Preference is given to letters commenting on contributions published recently in the JRSM. They should not exceed 300 words and should be typed double spaced

Research on complementary medicine

The paper by Professor Ernst (April 2002 JRSM[1]) is a welcome addition to the debate on complementary/alternative medicine (CAM). However, even if the arguments on methodology and outcome measurement are accepted, the question of application remains. Is the whole spectrum of CAM to be researched or are specific areas to be chosen? Presumably, some justification will be required to gain access to funds and resources to carry out such projects and they will have to compete against other worthy causes. Research is a formalized and sophisticated form of argument, so that one study is seldom sufficient and the most that can be offered by even the best studies is a measure of probability. In addition to this, even seminal research may be overlooked by the 'establishment' for lack of a 'respectable' sponsor. Mendel's work languished for 40 years before it was recognized.

This is not a polemic against research and it would be tragic if research were to be stifled by over-regulation but the assumption implicit in the paper that it is an immaculate and robust creature is unfounded. In the present times every head of a research department is aware of the realpolitik of fund chasing and justifying one's existence. So, what is to be the target of Professor Ernst's methodology? Is it to uncover iatrogenic damage in a branch of CAM such as herbal medicine or is it to disprove the efficacy of all CAM? In the first instance, would not the funds be better allocated to the considerable iatrogenic disease existing in allopathic medicine. In the second instance, such a herculean task would absorb the resources of many research departments and could hardly be justified.

Before applying a scattergun approach to research on CAM it is worth examining the efforts that have been already made in several branches of CAM to institute courses of training and approved qualifications. Unfortunately, there is little effort to distinguish these trained practitioners from the untrained, and if some fault is discovered they are all tarred with the same brush.

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REFERENCE

1 Ernst E. What's the point of rigorous research on complementary/alternative medicine? J R Soc Med 2002;95:211–13

Professor Ernst[1] asks for extra suggestions against applying the rules of science to complementary/alternative medicine (CAM) in addition to the eight arguments he counters. His paper can be likened to a boxing match where he can reasonably claim to have won the first six rounds and to be well ahead on points. His problem though is round 7, 'Science destroys the very nature of CAM, so its application must be opposed'.

The preceding article, by Laugharne and Laugharne[2], shows that there is a fundamental philosophic chasm between the two sides, stronger than argument 7, and which is the hidden agenda behind the other seven arguments. The crux is the whole postmodern rejection of the search for truth and objectivity and its agent science—the distillation of accumulated wisdom and knowledge—to be replaced by individualistic sentiments, distrust of expertise, personalized feelgood morality. This is the reductio ad absurdum of democratization, the replacement of the public good by populism or even fascism.

Ernst is trying to box against opponents who do not recognize the Queensberry rules and who reject the authority of a referee. It will thus end up as a bareknuckle fight, where unless one side lands a knockout punch, the result will be left to the acclamation of the crowd, which I fear is not on Ernst's side. I suggest Ernst throws some low blows in round 7.

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REFERENCES

1 Ernst E. What's the point of rigorous research on complementary medicine? J R Soc Med 2002;95:211–13

2 Laugharne R, Laugharne J. Psychiatry, postmodernism and postnormal science. J R Soc Med 2002;95:207–10

Decline in rehabilitation services

Professor Grahame outlines the decline in rehabilitation services and its possible relation to the increase in disability benefits in the UK (March 2002 JRSM[1]). We agree that often the nearest a rheumatologist gets to rehabilitation is signing a benefits form and that patient care and the specialty may be the poorer for this. However, the phenomenon may have complex origins. The post-war period saw low unemployment levels and there was an expectation that the male of the family would be the breadwinner. With rising unemployment the job market has become more competitive and traditional gender roles have changed, perhaps 'allowing' more males to accept sickness roles. Litigation is more

common and rising benefit claims may support Hadler's view that 'if you have to prove you are ill, you can't get well'[2]. Rheumatology, like other specialties, is becoming more complex and many rheumatologists also have general medical responsibilities; rehabilitation may be an additional and intolerable burden.

The expanding specialty of elderly care may be partly bridging the service gap; in our area the lower age limit for admission to rehabilitation under the elderly-care multidisciplinary team is 18 years, and rheumatology patients, among many others, have greatly benefited from the service. In addition, the National Service Framework for Older People makes specific recommendations regarding the enhancement of access to rehabilitation and makes an attempt to end ageism in the provision of services, which should benefit young and old patients in the future.

