Letters

First myocardial infarction in patients of Indian subcontinent and European origin

Ethnic differences in outcome may be confounded by socioeconomic status

EDITOR—N Shaukat and colleagues analysed ethnic differences in risk factors for and the management and outcome of myocardial infarction.[1] Their results show a significantly higher prevalence of diabetes and angina in patients presenting with myocardial infarction. They also confirmed what has been suggested by others—that outcomes after first myocardial infarction may be worse in patients whose ethnic origin lies in the Indian subcontinent than in Europeans.[2] These differences may be related to patient management, and the authors imply that this may be a result of similar treatment being applied to different ethnic groups with different patterns of disease, a fact that may have been overlooked until now.

While these findings have potentially important implications for policy and practice, two notes of caution should be sounded. Firstly, the ethnic groups compared in this study were identified by analysis of surnames.[3] Although this is a useful technique, searches based on surnames alone are inaccurate and result in rather heterogeneous groups.[4] For example, a sample identified with Indian sounding surnames may include recent immigrants and second or third generation progeny of immigrants, together with non-south Asian wives of south Asian men or their mixed race children; all these groups have different risk profiles for coronary heart disease.

Secondly, in their analysis Shaukat and colleagues make no reference to socioeconomic position as a potential confounder. Even with relatively crude measures of socioeconomic position, twofold differences in the incidence of myocardial infarction have been shown between the poorest and richest quarters of the population.[5] Similar stratification of hospital admissions for myocardial infarction and community deaths from myocardial infarction by socioeconomic position has been reported.[5] It is likely that there were socioeconomic differences between the European and Indian origin groups which may have confounded the findings, although such differences were not examined in this study. While ethnic group is clearly a strong predictor of the outcome of several chronic diseases in Britain[1 2] and it is important to discover the causal processes underlying these findings, care must be taken in drawing conclusions in studies with a historical cohort design. Often key information on variables (such as details of ethnic origin and socioeconomic position) are not available in routine datasets or documentary sources. Prospective study with attention to such details is needed to explore these findings further.

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1 Shaukat N, Lear J, Lowy A, Fletcher S, de Bono DP, Woods KL. First myocardial infarction in patients of Indian subcontinent and European origin: comparison of risk factors, management, and long term outcome. *BMJ* 1997;314:639-42. (1 March.)
2 Wilkinson P, Sayer J, Koorithottumaki L, Grundy C, Bradely M, Kopelman P, *et al.* Comparison of case fatality in south Asians and white patients after acute myocardial infarction: observational study. *BMJ* 1996;312:1330-3.
3 Balarajan R, Raleigh VS. The ethnic populations of England and Wales: the 1991 census. *Health Trends* 1992;24:113-6.
4 Nicoll A, Bassett K, Ulijaszek SJ. What's in a name? Accuracy of using surnames and forenames in ascribing Asian ethnic identity in English populations. *J Epidemiol Community Health* 1986;40:364-8.
5 Morrison C, Woodward M, Leslie W, Tunstall-Pedoe H. Effect of socioeconomic group on incidence of, management of, and survival after myocardial infarction and coronary death: analysis of community coronary event register. *BMJ* 1997;314:541-6. (22 February.)

Selection of patients may have influenced outcome of study

EDITOR—N Shaukat and colleagues reported higher long term mortality after myocardial infarction in patients originating from the Indian subcontinent.[1] We have reported a similarly high relative risk in Asians in the first six months after infarction,[2] but there are important differences in our findings, particularly with respect to the contour of the survival curves. Inspection of the curves in Shaukat and colleagues' study shows that survival among Asians and Europeans was similar in the first year, divergence occurring only later. Adjustment for diabetes made little difference to the relative risk of the Asian group. In contrast, reanalysis of our updated database for patients aged <65 (218 Asian patients (mean age 52.6 years) and 457 white patients (mean age 54.4 years)) suggests that the higher risk in Asians is confined to the early period after infarction and is largely attributable to diabetes. The relative risk for Asians versus white patients adjusted for age, sex, and treatment was 1.97 (95% confidence interval 1.23 to 3.14) in the first six months and only 1.08 (0.59 to 1.96) thereafter. As before, additional adjustment for diabetes reduced the relative risk in the first six months to 1.37 (0.82 to 2.30).

