primary school level texting gibberish that passes for computer notes that I have encountered.

Clinicians also need to be able to access several data fields simultaneously, not in sequence.

Nothing counts except what is in front of the clinician in the thick of the action and what can be done with it.

Steven Ford *general practitioner*
Haydon and Allen Valleys Medical Practice, Haydon Bridge, Northumberland NE47 6LA
doctor.ford@virgin.net

Competing interests: SF is subject to daily foaming frustration with the IT systems foisted on us.

1 Hendy J, Reeves BC, Fulop N, Hutchings A, Masseria C. Challenges to implementing the national programme for information technology (NPfIT): a qualitative study. *BMJ* 2005;331:331-6. (6 August.)

Clinicians are becoming increasingly more influential

Editor—In their qualitative study of the challenges to implementing the national programme for information technology (NPfIT) Hendy et al say that "persuading people that 'it will all be worthwhile' is at least as great a challenge as the technical one."[1] They also say that "senior managers responsible for the NPfIT need to ensure that NHS staff see the glass as half full." But half full of what?

In the east of England we are working hard to make sure that the glass contains a grand cru wine rather than plonk.

We recognise that future end users of the system must be intimately involved at the earliest stages of design so that the software not only functions well but also facilitates best working practices to deliver benefits for patients. I am currently devising a process that will enable a broad input from NHS staff into the design of new systems in conjunction with the local service provider. In this way we in this area will have real influence in tailoring new systems. This approach may take a little longer, and it will certainly require more effort, but the end product should be high quality and therefore more easily sold to a sceptical profession.

This is just one example of a change in NPfIT policy, also illustrated by the recent appointment of national clinical champions, whereby clinicians are becoming increasingly more influential on the whole programme. All is not lost.

Tony M Penney *general practitioner*
Linden Medical Group, Kettering NN15 7NX
tony.penney@northants.nhs.uk

Competing interests: TP is currently seconded part time to the East of England NPfIT Cluster team.

1 Hendy J, Reeves BC, Fulop N, Hutchings A, Masseria C. Challenges to implementing the national programme for information technology (NPfIT): a qualitative study. *BMJ* 2005;331:331-6. (6 August.)

Problems are inevitable but goal is worth while

Editor—Many anxieties and frustrations were identified in the small but perceptive study carried out by Hendy et al on the challenges of implementing the national programme for information technology (NPfIT).[1] I am part of the North West and West Midlands Connecting for Health Cluster, where commendable efforts have been made to involve IT staff, managers, and representative clinicians.

Primary care is less problematic as there has been a 15 year programme of investment in generic electronic patient record systems oriented towards multidisciplinary clinical needs. In acute and community care, however, few organisations have invested in generic clinical IT applications. In consequence, the rays of hope generated by NPfIT have given rise to expectations which, because they are undeliverable in the short term, are beginning to sap morale.

Hendy et al conclude that staff may not embrace clinical information technology with enthusiasm. However, frustration has arisen because staff are enthusiastic to use electronic records. Experience in the few places where generic electronic patient record systems have been implemented throughout an enterprise confirms that clinical staff are hungry for this change. The current disquiet derives predominantly from this long desired development remaining tantalisingly beyond their current reach. It may be difficult to persuade those who have built up highly customised departmental systems to move to a generic product, but our local experience in moving from such systems to an enterprise-wide electronic patient record suggests that the benefits of integration and connectivity are quickly seen to outweigh the initially perceived disadvantages of adaptation to a generic format.

Because of the dismal starting point this will no doubt be a long hard road. But, as clearly identified by the Institute of Medicine,[2] it remains the most long overdue reform of health care system likely to deliver widespread improvements in patient care. Connecting for Health needs to hold its nerve but never underestimate the need to communicate with all the NHS staff throughout.

Robert J Young *consultant physician*
Hope Hospital, Salford M6 8HD
bob.young@srht.nhs.uk

Competing interests: None declared.

1 Hendy J, Reeves BC, Fulop N, Hutchings A, Masseria C. Challenges to implementing the national programme for information technology (NPfIT): a qualitative study. BMJ 2005;331:331-6. (6 August.)
2 Institute of Medicine. Crossing the quality chasm: a new health system for the 21st Century (2001).www.nap.edu/execsumm/0309072808.html (accessed 25 Aug 2005).

