Letters

Partial smoking ban would worsen health inequalities

EDITOR—Several studies have shown that in small areas—such as across a local authority—a partial smoking ban would be likely to increase health inequalities. We present what we believe is the first evidence that this is indeed the case across England as a whole.

We generated a random sample of 500 pubs from a national commercial database of 36 586 English pubs, bars, and inns (Thomson directory) and referenced each pub's postcode to its index of multiple deprivation (IMD) score.[1] We telephoned each pub in our sample and asked whether it served hot food.

Our power calculation showed that a sample size of 500 would permit us to contrast any two fifths of deprivation. IMD scores for England are based on an exponential scale, so we log transformed this variable for analysis.

We used a *t* test to test the hypothesis that pubs serving hot food had the same deprivation scores as those not serving food, and repeated this analysis after excluding all town centre pubs.[2] This was to deal with the possibility that town centre pubs may serve a wider population than their immediate vicinity.

We obtained a response from 483 (96.6%) of the pubs (table).

Relation of deprivation to food availability

Deprivation fifth	No of pubs	No (%) serving hot food
1 (least deprived)	99	87 (88)
2	99	80 (80)
3	98	69 (70)
4	97	60 (62)
5 (most deprived)	90	41 (46)
Total	483	337 (70)

Pubs that serve hot food have lower IMD scores than those that do not ($t = -6.07$, difference in mean log IMD score −0.35, 95% confidence interval −0.47 to −0.24; $P < 0.0001$). This remains significant when pubs in town centres are excluded ($n = 382$; $t = -5.99$, difference in mean log IMD score −0.42, −0.56 to −0.28; $P < 0.0001$).

Our nationwide study confirms that the proposed partial smoking ban is set to exacerbate health inequalities from smoking andsecondhand smoke, through a disproportionate increase in the number of smoke free pubs in affluent areas of England.

Geraint H Lewis *specialist registrar in public health*
geraint.lewis@nhs.net
David C Osborne *specialist registrar in public health*
Tim J B Crayford *director of public health*
Department of Public Health, Croydon PCT, Leon House, Croydon CR0 9XT

Adrian C Brown *specialist registrar in public health*
South-East London Strategic Health Authority, London SE1 7NT

Competing interests: None declared.

1 Office of the Deputy Prime Minister. *The English indices of deprivation (revised).* London: ODPM, 2002.
2 Office of the Deputy Prime Minister. *Town centre boundaries and statistics for England and Wales—2002.* London: OPDM, 2002.

Sex workers to pay the price

Prostitution strategy is a missed opportunity

EDITOR—The safety of sex workers in prostitution as well as the neighbourhoods where it takes place is paramount, and therefore tolerance zones seem to be a better way to achieve this objective. Like Boynton and Cusik,[1] I am disappointed that the Home Office has missed the opportunity to consider tolerance zones in its strategy.

Walsall has its own prostitution and associated problems. During the mid and late 1990s, considerable anger prevailed among the community experiencing the direct affects of prostitution. We initiated a qualitative study to obtain the views of residents and sex workers so that a robust strategy could be developed. The findings of this study surprised many as they included hitherto unknown facts. For example, more than half the sex workers and their clients were Walsall residents, which was contrary to the perception of many, that prostitution was an imported problem. This finding alone made individuals and agencies own the problem. Most community representatives and sex workers also believed that tolerance zones were the best way for safety, health, and indeed prevention.[2]

A multiagency task group has been in existence, led by the police, for implementing many of the recommendations arising from this study. The prostitution problem and its impact on the community are better managed and a great deal of trust has been established. Some innovative programmes have been initiated, including a theatre in education programme in schools to discourage children from prostitution; intervention by the community arts team to identify sex workers' aspirations; and an active rehabilitation process. Clearly we could not pursue a tolerance zone proposal as there was no legal framework to do so. Hence my frustration with the current strategy.

Sex work is an extremely dangerous activity, and the use of harm reduction principles can help to safeguard sex workers' lives.[3] An opportunity to establish tolerance zones as an effective option in this process has been lost in the recent strategy.

