

## Letters to the Editor

Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk]. Letters should be no longer than 300 words and preference will be given to letters responding to articles published in the *JRSM*. Our aim is to publish letters quickly. Not all correspondence will be acknowledged.

### Hubris and Nemesis in heads of government

By couching the discussion of Blair and Bush in terms of hubris and nemesis, Lord Owen<sup>1</sup> has avoided the pitfall of diagnosis from afar while still highlighting serious problems with the two world leaders (*JRSM* November 2006). He does dip his toe into psychodynamics citing Freud and Justin Frank, but, by and large, he sticks to discussing behaviour and its relation to hubris and power.

As a politician, Lord Owen is qualified to discuss the political leaders he has encountered. As a physician, should he be making medical judgments on political leaders? Simon Wessely has questions about this and about whether or not psychiatrists should venture beyond the consulting room.<sup>2</sup>

Should psychiatrists limit their judgments to patients they have examined? The American Psychiatric Association says 'yes' and Dr Wessely cites data to support that view. But the question remains, can psychiatrists and neuroscientists, with the help of philosophers, provide useful insights that contribute to the understanding of leaders and their followers?

I believe that we should try. We should bring whatever scientific data there may be to counter ideology, blind faith and the intoxicating effects of power. It is true hubris often comes with power. Even though we do not have a psychiatric diagnosis for hubris, it is a psychological entity and as such should potentially be understood by science, as are other psychological phenomena.

We do not diagnose those that we have not personally examined and we cannot diagnose an entire population, but perhaps we can bring clinical and scientific insights to help understand destructive behaviour

As scientists and clinicians, we too must guard against hubris. Hopefully our colleagues will help us with that. *JRMS* should be applauded for exploring the issue.

*Competing interests* None declared.

#### Robert L Leon

Department of Psychiatry 7792, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, Texas 78229-3900, USA  
E-mail: leon@uthscsa.dccci.com

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### Overconfidence in warfare

Lord David Owen's analysis of hubris and nemesis in heads of government (*JRSM* November 2006)<sup>1</sup> is a valid and useful set of medical insights into a topic of literally life and death importance. But we also need to ask why overconfident men—and it is mainly men—rise to power so often, and yet also then make so many political and military blunders.<sup>2</sup>

Evolutionary psychology is the effort to identify those universal human behaviours that adapted us to the environment in which we evolved—primarily a world of small competing clans of hunters and gatherers.<sup>3</sup> In such a world, where conflict was frequent (in preliterate societies, adult mortality from warfare is rarely less than 10% and can rise to 50% or more<sup>4</sup>) overconfidence could have been adaptive. The ability to bluff an enemy into submission and genuine optimism in the face of heavy adverse odds may well have been promoted by natural selection.<sup>5</sup> In Iraq, Bush and Hussein both showed a similar lack of reality (Hussein was convinced the Americans would never invade and that if they did his forces would win, while Bush is quoted as 'relentlessly optimistic' and convinced the postwar occupation 'would resemble the American liberation of Germany and Japan').<sup>6</sup>

Democracies need to be led by intelligent, curious, analytical, and cautious leaders of either sex. Unfortunately, our political systems (and especially the US system of primaries to select presidential candidates) tend to select overconfident men. The first step in overcoming this danger is correct diagnosis, and the *JRSM* is to be congratulated on beginning this process.

*Competing interests* None declared.

#### Malcolm Potts

School of Public Health, University of California, Berkeley, USA  
E-mail: pottsmalcolm@yahoo.com

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5 Linkov F, Lovalekar M, La Porte R. Scientific journals are 'faith based': is there science behind peer review? *J R Soc Med* 2006;99:596

**Clinical studies in medical journals**

A number of articles relating to issues of confidence in the reporting of clinical studies in medical journals occupied the pages of the *JRSM* during 2006.<sup>1–5</sup>

Bastian<sup>1</sup> raised the issue of a very high percentage of clinical research being sponsored by the pharmaceutical industry and the resulting conflicts of interest, and in a number of articles Smith<sup>2–4</sup> drew attention to the fact that even the editors of prestigious medical journals can have conflicts of interest when accepting certain articles for publication.

The concerns relating to the potential conflict of interests of researchers and authors (not necessarily one and the same), those involved in the peer review process of articles submitted for publication, and the commercial interests of journal editors identified in these articles, all have their parallels in the drug regulatory processes.

Applications from the pharmaceutical industry for marketing approval may contain reports of many clinical studies many of which are those submitted for journal publication. The 'peer review' is conducted by the permanent staff of the national regulatory authority (the MHRA in the UK, and the FDA in the USA) and their advisory committees. In the past it was not uncommon for the independent experts appointed to serve on the Committee on Safety of Medicines to have to declare an interest in the submissions for marketing approval put before them.