Computerised medical history is key to connecting health

Editor—Hendy et al suggest that before Connecting for Health can work, its national programme managers will have to improve communication with frontline staff.[1] But there also needs to be an improved approach to communication that connects us as frontline staff with each other and our patients. This can be achieved by producing a computerised medical history.

A computerised medical history can be updated by the last doctor to see the patient to help the next doctor (or any member of the team), who can also update it. It can be created initially from prepared guidelines by

pasting them into the structured medical history, which is quick and allows the clinical management to be checked for errors.[2] It can also be produced automatically in Microsoft Word from general practice computer systems by designing the appropriate database report forms.

A full evidence based computerised medical history outlines the particular diagnostic evidence for a particular patient, followed by an outline of the management, with dates and times.[2 3] The particular evidence in the patient's electronic patient record and the general scientific evidence in the literature could be accessed from the history or its prepared guidelines by using hypertext or other links provided by Connecting for Health.

The patient and members of the multidisciplinary team can see clearly the diagnostic indication for the various treatments and the evidence for the diagnosis. The history can be given to patients and used to explain diagnoses and decisions in a transparent and reassuring way,[3] empowering those who wish to become expert patients. It can reduce the amount of paperwork for doctors and secretaries,[2] and it would be a useful source of information for audit databases and hospital coders. Updating it on the ward reduces the length of inpatient stay,[3] and the evidence based history can also be used to teach diagnostic problem solving.[4]

Computerised medical histories can be introduced now on existing networks without much disruption. They can be attached to the NHS spine and the individual patient's health-space record in future.[5] They are the bridge between traditional medical records and the culture of logical clarity that is needed before information technology systems can work.

Huw Llewelyn *physician*
Whittington Hospital, London N19 5NF
Huw.Llewelyn@whittington.nhs.uk

Competing interests: None declared.

1 Hendy J, Reeves BC, Fulop N, Hutchings A, Masseria C. Challenges to implementing the national programme for information technology (NPfIT): a qualitative study. *BMJ* 2005;331:331-6. (6 August.)
2 Llewelyn DEH, Ewins DL, Horn J, Evans TGR, McGregor AM. Computerised updating of clinical summaries: new opportunities for clinical practice and research? *BMJ* 1988;297:1504-6.
3 Llewelyn H, Chaudhry A, McGibbon V. Professional performance, transparency and the GMC. Electronic response to: Smith R. The GMC: expediency before principle. http://bmj.bmjjournals.com/cgi/eletters/330/7481/1#100104
4 Llewelyn DEH, Ang HA, Lewis K, Al-Abdullah A. *Oxford handbook of clinical diagnosis*. Oxford: Oxford University Press, 2005.
5 Llewelyn H. NHS culture, data protection and freedom of information. Electronic response to: Meredith B. Data protection and freedom of information. http://bmj.bmjjournals.com/cgi/eletters/330/7490/490#104264

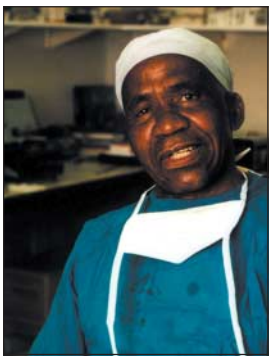
Obituary of Hamilton Naki

See Correction, p 519

Obituary was historically inaccurate

Editor—It is unfortunate that the remarkable life and achievements of Hamilton Naki were so inaccurately reported in the *BMJ*.[1] He did not participate in the first heart transplant, did not ever operate on humans, nor ever work in Groote Schuur Hospital. Christiaan Barnard sequentially performed both historic donor and recipient operations, assisted by four cardiac surgeons.

Hamilton Naki was one of four highly talented technicians in the research laboratory at the medical school. He was a man of great humanity and dignity, and I had the pleasure of working with him at the time of the historic heart transplant. Numerous young surgeons in training spent time in the animal laboratory to perform research—then transplantation of kidneys, hearts, and livers—and to obtain higher research degrees. Hamilton Naki assisted them. In 2003 the university awarded him the degree MMed [honoris causa], citing "Mr Naki assisted with the experimental work that preceded . . . the historic first heart transplant."