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REFERENCES

1 Grahame R. The decline of rehabilitation services and its impact on disability benefits. J R Soc Med 2002;95:114–17

2 Hadler NM. If you have to prove you are ill, you can't get well. The object lesson of fibromyalgia. Spine 1996;21:2397–400

The death of Claudius

Though arguing for a natural death, Mr Marmion and Professor Wiedermann (May 2002 JRSM[1]) concede that no-one can really know whether the Roman Emperor Claudius was poisoned. Their interpretation relies heavily on writings from Lucius Annaeus Seneca, who was banished from Rome for eight years by Claudius and was hardly a disinterested observer. He was brought back from exile to be Nero's tutor, and was forced to commit suicide by Nero in 65 AD. I favour the poison theory myself, on the basis of the texts they mention and the fact that all the other Caesars were assassinated.

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REFERENCE

1 Marmion VJ, Wiedermann TEJ. The death of Claudius. J R Soc Med 2002;95:260–1

Missed outpatient appointments

Dr Murdock and his colleagues (June 2002 JRSM[1]) think that an important reason for the 14% non-attendance rate in their clinics was patient apathy. I found a similar rate in an inner-city general practice, audited as part of my final year studies. Of 7282 patients given appointments in the year to March 2001, 1032 (16%) were either late or did not attend. The average appointment was ten minutes; and, if there was no other useful activity when an appointment was missed, the time lost to the practice in a year would have been 172 hours. The running cost of the practice, excluding prescriptions, was about £20 per appointment. If there are 38 000 general practitioners in the UK and each sees 8000 patients a year, and if we take a conservative non-attendance rate of 10%, the annual loss to the National Health Service comes to over £600 million—to be added to the £300 million wasted on missed hospital outpatient appointments.

The solution proposed by Murdock and colleagues is overbooking—as used by many airline companies and hotels to make up for anticipated non-attendance. The difference is that they are dealing with customers who have already paid for their service directly. I feel a more fruitful way to encourage attendance would be to instigate a system of fines for non-attendance. The fine, which might be £10, could be avoided by cancelling within 24 hours, thereby giving the practice time to find a replacement patient. It is impossible to say how much extra revenue would be generated nationally by the system, since we cannot predict how many people would cancel appointments and how many would pay the penalty. Some other questions would arise—for example, should fines be means-tested? Is £10 too much or too little? How should any such payment be made? Who exactly should coordinate penalty fines? Where should the proceeds go? Should the outpatient department or general practice make 'reminder' phone calls if possible? Should any group of people be exempt (e.g. the homeless)? Should the penalty be increased if not paid promptly (as happens with parking fines)? What form should an appeals system take?

This system of fines would not compromise the ethos of free healthcare at the point of delivery, nor could it be condemned as a 'stealth tax' since the fine is entirely avoidable. Many other institutions impose fines for rule-breaking—for speeding, for late return of library books—and these seem to work. The general public might support the scheme since most people do keep their appointments and are paying through their taxes for those who do not.

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REFERENCE

1 Murdock A, Rodgers C, Lindsay H et al. Why do patients not keep their appointments? Prospective study in a gastroenterology outpatient clinic. J R Soc Med 2002;95:284–6

Revalidation of the retired

As I shall later show, I am very much older than Sir John Rawlins and Dr E N Wardle, but I think that both of them are quite old enough to have discerned the motives for the General Medical Council's (GMC's) assault on retired doctors (May 2002 JRSM[1,2]). The GMC, having betrayed doctors and their patients by conniving in the subordination of the clinical/professional to the managerial ethos, is deeply concerned now to preserve its own existence. Retired doctors are an easy target at which the GMC can aim in order to show the Government its continuing zeal.

Fifteen months ago, I responded to the GMC's request for comment on its paper Revalidating Doctors, putting most of the points now made by Rawlins and Wardle. Of course I received neither reply nor acknowledgment, but in the course of my enquiries I learned that, in spite of previous letters and phone calls, the GMC could not get my address right. Even better: my date of birth was (perhaps still is) recorded as 1 January 1700—for technical reasons, I was later told. This is the quality of body that now proposes to judge us. Quis, as we say in this part of Buckinghamshire, custodiet ipsos custodes. Or, as we used to say in Praed Street, Mit der Dummheit kämpfen Götter selbst vergebens.

