# Letters

## Good quality monitoring is crucial for informed choice

Editor—In accordance with the patient choice scheme, all 303 primary care trusts in England were obliged from January 2005 to offer patients a choice of at least two providers for cataract surgery.[1] The scheme allows patients to be involved in how, where, and when they are treated. Providers can be NHS trusts, diagnostic and treatment centres, or independent sector providers from the UK or overseas. By February 2005 13 000 extra operations had already been performed under the independent sector treatment programme.[2] However, concern was raised about variations in clinical safety between different providers.[3]

We sent a postal questionnaire to the leaders of patient choice for each of the primary care trusts in England asking how they monitor the quality of care from their providers. The table shows the replies from 125 trusts.

The quality monitoring of providers by primary care trusts is poorly structured and variable. Who then should monitor standards and what variables should they use? Traditionally, NHS providers have used audit and clinical governance to measure their performance. Should it now be the role of the Strategic Health Authority, the provider, or the purchaser in the form of primary care trusts to monitor the product offered to the patient?

Information technology exists to collect accurate data about adverse events in addition to visual acuity and refractive outcomes. The public expect that safe cataract care should be commissioned for them,[4] and robust methods of monitoring need to be agreed and implemented so that patients can make a truly informed choice. These decisions need to be made not only for cataract surgery but also for other elective procedures that will increasingly be made available to patients through the patient choice scheme.

How 125 primary care trusts monitor providers' quality of cataract surgery

| Quality variable stated | No of primary care trusts |
|---|---|
| Non-specific and service level agreements | 33 |
| Patient questionnaires and feedback | 36 |
| Audit | 24 |
| Don't know | 15 |
| None | 3 |
| Outcome | |
| Non-specific | 11 |
| Postoperative refraction | 2 |
| Visual acuity | 1 |
| Reporting by GPs | 4 |
| Optometry reporting | 5 |
| Infection rate | 2 |
| Complaints | 7 |
| Cancelled operations | 2 |
| Complications | 2 |
| Waiting times | 1 |
| Cooperation of provider | 1 |

GPs=general practitioners.

**Paul R Brogden** *specialist registrar ophthalmology*
paul@paulbrogden.freeserve.co.uk
**Ian G Simmons** *consultant ophthalmologist*
Department of Ophthalmology, Leeds Teaching Hospitals NHS Trust, St James's University Hospital, Leeds LS9 7TF

Competing interests: None declared.

1 Department of Health. *Choose and book—patient's choice of hospital and booked appointment.* London: DoH, 2004.
2 More choice for cataract patients. NHS England news archive Feb 2005. www.nhs.uk/england/news/article.aspx?newsID=17499 (accessed 6 Jan 2006).
3 Kelly SP, Mathews D, Mathews J, Vail A. Reflective consideration of postoperative endophthalmitis as a quality marker. *Eye* advance online publication 13 July 2005; doi: 10.1038/sj.eye.6701996.
4 Kelly SP, Astbury NJ. Patient safety in cataract surgery. *Eye* advanced online publication 1 July 2005;doi:10.1038/sj.eye.6701987.

## Deficiencies in rehabilitation after traumatic brain injury

Editor—Fleminger and Ponsford in their editorial on long term outcome after traumatic brain injury highlight the need for more attention to be paid to neuropsychiatric functioning.[1] The authors say that early assessments after injury concentrate more on physical disability than cognition.

Our experience is that neither is tackled adequately. In 2000 we set up the Eastern Region Head Injury Study Group to quantify the requirements of patients with traumatic brain injury. This has identified major deficiencies in the rehabilitation of these patients with absolutely no provision for rapid assess rehabilitation in the east of England.[2] The tendency for patients being left to languish on general medical, surgical, and orthopaedic wards continues to their detriment and to the detriment of those requiring admission to acute district general hospital beds. In a six month period, 37 patients with major head injury were transferred back from the regional neurosurgical unit to inappropriate district general hospital beds and within the regional neurosurgical unit, 1500 bed days were occupied by patients who were appropriate for acute rehabilitation.[3]

Furthermore, this represents the needs of severely injured patients. The rehabilitation needs of the much larger cohort of moderately injured patients in our region is currently unknown. We support the arguments of Fleminger and Ponsford, but neuropsychiatry sequelae are only a small component of the much larger problem of physical, cognitive, and vocational rehabilitation. We anxiously await the deliberations of the implementation group for the national service framework for long term conditions.