Sam Ramaiah *director of public health medicine*
Walsall Teaching Primary Care Trust, Walsall WS1 1TE
sam.ramaiah@walsall.nhs.uk

Competing interests: None declared.

1 Boynton P, Cusik L. Sex workers to pay the price. *BMJ* 2006;332:190-2. (28 January.)
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A street sex worker responds to new government strategy

EDITOR—Responses to the government proposals on prostitution vary from sex worker to sex worker.[1] The following is the view of a Glasgow street sex worker I spoke to recently.

"I've seen the stuff in the papers about it, and I have to tell you, I'm totally pissed off about it. They're saying they're going to chase the punters, and what are we meant to do? Work in flats? Are they kidding? The lassies that work round here are only doing it because of drugs, me included, and we cannae [get a job to] work in the [commercial sex] flats, and if we work in our own flats we'll just end up getting it taken off of us. And then they'll be homeless. I don't know what it is with the high heed yins, you'd think they wanted the lot of us murdered. We've done everything they told us to. Ugly mugs, reporting, condoms, not working certain places like the lane at the drop in [specialist health service], everything. Now they're setting up the punters against us and the whole thing will fall apart."

LC: "Does that mean you will stop working?"

"I'll still need the money, no."

Linda Cusick *reader in substance use*
Institute for Applied Social and Health Research, University of Paisley, Paisley PA1 2BE
linda.cusick@paisley.ac.uk

Competing interests: None declared.

1 Prostitution shake-up: one sex worker's view. *BMJ* 2006; 332:245. (28 January.)

Turning round NHS deficits

. . . is more difficult for PCTs

EDITOR—Ham believes that the turnaround teams from the private sector will find it difficult to deal with NHS deficits.[1] The solution he describes entails reducing spare capacity, increasing performance, and fully engaging clinicians. These measures, aspects of the failure regime for hospitals,[2] have some chance of success in provider organisations. The position for primary care trusts (PCTs) in deficit is even more difficult and likely to be even more alien to the expertise of those now being bought in from the private sector as recovery teams.

Primary care trusts are largely commissioning organisations and do not have direct levers to reduce acute capacity, even when it is recognised not to be affordable. Directly provided services form only a small proportion of their spend and are needed to help reduce hospital activity. Were local hospitals to increase their efficiency—say, by reducing length of stay—this would exacerbate the problem for primary care trusts, unless those freed-up beds were closed rather than used to suck in more income underpayment by results. General practitioners are the clinicians who most need to be engaged by primary care trusts, but they cherish their independent status. It takes exceptional leadership to persuade them to act outside their direct interests in demand management, in advance of any of the benefits promised for them from practice based commissioning.

There is little infrastructure in primary care trusts to downsize. Deficits of the size now seen in some trusts would be dealt with by bankruptcy in the private sector or increased long term borrowing, neither of which is available to the trust. Many chief executives believe that the current difficult financial situation is generated by government policies, rather than local incompetence.[3] In these circumstances, private sector recovery teams have an exceptional and perhaps impossible task before them,[3] especially in primary care trusts.

Hilary G Pickles *director of public health*
Hillingdon Primary Care Trust, Yiewsley UB7 7HJ
hilary.pickles@hillingdon.nhs.uk

Competing interests: Hillingdon Primary Care Trust is declaring one of the biggest projected deficits among primary care trusts for 2005-6.

1 Ham C. Turning round NHS deficits. *BMJ* 2006;332:131-2. (21 January.)
2 Palmer K. *How should we deal with hospital failure?* London: King's Fund, 2005.
3 The winter of discontent: chief execs tell their story. *Health Serv J* 2006 Jan 19:10-1.

Who says there are surplus hospital beds?

EDITOR—Ham's editorial is a clear summary of the NHS's current financial plight.[1] However, in his fourth paragraph he illustrates a gulf between health economic and medical thinking.

There seems to be a specific belief in health economic circles that there is overprovision of beds in acute hospital settings. As a doctor I do not share this belief.