Regulatory approval of an application for marketing approval of a new medicine is a paper exercise based on the acceptance of the integrity of the data submitted and trust in the 'peer review' system and those who operate it. The editorial by Kamran Abbasi<sup>5</sup> raises the issue of whether scientific journals are 'faith based'. The same question has to be directed at the drug regulatory system for identical reasons.

*Competing interests* None declared.

**J P Griffin**

Quartermans, Digswell Lane, Welwyn, Herts AL6 0SP, UK  
E-mail: Jqmans5@aol.com

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1 Bastian H. A reader's guide to author and sponsor biases in clinical research. *J R Soc Med* 2006;99:611

**Commercial aircraft cabin altitude**

It was a pleasure to read the review in *JRSM*<sup>1</sup> of an aviation medicine topic based on fact rather than emotional opinion. However, when considering the aircraft cabin environment it is incorrect to state that the cabin pressure is standardized to an equivalent of 8000 feet.

The regulations<sup>2,3</sup> stipulate that the maximum cabin altitude should not exceed 8000 feet during normal operations, and, in fact, at usual cruising altitude the cabin altitude rarely exceeds 6000 or 7000 feet in a modern jet airliner.

Finally, the authors should have credited Boeing as well as Airbus with announcing a maximum design cabin altitude of 6000 feet, which they did for the new Boeing 787.

*Competing interests* Michael Bagshaw is Aeromedical Adviser to Airbus.

**Michael Bagshaw**

Director Aviation Medicine, King's College London  
E-mail: michael.bagshawe@kcl.ac.uk

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**Forced change of language**

Mr Cayton has made the very useful contribution of reminding us that language, however simple, always gives away our attitudes.<sup>1</sup> Much research has shown that most of these attitudes are both communicated and received unconsciously.

I recently reviewed the unconscious attitudes portrayed in information leaflets given to patients attending departments of radiology in two teaching hospitals for day-case or outpatient procedures, using standard techniques in functional grammatical analysis. The leaflets were extremely courteous, as Mr Cayton recommends, but they consisted almost entirely of instructions: the patients were repeatedly put under social pressure to conform to the wishes and requirements of the radiology staff. On the

other hand, there was no documentation of any requirement to respond to the patients' wishes and the staff themselves appeared to have an extremely authoritative position. Most surprising of all, the only route of communication of anything other than demographic details mentioned for the patients was by means of a formal complaint to the Trust authorities. This was all in spite of the fact that at least some of these leaflets had been approved by the central Trust information committee.

In this case, an obvious plea in mitigation is that patients have to be examined in a routine manner in order to produce reliable results, and I am not necessarily advocating a major change in our practice. What has surprised me is that, when these results were presented to them, none of the professional people involved realized that such attitudes could be communicated like this.

Thus, Mr Cayton's proposal of forced change of language will not usually affect underlying attitudes, as many health professionals do not always have insight into their own attitudes and their own use of language. Changing underlying attitudes, of course, will be much more difficult.

*Competing interests* None declared.

#### **Brennan Wilson**

Royal Manchester Children's Hospital, Pendlebury, Manchester M27 4HA, UK  
Brennan.Wilson@CMMC.nhs.uk

#### **REFERENCE**

- 1 Cayton H. The alienating language of health care. *J R Soc Med* 2006; **99**:484

#### **Inconvenient truths**

Ian Forgacs (December 2006 *JRSM*<sup>1</sup>) confessed to being trapped by the conflict of interest generated by his moral allegiance towards the principles of the NHS and his ethical concerns regarding best practice for a particular patient. This was solved in that case by seeing the patient privately. We must assume that the personal financial gain did not enter into the equation. However, this solution can only be seen as a positive gain for the NHS if the patient can afford to pay.

Dr Forgacs' ability to facilitate rapid resolution for a private patient's medical problem was because *he* was in control of the management process. The NHS situation could be improved if doctors were given the opportunity to exploit similar management pathways.

My approach was to develop my own outpatient IT system, so that from the receipt of the general practitioner communication the patient could be seen on any of the four weekdays on which I had a clinic. Clearly, I decided the degree of urgency but, when appropriate, I could see the patient on the next day. Any complex imaging process that might be necessary unfortunately fell into the NHS

resource-driven black hole, because management refuses to run a theatre or scanner outside of 'normal working hours' unless the patient can stomp up the associated fee.

