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

WHAT'S WRONG WITH THE NHS?

Well, if you are old and frail . . .

The personal view describing deficient care of the author's ageing mother with mental health problems was harrowing.[1] Although many service users do not experience such poor care, there is much objective evidence of "undignified and indifferent care" and "deep rooted and persistent attitudes by hospitals and staff to older people."[2] The old and mentally ill suffer discriminatory attitudes considered unacceptable in other groups.

Some of the problems described are down to lack of professionalism. Ageist attitudes in society infect clinical professionals. Patients with legitimate medical illnesses are labelled as "social admissions" or "bed blockers," rather than being diagnosed and treated. Even though much hospital and primary care work involves older frailer patients, most medical and nursing students don't want to work with older people. Specialist training for care of the elderly and mental health is inadequate for future needs. A 2001 national service framework recommended education and training for all professionals caring for older people, but no funds were earmarked and it hasn't happened.[3] The Healthcare Commission's plan to use inspection and performance management to improve these aspects of care provides some hope.[4] But we still have a system with a clear hierarchy of performance targets, and the "basic care" clearly lacking in this case[1] is well down the list.

The recent report on the Maidstone and Tunbridge Wells scandal showed how external targets distort priorities.[5] The whole performance framework for the NHS encourages a view of unselected acute older patients as a loss leader. Experienced nurses who should act as mentors, educators, and role models are being financially rewarded for leaving the bedside and taking on management roles. Once they have taken the corporate shilling, they are no longer an independent advocate for patient care. While there is no excuse for the total lack of care or professionalism described by the author,[1] system reform could prevent a repetition of this tale. If the same performance pressures were applied to basic care and communication as for outpatient access times or financial balance then perhaps directors of nursing and trust boards would take more interest.

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PRE-ECLAMPSIA

Pre-eclampsia is an inflammatory disorder

Two research articles highlight the link between pre-eclampsia and cardiovascular diseases including ischaemic heart disease, hypertension, and stroke.[1 2] The common factor in these conditions is endothelial dysfunction. What triggers this endothelial damage is not clear. Interestingly, atherosclerosis—an initiating factor for most of these diseases—has been increasingly recognised as an inflammatory disorder. Inflammatory markers, such as C reactive protein (CRP), increase in atherosclerosis and are risk factors for ischaemic heart disease, diabetes mellitus, and cerebrovascular disease. If these different conditions are risk factors for pre-eclampsia, then inflammation may be important in the pathophysiology of pre-eclampsia.

Evidence suggests pre-eclampsia may be an inflammatory disorder. Serum CRP concentrations were significantly higher in all groups of women whose hypertension developed during pregnancy than in controls and those with chronic hypertension.[3]

Other workers have investigated haemostatic function after pre-eclampsia to determine future risk of coronary heart disease.[4] Patients with a history of pre-eclampsia had higher plasma concentrations than controls of von Willebrand factor and fibrinogen, which correlated with blood pressure increases but not proteinuria during the index pregnancy. The authors concluded that persistent endothelial dysfunction, continuing haemostatic alterations, and dyslipoproteinaemia after pre-eclampsia may be associated with future coronary heart disease.

Another study measured plasma thrombomodulin values in primigravidas at risk of pre-eclampsia.[5] Increases in plasma thrombomodulin were not seen until week 32 in uneventful pregnancies, but were present by week 24 in women who later developed hypertensive complications.

Thus, in addition to considering pre-eclampsia as a risk factor for future vascular events in women, it should be considered an inflammatory disease to help identify factors that can predict its severity and develop new therapeutic strategies.

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Competing interests: None declared.

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REDUCING CARBON FOOTPRINTS

How telemedicine helps

Last year Stott and Godlee asked what we as health professionals can do about climate change.[1]

Three examples show how doctors can reduce their carbon footprint using telemedicine. A telepaediatric service in Queensland, Australia, provides a broad range of specialist services to children living remotely.[2] Telemedicine is used to manage 17% of paediatric outpatients with burns. Over six years, 1000 videoconference consultations eliminated about 1.4 million km of patient travel,[3] which reduced CO_2 emissions by 39 tonnes each year. If the analysis included all telepaediatric activity (around 1300 consultations a year), the benefits would be even greater.