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REFERENCES

1 Rawlins J. Revalidation of the retired. J R Soc Med 2002;95:272
2 Wardle EN. Revalidation of the retired. J R Soc Med 2002;95:272

Waiting in the NHS

Dr Devlin and her colleagues (May 2002 JRSM[1]) ask what mechanisms have been used in Dorset to achieve a sustained reduction in waiting times. The answer is many.

First, Dorset is a pleasant part of the country. As a consequence many of the people who chose to live here can afford private health insurance, which takes a load from the NHS. Because it is a nice place to live, there is competition for medical posts leading to the appointment of general practitioners and consultants of very high quality. This has engendered happy relationships between doctors, without feuds that characterize metropolitan health providers and that so impair efficiency. The best managers are also attracted.

Second, numerous large houses, once family hotels, have been converted to private nursing homes, and the availability of these means that relatively few 'bed-blockers' occupy acute medical beds.

Third, the cooperation between the two largest hospitals in Bournemouth and Poole has meant that services can be shared rationally across the county without vain competition. For example, beds for elective orthopaedics are separated from acute trauma. It has thus been possible to avoid wasting money on trying to staff small inadequate units, merely to maintain a presence of that specialty in a district general hospital.

Fourth, the main purchaser has been single-minded in wanting to abolish waiting lists and has spent money wisely to remove bottlenecks, without regard to political dogma. Nevertheless, he has listened to the doctors and always responded to genuine concerns for other parts of the service while not being fooled by 'kite-flying' operations.

Fifth, the whole medical community has been visionary in spotting new developments. For example, cancer services were developed and new oncologists appointed while the new drugs had only numbers and had not yet been named, and before the shortage of trainees in oncology began to bite.

Finally, the relative affluence of the community has made it possible to fund from non-exchequer sources a good deal of capital improvement.

Most of these factors are site-specific; they will not work in Croydon or Workington. But several health authorities with similar populations have been much less successful, and the reason cannot simply be that their beaches are covered with pebbles while ours have seven miles of golden sand.

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REFERENCE

1 Devlin N, Harrison A, Derrett S. Waiting in the NHS: part 1—a diagnosis. J R Soc Med 2002;95:223–6

Public health in the NHS

The May issue of JRSM reports a further debate on public health in the UK[1]. As a chest physician working in Liverpool I am becoming increasingly frustrated by the arguments around public health while my patients and I are

daily subjected to extensive tobacco advertising on our television screens and on enormous billboards all around the city. Any debate on public health reorganization seems completely irrelevant in the face of the overwhelming advertising to which we are still subjected by the tobacco industry.

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REFERENCE

1 Stanwell-Smith RE. More changed against than changing? Public health in the new NHS. J R Soc Med 2002;95:255–6

CORRECTION

Renal cell carcinoma in pregnancy—In this case report by Gladman et al. (April 2002 JRSM[1]), some words were lost from the fifth sentence of the final paragraph. It should read:

> 'When surgery is performed during the first trimester of pregnancy there is an increased risk of miscarriage, and during the third trimester there is an increased risk of preterm labour with its associated problems of fetal prematurity.'

REFERENCE

1 Gladman MA, MacDonald D, Webster JJ, Cook T, Williams G. Renal carcinoma in pregnancy. J R Soc Med 2002;95:199–201

The morning lecture

Ovoid semipellucid discerned discs are there,
like frosted scales on a fish,
with its skin stretched out enormously.
These, in the morning faces of alarmclock awakened students,
their faces semisurrounding me, quasi-expectantly
as if my words may stem some unconscious apparition
of their past, resolve the memory of a dream
or awaken some inkling of the future.
I have for hours been searching for the phrases,
the way in which to convey to them
how and why things should be
distilled from the horrors of what I have seen
what done, what not done, the tears, the memories
of mistakes, and the rare triumphs for which God has acted
and I have taken credit,
and I know I cannot reach them, for it is certain
that they must agonize alone along the way,
as I have done, and reach the solutions by themselves.
And some of my listeners are sensing this,
covering themselves with a veneer of concern,
and others feel this as an unanticipated perception,
and some few show incuriosity, and apathy—
from adolescence and last night's partying
or so I trust—
And I hope that, sometime before the inevitable blight
of a catastrophe,
someone else has forewarned them.

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