My system met with managerial obstruction and resentment: patients loved it. Letters were only dictated on new referrals. The remaining correspondence was IT generated. The reduction in secretarial time was rewarded by reducing my access to secretarial help to 2½ days per week without the budget savings being returned to my speciality. (The penalty I paid for rocking the boat.) It is the numerous conflicts of interest within health-care provision which fuels the demand for and the acceptance of private practice.

*Competing interests* None declared.

#### **Mark Aitken**

Colchester General Hospital, Colchester CO4 5JL, UK  
E-mail: mark.aitken@essexrivers.nhs.uk

#### **REFERENCE**

- 1 Forgacs I. Private practice—definitely not a zero sum game. *J R Soc Med* 2006; **99**:644

#### **'A brief history of homeopathy'**

I was delighted to see an article in the *JRSM* on homeopathy,<sup>1</sup> but my pleasure soon turned to dismay when the terms 'quackery' and 'quacks' appeared no less than eight times on the first page. No prejudice or bias here then! The author's hostility and frustration could be clearly felt through the rambling and bitter prose.

It is a puzzle why a proportion of one's colleagues become so very angry when the subject of complementary medicine is raised. Practitioners of complementary medicine, including homeopathy, are among the mildest mannered and most well meaning of individuals, who have only their patients' best interests at heart.

The idea that a doctor would go into homeopathy 'for the money' is ludicrous—there's precious little of that in it. What draws so many of our colleagues and their patients is disenchantment with the harshness and side effects of modern therapeutics. Homeopathy and other gentle complementary therapies are both effective and free of those side effects that so plague conventional medicine, with its mechanistic approach to human illness. Since we are all part of a caring profession, why should such an approach be so distressing to so many in the medical establishment?

The wiser heads among us realise that all forms of therapeutics have their place and that we should be grateful for the diversity of approach that so adds to the interest of the medical world. Homeopathy copes well with those awkward illnesses (e.g. skin conditions, depression and asthma) for which conventional medicine has few answers,

and vice versa. More tolerance and understanding would be a good thing.

*Competing interests* DH is a Licensed Associate of the Faculty of Homeopathy and is able to practice homeopathy in relation to dentistry.

**David Horobin**

Orthodontic Practice, 39 Chapel Road, Bexleyheath, Kent DA7 4HW, UK  
E-mail: reception@bexleyortho.co.uk

**REFERENCE**

- 1 Loudon I. A brief history of homeopathy. *J R Soc Med* 2006;**99**:607–10

**Gender bias in research**

Holdcroft<sup>1</sup> writes about the very real shortage of clinical trials data from studies in women. While this is true in a number of disease areas; it is not true of studies in hormone replacement and related fields, for example.

The exclusion of women from clinical research studies was the direct result of the Thalidomide disaster, which led to the setting up of the Dunlop Committee, forerunner to the Medicine's Control Agency. It was for many years considered to be unethical to include women in clinical trials who were known to be, or who might possibly have been, pregnant. This effectively excluded females from between 12 and 55 years of age. There was no intent to deny women the benefits of medical advances and any suggestion that this situation accorded a lower status to women is misconceived.

It is true that the difference between the sexes has been neglected in research at all levels,<sup>2</sup> something that requires much greater emphasis and more investigation in the future.

*Competing interests* None declared.

**Richard Walden**

Hon Research Fellow, Clinical Pharmacology UCL, 40A Titsey Road, Limpsfield, Surrey RH8 0DF, UK  
E-mail: richard@walden60.fsnet.co.uk

**REFERENCES**

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**Normal hearing tests: is a further appointment really necessary?**

We read the article 'When a normal hearing test is just the beginning', by Kennedy *et al.*, with great interest.<sup>1</sup> The authors mention King Kopetzky syndrome, which is both a rare diagnosis and a diagnosis by exclusion. Patients complaining of repeated hearing loss but with normal pure

tone audiogram should have their social and psychological issues explored rather than being labelled as suffering from this syndrome. Patients with a normal pure tone audiogram without any audio-vestibular symptoms need no follow up.

Our department examines 4000 patients a year complaining of hearing loss. Ten per cent of these patients have normal pure tone audiometry. Each follow up appointment costs £65–£70.<sup>2</sup> At present, when so many NHS trusts are in debt, regular follow up or open appointments for patients with normal pure tone audiograms are not cost effective. It is our departmental policy that such patients should return to their General Practitioner for a new referral to the local ENT department if they develop further hearing loss or new symptoms.

*Competing interests* None declared.

