Letters

Death on the roads

Article lacks logic

Editor—Walker et al show convincingly that drivers and other occupants of heavy four wheel drive vehicles are safer in crashes than those in smaller or lighter vehicles and those on foot or cycle.[1] They also show that drivers of these vehicles use mobile phones more often and seat belts less often than drivers of other cars.

But by conflating mobile phone use (which distracts drivers) and non-use of seat belts (which makes drivers feel less safe) as equally important examples of illegal and dangerous practices they have sown confusion and undermined the prospect of a constructive approach to road safety.

Using mobile phones and not using seatbelts have opposing consequences for other road users. The distraction caused by mobile phones increases the threat to others, but the non-use of seat belts decreases it. As the authors note, deaths of pedestrians, cyclists, and rear seat passengers increased (by 8%, 13%, and 28% respectively) after laws mandating the use of seat belts in front seats were introduced in the United Kingdom.

John Adams *emeritus professor*
Department of Geography, University College London, London WC1E 6BT
John.Adams@UCL.ac.uk

Competing interests: None declared.

1 Walker L, Williams J, Jamrozik K. Unsafe driving behaviour and four wheel drive vehicles: observational study. *BMJ* 2006;333:71-3. (8 July.)

No strong support for risk compensation

Editor—That the observation by Walker et al of more unsafe behaviour by the drivers of four wheel drive vehicles provides "strong support" for the risk compensation theory is unconvincing.[1] This theory implies that because drivers feel intrinsically safer in bigger more robustly built vehicles they can indulge in unsafe behaviours without putting their life unduly at risk.

The study provides at best weak support because the authors' observations have a simpler explanation: variation in personality or other traits linked to car choice and behaviour in the car. The study would be convincing if drivers were randomised to cars rather than being allowed to select them themselves. There is a strong chance that traits that affect decisions about which car to buy also affect in-car behaviour.

For example, people in their 60s are less likely to own a sports utility vehicle than those in their 30s and to use a mobile phone at any time (whether in the car or not). Sex is another likely confounding factor, as are numerous personality traits.

Graeme D Ruxton *professor of theoretical ecology*
University of Glasgow, Glasgow G12 8QQ
G.Ruxton@bio.gla.ac.uk

Competing interests: None declared.

1 Walker L, Williams J, Jamrozik K. Unsafe driving behaviour and four wheel drive vehicles: observational study. *BMJ* 2006;333:71-3. (8 July.)

Is unsafe behaviour due to the choice or the chooser?

Editor—With reference to the article by Walker et al,[1] in the United States, pick-up truck drivers use seat belts less often and have the highest fatality rates.[2] The National Highway Safety Administration asked male drivers of pick-up trucks whether they wore seat belts.

The men reported that they felt protected by size of vehicle, nature of vehicle use (short, work related trips), being "trapped" after the crash, and anger or resentment over mandatory seat belt laws. They were, however, more likely to wear their safety belts when family or friends were with them, on interstate highways, in large cities, and in bad weather.

Peter L Jacobsen *public health consultant*
Sacramento, CA 95818, USA
jacobsenp@medscape.com

Competing interests: None declared.

1 Walker L, Williams J, Jamrozik K. Unsafe driving behaviour and four wheel drive vehicles: observational study. *BMJ* 2006;333:71-3. (8 July.)
2 National Highway Traffic Safety Administration. Rural pickup truck drivers and safety belt use: focus group report. www.nhtsa.dot.gov/people/injury/airbags/RuralPickUpTruckupdate/ExecutiveSummary.htm (accessed 13 Jul 2006).

Perceived threat is important in road safety

Editor—As Walker et al show, the more insulated and "safe" drivers are from the consequences of their behaviour the more likely they are to drive more dangerously.[1]

However, sports utility vehicles (SUVs) differ in one important way from the engineering features—seat belts, airbags, and antilock breaking systems, for example—that have often provided data on risk and behaviour. Engineering features are unobtrusive to the casual observer, whereas SUVs are immediately noticeable because of their great size compared with other private cars. The size of SUVs plausibly makes them unusually threatening to other car drivers, if only because visual size at the eye is a determinant of perceived distance: a larger vehicle is inherently more likely to appear unduly close.[2] Hence other car drivers may be more cautious in the presence of SUVs, which in turn may exacerbate SUV drivers' tendency to risky behaviour.