**Peter J Hutchinson** *senior academy fellow*
pjah2@cam.ac.uk
**John D Pickard** *professor of neurosurgery*
Department of Clinical Neurosciences, University of Cambridge, Addenbrooke's Hospital, Cambridge CB2 2QQ

Competing interests: None declared.

1 Fleminger S, Ponsford J. Long term outcome after traumatic brain injury. *BMJ* 2005;331:1419-20. (17 December.)
2 Pickard JD, Seeley HM, Kirker SG, Maimaris C, McGlashan K, Roels E, et al. Mapping rehabilitation resources for head injury. *J R Soc Med* 2004;97:384-9.
3 Bradley LJ, Kirker SG, Corteen E, Seeley HM, Pickard JD, Hutchinson PJ. Acute neurosurgical bed occupancy and rapid access rehabilitation. *Br J Neurosurg* (in press).

## Mental health legislation and decision making capacity

### Autonomy in Alzheimer's disease is ignored and neglected

Editor—Doyal and Sheather and the accompanying commentaries raise important issues,[1] but they do not mention one of the most striking inequalities in current mental health and capacity legislation.

If someone with schizophrenia is admitted against his or her will, three independent recommendations are required, and the person has access to legal representation and at least two rights of appeal—this for a 28 day admission. However, if an inpatient with mild to moderate Alzheimer's disease wishes to return home but is thought to be at risk, he or she can be judged to be lacking capacity by a single medical opinion and transferred to an institutional facility "in their best interests," with little chance of being able to leave and little or no access to appeal.

Protecting the autonomy of people with dementia does not attract much attention, although there may be uneasiness that things are not right. Conflicts of interest exist at every level. Secondary care services

wish to avoid blame arising from adverse outcomes (and institutional placement is seen to be a "safe" option, although morbidity and mortality in people admitted against their will are not known). Families may have similar but perhaps less conscious concerns, and charitable agencies exist to support caregivers as well as people with dementia. Old age psychiatrists dread the prospect of legal checks on compulsory admission to institutional care for people with dementia because existing clinical services would be overwhelmed.

Furthermore, many would say that capacity assessment in dementia is not a core duty of psychiatrists but should be carried out by the supervising team, therefore removing any opportunity for independent assessment. The 2005 Mental Capacity Act acknowledges the issue of advocacy, but independent services are to be provided only for people with no identifiable next of kin (regardless of whether they wish the next of kin to act on their behalf).

In practice many people with dementia are admitted permanently against their will to institutional facilities because of pressure from families and on the say so of a single doctor. This is strongly reminiscent of what used to be the case for asylum inmates. And wasn't that what mental health legislation was all about in the first place?

**Robert Stewart** *consultant in liaison old age psychiatry*
Institute of Psychiatry, King's College London, London SE5 8AF
r.stewart@iop.kcl.ac.uk

Competing interests: None declared.

1 Doyal L, Sheather J. Mental health legislation should respect decision making capacity [with commentaries by D Chiswick and D Crepaz-Keay]. *BMJ* 2005;331:1467-71. (17 December.)

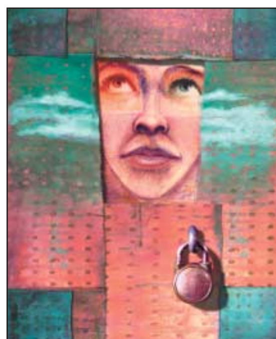
### Capacity is more complex than it looks

Editor—We agree with Doyal and Sheather that mental health legislation should respect decision making capacity because patients with a mental disorder should not be discriminated against.[1] The current legal test of capacity and the criteria of capacity in the forthcoming mental capacity act in England and Wales largely focus on the intellectual and cognitive abilities of the patient. This legal concept is insensitive to some of the subtle and complex ways in which mental disorders can affect capacity.

