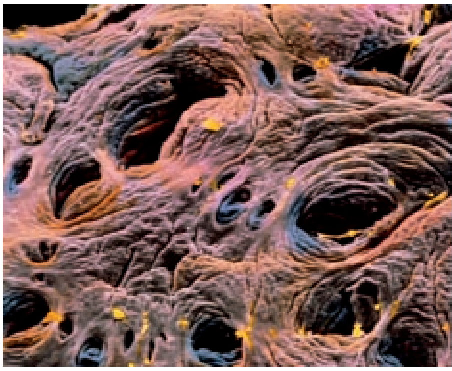
We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS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ADULT COELIAC DISEASE

Rheumatic presentations are common

Hopper et al highlight the non-specific way in which coeliac disease can present in adults.[1] Presentations to rheumatology services are not uncommon with symptoms including fatigue, weakness, non-specific arthralgia, muscle cramps, and myalgia. A good argument therefore exists for screening for this disease when patients present with what may seem initially to be fibromyalgia or chronic fatigue syndrome (CFS), using combined serological testing. Such screening for coeliac disease is included in the recently published NICE guidance on the management of CFS.[2] A true arthritis has also long been recognised.[3] [4] Presentation in elderly people is rare but also described and deserves mentioning.[4]

A gluten-free diet is the mainstay of treatment of the metabolic bone disease that may complicate coeliac disease. A mixture picture of osteomalacia and osteoporosis may be seen, and vitamin D replacement may have an additional role to improve both symptoms and to reduce the risk of fracture. A low serum measurement of vitamin D may be the only abnormality found on biochemical testing, and screening should be considered in patients with premenopausal and male osteoporosis. Presentation with mixed deficiency anaemia is also possible, rather than iron deficiency alone, a low serum concentration of folate in particular being a fairly sensitive early indicator of the disease. Finally, coeliac disease may develop in patients with primary autoimmune rheumatic disease such as systemic lupus erythematosus and Sjogren's syndrome, and vice versa.

Occasionally non-specific musculoskeletal presentations may lead to the erroneous prescribing of corticosteroids. This may lead to false negatives on subsequent duodenal biopsy. However, corticosteroids may improve both gastrointestinal and musculoskeletal symptoms, and may be used to treat refractory disease. Other forms of immunosuppression—such as azathioprine and infliximab—are also used in refractory cases.[5]

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Competing interests: None declared.

1 Hopper AD, Hadjivassiliou M, Butt, S, Sanders DS. Adult coeliac disease. *BMJ* 2007;335:558-62. (15 September.)
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VALUE OF VIDEO CLIPS

Mobile phone videos could help treat sick children

Cutting argues that screen images of sick children are good enough to train those who have to assess sick children.[1] Most parents (even the most socially deprived) now have access to mobile phones with video recording facilities that may be transmitted immediately through the mobile phone network. If screen images are good enough for teaching, they may be good enough to aid assessment.

Centralised of out of hours services could easily and inexpensively be enhanced to permit parents to transmit video images of sick children for assessment by a suitably trained clinician.

Modern technology in the form of video clips should play a part not only in training but also in treatment.

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1 Cutting WAM. Video clip is worth 1000 words. *BMJ* 2007;335:527. (15 September.)

PRP FOR GPS

Summary of responses

The editorial by cardiologist David S Wald on performance related pay (PRP) in primary care sparked 12 responses, mostly from aggrieved UK general practitioners (GPs).[1] [2] United in their opposition to Wald's suggestions for a "revised" quality and outcomes framework (QOF), several of the respondents point out that a hospital consultant may not be best placed to write about issues affecting primary care and the increasing complexity of primary care consultations.

Many are compelled to clarify that the QOF payments are not incentives for the GPs themselves. There may not be enough awareness of the changed ways of working and workloads that GPs have adopted, which, combined with their achievements in implementing new systems and targets, may justify a different system of pay and incentives. And measuring risk factors is only a part of preventive measures, not an end in itself.

Andrew Wijnberg, a GP in Birmingham, takes issue with Wald's comparison: "It is not fair to compare the QOF with paying police to catch criminals or firemen incentives to put out fires; the payments for performance are more akin to a performance pay for the police or fire organisation in achieving national standards in detection rates and prevention."

One way out of GPs having to justify themselves every step of the way might be "to ask the public what it wants from their GPs and then pay GPs to provide it," writes Ian Quigley, a GP from Romford. And in the only letter from outside the UK, academics Joachim Sturmberg and

Carmel Martin identify that what matters for health systems is the improvements to the patient's health experience rather than the "simplistic approach of ticking process items that bean counters can understand."