In contrast, anecdotally, drivers of small cars are defensive in their behaviour because small cars are more likely to be "cut up" by other cars. Hence official efforts to promote the use of small, fuel-efficient cars may be undermined. The issue of perceived threat needs more prominence in moulding road travel generally.

Tony H Reinhardt-Rutland *reader in psychology*
University of Ulster, Newtonabbey, County Antrim BT37 0QB
ah.reinhardt-rutland@ulster.ac.uk

Competing interests: None declared.

1 Walker L, Williams J, Jamrozik K. Unsafe driving behaviour and four wheel drive vehicles: observational study. *BMJ* 2006;333:71-3. (8 July.)
2 Reinhardt-Rutland AH. Seat-belts and behavioural adaptation: the loss of looming as a negative reinforcer. *Safety Sci* 2001;39:145-55.

Should we advocate daytime running lights?

Editor—None of the articles on road traffic accidents in the issue of 8 July mentions the use of daytime running lights (the use of dipped headlights all day regardless of lighting conditions), which are compulsory in several European countries and have been shown to result in a significant reduction in accidents.[1–4] A review in Bandolier mentions a reduction of up to 15% from different studies.[5]

Surely this warrants further research, and if the results are confirmed we should be advocating compulsory dipped headlights all day. This would cost nothing and should save substantial numbers of lives.

Richard G Henderson *consultant radiologist*
Darlington Memorial Hospital, Darlington DL3 6HX
richard.henderson@cddah.nhs.uk

Competing interests: None declared.

1 Ameratunga S, Jackson R, Norton R. Death and injury on roads. *BMJ* 2006;333:53-54. (8 July.)
2 Walker L, Williams J, Jamrozik K. Unsafe driving behaviour and four wheel drive vehicles: observational study. *BMJ* 2006;333:71-3. (8 July.)
3 Gill M, Goldacre MJ, Yeates DGR. Changes in safety on England's roads: analysis of hospital statistics. *BMJ* 2006;333:73-5. (8 July.)
4 Nabi H, Guéguen A, Chiron M, Lafont S, Zins M, Lagarde E. Awareness of driving while sleepy and road traffic accidents: prospective study in GAZEL cohort. *BMJ* 2006;333:75-7. (8 July.)
5 Bandolier. A light in the darkness—daytime car lights. www.jr2.ox.ac.uk/bandolier/band59/b59-3.html (accessed 13 Jul 2006).

Schools obstruct road safety measures

EDITOR—Gill et al discussed changes in safety on England's roads.[1] Schools in Surrey seem to compete to have the most conservative school uniforms. Most require students to wear dark coloured outer clothing and explicitly ban brighter coloured outer clothing. This prevents students from following the universal guidance to wear light, brightly coloured clothes to increase conspicuousness and reduce their odds of adding to the pedestrian accident statistics. Many school governing bodies refuse to discuss the issue, simply dismissing as "inappropriate" advice from road safety officers and organisations and parents that they might permit more appropriate outer clothing.

We should be encouraging children to walk or cycle to school; and schools should help us by not creating unnecessary additional disincentives.

Peter M English *consultant in public health medicine*
Leatherhead, Surrey KT22 9RX
peter_english@bigfoot.com

Competing interests: PGE has children at school in Surrey.

1 Gill M, Goldacre MJ, Yeates DGR. Changes in safety on England's roads: analysis of hospital statistics. *BMJ* 2006;333:73-5. (8 July.)

Tuberculosis and social exclusion

New approach is needed

EDITOR—The editorial by Story et al is a timely reminder of the growing problem of tuberculosis in London.[1] As tuberculosis control improves, social exclusion will characterise an increasing proportion of cases, as shown by the current outbreak of isoniazid resistant tuberculosis (>260 with the same strain).[2,3] The number of patients lost to follow-up with complex medical and social problems requires a new approach.