**Gaurav Kumar**

**Furrat Amen**

**Dev Roy**

ENT Department, St John's Hospital, Wood Street, Chelmsford, Essex CM2 9BG, UK

Correspondence to: Furrat Amen, 18 Poseidon Court, Homer Drive, London E14 3UG, UK

E-mail: Furrat@hadbai.co.uk

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**Bacillary Dysentery in Egypt, 1943–1944**

I would like to add a personal anecdote to Scadding's article<sup>1</sup> on bacillary dysentery in Egypt. In March 1944 I was admitted to hospital in Bangalore, India, with mild bacillary dysentery. My treatment consisted of repeated doses of a mixture of magnesium and sodium sulphate, the standard treatment at that time. It seemed to me that this purgation was perpetuating my original symptoms and that this might go on indefinitely. I therefore hatched a plot with the Italian orderly (Italian prisoners of war were employed as orderlies in hospitals in India) to chart my treatment but not to give it to me. The result was impressive; within 48 hours I was 'formed', and was discharged.

Scadding referred briefly to 'Some probably harmful procedures were still sometimes advocated; for instance there was even the residue of the idea that saline purgation ought to be helpful in ridding the bowel of the infective agent.' Exactly when sulphaguanide became available in India and South East Asia is not clear, but it was certainly in use in Singapore in September 1945. Stitt's *Diagnosis, Prevention and Treatment of Tropical Diseases*,<sup>2</sup> published in 1943, clarifies the situation; after quoting a number of

favourable trials of sulphaguanidine, it states, 'A large supply of this drug has been very recently sent from the United States to Cairo for the use of the British armies in the Near East and Africa'—but not to India, apparently.

One wonders how many military man-hours were wasted by this useless purgative treatment.

*Competing interests* None declared.

**John Black**

Victoria Mill House, Framlingham IP13 9EG, UK  
E-mail: dorothyblack@suffolkonline.net

**REFERENCES**

- 1 Scadding JR. Reflections on my studies of the effects of sulphonamide drugs in bacillary dysentery in Egypt, 1943–1944. *J R Soc Med* 2006;**99**:423–6
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**Optimizing diabetes care: perspectives from a practical view point**

Mainous *et al.* highlight some important aspects with regard to the intricacies in the provision of diabetes care depending on the health care delivery system.<sup>1</sup> In the UK, however, what we experience is only a tip of the iceberg if we take into consideration:

- (1) The findings of the national diabetes audit, which suggested that a quarter of people with diabetes remain undiagnosed;
- (2) The high coexistence of hypertension with diabetes, which in itself is a becoming a global public health challenge with implications for vascular risk;
- (3) The burden of disease and the burden of cost of disease;
- (4) The discrepancies in physicians' choice of therapy; and
- (5) The proportion of patients with a glycosylated haemoglobin <7.4% having increased only non-significantly from 37.9 to 39.7% ( $P=0.19$ ) over five years, suggesting that glycaemic control *per se* has to get better, and needs to be addressed even further.<sup>2</sup>

These issues become all the more pertinent if we take into account other aspects of diabetes care, such as maternal health and the role of deranged glucose metabolism from a cardiovascular perspective.<sup>3–5</sup> Other important issues include diabetes care provided in the community, such as eye screening and foot care.

Indeed, the pathophysiology of complications in the setting of diabetes is multifactorial, and in addition to the predictable risk factors, there are many other closely inter-related processes that develop in parallel, progress with time, and are robustly and individually associated with the risk of death on a background of diabetes.<sup>2,4</sup> The concept of using national diabetes registers should be recognized as a good role model to advance surveillance, and the new contract for general medical services introduced in 2004

constitutes the biggest change in UK primary medical care for many decades.<sup>2</sup> Hopefully, the results can only be even more rewarding and impressive for this growing epidemic and things will only get better.

*Competing interests* GIV, DJ and AAT are involved with the management of patients with diabetes mellitus in routine daily clinical practice.

**George I Varughese**

**Divakar Jammalamadaka**

**Abd A Tahrani**

Diabetes & Endocrinology, University Hospital of North Staffordshire, Stoke-on-Trent ST4 6QG, UK

Correspondence to: George Varughese

E-mail: georgeiv@doctors.org.uk

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**The diagnosis of art: Diastrophic dysplasia and Hephaistos**

The piece by Manoj Ramachandra and Jeffrey Aronson<sup>1</sup> is quite interesting, but they seem to ignore some vital questions. Why assume that Hephaistos was believed to be lame from birth? The ancient Greeks would certainly have known the risks and effects of handling and working metal ores, some with moderate to high arsenic contents and also mercury. One effect can be the development of peripheral neuritis, which often leads to weakness in the legs and feet. Hephaistos was the Greek god of metal craftsmen in the first millennium BC and is lame, as are other gods of metalworkers—the Teutonic god Wieland, the Scandinavian deity Völunder and the Finnish Ilmarinen. Perhaps this is no coincidence?