Our ongoing research in anorexia nervosa implies that there are difficulties in using the current criteria of capacity to determine whether compulsory treatment should be used in this disorder. These current legal criteria fail to capture the range of complex difficulties affecting decision making, such as shifts in values and changes in the sense of personal identity.[2 3]

Patients themselves support the use of compulsory treatment, particularly to save life, despite finding the experience painful.[4] However, capacity is not the main factor in determining whether patients feel they benefit from compulsory treatment. Instead, respect from and trust in professionals and the context are all important in determining whether compulsory treatment is experienced as helpful and appropriate.[4 5]

If capacity in its current form were to be introduced into mental health legislation, problems would be encountered when it is applied to some mental disorders. When the current notion of capacity is used to determine whether to apply compulsory treatment, some patients who have real difficulties with making treatment decisions may be falsely judged as possessing capacity. A capacity based act may leave such patients at risk of "dying with their rights on."



**Jacinta O A Tan** *Wellcome Trust Research fellow*
jacinta.tan@ethox.ox.ac.uk
**Tony Hope** *professor of medical ethics*
Ethox Centre, University of Oxford, Oxford OX3 7LF

Competing interests: None declared.

1 Doyal L, Sheather J. Mental health legislation should respect decision making capacity [with commentaries by D Chiswick and D Crepaz-Keay]. *BMJ* 2005;331:1467-71. (17 December.)
2 Tan J, Hope T, Stewart A. Competence to refuse treatment in anorexia nervosa. *Int J Law Psychiatry* 2003;26:697-707.
3 Tan JO, Hope T, Stewart A. Anorexia nervosa and personal identity: The accounts of patients and their parents. *Int J Law Psychiatry* 2003;26:533-48.
4 Tan JO, Hope T, Stewart A, Fitzpatrick R. Control and compulsory treatment in anorexia nervosa: the views of patients and parents. *Int J Law Psychiatry* 2003;26:627-45.
5 Tan JOA, Hope T, Stewart A, Fitzpatrick R. Competence to make treatment decisions in anorexia nervosa: thinking processes and values. *Philosophy, Psychology and Psychiatry* (in press).

### Capacity is of more than practical benefit

Editor—Doyal and Sheather's suggestion to base mental health legislation on capacity is bold and timely, but Chiswick's commentary misses the point.[1] Freedom to choose assumes the ability to make choices, or autonomy and decision making capacity are synonymous. The principle of autonomy is enshrined as the highest possible biomedical principle, trumping all others.[2]

Common law allows enforced treatment only because in certain situations patients are considered to have lost decision making ability, and therefore autonomy, by virtue of their physical illness. For reasons that are never explained, this important ethical principle is not extended to people with mental illness. To add to the moral confusion, most mental health professionals justify the detention of patients with mental illness by using similar arguments to that used in common law,[3] while opposing the incorporation of these principles into formal mental health legislation.

Doctors are locked into a diagnostic paradigm that the concept of capacity does not conform to. We assume that diagnosis is scientific and "precise," but in reality, diagnosis is more of an evaluative concept than we dare admit.[4] With this in mind, the concept of capacity is not as vague or muddled as Chiswick supposes. Compared with the conveniently vague criteria used to detain individuals under section 2 of the current Mental Health Act, the criteria used to judge decision making capacity are laser-like in their precision.

Instead of asking what the concept of capacity can add to the existing criteria for detention, Chiswick needs to ask what concepts such as diagnosis and risk have to add to the central plank of capacity. If someone's mental illness causes him or her to lose decision making capacity the way forward is clear; but then this makes diagnosis virtually redundant. Conversely, would Chiswick really be comfortable detaining a patient who has clearly understood and made an autonomous decision about his treatment, just because he happens to have a psychiatric diagnosis?

The current attempts to reform the Mental Health Act are an opportunity to make legislation fairer and more logical. It would be a pity to pass up such an opportunity.

**Brian J Murray** *consultant psychiatrist, older adult*
John Hampden Unit, Stoke Mandeville Hospital, Aylesbury HP21 8AL
brian.murray@bmh.nhs.uk

Competing interests: None declared.

1 Doyal L, Sheather J. Mental health legislation should respect decision making capacity [with commentaries by D Chiswick and D Crepaz-Keay]. *BMJ* 2005;331:1467-71. (17 December.)
2 Beauchamp T, Childress J. *Principles of biomedical ethics*. 2nd ed. Oxford: Oxford University Press, 1983.
3 Bartlett P, Sandland R. *Mental health law: policy and practice*. Oxford: Oxford University Press, 2003.
4 Fulford KM. Analytic philosophy, brain science, and the concept of disorder. In: Bloch S, Chodoff P, Green SA. *Psychiatric ethics*. 3rd ed. New York: Oxford University Press, 1999.