At London's Homerton University Hospital, an initial risk assessment for adherence identifies patients with tuberculosis who would also be classified in the editorial as socially excluded: homeless people, problem drug users, prisoners, people with an alcohol problem and concurrent HIV infection. The assessment includes psychiatric illness. Enhanced surveillance identifies people who have recently come from countries experiencing chronic civil strife. The table indicates the increasing percentage of tuberculosis patients with one or more of these factors. The proportion of those receiving directly observed therapy (DOT) has increased in line with the greater risk of non-adherence, and yet a high number of patients are still lost to follow-up.

Categories of social exclusion and outcome in treatment of tuberculosis (TB)

Year	No*	% of all TB cases with factors of social exclusion	% receiving directly observed treatment	% lost to follow-up	No of patients with ⩾4 factors	No (%) of patients with ⩾4 factors who did not complete treatment
1997	32	25.0	13.8	12.9	0	0
1998	32	22.3	24.2	5.9	0	0
1999	26	26.8	30.0	7.2	0	0
2000	36	24.3	26.0	7.9	0	0
2001	46	27.7	31.0	7.0	1	1 (100)
2002	67	32.5	41.5	8.5	4	1 (25)
2003	87	24.7	34.0	4.9	8	2 (25)
2004	112	34.9	40.0	7.4	13	4 (31)

*Total No of categories signifying social exclusion. Includes homeless people, problem drug users, prisoners, people with an alcohol problem and psychiatric illness but not those with HIV, and recent immigrants.

A case worker coordinates the different services required. However, there is no statutory obligation to house "intentionally" homeless people or those who cannot prove right of residence. Drug rehabilitation services can provide methadone replacement for opiates but cannot deal with cocaine addiction. Alcohol addiction is tackled entirely by voluntary organisations, and the psychiatric services can deal with acute psychotic episodes, but struggle with personality disorders and social pathology. An acute ward is expensive and a poor environment in which to tackle these problems. A unit that has rooms with ensuite facilities, access to rehabilitation, and areas for exercise has been successful in Boston.[4] A similar unit in London would likely be cost effective (estimated cost of the current outbreak of isoniazid resistant tuberculosis is >£2m (€3m; $3.8m)[5]).

Graham H Bothamley *consultant physician*
NE London TB Network, Homerton University Hospital, London E9 6SR
graham.bothamley@homerton.nhs.uk

Competing interests: None declared.

1 Story A, van Hest R, Hayward A. Tuberculosis and social exclusion. *BMJ* 2006;333:57-8. (8 July.)
2 Nolan CM, Valdiserri RO, Cohn DL, et al. Tuberculosis elimination revisited: obstacles, opportunities and a renewed commitment—Advisory Council for the Elimination of Tuberculosis (ACET). *Morb Mortal Wkly Rep MMWR* 1999;48:1-13.
3 Maguire H, Ruddy M, Bothamley G, Patel B, Lipman M, Drobniewski F, et al. Multidrug resistance emerging in North London outbreak. *Thorax* 2006;61:547-8.
4 Singleton L, Turner M, Haskal R, Etkind S, Tricario M, Nardell E. Long-term hospitalization for tuberculosis control; experience with a medical-psychosocial inpatient unit. *JAMA* 1997;278:838-42.
5 White VL, Moore-Gillon J. Resource implications of those with multidrug resistant tuberculosis. *Thorax* 2000;55:962-3.

Do developed countries really need new strategies?

EDITOR—Story et al write that developed countries need new strategies for controlling tuberculosis.[1] However, the old strategies for controlling tuberculosis may well work if they are enforced as intended.

In Norway all new arrivals are to be screened for tuberculosis, but this is only achieved among asylum seekers arriving at reception centres. In 2005, 40 100 people immigrated into Norway; only 19 were diagnosed with tuberculosis on arrival.

Among 290 cases of tuberculosis notified in Norway during 2005, 214 were confirmed by culture, and all these isolates were analysed by DNA fingerprinting (IS6110 RFLP). The DNA patterns were compared with those of all strains isolated in Norway since 1994. A total of 175 strains had not been identified previously, whereas 39 carried a pattern observed among strains of 25 different outbreaks. These imported strains originated mainly from Somalia, Ethiopia, Vietnam, and the Philippines.