It is interesting to speculate on the reasons for these differences. In Shaukat and colleagues' study only 10 (4.1%) of the 241 Asians and 8 (3.3%) of the 241 Europeans died in hospital, compared with 21 (9.6%) of the 218 Asians and 28 (6.1%) of the 457 white patients in our study. The unusually low hospital mortality reported by Shaukat and colleagues is particularly surprising given that their patients were older than ours (57.6 *v* 53.8 years) and had a lower rate of treatment with thrombolytic drugs (58% *v* 77%). This raises questions about the selection of patients, which could have greatly influenced short term and long term outcome.

The Asian and white populations of Shaukat and colleagues' group and our own cohort were similar in terms of the incidence of diabetes. Our findings with respect to the effect of diabetes are in keeping with the known adverse prognostic importance of the disease, and it is surprising that diabetes made so little difference to the survival analysis in Shaukat and colleagues' study.

Advice to authors

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When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the BMJ article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

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Letters will be edited and may be shortened.

While it is important to establish whether mechanisms in addition to diabetes contribute to the adverse prognosis of Asian patients after myocardial infarction, the low hospital mortality reported by Shaukat and colleagues suggests that selection factors may have undermined the validity of their conclusions.

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2 Wilkinson P, Sayer J, Koorithottumkal L, Grundy C, Marchant B, Kopelman P, *et al.* Comparison of case fatality in Asian and white patients after acute myocardial infarction: observational study. *BMJ* 1996;312:1330-3.

Longstanding high insulin concentrations may play a part in findings in Asians

EDITOR—N Shaukat and colleagues draw further attention to the issue of coronary heart disease in south Asian patients and the association with diabetes.[1] Their report and a previous one[2] almost certainly underestimate the prevalence of impaired glucose metabolism, particularly in Asian subjects. In both studies the diagnosis of diabetes was based on the history given by the patient and was not accompanied by any formal testing of glucose metabolism. In the Asian patients the reported prevalence was 38% and 35% respectively.

The prevalence of impaired glucose homoeostasis is perhaps not widely appreciated. A study of 967 randomly selected adults in a rural town in Pakistan showed that the prevalence of diabetes and impaired glucose tolerance combined was 25% in the population aged over 25. At age 60 the prevalence averaged 36%.[3] Similar findings were obtained in Punjabi male controls in New Delhi and Manchester; in men with known coronary artery disease the figures were 56% and 48% respectively.[4]

Hyperinsulinaemia may promote atherogenesis through various mechanisms.[4 5] In diabetes the tendency is for more diffuse coronary artery disease.[1] The villain is more likely to be insulin than glucose. Current or previous hyperinsulinaemia is the usual feature in glucose intolerance and non-insulin dependent diabetes. The disorders and normality are, however, defined somewhat crudely and arbitrarily on the degree of impaired glucose homoeostasis, without consideration of insulin concentrations or dynamics; this is an unusually unsophisticated approach in endocrine disorders. A notable finding in the normoglycaemic Punjabi men with ischaemic heart disease was that the mean insulin concentrations while the men were fasting and after a glucose load were twice those in their white counterparts. Equally noteworthy was the fact that "healthy" normoglycaemic Asian controls also had insulin concentrations twice those of white controls.[4]

Relative hyperinsulinaemia is probably present in most older south Asians. Longstanding high insulin concentrations may explain the pattern of atheroma predominating in the hyperglycaemic and normoglycaemic Asian patients in Shaukat and colleagues' study.