When I admit acutely ill patients I see no evidence of oversupply of acute beds. Instead I am often asked to delay the admission or deflect it to the accident and emergency department first. The psychiatrist tells me that he can admit patients only if they are homicidal or suicidal. The phenomenon known as bed blocking does not speak of overprovision of care in hospital, intermediate, or residential care settings.

All these examples speak of lack. I challenge Ham to show me which patient specifically is currently being overprovided for in any NHS bed.

Roemer's law of demand, that a bed created is a bed filled, is a reflection of the fact that there is still much unmet need for healthcare. One of the commonest research findings is that this disease is undertreated or diagnosed in primary or secondary care and more time, money, and education should be put into it. This unmet need is a consequence of the icebergs of symptoms and disease.[2 3]

The NHS should be gearing up to meet unmet need. Instead it is currently being downsized and fragmented, whilst expectations of it are being upsized. The attempt by the government to sustain it solely from taxation is falling apart. In 2002 I asked what exactly would be bought by increased NHS funding.[4] In 2006 we can see that little has been bought, and much wasted.

Peter G Davies *general practitioner principal*
Keighley Road Surgery, Halifax HX2 9LL
npgdavies@blueyonder.co.uk

Competing interests: None declared.

1 Ham C. Turning around NHS deficits. *BMJ* 2006;332:131-2. (21 January.)
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Deficits are not for turning

EDITOR—Ham is right to be sceptical about the private turnaround teams.[1] Personal experience with "franchising," a similar process, has led me to a similar position.[2] Faith in their abilities is misplaced for three reasons.

Firstly, the private sector underestimates the wider responsibilities of hospitals. Unlike the private sector, public institutions are not free to simply disinvest in non-profitable areas. Accountabilities run wider than just the organisation itself, into the wider local community. Also the demands of transparency and the burden of governance are more stringent.

Secondly, the private sector does not genuinely comprehend the complexity of medical care. As in chaos theory, one small action in the organisation can have a myriad of unforeseen consequences for the whole system.

Thirdly, NHS finances and organisation have major structural problems. Resources are not distributed equitably at the national and health authority level. Only selfless political leadership will resolve these problems. Ham is right to point out that the solution lies with the full engagement of clinical teams. However, the Department of Health will have to rebuild confidence in clinicians and managers. It may be unpalatable to hear, but after years of being blamed for the failure of the NHS, managers and clinicians at the frontline have distaste for all things central.

It is time to stop trying to remodel the NHS on the private sector and start taking stock of its successes over the past 60 years and reaffirm the founding principles. Then the experience of the NHS workforce should be brought to bear on the problems of the NHS. Local teams must be allowed to take risks and politicians should have the courage to support them, even in the face of opposition from the public and vested interest groups.

David Churchill *consultant obstetrician*
Royal Wolverhampton Hospitals NHS Trust, New Cross Hospital, Wolverhampton WV10 0QP
david.churchill@rwh-tr.nhs.uk

Competing interests: None declared.

1 Ham C. Turning round NHS deficits. *BMJ* 2006;332:131-2. (21 January.)
2 Churchill D, Zissman B. The facts about franchising at Good Hope Hospital. *BMJ* 2003; 327:412.

Clinical governance, 1998-2006: RIP

EDITOR—With these words, we were introduced to the idea of clinical governance: "A commitment to deliver high quality care should be at the heart of everyday clinical practice. In the past many health professionals have watched as board agendas and management meetings have become dominated by financial issues and activity targets. The government's white paper on the NHS in England outlines a new style of NHS that will redress this imbalance. For the first time, all health organisations will have a statutory duty to seek quality improvement through clinical governance."[1]

I was doubtful about clinical governance, although pleased that financial matters were to be thought less important than clinical ones.

In the *Guardian* of 23 January, secretary of state Patricia Hewitt was reported to be demanding that financial management be once again put ahead of clinical objectives.[2] By 26 January, apparently responding to the earlier story, strong financial discipline was to be a "prerequisite" instead of "top priority."[3] I fail to understand the difference.