## HIV/AIDS is still a double sentence in prisons

Editor—The news that a prisoner dying of AIDS in South Africa was released to be with his family in his last few days is welcome but a grim reminder that living with HIV/AIDS, and many other chronic illnesses, in prisons is still a double sentence for prisoners in many parts of the world.[1]

The Joint United Nations Programme on HIV/AIDS (UNAIDS), the organisation mandated by the global league of nations to spearhead and coordinate the response to the pandemic, has repeatedly called for equity of HIV/AIDS services between people in prisons and people outside.[2] In Zambia, a recent report from prison headquarters reported that in 2004 alone some 449 inmates died of AIDS related illnesses.[3]

The report lamented the high rates of infectious diseases in the country's prisons owing to congestion and the poor hygiene in most prisons. The exact number of inmates with HIV/AIDS in Zambian prisons

is not known, although we found in 1998-9 an HIV seroprevalance rate of 27% compared with the then national average of about 19%. The main risk behaviours found included tattooing and sex between men, and 15% of inmates had a positive serological test for sexually transmitted infections.[4] No condoms are distributed in the country's jails, and as a precaution tattooing has been discouraged. Only a few prisoners with HIV/AIDS are currently receiving antiretroviral treatment.

Given this background, standard HIV/AIDS services, backed by an aggressive campaign to improve living conditions in prisons, are urgently needed in Zambia and other countries affected by the AIDS pandemic. These services must be equivalent to those found outside and should include counselling services as well as access to antiretroviral treatments.

**Oscar Ozmund Simooya** *medical officer*
cbumed@zamnet.zm

**Nawa Sanjobo** *senior clinical officer*
Copperbelt University, PO Box 21692, Kitwe, Zambia

Competing interests: None declared.

1 Sidley P. Prisoner with AIDS released to die at home. *BMJ* 2005; 331:1246. (17 December.)
2 Joint United Nations Programme on HIV/AIDS (UNAIDS). *Prisons and AIDS: UNAIDS point of view.* Geneva: UNAIDS, 1997.
3 Commissioner of Prisons. Speech to HIV/AIDS workshop on home based care, Kamfinsa Prison, Kitwe, Zambia, 21 March 2005.
4 Simooya OO, Sanjobo N, Sijumbila G, Kaetano L, Musonda R, Mukonze F, et al. "Behind walls": a study of HIV risk behaviours and seroprevalance in prisons in Zambia. *AIDS* 2001;15:1741-4.

## UK experience of smoke-free young offenders institute

Editor—Lincoln et al report the US experience of smoke-free prisons.[1] We report experience in Ashfield Young Offenders Institute, a prison in South Gloucestershire which accepts remand and sentenced young people between the ages of 15 and 18. Ashfield introduced a smoke-free policy on 1 February 2005. Smoking is not permitted in the prison by young offenders or staff, and all tobacco related products are banned.

Prison staff were trained by the NHS stop smoking service of South Gloucestershire Primary Care Trust to give smoking cessation advice to staff and young offenders. Some staff received support from their general practice. The prison offered to pay for nicotine replacement patches. Staff are able to use patches and nicotine lozenges in the prison.

Staff who continue to smoke have the opportunity to go outside the prison during their breaks, but this option is not available to staff who are working the night shift.

The response from staff has been mixed. Some staff welcomed the change, including some smokers, because it has provided an impetus to stop smoking.

The offenders threatened to cause disruption, but this did not materialise. Minor altercations between young offenders increased about a month after the policy was introduced, which may have been related to many of them experiencing withdrawal from nicotine. In contrast to 27 fires in the first 10 months of the previous year,[2] only one minor fire has occurred in the prison since the smoke-free policy was introduced.

Notable differences exist between juvenile and adult prisons with regard to greater challenges in stopping smoking and the length of detention, but our results should encourage other prisons to provide some smoke-free environments for prisoners and staff.

**Ruth R Kipping** *public health specialist trainee*
rrkipping@yahoo.co.uk

**June Martin** *smoking cessation and tobacco control coordinator*
South Gloucestershire Primary Care Trust, Bristol BS16 7FH

**Lee Barnes** *deputy director*
Ashfield Young Offenders Institute, Bristol BS16 9QJ

Competing interests: None declared.