There is no notable difference between Asians and white people in fat intake; some differences in exercise, smoking, and alcohol consumption exist. The current British recommendation is to reduce fat intake to below 35% of total energy. Should we recommend a lower figure for Asians—approaching the 15% reported in rural Indian communities? These communities also have increased physical activity, and the prevalence of coronary disease is low.[4] If we are to avoid an increasing problem, Asian health workers and religious and community leaders need to be aware of it.[5]

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2 Wilkinson P, Sayer J, Laji K, Grundy C, Marchant B, Kopelman P, *et al.* Comparison of case fatality in south Asian and white patients after acute myocardial infarction: observational study. *BMJ* 1996; 312:1330-3.
3 Shera AS, Rafique G, Khwaja IA, Ara J, Baqai S, King H. Pakistan national diabetes survey: prevalence of glucose intolerance and associated factors in Shikapur, Sindh Province. *Diabetic Med* 1995;12:1116-21.
4 Dhawan J, Bray CL, Warburton R, Ghambhir DS, Morris J. Insulin resistance, high prevalence of diabetes, and cardiovascular risk in immigrant Asians. Genetic or environmental effect? *Br Heart J* 1994;72:413-21.
5 Gupta S, de Belder A, Hughes OL. Avoiding premature coronary deaths in Asians in Britain. *BMJ* 1995;311:1035-6.

Management differed greatly between the two groups

EDITOR—N Shaukat and colleagues compare long term outcome after first myocardial infarction in patients of Indian subcontinent and European origin.[1] They found a substantially higher mortality among those of Indian subcontinent origin.

Indications for coronary bypass grafting are either symptomatic, when angina is inadequately controlled by medical treatment alone, or prognostic, in the case of left main stem disease and triple vessel disease with impaired left ventricular function.[2] Patients from the Indian subcontinent had significantly higher rates of angina than matched European controls (54% *v* 29%, $P < 0.001$), and, in the minority in whom angiography was performed, a significantly higher proportion had triple vessel disease (51% *v* 21%, $P < 0.0001$).

Despite this the authors report that rates of bypass grafting did not differ between the group from the Indian subcontinent (42/241 (17%) *v* (51/341 (15%)). This conservative interpretation may be misleading. Since the rates of triple vessel disease and angina were disproportionately high in the patients from the Indian subcontinent the requirement for grafts was likely to have been correspondingly high. A more meaningful comparison is made when the denominator for the proportion of patients receiving grafts is the number in each group with proved triple vessel disease rather than the total number in each group. In this instance the ratio of European to Asian patients receiving grafts was 2.2:1. It would be instructive to know in more detail the proportion of patients with disease requiring surgery. The rates of referral for consideration for surgery were not stated.

Shaukat and colleagues conclude that accurate identification of patients with triple vessel disease is needed since coronary bypass grafting confers a survival benefit in this group. This is true, but they must also examine why stark differences in management exist between their two groups. American authors have recently noted a significant disparity in coronary intervention and mortality between black and white patients.[3] In the light of this and concern about discrimination in the NHS,[4] evidence of variation in the treatment afforded to distinct racial groups is something for which we must all rigorously account.

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2 Chaitman BR, Ryan TJ, Kronmal RA, Foster ED, Frommer PL, Killip T. Coronary artery surgery study (CASS): comparability of 10 year survival in randomised and randomisable patients. *J Am Coll Cardiol* 1990;16:1071-8.
3 Peterson ED, Shaw LK, DeLong ER, Prynor DB, Califf RM, Mark DB. Racial variation in the use of coronary revascularization procedures. *N Engl J Med* 1997;336:480-6.
4 Esmail A, Carnall D. Tackling racism in the NHS. *BMJ* 1997;314:618-9. (1 March.)

Authors' reply

EDITOR—We agree with Martin White about the problems of using analysis of surnames when looking at ethnicity, but such analysis is probably as good as any other measure at identifying patients of Indian subcontinent origin. It has been used in other studies of subjects of Indian subcontinent origin, and a considerable amount of our mortality data in this population comes from this method.[1 2] Although socioeconomic status itself was not assessed and could be a confounder, our population studies in Leicester indicate that the proportions of people in the manual and non-manual groups and who are unemployed are similar in the two ethnic groups.[3]

Of the 259 patients whom we initially identified, 14 were lost to long term follow up and it was not possible to find a match for four. This makes it unlikely that our selection of patients would influence either early or late outcome. The study was designed to look at differences in case fatality and morbidity after first infarction between the two ethnic groups, rather than causal mechanisms, which have been examined in other studies.[4 5] A history of diabetes does not account for the differences in mortality and morbidity between patients of

Indian subcontinent origin and European patients after first myocardial infarction in our study. As B S Smith points out, however, this type of study design underestimates the true prevalence of diabetes and impaired glucose intolerance (which requires formal glucose tolerance testing) and therefore limits its conclusions on the total impact of impaired glucose metabolism on morbidity and mortality.