In the United Kingdom a neurologist now carries out half of his rural clinics via videoconferencing.[4] This eliminates 2560 km of travel each year, and reduces greenhouse gas emissions by 705 kg. Even a 20% reduction in travel of all UK specialists would eliminate tonnes of greenhouse gas emissions annually.

A recent study estimated that about 36% of the 32 241 092 annual home nurse visits across Canada could be performed virtually. This would eliminate 120 710 648 km of travel each year and reduce greenhouse gas emissions by 33 220 tonnes each year.

Despite the feasibility and value of virtual health techniques in many clinical situations, uptake remains slow. Our examples show the environmental benefit of telemedicine, which accrues each year. This should encourage doctors and professional bodies to become more socially and environmentally responsible by asking whether they could perform some of their current practice virtually.

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Competing interests: None declared.

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HULTON/GETTYIMAGES

SHOULD DRUGS BE DECRIMINALISED?

Prohibition is an ideologically driven failure

Califano's objections to legal regulation of illicit drugs are based on misrepresentation of the reform position bolstered by irrelevant, cherry picked, or misleading facts.[1] A similar piece appeared in the *Financial Times*[2] and was systematically critiqued in the paper's economists' forum.[3] While Califano's rhetoric has since been moderated, and facts fine tuned, the conceptual flaws remain.

The example of Zurich's "needle park" misrepresents legalisation as heroin was never legally supplied. As an experimental tolerance zone it was a failure. Yet, Califano fails to mention that the government responded by legalising heroin. It set up clinics for long term users, where legally prescribed heroin was used under supervision. The success of this approach on key social, health, and criminal justice indicators led to its replication by many countries including Canada, Australia, and much of mainland Europe. The UK is piloting a similar scheme.

Califano relates Italy's high heroin addiction rate to its de facto decriminalisation for possession, but other countries with similar approaches have lower levels of addiction (Netherlands, Portugal), while the UK has a punitive approach yet higher addiction. Califano's grotesque conflation of Italy's decriminalisation policy with the spread of AIDS ignores the reality that supervised use of prescribed heroin with clean needles results in zero HIV transmission. Califano defends a policy that caused the tragic outcomes he identifies, while attacking advocates of responses that eliminate the problem.

Cheap illicit drugs are freely available under prohibition. Despite Califano's assertions, once an illicit market is established (and criminal profiteers will see to that) levels of use are mostly culturally determined and demand led. Problematic drug use is not driven by changes in availability or price.[4]

Califano doesn't understand that the huge profits offered by prohibition attract the violent gangsters now in control, while it is precisely because drugs are dangerous that they need to be regulated and controlled. They are too dangerous to be left in the hands of criminals.

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Debate the balance of harm

Any resolution of the debate should focus on the balance of harm[1 2] But neither side has defined what evidence could or should be brought to bear on this.

Clearly, being addicted to a drug is harmful, but would it be more harmful if the person could access constant strength pure drugs? I have never seen figures on mortality of long term users of pure heroin, and liberalisers need to use this evidence to make a clear case.

If drugs are decriminalised, the number of users could possibly increase. The balance of harm to society here depends on two factors—the increase in harm to addicts and the reduction of crime associated with addiction. Because a large proportion of crime is drug related, harm should be reduced. In Switzerland, medicalisation of the problem seems to have reduced the number of new addicts.[3] Why did neither side quote this experiment?

The debate could be improved by prohibitionists spelling out their assumptions and evidence about how much harm would be caused by increased use, and explaining why that would be worse than the current situation where prisons and crime are dominated by the side effects of prohibition. The liberalisers should explain what sort of liberalisation is proposed and what the balance of harms is; they should admit that some things could get worse with some policy options.

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Prevention campaigns work

A strong prevention campaign supported by the whole population can work.[1] In 1979 the "Just say no" campaign started in the United States. By 1991 the 23 million drug users had been reduced to 14 million. Cocaine and cannabis use halved.[2] Surveys at the time found over 70% of adolescents abstained from using cannabis because of fear of the physical or psychological damage, 60% because of parental disapproval, and 40% because of the law (PRIDE (Parents Resource Institute for Drug Education), world drug prevention conference, US 1987). A similar survey had similar findings.[3]

Prohibition of alcohol in the US in many respects also worked. Consumption of alcohol dropped, cases of cirrhosis of the liver fell by over a third, while alcohol related divorce, delinquency, and child neglect all fell by 50% and alcohol induced psychosis plummeted.[4 5]

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Look beyond legalisation

Many issues go beyond the medical arguments for the decriminalisation of drugs.[1] The use of illegal drugs has increased in the past few decades. In 1970, there were around 5000 problematic drug users in the UK, and now there are between 280 000 and 500 000.[2] The National Treatment Agency recently released figures showing that spending on drug services had increased over the past few years, although the number of people who became addiction free had hardly changed in three years (5759 drug free three years ago and 5829 in 2006).[3] Thus, we are not succeeding in treating addiction.