1 Lincoln T, Chavez RS, Langmore-Avila E. US experience of smoke-free prisons. *BMJ* 2005;331:1473. (17 December.)
2 House of Commons. Hansard written answers for 7 Dec (pt 2). Prisons (Fires) 7 Dec 2004 : Column 411W. www.publications.parliament.uk/pa/cm200405/cmhansrd/cm041207/text/41207w02.htm (accessed 5 Jan 2006).

## How Islam changed medicine

### Ibn al-Haytham and optics

Editor—Majeed elaborated on the role of Muslim physicians and scholars in modern medicine and mentioned the contributions of various Arab doctors during the middle ages.[1] Here is a contribution to optics.

Ibn al-Haytham (known to the West as Alhacen or Alhazen) lived from 965 to about 1040. He was a distinguished mathematician, astronomer, and philosopher of his time, and he became known in Europe as the author of a monumental book on optics, *Kitab al-Manazir* (translated into Latin as *De Perspectiva* or *De Aspectibus*[2] and partly translated into English as *The Optics*[3]). Ibn al-Haytham described in detail the various parts of the eye and introduced the idea that objects are seen by rays of light emanating from the objects and not the eyes, as was popularly believed at the time, following Ptolemy's and Euclid's theory of vision. "Sight perceives the light and colour existing on the surface of the contemplated object . . . Vision perceives necessarily all the objects through supposed straight lines that spread themselves between the object and the central point of the sight."[4]

He also discovered the laws of refraction and carried experiments on the passage of light through various media and the dispersion of light into its constituent colours. He wrote about optical illusions, spherical and parabolic mirrors, shadows, and eclipses. Because of his contribution in optics, many regard him as "the father of optics."[5]

**Mohammad T Masoud** *senior house officer, ophthalmology*
Stirling Royal Infirmary, Stirling FK8 1LU
seham_tm@hotmail.com

**Faiza Masoud** *senior house officer, gastroenterology*
Ayub Teaching Hospital, Abbottabad, Pakistan

Competing interests: None declared.

1 Majeed A. How Islam changed medicine. *BMJ* 2005;331:1486-7. (24-31 December.)
2 Gonzalez V. *Universality and modernity of Ibn al-Haytham's thought and science.* London: Institute of Ismaili Studies, 2002. www.iis.ac.uk/learning/life_long_learning/universality_modernity/universality_modernity.htm (accessed 25 Dec 2005).
3 Sabra AI. *The optics of Ibn al-Haytham.* London: Warburg Institute, 1989.
4 Vilchez JMP. *Historia del pensamiento estetico arabe: Al-Andalus y la estetica arabe clasica.* Madrid: Ediciones Akal: 689-90.
5 Islam Online. Ibn Al Haytham. 16 June 2004. www.islamonline.com/cgi-bin/news_service/profile_story.asp?service_id=743 (accessed 25 Dec 2005).

### Ibn Sina (Avicenna) saw medicine and surgery as one

Editor—In the second Al Hammadi lecture at the St Andrew's Day symposium on therapeutics at the Royal College of Physicians of Edinburgh in 2002, I contrasted Ibn Sina's *Canon of Medicine*, written about 1012, with Osler's *Principles and Practice of Medicine* (1892).[1-3]

Both books have about the same bulk. I asked: "If the year were 1900 and you were marooned and in need of a guide for practical medicine, which book would you want by your side?" My choice was Ibn Sina. A leading reason is that Ibn Sina gives an integrated view of surgery and medicine, whereas Osler largely shuns intervention. Ibn Sina, for example, tells how to judge the margin of healthy tissue to take with an amputation, a basic topic uncovered by Osler. The gap between medicine and surgery is now closing, with the advent of interventional cardiology, gastroenterology, radiology, etc. Ibn Sina correctly saw medicine and surgery as one.

**John Urquhart** *professor of biopharmaceutical sciences, University of California at San Francisco*
Palo Alto, CA 94301 USA
urquhart@ix.netcom.com

Competing interests: None declared.