Ham in his editorial asked whether private finance would really help the NHS.[4] In an earlier editorial,[5] about an earlier set of reforms, he asked the question that all

governments refuse to ask. That question is: "What is the purpose of a national health service?" Until this question is answered, we will stagger from crisis to crisis, pressure groups forcing the government to give in on expensive but dubious therapies, while the government imagines that all it needs is the next big restructuring to get things right.

It didn't work for clinical governance, and it won't work for whatever comes next. The sort of courage needed to even ask, let alone answer, the question does not go with the need for re-election.

Neville W Goodman *consultant anaesthetist*
Southmead Hospital, Bristol BS10 5NB
Nev.W.Goodman@bris.ac.uk

Competing interests: None declared.

1 Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998;317:61-5.
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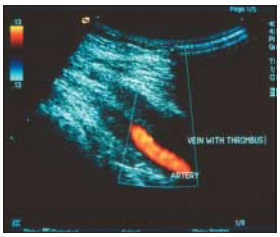
Venous thromboembolism

Potentially dangerous diagnostic pitfalls arise from diagnostic tests

EDITOR—The review of venous thromboembolism by Blanna and Lip did not draw sufficient attention to the diagnostic pitfalls that are an almost inevitable consequence of the reliance that many frontline medical staff place on diagnostic tests when differentiating between three of the most life threatening chest pain syndromes.[1] These I would call the three ugly sisters—namely, pulmonary embolism, dissecting aortic aneurysm, and myocardial infarction.



JAMES KING HOLMES/SPL

Dissecting aneurysm simulates pulmonary embolism when it presents with chest pain and/or collapse in association with raised D-dimer concentrations of the order of > 0.5 μg/ml, so much so that "testing for D-dimer should be part of the initial assessment of patients with chest pain, especially if aortic dissection is suspected."[2] When pulmonary embolism presents with chest pain and raised serum cardiac troponin[3] a mistaken diagnosis of myocardial infarction might lead not only to inappropriate thrombolysis but also to a false sense of security given the likelihood that in that context, thrombolytic treatment will not be followed by a course of oral anticoagulation lasting at least three months as recommended by Blann and Yip.[1]

The reality is that, such is the overlap in the symptoms of the three ugly sisters that, to paraphrase the authors of a recent study evaluating the limitations of a chest pain history, none of the elements of the chest pain history, alone or in combination, identify a group of patients that can be safely categorised without further diagnostic testing.[4] If, as in the real world, a patient with chest pain enters the diagnostic algorithm on the basis of the D-dimer test, even when pulmonary embolism is deemed unlikely,[5] or on the basis of troponinosis, even where myocardial infarction is deemed unlikely, the consequences will be incalculable unless these diagnostic pitfalls are highlighted.

Oscar M Jolobe *retired geriatrician*
Manchester M20 2RN
oscarjolobe@yahoo.co.uk

Competing interests: None declared.

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Stockings are important

EDITOR—In two recent articles on venous thromboembolism, only 15 words referred to the use of compression stockings and pneumatic compression devices.[1 2] These cheap and completely non-invasive devices should have a more prominent place.

The evidence behind compression stockings and pneumatic device use is well known. Twenty years ago, controlled trial evidence showed the efficacy of graduated compression stockings compared with low dose heparin.[3] More recently, a meta-analysis showed that graduated compression stockings are a useful adjunct to low molecular weight heparins and reduce the incidence of venous thromboembolism in colorectal surgery.[4]

These devices, which are often used as a direct alternative to heparins, deserve more space, especially when the consequences of bleeding are dire.

Daniel A Shaerf *preregistration house officer, orthopaedics and trauma surgery*
Royal Free Hospital, Pond Street,
London NW3 2QG
shaerf@gmail.com

Competing interests: None declared.