Mark Davies, university lecturer in law, detects that poor communication is fanning the flames: "Some of the general public are asking what exactly the taxpayer is receiving in return for the extra money pumped into general practice, and whether GPs are being paid extra for doing what a good doctor should have been doing anyway. Justified or not, it seems that the medical profession's communication with the public over this issue leaves a lot to be desired."

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Competing interests: None declared.

1 Wald DS. Problems with performance related pay in primary care. *BMJ* 2007;335:523. (15 September.)
2 Electronic responses. Problems with performance related pay in primary care. bmj.com 2007. www.bmj.com/cgi/eletters/335/7619/523 (accessed 21 Sep 2007).

DARZI REVIEW OF HEALTH CARE

None so blind

Heath puts forward some solid arguments against the polyclinic concept proposed in Lord Darzi's review of health care in London,[1] but she is blind to the deficiencies in our services, cited in *A Framework for Action*.[2]

In some places, access to general practitioners' services, even by telephone, is inadequate. Some practices still close for half a day each week or are not open throughout the day. The problem of poor access and availability is perceived by public and politicians as unacceptable in a service that has received so much investment in recent years and as major contributors to the rise in emergency activity and attendance at hospital accident and emergency departments. Pressure is mounting on us to increase our hours of routine availability.

Polyclinics will not solve all these problems, but they will facilitate groupings of clinicians sufficient to offer extended hours and types of care and to act as the front door to accident and emergency care in some locations. Over 50% of people attending accident and emergency departments would receive better care from primary care practitioners rather than being seen by junior doctors, over-investigated, and even admitted to hospital.

Accident and emergency care is also the preferred place of attendance of some of our most vulnerable and disadvantaged patients, including those with multiple physical, mental, and social problems, who will be much more appropriately assessed and treated in primary care. The trick, however, will be to ensure that such urgent care practitioners maintain their primary care credentials rather than defaulting to hospital accident and emergency behaviours.

I found a strong consensus among primary and secondary care clinicians about what is required to transform London's health care. This was about much more than polyclinics, laying great emphasis, for example, on the need to transform the infrastructure of local intermediate care and social services to support patients out of hospital.

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Competing interests: MCW chaired the clinical working group for planned care for the report *A Framework for Action*.

1 Heath I. The blind leading the blind. *BMJ* 2007;335:540. (15 September.)
2 Darzi A. *Healthcare for London: a framework for action*. London: Healthcare for London, 2007.

HEALTH EQUITY FOR ALL

Ignorance isn't always bliss

I am struck by the global absence of a debate about health literacy in achieving health equity for all.[1] Patients (users) in all countries have a right to information about health. This is enshrined in the constitution of the World Health Organization of 1946. If we are to share our knowledge we need to share a common language. Up to now advocates of health literacy have suggested we remove technical language—a sort of dumbing down.

I propose that we give up our hold on medical information and make it available to all from primary school on—this would entail a massive effort by government, medics, and educationalists to re-package the information, but it's worth looking at. By doing this we would be educating children about the social, political, geographical, and "medical" (infectious, degenerative, etc) causes of disease, and we would be altering presently dry subject areas such as history, geography, and statistics. Furthermore, we would be emancipating children to make their own decisions and possibly helping with the downturn in interest in pure sciences in the developed nations.

I have started an educational pilot programme (www.facts4life.org) along these lines in my local secondary school and will soon start direct patient education in my surgery. The aim with both is for clients to understand the processes involved in illness and by doing so reach a more rounded view about their problem and be better able to own their condition and take more responsibility for it. This doesn't mean we are trying to teach them that the doctor is always right—more that the science on which we make decisions is valid if sometimes poorly used.

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Competing interests: None declared.

1 Maryon-Davis A. Achieving health equity for all. *BMJ* 2007;335:522-3. (15 September.)

Capitalism is a force for good

Maryon-Davis's editorial embodies the doctrinaire anticapitalism characteristic of public health administrators, including the World Health Organization.[1] This bias leads to stunning misrepresentations of reality and currently stands as a major obstacle to improving world health.

The largest scale reduction of poverty in the history of the planet has occurred over the past two decades.[2] This unprecedented progress is mainly due to the progressive adoption of capitalism by the vast populations of China, India, and other Asian nations: China alone is lifting a million people a month out of poverty.[3] Yet Maryon-Davis seems not to have noticed this.