Robin P Choudhury and Punit S Ramrakha rightly point out that one of the main messages of the paper is that, despite higher morbidity and mortality after infarction in patients of Indian subcontinent origin than in white patients, investigation and revascularisation are less common. This difference in access to cardiological care is currently being investigated in Leicester.

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1 Donaldson TJ, Taylor JB. Patterns of Asian and non-Asian morbidity in hospitals. *BMJ* 1983;286:949-51.
2 Balarajan R. Ethnic differences in mortality from ischaemic heart disease and cerebrovascular disease in England and Wales. *BMJ* 1991;302:560-4.
3 Shaukat N, Ireland D, Douglas JT, de Bono DP. The relationship of metabolic and haemostatic cardiovascular risk factors to physical activity in Indo-origin and European populations. *Heart* (in press).
4 Shaukat N, de Bono DP, Cruickshank JK. A comparison of risk factors and referral delay in Indo-origin and European patients undergoing coronary angiography. *BMJ* 1993;307:717-9.
5 Shaukat N, de Bono DP, Jones DR. Like father, like son? Sons of European and Indo-origin patients with coronary artery disease reflect their parents' risk factor patterns. *Br Heart J* 1995;74:318-23.

Facial disfigurement

Both counselling for patients and education for the public are necessary

EDITOR—D A McGrouther is right: whether from birth, accident, or medical condition, facial disfigurement is packed with negative connotations.[1] Research suggests that public inexperience when meeting someone who looks different accounts for the staring and turning away[2]; but stigmatisation is still too common and lies behind the name calling and employment problems—advertising, films, and media are usually the culprits and need to be continually challenged. More positively, at Changing Faces we know of many employers, school teachers, and people in the media who admit their assumptions and lack of knowledge and are running projects to raise awareness, but there is a long way to go.

McGrouther is also right that general practitioners need to take seriously the impact of stigmatisation of appearance, especially as research suggests that adapting psychologically to a major facial disfigurement can be more straightforward than adapting to quite minor facial marks.[3 4] Most importantly, however, McGrouther is strong enough in his specialty of plastic surgery to acknowledge its limitations: "It is becoming clear ... that surgery alone is not sufficient: such patients also require informed supportive counselling." I would particularly emphasise the "also." Such intervention should not be an optional extra but an integral part of quality care and rehabilitation. And, of course, it must be shown to be cost effective.

What does that intervention entail? Over the past five years Changing Faces has developed a package of help for anyone with a disfigurement or any member of his or her family who makes contact. Through support, self help advice, and a focus on social skills, we aim to help people to develop positive beliefs about the future, thereby debunking their stereotypes, and to discover how to take more control over their social encounters. An objective evaluation has shown a rise in self esteem and confidence.[5]

We have set up the Outlook Unit based at Frenchay Hospital, Bristol, to pilot the means of introducing this approach into the NHS. We are shortly to start an audit project working with a range of clinical teams so that they can design effective psychosocial help; this will be funded by the Nuffield Provincial Hospitals Trust and the King's Fund.

Some of the research for which McGrouther rightly argues is already on the go, but there is much more to be done—something which a new research foundation could promote.

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1 McGrouther DA. Facial disfigurement. *BMJ* 1997;314:991. (5 April.)
2 Bull R, Rumsey N. *The social psychology of facial appearance.* New York: Springer-Verlag, 1988.
3 Baker C. Factors associated with rehabilitation in head and neck cancer. *Cancer Nurs* 1992;15:395-400.
4 Macgregor F. Facial disfigurement: problems and management of social interaction and implications for mental health. *Aesthetic Plast Surg* 1990;14:249-57.
5 Robinson E, Rumsey N, Partridge J. An evaluation of the impact of social interaction skills training for facially disfigured people. *Br J Plast Surg* 1996;49:281-9.