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Sweden's story in responses

Echoing Califano's citation of Sweden's drug policy in his contribution to the head to head debate,[1] H C Raabe writes:

"Around three decades ago, Sweden adopted the goal to create a 'drug-free society.' The result is impressive with essentially the lowest rates of drug abuse in Europe, lower than, for example, the Netherlands and much lower than the UK."

But, replies Andrew Byrne, "Sweden's goal of a drug-free society has been a cruel hoax on its people. Read the official EMC [European Monitoring Centre] figures from Lisbon: high rates of hepatitis C, enormous alcohol problems, amphetamines at higher rates than many other European countries. Its approach has been repressive, expensive, and largely ineffective. Along with the USA, Sweden is one of the last western countries without a needle services for drug users. This leads to HIV, bacterial infections, and other preventable and costly burdens on the Swedes."

Stephen A Rolles concludes that there is no correlation between the harshness of prohibition's enforcement and the use or misuse of drugs. "Some countries with harsh enforcement policies (including, prominently the UK and US) have very high levels of use while other countries with very different policies, such as Greece, or more famously, the Netherlands, have low levels of use comparable to Sweden."

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1 Califano JA, Jr. Should drugs be decriminalised? No. *BMJ* 2007;335:967. (10 November.)

Try a little compassion

The idea that the availability of drugs creates addicts is rubbish and backs up the panoply of sanctions that support the present law.[1 2]

Most people accept that government is responsible for preventing the actions of some people harming others. Thus, we can harm ourselves by smoking, drinking, and overeating, but unless these habits damage others the law is indifferent, and rightly so. Laws arbitrarily criminalising the ingestion of some substances are illogical and discriminatory. Another government responsibility is to ensure that all available drugs are clean, relatively safe, licensed, and strictly controlled. Illegal drugs absolve government from this responsibility. Thus, the effects of the illegal filthy brown heroin and the sharing of "gear" in prisons (where there is still no needle exchange) is nobody's responsibility.

Our heroin addicts are a pretty docile lot, who cause little mayhem compared with alcohol users, but the harm caused to them—HIV, hepatitis B, hepatitis C, cellulitis, and death by overdose—is caused by the illogical, uncaring ass of a law and is totally disproportionate to their "crime."

I am surprised at the lack of compassion for drug addicts in your articles. For the past 18 months, we have asked addicts to tell us their life stories (not asking them direct questions, just listening) and have recorded and coded important events. Nearly all our addicts have had terrible, nay, horrific, childhood experiences, and I now believe there is a strong association between this and their addiction. We also noticed that many had a "dual diagnosis" of mental illness, much of which predated drug taking.

It seems to me the huge amounts of money spent in the UK to maintain the illegal drugs status quo should be used to set just laws and rescue addicts from the consequences of legalised societal neglect dressed up in a sanctimonious, self righteous law. We should also check and prevent the conditions that "create" the next generation of addicts by helping families to love and care for (not just abuse) their children and only separate children from their parents as a last resort.

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1 Chand K. Should drugs be decriminalised? Yes. *BMJ* 2007;335:966. (10 November.)
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ALLERGY AFTER BREAST FEEDING

Testing hypotheses: reply

Silvers et al say that our recent paper was written as if the study's main aim was to test the association between prolonged exclusive breast feeding and asthma and allergy.[1] Every randomised controlled trial has a primary outcome that serves as the basis for estimating sample size requirements and for obtaining funding. But we also examined secondary outcomes in the first year of life and sought support for follow-up of the

PROBIT cohort to assess important health outcomes at older ages that observational studies had associated with infant feeding. Cluster randomised allocation of the breastfeeding promotion intervention yielded two groups that differed greatly in the duration and exclusivity of breast feeding. This created a unique opportunity to study longer term child health outcomes, including growth, adiposity, neurocognitive development, behaviour, and dental caries, as well as asthma and allergy.[2 3]

In our recent *BMJ* paper reporting on the last two outcomes, my colleagues and I did not compare any breast feeding with no breast feeding.[4] All PROBIT infants were breast fed at birth; the difference between the two randomised groups was limited to the duration and exclusivity of breast feeding. Our inference was thus not that "breast feeding has no effect,"[1] but that prolonged and exclusive breast feeding did not protect against asthma and allergy. That inference is justified by the randomised design, intention to treat analysis, and observed results.