The genetic diversity of the *Mycobacterium tuberculosis* population in Norway has increased steadily since 1994, indicating an increased import of new strains. A total of 130 transmission chains have been identified, but only 13 of these include more than five individuals. Of the 13 strains, 10 were imported from other countries, and all have been ongoing for more than five years.

In Norway, as in other countries with a low incidence, tuberculosis has increasingly come to be a disease of specific subgroups of the population. This trend provides an opportunity for focused intervention but depends on correctly identifying the population groups at risk and their cooperation. In Norway, tuberculosis is not related to homelessness, HIV, drug use, or alcohol misuse.

Elimination of tuberculosis requires better efforts to prevent and control the disease among specific groups of immigrants and greater efforts to control it in countries from which these immigrants originate.

Ulf R Dahle *senior scientist*
Norwegian Institute of Public Health, PO Box 4404 Nydalen, 0403 Oslo, Norway
ulf.dahle@fhi.no

Competing interests: None declared.

1 Story A, van Hest R, Hayward A. Tuberculosis and social exclusion. *BMJ* 2006;333:57-8. (8 July.)

Low back pain

Think of tuberculosis

Editor—Koes et al in their clinical review on low back pain identify some red flags that may indicate underlying spinal disease in people presenting with back pain.[1]

We recently completed a retrospective study of patients with spinal tuberculosis at Ealing Hospital. Of 29 adult patients diagnosed between 2002 and 2005, 23 (80%) were aged between 20 and 50 years (mean age 38.5 years). All were originally from the Indian subcontinent or Africa. Most patients had been in the United Kingdom for more than 5 (range 1-26) years. None was HIV positive, gave a history of carcinoma, or reported steroid use. Only four (14%) had a history of previous tuberculosis or close contact with someone with tuberculosis. Almost all of the patients gave a history of constitutional symptoms (fever, night sweats, weight loss, or loss of appetite). Lumbar and cervical back pain was seen more commonly than thoracic. The erythrocyte sedimentation rate was greater than 35 mm in the first hour on presentation in almost all of them (96%). Many had repeatedly sought healthcare advice from their general practitioners or the accident and emergency department before a diagnosis was made.

A delay in the diagnosis of tuberculosis exposes young patients with a treatable condition to the risk of permanent disability. Non-pulmonary tuberculosis accounts for around 40% of all tuberculosis notifications in the UK.[2] The incidence of tuberculosis in London has reached 48/100 000, and in areas such as Ealing, with a large immigrant population, the rates are as high as 82/100 000.[3] Spinal tuberculosis is therefore a diagnosis that attending doctors need to consider early.

Patients from countries with a high prevalence of tuberculosis presenting with back pain in association with constitutional symptoms and a high erythrocyte sedimentation rate should be investigated to exclude tuberculosis. In the context of a normal spinal x ray and a high clinical suspicion, further cross sectional imaging may be warranted. This is irrespective of patients' age or duration of stay in the UK.

Lavanya Diwakar *clinical research fellow*
klavanya99@yahoo.com
Sarah Logan *specialist registrar*
Nadia Ghaffar *F1 trainee*
Andrew Hare *TB specialist nurse*
William Lynn *consultant*
Steve Ash *consultant*
Department of Infectious Diseases, Level 8, Pasteur Suite, Ealing Hospital, Middlesex UB1 3HW

Competing interests: None declared.

1 Koes BW, van Tulder MW, Thomas S. Diagnosis and treatment of low back pain. *BMJ* 2006;332:1430-4. (17 June.)
2 Health Protection Agency. Annual report on tuberculosis cases reported in England, Wales and Northern Ireland in 2003; www.hpa.org.uk/infections/topics_az/tb/pdf/2003_Annual_Report.pdf (accessed 13 Jul 2006).
3 Health Protection Agency. *London surveillance bulletin.* May 2006, No 7.

Risk factors for suicide should be elicited

Editor—The review by Koes et al included including psychosocial interventions for low back pain.[1] In County Durham and Darlington we have been looking at suicide prevention in several agencies. One of these areas was contact with primary care in the three months before suicide. We were able to get general practitioners' records for 147 out of 205 "probable" suicides cases. Of these, 98 (66.7%) had seen their doctor in the three months before suicide. A surprising finding was that 76 of these 98 attendances were for low back pain.