The poorest parts of the world are the least capitalist. Some nations in sub-Saharan Africa are going backwards. In Malawi the standard of living (daily calorie consumption) is perhaps the lowest that has ever existed in human history. This is a consequence of medical advances which allow population to increase even during chronic famine.[4]

Poverty is bad for health; and wealth is the only thing that can cure poverty.[5] And China and India show that capitalist wealth creation is effective, while the more "socialist" and redistributive WHO strategy (focusing on health equity) has a poor track record.

The entrenched ideology of antimodernisation among international public health professionals stands in the path of further progress, both at home and abroad. What the sick and poor of the world need is more capitalism, more industrialisation, and more globalisation.

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Competing interests: None declared.

1 Maryon-Davis A. Achieving health equity for all. *BMJ* 2007;335:522-3. (15 September.)
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THE GILLBERG AFFAIR

Profound ethical issues were smoothed over

The issue at the heart of the Gillberg affair concerns the relation between raw data and the representation of those data.[1] That issue is central to most recent scandals that have damaged the scientific basis of medicine and the trust of patients. It also concerns the availability of raw data to journals, fellow scientists, consumers, those who claim to police matters of integrity in science, and even to authors themselves. In short, it concerns the safety of the entire scientific enterprise.

Gornall's article skirts around every one of the principles while making conjectures about the personalities involved.[1]

The only fact of the affair that is relevant to a serious discussion of ethics is straightforward. The Gillberg team destroyed raw data, having faced an accusation of research misconduct pertaining to those data. They destroyed those data despite a court order that the data should be made available for scrutiny.

The argument about confidentiality is entirely spurious and could be made about practically every bit of clinical research that has ever been carried out. Is it really being suggested that no one (regulatory bodies, courts, bodies investigating research misconduct, trial participants themselves, coauthors, journal editors, research councils, or even authors of the science itself) should ever be allowed to scrutinise any aspect of research? This is not science, and the article that originated this discussion is not part of any form of legitimate scientific debate.

Journals such as the *BMJ* may request raw data from human studies when fraud is suspected, as do a variety of other bodies. There is nothing at all special about the Gillberg study that makes it an ethical outlier exempt from the usual norms of science. At least no such reason has been provided in anything I have read. In the well publicised case of Singh, which also involved the destruction of raw data (in his case termites provided the excuse), the failure to provide raw data provided grounds for suspicion of scientific misconduct—not congratulations.[2] The apparent moral of the report by Gornall[1] is that future researchers faced with questions about the plausibility of their findings should simply destroy their data.

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Competing interests: None declared.

1 Gornall J. Hyperactivity in children: the Gillberg affair. *BMJ* 2007;335:370-3. (25 August.)
2 White C. Suspected research fraud: difficulties of getting at the truth. *BMJ* 2005;331:281-8.

SYLVAIN LEFEVRE/GETTY IMAGES

ASYLUM SEEKERS' HEALTH RIGHTS

BMA is in denial

Despite the evidence that the 2004 charging regulations that bar access to free NHS hospital care violate refused asylum seekers' human rights,[1] the BMA has never acknowledged the fact. Now the government has raised the stakes immeasurably[2]—the years of confusion, procrastination, hounding, and denial of hospital care[3] will appear small beer if its threat to also ban access to free primary care is implemented this October, as is widely expected.

An unconscionable disconnect exists between BMA high profile support for health rights, as reflected by Mary Robinson's prestigious launch of the BMA's *Right to Health: a Toolkit for Health Professionals*,[4] and apparent institutional resistance to incorporate health rights into policy. As the toolkit says, the right to the highest attainable standard of health is a fundamental human right, protected by international law, and the state must refrain from denying equal access for asylum seekers and illegal immigrants.

The ethics department stipulation that the membership inform BMA policy[5] has been met by the unequivocal 1997 instruction from the annula general meeting to the BMA Council "to campaign against embargoes which damage health." On this occasion the government imposing sanctions is British and the victims live in the UK, but the ethical issues are identical.

As the chairman of the international committee proudly explained in his ARM speech, the toolkit provides a basis by which medical associations and populations can hold their governments to account regarding the provision of health care. If the BMA continues to disregard its own educational material, it will surrender its reputation for integrity and its status as an authority on human rights. If it persists in its role as the watchdog that failed to bark, and the government withdraws free access from all health care for refused asylum seekers, the medical profession will—to the extent that its passivity has shown a green light to the government's violation of international human rights law—share responsibility for the suffering and deaths that ensue.

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Competing interests: PLH played a part in developing the General Comment 14 of the International Covenant on Economic, Social and Cultural Rights.

