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.

LETTERS

SCOTT CAMAZINE/ALAMY

MMC

Raging against MTAS

A suggested definition of MTAS (Medical Training Application Service) for Modernising Medical Careers (MMC) for Wikipedia[1]: "Appointment of doctors by lottery, plagiarism and creative writing; sacrifice of skill and track record at the altar of political correctness. Like a bad dream, consultants desert patients for days on end to read fragments of applications and interview candidates without cvs; while the juniors mind the shop until one day a website tells them their career hopes are ended—wrecked by MMC."

This nightmare must stop. It is self indulgent to scream and rage, because time is now pressing[2]; but junior doctors must know that consultants are, at last, roused by their fate. We need facts and action. How many UK graduates were not shortlisted? How many places will remain in the second round? How many juniors of distinction, deserving their first choice career, will be sacrificed if interviews of a more fortunate majority are not aborted?

Our leaders have pressed MMC and ministers hard for changes before the second round. Will politicians deliver when the news agenda has moved on? We fear movement of the deckchair variety, and that something titanic will hit the profession if MTAS is not removed or reinvented altogether. Thirty five thousand applicants—and the new UK medical schools have yet to produce a doctor.

It is time for the mass of consultants to find voice. Please register your views at http://www.cai.cam.ac.uk/people/mjb14. You decide whether we call for a temporary halt, a back-to-the-drawing-board halt, or complete resignation of the architects of MMC. We are not against change or modernisation. We are passionate about quality, rigour, and humanity.

Morris J Brown professor of clinical pharmacology University of Cambridge, Cambridge CB2 2QQ mjb14@hermes.cam.ac.uk On behalf of 25 senior consultants listed at www.bmj.com/cgi/eletters/333/7579/0-f#161670

Competing interests: None declared.

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REGULATION

Australia shows benefits of an independent tribunal

UK doctors should welcome the transfer of judging and deregistering doctors from the General Medical Council to an independent tribunal comprising legal, medical, and lay personnel.[1] This change, demanded by the profession in New South Wales in 1986, resulted in legislative amendments setting up just such a tribunal under the chairmanship of a district court judge. Parties have a right of appeal to the NSW supreme court.

Advantages to the public and profession are that it is transparently clear that unpopular doctors are not scapegoated and that misdemeanours of leaders of the profession are not swept under the carpet. The tribunal has the trust of all.

An advantage for the NSW Medical Board (equivalent to the GMC) is that, since 1987, it has not had to face public opprobrium about being too lenient or too severe, as has been the case for the GMC.

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Competing interests: None declared.

1. Johnson J. Will we be getting good doctors and safer patients? *BMJ* 2007;334:451. (3 March.)

Clinical governance can become oppressive

Bruce mentions the climate of fear and the culture of defensive practice created by increasing regulation of doctors.[1] The government white paper on which his editorial is based recognises that there has been managerial over-reaction in NHS trusts.[2] It also concedes that more should be done to ensure clinical governance structures can facilitate fair and effective action locally.

Clinical governance must be implemented in a facilitative and non-oppressive way. The belief that medical errors are necessarily due to incompetence, carelessness, or recklessness for which naming, blaming, and shaming are appropriate responses is perhaps the greatest obstacle to improving patient safety.[3] NHS organisations can also be idiosyncratic, self serving, and autocractic, so they react to problems in arbitrary and sometimes capricious ways.[4]

Independence may not be sufficient to limit the potentially oppressive nature of governance when things go wrong.[5] The government needs to support a credible and effective quality improvement system that meets the needs of patients and health professionals.

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Competing interests: None declared.

1. Bruce DA. Regulation of doctors. *BMJ* 2007;334:436-7. (3 March.)
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SPECIALIST CENTRES

Haematologists should treat sickle cell disease

I understand the case for dedicated sickle cell centres,[1] but we should be wary of centralising services for these patients. Day centres are excellent, but during weekends or nights patients may find access difficult. Also, these patients may come under the care of non-haematology specialists in district general hospitals. The key to care for patients in these circumstances is active involvement of haematologists. Just as intensive care has adopted the "without walls" approach with readily available

outreach services, patients with sickle cell disease should receive expert haematology input on a daily basis wherever they are in the hospital. Support for non-haematology staff—including good communication and 24 hour availability of advice—would help them understand the problems and their management and increase their experience and confidence.

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Competing interests: None declared.