Asking about mental wellbeing (especially depression) is important in any ongoing medical condition, and if pertinent sensitive inquiry about suicide thoughts. Low back pain should alert practitioners to inquire about how patients are coping and, to ask about suicide thoughts if any concerns arise.

Keith R Linsley *consultant psychiatrist*
keith.linsley@cddps.nhs.uk
Jessica Martin
County Hospital, Durham DH1 4ST

Competing interests: None declared.

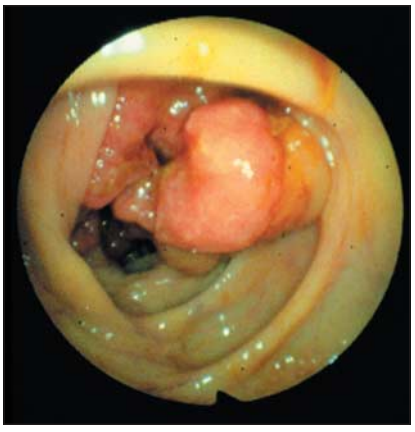
1 Koes BW, van Tulder MW, Thomas S. Diagnosis and treatment of low back pain. *BMJ* 2006;332:1430-4. (17 June.)

Colorectal cancer and rectal bleeding in primary care

Rectal bleeding needs attention in primary care

Editor—Du Toit et al emphasise the importance of rectal bleeding in primary care and try to address this important management dilemma.[1] One potential weakness of the study, however, was its assumption that bleeding was caused by any neoplasia found, rather than more common causes. The character of rectal bleeding (bright red *v* dark) was not mentioned, nor was the coexistence of piles, probably because rigid sigmoidoscopy rather than proctoscopy was carried out. In addition, the presence of anal symptoms, usually due to piles, which is a protective factor to the finding of neoplasia, was not said to be recorded.

As Weller's editorial in the same issue says,[2] the specific characteristics of the bleeding are important to record; if the colour of the blood was recorded it may help plan investigations. Bright red bleeding is well investigated by flexible sigmoidoscopy, but it is generally agreed that darker bleeding usually requires colonoscopy. The paper did not report why three different modes of investigation were used, nor the rationale for choosing between the three. The location of the cancers was not stated but should have been; caecal cancer would be unlikely to cause bright rectal bleeding. Finally the size and number of adenomas are necessary information to estimate whether these lesions are important in a study population largely older than 65.



CUSTOM MEDICAL STOCK/SPL

If the nature of the bleeding and presence of bleeding piles is to be ignored and a one-off bleed results in booking an endoscopy, then up to 20% of the adult population (the widely accepted incidence in a population, not those presenting) would need an endoscopy every year. In practice most patients, rather than having new rectal bleeding, have chronic bleeding, and neoplastic causes persist whereas benign causes abate, which allows some sorting into who to investigate with what urgency.

Christopher M Newman *specialist registrar general surgery*
chrisnewman@doctors.org.uk
Guy F Nash *consultant colorectal surgeon*
Tom Armstrong *specialist registrar general surgery*
Kieren Darcy *senior house officer general surgery*
Poole General Hospital, Poole BH15 2JB

Competing interests: None declared.

1 Du Toit J, Hamilton W, Barraclough K. Risk in primary care of colorectal cancer from new onset rectal bleeding: 10 year prospective study. *BMJ* 2006;333:69-70. (8 July.)
2 Weller D. Colorectal cancer in primary care. *BMJ* 2006;333:54-5. (8 July.)

Urban or rural myth?

Editor—Du Toit et al's finding of a one in 10 chance of patients over age 45 presenting with rectal bleeding and subsequently being diagnosed with colorectal cancer is comparable to other recent studies,[1 2] but their data were collected from a single rural practice in the United Kingdom, including less than 300 patients. A recent population based, case-control study consisting of over 1500 patients has shown that residence in a rural area was associated with an increased risk of colon cancer (odds ratio 1.4, 95% confidence interval 1.1 to 1.8).[3] However, a large epidemiological study of around 500 000 patients shows that black men who reside in metropolitan areas have a higher risk of colorectal cancer than black men who reside in rural areas.[4] Both these studies have evaluated populations in the United States, but UK populations are similar. It is therefore important to consider both urban and rural cohorts for such studies for precise positive predictive values that may be useful for the population in general.