1 Majeed A. How Islam changed medicine. *BMJ* 2005;331:1486-7. (24-31 December.)
2 Avicenna (Abu Ali al-Husayn ibn Abd Allah ibn Sina). *The canon of medicine (al-Quanun fi'l-tibb).* Adapted by L Bakhtiar. Chicago: KAZI Publications, 1999.
3 Osler W. *The principles and practice of medicine, designed for the use of practitioners and students of medicine.* New York: Appleton, 1892.

### Al-Nafis, Servetus, and Colombo

Editor—Majeed comments that Al-Nafis described the pulmonary circulation more than 300 years before William Harvey.[1] Harvey always gets the credit in the West, but I would like to remind readers that Michael Servetus was the first Western writer to describe the pulmonary circulation, in *Christianismi Restitutio* in 1552, finally printed a year before he was burnt at the stake in Geneva.[2] Lomas points this out in his article in the same issue of the *BMJ*.[3]

Colombo (1516-59) can also lay claim to having made the discovery, in *De re anatomica* (completed in 1559). It would

seem that all three men made the same discovery independently, and for different reasons. Al-Nafis realised the interventricular septum was too thick to allow blood to pass across. Colombo noticed the large blood flow of the pulmonary vein. Servetus realised the importance of the size of the pulmonary artery. Al-Nafis was first, but none developed an understanding to include the concept of a systemic circulation. That was indeed Harvey's discovery.

**Giles N Cattermole** *specialist registrar, emergency medicine*
University Hospital of Wales, Cardiff CF14 4XW
cattermole@doctors.org.uk

Competing interests: None declared.

1 Majeed A. How Islam changed medicine. *BMJ* 2005;331:1486-7. (24-31 December.)
2 Cattermole G. Michael Servetus: physician, Socinian and victim. *J R Soc Med* 1997;90:640-644.
3 Lomas D. Painting the history of cardiology. *BMJ* 2005;331:1533-5. (24-31 December.)

## Disappearing teaspoons

### French data indicate global phenomenon

Editor—I read with interest the longitudinal cohort study of the displacement of teaspoons in an Australian research institute reported by Lim et al.[1]

In France, the tea ritual is not as widespread as in English speaking countries, but spoons are also used during conventional meals. Unpublished data obtained in our hospital located near Paris show that in the first five months of 2001, some 1800 spoons disappeared during lunchtime from the workplace cafeteria, which is attended by about 550 employees. These disappearances occurred despite (or because) of the fact that 6000 spoons had been purchased the previous year.

Lim et al may be right when they postulate that spoon disappearance may implicate the whole planet. Measures against the loss of (tea)spoons may be not only a national but a global priority.

**Bertrand Herer** *physician*
Centre de Forcilles, 77150 Férolles-Attilly, France
herer@forcilles.com

Competing interests: None declared.

1 Lim MSC, Hellard ME, Aitken CK. The case of the disappearing teaspoons: longitudinal cohort study of the displacement of teaspoons in an Australian research institute. *BMJ* 2005;331:1498-500. (24-31 December.)

### Teabags and forks are confounding factors

Editor—The valuable piece of research by Lim et al will be circulated as urgent reading around my primary care trust, where institutional attrition of teaspoons may be a factor in the ongoing financial crisis for the NHS.[1]

However, I suggest that the research team consider using a parallel supply of marked "forks" as well as teaspoons and monitor attritional loss again in a more in-depth study across a range of healthcare institutions. In England, where tea drinking often exceeds use of instant coffee in institutions, in the absence of available teaspoons (or clean spoons) tea drinkers will often use a fork to remove the teabag from their cup during the preparation of the beverage. This obviously is not an option available to coffee drinkers; one would therefore suspect that tearooms where coffee drinkers predominate would experience a higher rate of spoon loss. Therefore, a potential confounding factor in the study is the ratio of instant coffee drinkers to tea drinkers in each room. Including a parallel cohort of marked forks would allow this phenomenon to be monitored. Of course, any consumption of birthday cake during the monitoring period may lead to a rapid loss of forks, so birthday celebrations, etc will need to be adjusted for.

**Alan A Woodall** *specialist registrar public health medicine*
Telford Primary Care Trust, Somerfield House, Telford TF1 5RY
woodall@doctors.org.uk

Competing interests: AAW had a hoard of three teaspoons and two mugs on his desk on 23 December 2005.