Finally, the wide confidence intervals noted by Silvers et al around the cluster adjusted odds ratios for the skin prick test results have nothing to do with "important confounding and predictor variables."[1] As shown in table 1, and as expected from the randomised allocation, the two groups had similar baseline characteristics.[4] The wide confidence intervals are a function of the high degree of clustering for the skin prick test results (table 5). Clustering was far less evident for the allergic symptoms and diagnoses (table 4) and for the sensitivity analysis for the skin prick tests (table 6), with considerably narrower confidence intervals.

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Competing interests: None declared.

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GMC AND THE MMC COLLAPSE

Role of the PLAB test

The summary of responses published under the banner "GMC and the MMC collapse" contains several inaccurate statements about the role of the General Medical Council and that of the Professional and Linguistic Assessments Board (PLAB) test.[1]

As the medical regulator, the GMC sets the standards of practice in the UK. It has no role in workforce planning, including recruitment and retention of doctors to work in the NHS. The GMC has never conducted a recruitment drive for medical staff either within the UK or overseas.

The PLAB test is one way that international medical graduates (IMGs) can show their medical skills and knowledge in order to join the UK medical register. It is not a tool for controlling the number of doctors entering the UK or for determining who should get jobs. If, after considering the relevant information, IMGs wish to take the PLAB test, we do not think they should be compelled to come to the UK to sit part 1 of the test. To withdraw or ration the PLAB test would deny IMGs the opportunity to demonstrate their knowledge and skills and to compete for jobs. That would be unfair.

For the past 10 years we have warned prospective candidates for the PLAB test to check the job situation before applying for the test. The GMC website clearly states that the job situation has been increasingly difficult for IMGs for several years.

Finally, the GMC makes no profit from the PLAB test. The fees pay only for the costs of running the test.

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Competing interests: None declared.

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SIMON ROBERTS/REX

POVERTY ON THE DOORSTEP

Summary of responses

Why *do* people ignore poverty on their doorstep?[1] They don't, says Peter West. "Many people help, for example, through reading schemes in schools and by working in many different community groups. In addition, many British people give money to charities to help improve the social conditions of poor people."[2]

It is not surprising that rich Britons concentrate their charitable efforts on poverty in the developing world, adds Rachel Walpole. "It is not a matter of whether or not our fellow Britons are poor through their own choices; it is just that in worldwide terms, they are rich."

Our choices define and divide us, says Alison Munns, who lists as her competing interests "inner 'new town' GP, socialist, mother, observer of the genetic inheritance of incapacity benefit (families where no adult has worked in two generations), sponsor of an African child, and supporter of local charities." She describes waiting for her son to finish karate training in "a community hall full of children who are courteous, respectful, and working hard. In sharp contrast outside are children of the same age trampling on the flower beds and hurling stones and abuse at the shop windows. It is not cash, connections, or class that separate them. Someone made a choice."

"You did," responds L S Lewis. And it is indeed cash, connections, or class that separate them.

But Munns responds "I know that some in the club have very little in terms of material possessions. I know that some of the children outside have more in the way of material possessions than my child. They or their families made the choice to spend that which they have (time and money) in the way that they do. We will get nowhere in understanding or changing our world by saying that those families who choose to let their children damage property and insult adults have no choice when other families (who objectively have less resource) do not behave in that way."

Choice requires insight, points out Richard Bartley, quoting Ruskin: "Education is not that one knows more, but that one behaves differently."

Indeed, so the state must act as a catalyst that allows people to drag themselves out of poverty by making better choices, says Ben Dean. Munns concludes: "I know why I make the choices I do. Other people know why they make the choices that they do. But we shy away from asking about them. Much easier to say they have no choice or that they do not have the capacity to make a true choice as they lack insight. I don't think as a society we want to hear the answers that we would get if we did ask. But if we don't the elephant stays in the room."

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Competing interests: None declared.

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