The findings of du Toit et al also bring into question which referral pattern to use for these young patients with rectal bleeding alone. Referral under the two week wait rule would increase the numbers of patients referred as urgent cases to gastroenterolo-

gists and colorectal specialists but may also increase the yield of cancers diagnosed. Time to treatment may fall, as referral lag time may need to be reduced for quicker treatment for colorectal cancers in the UK.[5] With targets such as 18 weeks and the 62 day rule for treatment and with screening for colorectal cancer starting this year, the burden on the endoscopy services is potentially huge. Lower gastrointestinal endoscopy should be further organised, along with collaboration with radiological diagnostics such as computed tomographic colonography, to ensure that efficient diagnosis of colorectal cancer continues in the UK as referrals increase.

Sanjay Purkayastha *clinical research fellow*
s.purkayastha@imperial.ac.uk
Ara Darzi *professor*
Department of Biosurgery and Surgical Technology, Imperial College, London W2 1NY

Competing interests: None declared.

1 Du Toit J, Hamilton W, Barraclough K. Risk in primary care of colorectal cancer from new onset rectal bleeding: 10 year prospective study. *BMJ* 2006;333:69-70. (8 July.)
2 Ellis BG, Thompson MR. Factors identifying higher risk rectal bleeding in general practice. *Br J Gen Pract* 2005;55:949-55.
3 Kinney AY, Harrell J, Slattery M, Martin C, Sandler RS. Rural-urban differences in colon cancer risk in blacks and whites: the North Carolina colon cancer study. *J Rural Health* 2006;22:124-30.
4 Coughlin SS, Costanza ME, Fernandez ME, Glanz K, Lee JW, Smith SA, et al. CDC-funded intervention research aimed at promoting colorectal cancer screening in communities. *Cancer* 2006 Jun 26; Epub ahead of print www3.interscience.wiley.com/cgi-bin/fulltext/112664307/HTMLSTART (accessed 9 Jul 2006).
5 Flashman K, O'Leary DP, Senapati A, Thompson MR. The Department of Health's "two week standard" for bowel cancer: is it working? *Gut* 2004;53:387-91.

Sublingual varices are not unusual

Editor—The picture case by Nasir et al in Minerva is in danger of giving a false impression.[1] Sublingual varices are not unusual. They are common, and a common clinical finding (if in doubt, just ask your dentist).[2] Their prevalence increases with age, with surveys indicating that they are present in up to 60% of elderly patients, in both sexes, and in different population groups.[2–4]

Haemoptysis has once been reported due to bleeding from varices at the base of the tongue, associated with portal hypertension, but a textbook and Medline search for spontaneous haemorrhage from sublingual varices does not show any similar reported cases to that described.[5] The advice given that sublingual varices can cause subtle and potentially dangerous bleeding is based on negligible evidence. It would be unfortunate if the case depicted induced a growth of unnecessary cauterisation of sublingual varices and misled clinicians from searching for the true cause of a patient's haemoptysis.

Michael N Pemberton *consultant in oral medicine*
University Dental Hospital of Manchester, Manchester M15 6FH
mike.pemberton@manchester.ac.uk

Competing interests: None declared.

1 Nasir A, Gupta D, McBride G. Minerva picture case. *BMJ* 2006;333:104. (8 July)
2 Ettinger RL, Manderson RD. A clinical study of sublingual varices. *Oral Surg Oral Med Oral Path* 1974;38:540-5.
3 Kleinman HZ. Lingual varicosities. *Oral Surg Oral Med Oral Path* 1967;23:546-8.
4 Kovac-Kavcic M, Skaleric U. The prevalence of oral mucosal lesions in a population in Ljubljana, Slovenia. *J Oral Pathol Med* 2000:29:331-5.
5 Jassar P, Jaramillo M, Nunez DA. Base of tongue varices associated with portal hypertension. *Postgrad Med J* 2000;76:576-7.