TRACE IMAGES

It is distressing that a fiction is gathering momentum and tarnishing the name of a highly talented and good man with an untruth. The suggestion that Hamilton Naki performed the donor operation was never mentioned in life by the man himself, by the department of cardiac surgery, or by the university in his citation for his honorary degree in 2003. It was not mentioned after his death at his family funeral, or at the memorial service in the medical school experimental laboratory. The reason for this: it never happened.

David M Dent *acting dean*
Faculty of Health Sciences, Cape Town 7925, South Africa
DMDENT@uctgsh1.uct.ac.za

Competing interests: None declared.

1 Richmond C. Hamilton Naki. *BMJ* 2005;330:1511. (25 June.)

Author's reply

Editor—When I wrote this obituary I relied on secondary sources because Hamilton Naki and Christiaan Barnard are both dead, and I thought it was unlikely that I could trace any of their former colleagues.

An obituary in the *Economist*, widely respected for the accuracy of its reporting, stated that Naki dissected out the donor heart,[1] and I had no reason to disbelieve it.

Dent says that Hamilton Naki never worked at Groote Schuur. However, in a 1993 BBC interview, Naki talked about his surgical work at Groote Schuur.[2] According to Alastair Leithead, BBC correspondent in Cape Town, "Mr Naki worked his way up to become even more nimble-fingered on the operating table than Professor Barnard himself. His work helped the first heart transplant become a reality and for years after that he passed on those skills to thousands of young surgeons."

Caroline Richmond *obituarist*
London SW3 5AQ
c@roline.demon.co.uk

Competing interests: None declared.

1 Obituary. Hamilton Naki. *Economist* 2005 Jun 11:88.
2 Leithead A. Gardener behind Africa's heart pioneer. *BBC News Online* 2003 May 9.. http://news.bbc.co.uk/1/hi/world/africa/3011105.stm (accessed 21 Aug 2005).

Clarification is certainly needed

Editor—I trust that the *BMJ* is in discussions with the *Economist* to clarify the truth of Hamilton Naki's obituary.[1 2] Hamilton Naki seemed not to be a boastful man, and if this story that he participated in the first heart transplant operation is untrue it seems odd that exaggerations should appear after his death. Pereira's interview hints that Naki did carry out surgery but was still unwilling to talk of it openly.[3]

Mike Ebdy *general practitioner*
Tarleton, Lancashire PR4 6UJ
mike@ebdys.wanadoo.co.uk

Competing interests: None declared.

1 Richmond C. Hamilton Naki. *BMJ* 2005;330:1511. (25 June.)
2 Obituary. Hamilton Naki. *Economist* 2005 Jun 11:88.
3 Pereira E. Transplant gardener. *BMJ* 2004;328(suppl):s98. (Career Focus.) http://careerfocus.bmjjournals.com/cgi/content/full/328/7439/98

Richard Doll's socialism did not please everyone

Editor—There is a splendid obituary of Sir Richard Doll in the *Independent* on Tuesday 26 July by his biographer, Conrad Keating.[1 2] I gather Keating's book will be published shortly.

It describes how Doll, appalled at the poverty in Lambeth, helped organise the St Thomas's Socialist Society. Its existence greatly antagonised the dean of the hospital medical school, who declared that "there could be no such thing as a St Thomas's Socialist Society," as it would alienate the wealthy people whose contributions were essential for keeping the hospital.

On the boat to Cairo during Doll's war service, his friend Archie Cochrane remembered Doll arranging concert parties and organising the singing of "You'll get no promotion on this side of the ocean."

His communism had so antagonised Professor John McMichael at the Hammersmith that he was told after the war, "You'll never work here."

Caroline Richmond *obituarist*
London SW3 5AQ
c@roline.demon.co.uk

Competing interests: None declared.

1 Keating C. Professor Sir Richard Doll. *Independent* 2005 July 26:32-3.
2 Richmond C. Sir Richard Doll. *BMJ* 2005;331:295. (30 July.)