1. Serjeant G. The case for dedicated sickle cell centres. BMJ 2007;334:477. (3 March.)

US cancer centres show the way

The ethos of a true cancer centre seems to have been lost on the groups concerned.[1] The US model of a cancer centre, overseen by the National Cancer Institute, is a facility with true expertise in medical oncology, surgical oncology, and radiation oncology with a multidisciplinary approach and all necessary ancillary support. These centres are staffed by personnel with specific training and offer extensive fellowship programmes to develop the national cancer programme. The centres offer the index level of cancer care. It seems bizarre that several royal colleges should be dismayed that non-specialist centres may lose control of cancer services in the United Kingdom; the primary endpoint of cancer care should be excellence in clinical care with patient outcome reflecting this. It is imperative that cancer centres in the UK have appropriate staffing with experts in clinical care to ensure this happens.

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Competing interests: None declared.

1. Eaton L. Experts call for close scrutiny of new cancer centres. *BMJ* 2007;334:447. (3 March.)

POSTPARTUM DEPRESSION

NICE may be discouraging detection

National Institute for Health and Clinical Excellence (NICE) recommends these questions for routinely screening pregnant and postpartum women for depression: has she been sad or blue for at least two weeks; has she had anhedonia for that period; has she sought help for these problems?[1] The NICE website offers no empirical support for these criteria.[2] The requirement that women endorse sadness and anhedonia is more stringent than that for a formal diagnosis of depression. A recent meta-analysis[3] found that requiring both symptoms to be endorsed caused many depressed patients to be missed. Adding the help question can only make matters worse. Uptake of treatment in depressed pregnant and postpartum women is already low.[4]

Women may be reluctant to seek help because they have not had the opportunity to discuss treatment options, including the relative risks and benefits of drugs, particularly in the context of any individual risk associated with a personal or family history of prolonged, severe, or otherwise impairing depression. The NICE guidelines may deny these women the chance to make an informed choice between psychotherapy and drugs.[5]

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Competing interests: None declared.

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DIAGNOSING HYPONATRAEMIA

Urine tests are often unhelpful

In their discussion of the management of hyponatraemia in primary care, Smellie and Heald correctly emphasise the importance of investigating sudden changes in serum sodium, but the investigational strategy they advocate is incorrect.[1] Firstly, they advocate submitting a sample for urine osmolality measurement after discussion with the laboratory of the serum osmolality on a prior sample. However, measurement of serum and urine osmolality must be contemporaneous to be meaningful, as urine osmolality may be labile in response to changes in hydration status. The likely timescale of obtaining a second sample in primary care makes this strategy unworkable and the results uninterpretable.

Secondly, measurement of urinary sodium and urinary osmolality is unlikely to be informative in patients with renal impairment, as interpretation of these tests assumes normal renal tubular function to allow deductions to be made about underlying water or sodium homoeostasis. In addition, measurement of urinary sodium content is unlikely to be informative in patients taking natriuretic drugs (furosemide and enalapril in this case), as deductions about underlying sodium homeostatic mechanisms are obscured by iatrogenic tubular dysfunction. These two factors will probably apply to many patients with hyponatraemia and will limit the clinical usefulness of these urinary tests.

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Competing interests: None declared.

1. Smellie WSA, Heald A. Hyponatraemia and hypernatraemia: pitfalls in testing. *BMJ* 2007;334:473-6. (3 March.)

PUBLISHER BOYCOTT **EDITORIAL p 547**

We must challenge war

It is all very well for publishers of medical journals, drug companies, and even private healthcare institutions to say they are involved in the "legitimate defence industry,"[1] but arms fairs also sell torture equipment and traders have no qualms about selling equipment to regimes that might be seen as less than legitimate or legal. How "legal" is most oppression and does legality reflect morality? "Legitimate defence" in the modern world seems to involve many more civilians than soldiers; hospitals and humanitarian organisations are in the direct firing line and much of it seems to go on in someone else's country.

If we, as healthcare professionals, are serious about improving the lot of humanity, I think it is our duty to encourage the firms we work with to think twice about their moral decisions. If profit at any cost is the bottom line, then we may as well give up now. If we continue to support these companies, then we have a direct line of responsibility to the child maimed by the unexploded cluster bomb.

Those of us working in health care have a moral imperative to speak out and directly challenge any involvement in war.

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Competing interests: None declared.

1. Dyer O. Boycott publisher because of holdings in arms trade, readers told. *BMJ* 2007;334:389-c. (24 February, online.)