1 Robinson GV. Pulmonary embolism in hospital practice. *BMJ* 2006;332:156-60. (21 January.)
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Heparins are of porcine origin

EDITOR—The two recent articles on thromboembolism made no mention of the porcine origin of heparins, which is an important issue in some religions, for example, Islam.[1 2] Many doctors and nurses are unaware of this and therefore cannot fully inform patients when giving advice about prophylaxis or treatment with heparin (unfractionated or low molecular weight). According to our trust's Muslim chaplain, however, when there is no alternative non-porcine treatment available and there is a risk to life, it is allowable for Muslims to receive a drug of porcine origin. Even so, some Muslims may choose not to receive treatment or prophylaxis with heparin because of its porcine origin and patients do have the right to make the decision for themselves.

Fondaparinux is a synthetic alternative for some of the indications for which heparins are currently used, and it may have advantages over low molecular weight heparin both in efficacy and cost effectiveness. Ethically, it should be available for use by Muslim patients and others who object to the use of medicines of porcine origin.

Colin White *consultant physician*
Pontefract General Infirmary WF8 1PL
colin.white@midyorks.nhs.uk

Competing interests: None declared.

1 Blann AD, Lip GYH. Venous thromboembolism. *BMJ* 2006;332:215-9. (28 January.)
2 Robinson GV. Pulmonary embolism in hospital practice. *BMJ* 2006;332:156-60. (21 January.)

Diagnostics is not Cinderella of health technology assessment

EDITOR—Furness makes an important point about the lack of emphasis on diagnostics but ironically has the wrong diagnosis.[1] As we tried to make clear in our editorial,[2] there is a long chain from health technology assessment (the scientific summation of evidence about effectiveness) through appraisal (the policy related judgments that the National Institute for Health and Clinical Excellence (NICE) and others then make on the basis of the assessments) to the implementation and availability of services. The neglect of diagnostics lies not with health technology assessment but further along the chain.

The NHS programme for health technology assessment has given much attention to diagnostics. Although health technology assessment covers all healthcare interventions from health promotion through disease prevention, diagnosis, treatment, and rehabilitation through to continuing care, the programme has devoted one of its four expert panels (until this year, one of only three) entirely to diagnostics and screening. The programme has published 36 monographs about diagnostic technologies and has commissioned a further 32 research projects that are now under way.

As we highlighted in our editorial, the assessment of diagnostics poses some particularly difficult methodological challenges.

Clearly, however, there is an even greater challenge to ensure that once a diagnostic technology has been assessed as cost effective it is made properly and widely available in the NHS. If we are to tackle that problem, then let us at least understand where and how it is happening, rather than jumping to blame the wrong part of the system.

John Gabbay *professor emeritus*
Wessex Institute for Health Research and Development, University of Southampton SO16 7PX
jg3@soton.ac.uk

Tom Walley *professor of clinical pharmacology*
Department of Pharmacology and Therapeutics, University of Liverpool, Liverpool L69 3GF

Competing interests: JG was director of the NHS National Coordinating Centre for Health Technology Assessment, 1998-2004. TW is director of the NHS HTA Programme.

1 Furness P. Introducing new health interventions. *BMJ* 2006;332:235-6. (21 January.)
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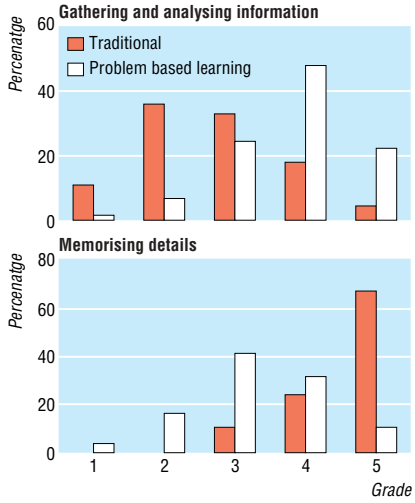
Students validate problem based learning

Editor—In 1993 the General Medical Council recommended that medical schools should develop student centred curriculums to discourage memorising detail in favour of information gathering and problem solving.[1] In response, most UK schools[2] have adopted a form of problem based learning, which, compared with traditional courses, at best produces graduates with only marginally better diagnostic acumen.[3] This has recently raised concerns about the cost effectiveness of introducing new learning formats without substantial validation,[4] a situation that is confounded by uncertainty about whether problem based learning courses conform to the GMC guidelines.