1 Lim MSC, Hellard ME, Aitken CK. The case of the disappearing teaspoons: longitudinal cohort study of the displacement of teaspoons in an Australian research institute. *BMJ* 2005;331:1498-500. (24-31 December.)

### Method of spoon surveillance was not adequate

Editor—I am not convinced that the method of spoon surveillance used by Lim et al (scanning desktops and other immediately visible surfaces) is entirely adequate.[1]

Not unlike the errant single socks cited by multiple other respondents on bmj.com,[2] teaspoons are unlikely to remain on immediately visible surfaces. Inevitable entropy aside, the teaspoon is a uniquely versatile implement (a search on www.google.com of "teaspoon" (30 December 2005, 1746 eastern standard time (EST)) yielded 7.2 million results; a search of "use a teaspoon" (quotes included) 15 700 (30 December 2005, 1748 hrs EST)).

Teaspoons in my own department are used to prop open doors, pry open file cabinets, and strategically position mousetraps in that annoyingly narrow space between the refrigerator and the wall. Scanning only visible surfaces may well result in undercounting of remaining spoons, or in counting only those utensils still used for stirring.

As it is unclear what exactly constitutes a teaspoon,[3] can we be certain the authors started with teaspoons at all?

**David A Silver** *fellow in cardiothoracic and intensive care anaesthesia*
Brigham and Women's Hospital, Boston, MA 02115, USA
dsilver1@partners.org

Competing interests: DAS pours coffee into a cup already containing milk, which obviates the need for stirring.

1 Lim MSC, Hellard ME, Aitken CK. The case of the disappearing teaspoons: longitudinal cohort study of the displacement of teaspoons in an Australian research institute. *BMJ* 2005;331:1498-500. (24-31 December.)
2 Electronic responses. The case of the disappearing teaspoons. http://bmj.bmjjournals.com/cgi/eletters/331/7531/1498 (accessed 6 Jan 2006).
3 Deodands. Turing, Fibonacci phyllotaxis, neutron teaspoons and me. The nonneutron teaspoon. www.swintons.net/deodands/archives/000077.html (accessed 30 December 2005, 1741 EST).

### Teaspoons may reappear

Editor—The paper by Lim et al has not taken account of the fact that teaspoons may reappear.[1] What steps were taken in this study to identify individuals? It is our experience in this institution that teaspoons regularly go on awaydays, when there are, of course, no teaspoons available in the office at all, but they then return, and a full cohort may be available and ready for use in a couple of days' time. Clearly, if teaspoons are replaced during the short absence of an awayday, they will feel under no obligation to return. This may invalidate the findings of this paper on number needed to keep an institution supplied.

**Katherine Darton** *information officer*
Mind, London E15 4BQ
k.darton@mind.org.uk

Competing interests: None declared.

1 Lim MSC, Hellard ME, Aitken CK. The case of the disappearing teaspoons: longitudinal cohort study of the displacement of teaspoons in an Australian research institute. *BMJ* 2005;331:1498-500. (24-31 December.)

### Spoon solutions

Editor—To solve the problem of disappearing spoons reported by Lee et al,[1] I would like to introduce the authors to the recently developed chaotic randomly uniform muddled botch-up system (CRUMBS), by which it is predicted that immobilisation and non-provision are the two possible ways of dealing with the matter.

The first solution, immobilisation, may be achieved by using chained teaspoons (analogous to the chained bibles of the Middle Ages), where a large chain with thick links attaches the spoon to a strongly mounted wall bracket. Non-provision solves the problem by not supplying teaspoons, forcing staff to bring their own, which they are more likely to protect than institutional spoons.

I hope this is helpful.

**Trevor Watts** *consultant in periodontology*
King's College London Dental Institute at Guy's, King's and St Thomas's Hospitals, London SE1 9RT
trevor.watts@kcl.ac.uk

Competing interests: TW keeps his teaspoon in a locked drawer in his office. He is thinking of starting a business in the supply of chained teaspoons.

1 Lim MSC, Hellard ME, Aitken CK. The case of the disappearing teaspoons: longitudinal cohort study of the displacement of teaspoons in an Australian research institute. *BMJ* 2005;331:1498-500. (24-31 December.)

bmj.com

*We select the letters for these pages from the rapid responses posted on bmj.com within five days of publication of the article to which they refer.*

*Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.*