*Competing interests* None declared.

**Robert Arnott**

Reader in the History and Archaeology of Medicine, Centre for the History of Medicine, University of Birmingham Medical School

E-mail: R.G.Arnott@bham.ac.uk

**REFERENCE**

- 1 Ramachandran M, Aronson J. The diagnosis of art: Diastrophic dysplasia and Hephaistos. *J R Soc Med* 2006;**99**:584–5

## Challenges of treating thyroid disease: the need for a revisit

We applaud Varughese *et al.* on their Grand Round (*JRSM*, November 2006) highlighting the caveats to be exercised from a practical perspective, when managing patients with hypothyroidism on levothyroxine replacement.<sup>1</sup> Their comprehensive discussion serves to remind clinicians of the intricacies in the management of hypothyroidism and the potential cautions to be remembered in such circumstances.

In this context it would be worth noting that tablet formulation of levothyroxine has also been demonstrated to be absorbed less well than powdered levothyroxine,<sup>2</sup> and interestingly the degradation of tablet based formulations of levothyroxine with preservative have been reported to occur faster in contrast to oral liquid formulation of levothyroxine 25 µg/mL compounded from crushed tablets.<sup>3</sup>

The controversial issues in the management of thyroid disease are crucial for both primary and secondary care clinicians.<sup>4</sup> Indeed, in some situations the timing of treatment in patients with hyperthyroidism is also equally important and should be explored in detail.<sup>5</sup> As an illustrative example, the same authors had reported on a patient with end stage renal disease on haemodialysis who developed hyperthyroidism.<sup>5</sup> Despite titrating the dose of treatment, carbimazole therapy in the setting of haemodialysis had been suggested to be less efficacious due to the fact that the conversion of carbimazole to its active form (methimazole) is inhibited in an acidic environment; it is of note that methimazole is not protein bound and is therefore dialysed.<sup>5</sup> Propylthiouracil, another antithyroid agent, is protein bound and would not get dialysed in such patients.<sup>5</sup> A high index of suspicion is required in such clinical scenarios and as Varughese *et al.* emphasize in their Grand Round, the possibility of other causes should be further explored before patient compliance is doubted.

*Competing interests* None declared.

**Biju Jose**<sup>1</sup>

**A James**<sup>2</sup>

<sup>1</sup>Specialist Registrar in Endocrinology, Department of Diabetes & Endocrinology, Princess Royal Hospital, Telford TF1 6TF, UK

<sup>2</sup>Specialist Registrar in Nephrology, Department of Renal Medicine & Transplantation, Royal London Hospital, Barts and the London NHS Trust, Whitechapel, London E1 1BB, UK

Correspondence to: Biju Jose

E-mail: bijujosek@yahoo.com

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## Training tomorrow's surgeons

Jackson and Gibbin<sup>1</sup> point out that one of the fundamental problems faced by today's surgical trainees is decreased operative exposure. This is a result of a combination of reduced working hours due to the European Working Time Directive, and shortened surgical training. In addition, there has been much debate over the medico-legal and ethical issues regarding consent, where trainees practice on real patients under the supervision of surgical tutors.<sup>2,3</sup> The traditional assessment of direct observation of trainee performance is often influenced by subjectivity, since different trainers have different expectations, and the use of a logbook only demonstrates individual trainee operative exposure and not competency. The accuracy of these logbooks are also often questionable as they rely heavily on self-assessment, and hence tend to lack reliability and validity.<sup>4</sup> We therefore agree with the authors that we have much to learn from the aviation industry, especially regarding the use of virtual reality simulators.

Virtual reality simulators allow automated objective measurements and assessment of surgical skills, which were not previously possible. It also allows new surgical trainees to be trained in their own time without endangering patient lives, and for some simulators, the predictive validity of skills transfer to real operations has been proven.

Although this type of training is still in its infancy, we can anticipate that virtual reality simulators will be a great asset to the surgical training curriculum, both as means of training, as well as an assessment tool.

*Competing interests* None declared.

**Vincent C Y Tang**<sup>1</sup>

**Elaine W Y Lee**<sup>2</sup>

<sup>1</sup>Clinical Fellow in Cardiothoracic ITU, St. George's Hospital, Tooting, London SW17 0QT, UK

<sup>2</sup>Foundation Year 1 in Urology, West Suffolk Hospital, Suffolk IP33 2QZ, UK

Correspondence to: Vincent Tang

E-mail: vincetang@hotmail.com

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