To ascertain whether problem based learning can deliver on these recommendations, 86 students from a traditional course and 246 graduates from a problem based learning course were asked to quantify on a five point Likert scale (1=small amount, 5=large amount) the extent to which memorising detail and gathering and analysing information featured in their courses. Statistical analysis was performed by χ^2 test and effect size.

Over 90% (75/83) of students attending the traditional course considered memorising details a prominent part of their course (grade 4/5, figure), whereas only 40% (115/284) of the students on the problem based learning course thought this a significant feature of theirs ($P<0.000001$, effect size −1.56). By comparison, gathering and analysing information was a major characteristic for <75% (198/284) of students on the problem based learning course (grades 4/5, figure 1), whereas only 22% (18/84) of students on the traditional course considered it was relevant in their curriculum ($P<0.00001$, effect size 1.6).



Students' perceptions of extent to which each variable characterised traditional and problem based learning courses

Problem based learning is reported to stimulate life long learning,[5] but the curriculum change followed education and psychology theories with only a limited evidence base that it improves clinical performance. These data show compelling, comparative, and objective proof that students perceive that the GMC objectives are being attained through problem based learning because it has altered their learning techniques. This therefore provides further justification for its assimilation into medical school curriculums.

J Burke *senior university teacher in medical education*
R G Matthew *professor of teaching, learning, and assessment*
M Field *reader in rheumatology and medical education*
mf4a@clinmed.gla.ac.uk
Wolfson Medical School Building, University of Glasgow, Glasgow G12 8QQ

D Lloyd *evaluation service manager*
Business School, Open University, Milton Keynes MK7 6AA

Competing interests: None declared.

1 General Medical Council. *Tomorrow's doctors: recommendations on undergraduate medical education.* London: GMC, 1993.
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Research governance is important

Editor—I have experience of obtaining research governance approval from both sides, as a primary care trust research management and governance manager and as an active researcher who has recently gained approval for a project across the local strategic health authority.[1 2]

Firstly, I see no reason why trusts should be asking fellow NHS employees for honorary contracts.[2] All NHS organisations are signed up to research governance, and that should be sufficient proof of their status. This is not a good use of researchers' or research governance staff's time.

Secondly, if a researcher has an honorary contract with one NHS organisation the facility exists to issue a letter of authorisation to accept this elsewhere, and unless there are compelling reasons not to do this—namely, no contact with children or vulnerable adults in other sites—then this is surely the way forward.[1]

Thirdly, procedures are inconsistent across trusts, partly because of the lack of nationally agreed procedures, for which the Department of Health bears an important responsibility. One way forward would be for trusts to endorse the research and development forum's toolkit or produce their own detailed guidance and standard forms. In the area of honorary contracts progress is being made by the R&D forum and the UK clinical research collaboration on introducing a research passport. Some kind of multicentre process is needed to give approval to large scale projects, allowing local research management and governance groups to concentrate on purely local issues.

Research governance is there for a purpose—namely, to provide local quality control on research projects and to protect the interests of patients and staff. In most cases, the projects we have dealt with have been unproblematic. However, in a few cases—in particular, commercial drug trials—we have had serious concerns either about the value of projects or about aspects of patients' safety. It has not always proved easy to get information on why these have been approved or to take up our concerns. I think this shows that research governance, although hopefully streamlined, still has an important role.

Mick E Bond *research manager*
North Derbyshire Public Health Network, Chesterfield S41 7PF
mick.bond@chesterfieldpct.nhs.uk

Competing interests: MEB's employer, Chesterfield Primary Care Trust, has received research management and governance funding from the Department of Health since 2002 to cover research governance activities in the three primary care trusts in north Derbyshire.

1 Galbraith N, Hawley C, De-Souza V. Research governance. *BMJ* 2006;332:238. (28 January.)
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