Another way to tame the monster

Editor—The Angell-Spence-Godlee proposal to ban pharmaceutical manufacturers from researching their products has considerable merit.[1] However, Healthy Skepticism advocates a more comprehensive alternative that will also reduce the harm currently caused by misleading promotion, biased industry funding of education, and high drug prices. Our alternative is also more politically achievable because implementation can be government revenue neutral while securing long term competitive return on investment for the pharmaceutical industry.

Pharmaceutical companies currently have four main functions: manufacturing, research, promotion, and education. Performance of those functions is currently distorted by incentive systems that reward only activities that increase sales of more expensive drugs regardless of the impact on health care. We recommend that the four functions be paid for separately by government agencies via iterative competitive public tender. This would allow the relevant divisions and subcontractors of pharmaceutical companies to compete with universities and non-profit non-governmental organisations for funding to provide each function separately. Incentives can then to be aligned to reward quality performance at each function separately. If a company performed poorly—for example, through research fraud or misleading promotion—then it would not get funding for that function in the next tender round. Drug prices would no longer include a premium for research, promotion, and education. Consequently, drug companies would no longer fund those functions from drug sales. Lower prices would make drugs more cost effective for larger numbers of people.

Our recommendations can be implemented quickly or slowly by gradually reducing prices and transferring the savings to organisations that fund research (such as the UK Medical Research Council), education (such as medical schools and royal colleges), and promotion (such as provided by the Best Practice Advocacy Centre, New Zealand). We also recommend improving both regulation of the industry and education for health professionals about treatment decision making.[2–5]

Peter R Mansfield *director, Healthy Skepticism*
34 Methodist Street, Willunga, SA 5172, Australia
peter@healthyskepticism.org

Competing interests: PM has received funding from organisations that would benefit from implementation of his recommendations including many universities, the Royal Australasian College of Physicians, and the National Health and Medical Research Council (Australia).

1 Godlee F. Can we tame the monster? *BMJ* 2006;333:0-f. (8 July.)
2 Sweet M. Doctors and drug companies are locked in "vicious circle." *BMJ* 2004;329:998.
3 Mansfield PR. Healthy Skepticism about drug promotion: memorandum for the UK House of Commons Health Committee Inquiry: the influence of the pharmaceutical industry. *Healthy Skepticism Int News* 2004;22:10-2.
4 Mansfield P, Rogers W, Jureidini J. Submission from Healthy Skepticism re RACP ethical guidelines. *Healthy Skepticism Int News* 2005;23:9.
5 Mansfield PR. Banning all drug promotion is the best option pending major reforms. *J Bioethical Inquiry* 2005;2:16-22.

Do not be fooled by photographs

Editor—Mahaffey is spot-on in the sentiments he expresses regarding the devaluation of medical professionals, notwithstanding the glossy photographs displayed in various foyers or lobbies depending on where you happen to be.[1] Much of what he says could equally be said of the US healthcare system.

The difference is that the devaluation of doctors perpetrated by "managers and jobsworths," as he puts it, is committed by insurance companies and hospital administrators (who do you think the United Kingdom learnt it from, after all?) in the pursuit of money. However, being business people they tend to be a bit wilier, so they put up glossy photographs of distinguished and eager looking medical staff—with glittering teeth and commercial looking smiles seemingly derived from motivational seminars. Thus the impression is created that these business functionaries value doctors. And they do: inasmuch as doctors provide services from which business parasites are able to extract a sizeable cut.

There is widespread frustration in the US medical profession for reasons not unlike those cited by Mahaffey. The flashy pictures of hospital staff do not tell the whole story. We should not be fooled by photographs, or any spin for that matter. If the pictures were a genuine reflection of the underlying reality then that would be a different matter.

Richard A Rosin *consultant psychiatrist*
VA Medical Centre, Puget Sound, Seattle, WA 98108, USA
richard.rosin@med.va.gov

Competing interests: None declared.

1 Mahaffey P. Senior doctors must stay part of the picture. *BMJ* 2006;333:103. (8 July.)

bmj.com

We select the letters for these pages from the rapid responses posted on bmj.com favouring those received 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.