1 Hall P. Failed asylum seekers and health care. *BMJ* 2006;333:109-10.
2 The Joint Committee on Human Rights. *Government response to the committee's tenth report of this session: the treatment of asylum seekers*. London: Stationery Office, 2007:17. www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/134/134.pdf
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5 Sheather J. BMA's response. *BMJ* 2007;334:917. (5 May.)

BMA's reply

While I have sympathy with Hall's comments it is difficult to see how much further it is possible to take policy in this area. The BMA is a democratic membership organisation, and a trade union and professional organisation. It is not a campaigning human rights organisation. The momentum behind its human rights work has come from the democratic work of its members. If the government decides that it wishes to withdraw eligibility for free primary health care for failed asylum seekers, then, should they chose to do so, it is for the BMA's members, working through its regional and committee structures, to develop targeted policy. As a member of the secretariat of the BMA's ethics department I have been involved in numerous meetings with BMA members and senior government figures, trying to ensure that any legislation in this area retains a minimum of humane flexibility. I have done this in quiet pursuit of established BMA policy.

On a broader point, working with a small secretariat the ethics committee has striven for many years to draw attention to the importance of human rights in both the provision of health care and in the underlying determinants of health. This has been in addition to its core work in medical ethics. The BMA has achieved some success in this area. I would call on Hall, as a committed human rights activist, to try to support us for the work that we have been able to achieve, rather than to criticise us for what we have been unable to deliver.

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Competing interests: JCS is a senior ethics adviser at the BMA. He is the department's lead on health and human rights and a coauthor of *The Right to Health: a Toolkit for Health Professionals.*

SICK DOCTORS

Uniquely disadvantaged

Klitzman's article on interviewing doctors as patients highlighted interesting and important perspectives on the patient's position, role, and motivations, as well as the unique position of doctors as patients.[1] Sometimes seen as a perk of the job by others, I suggest that doctors may occupy a uniquely disadvantaged position when ill.

We may struggle with taking time off work, taking up the time of an already busy colleague, and the impossibility of remaining objective about our own condition (usually underplaying symptoms). This position is further exaggerated by guilt at not having been able to manage our condition without recourse to a fellow doctor. The complicated set of dynamics can be further exaggerated if we present with a depressive illness or other psychiatric condition. Any objectivity and insight is long gone, and feelings of guilt, worthlessness, and inadequacy compound a difficult presentation but also affect the ongoing relationship needed for treatment. We may also harbour anxieties around having to maintain a professional relationship with our physician when we return to work.

As a profession I am not sure that we are sufficiently aware of (or comfortable with) the position of the sick doctor. Fearing a possible charge of nepotism should not deter us from looking closer.

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Competing interests: None declared.

1 Klitzman R. Pleasing doctors: when it gets in the way. *BMJ* 2007;335:514. (8 September.)

BANNING SMOKING

Confessions of an accordian cleaner

Haw and Gruer document the reduction in exposure to secondhand smoke since the implementation of smoke-free legislation in Scotland.[1] We report further evidence of reduced exposure to secondhand smoke in Irish pubs since the legislation in the Republic of Ireland.[2 3]

The pub session (or seisiún in Gaelic), where musicians gather to play traditional music together, is commonplace throughout bars in Ireland. Instruments include the accordion, concertina, melodeon, and Uilleann (or Irish) bagpipes, all of which are bellows driven instruments.

There is anecdotal evidence that the interiors of accordions played regularly in smoke filled environments are dirtied as a result of the trapping of contaminant particles circulating in the air as it filters through the instrument. We conducted a telephone survey of all workers involved in the cleaning, repair, maintenance, and renovation of accordions in the Republic of Ireland. We managed successfully to contact six out of seven such workers.

All participants pointed out that a strong smell of cigarette smoke emanated from accordions played in a smoke filled environment when they are opened. Soot-like dirt is also deposited throughout the instrument but particularly where air enters the bellows through the air inlet valve and on the reeds. One repairer commented that the deposition of dirt could be substantial enough to affect the pitch of the reed. Two others claimed that if a musician tended to play in a particular key, that this could be determined from the distribution of dirt around particular reeds. All who were questioned stated categorically that these signs had definitely improved in accordions they had worked on since the introduction of the smoking ban in Ireland.

ILPO MUSTO/REX

Our results show that the smoking ban has improved air quality in Irish bars and its implementation in the face of initial opposition has been music to the ears of the people of Ireland.

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Competing interests: None declared.

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2 Goodman P, Agnew M, McCaffrey M, Paul G, Clancy L. Effects of the Irish smoking ban on respiratory health of bar workers and air quality in Dublin pubs. *Am J Respir Crit Care Med* 2007;175:840-5.
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