Counselling is important in healing the whole patient

EDITOR—D A McGrouther's editorial raised an important issue for many people[1] and echoes the findings of a recent King's Fund report on the care of patients with head and neck cancer.[2] The report found that facial disfigurement was an issue which many patients thought was not handled well by professionals or the public. Many people with head and neck cancer have to come to terms not only with their cancer and an altered facial appearance but also with additional difficulties in eating or speaking. This increases social isolation. The high psychosocial impact of upper aerodigestive tract cancers—the most common head and neck cancers—is associated with high rates of suicide and depression.[3] Many patients indicated that they felt supported by their immediate family but isolated from wider society.

According to the report, the counselling services available for these patients were often inadequate: many patients had not been told of services available within their hospital and thought that asking to talk to someone was an admission of not coping. Others had had a form of counselling from various sources, but it was mostly inappropriate and of poor quality: the counsellors had not listened to the patients but had presented set solutions to what they perceived the patient's problem to be. What patients most wanted, but seldom received, was someone who was willing to listen and try to understand what they were going through—a guide on their cancer journey.[4] Many people found patient support groups and information services valuable. Other patients did not know of the existence of support groups, and some professionals reported that they did not advertise support groups as nobody had asked for them. Some patients contrasted the psychosocial support available for people with breast cancer with what they had received for head and neck cancer.

Listening to patients and providing adequate psychosocial support is an important step in helping to heal the whole patient. Given the individuality of the impact of this condition, I support McGrouther's call for evaluation of counselling and all aspects of care and a change in the public perception of facial appearance.

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1 McGrouther DA. Facial disfigurement. *BMJ* 1997;314:991. (5 April.)
2 Edwards D. *Face to face: patient, relative and professional views of head and neck cancer care.* London: King's Fund, 1997.
3 Briebart W, Holland J. Psychological aspects of head and neck cancer. *Semin Oncol* 1988;15(1):61-9.
4 Bushkin E. Excellence in the psychosocial care of the patient with cancer. *Oncol Nurs Forum* 1995;22:537-43.

Few government forecasts of public expenditure have been realistic

EDITOR—Matthew G Dunnigan points out that the government's forecast for funding the NHS for 1998-2000 is close to 0.1% growth in real terms—much lower than the average annual 3% real growth awarded to the NHS over the past 20 years.[1] Because colleagues and I used the figure of 3% in our projections for future spending in our series on funding the NHS, Dunnigan suggests that we may have been overoptimistic. However, the government's forecasts of public expenditure, and NHS expenditure in particular, are usually low and not thought to be realistic. In the past they have mostly not been adhered to even by governments traditionally hostile to public spending. We suggest that there is no reason to take the forecasts literally and that it is much safer to base projections on actual past expenditure.

Dunnigan is correct to point out that our series on NHS funding analysed trends in revenue expenditure rather than capital expenditure. Real spending on NHS capital in England has been cut for three of the past four years (table). This makes no allowance for any funds that may have been made available through the private finance initiative. In fact, the private finance initiative has slowed down the funding of capital projects, especially in London, which is a cause for concern.

Table NHS capital net expenditure, England, 1986-7 to 1996-7

Year	% Real growth compared with previous year
1986-7	-1.6
1987-8	-6.5
1988-9	-6.8
1989-90	24.0
1990-1	8.1
1991-2	0.4
1992-3	10.4
1993-4	-11.7
1994-5	15.0
1995-6	-9.1
1996-7	-7.7*

Source: Department of Health.
*Projected out-turn.

Finally, figures from the Department of Health on revenue expenditure (used in our series) and the capital figures shown in the table do not include the element of capital charging, which includes the 6% return on assets that NHS trusts must give back to the Treasury.

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1 Dunnigan MG. Trends in NHS expenditure. *BMJ* 1997; 314:974. (29 March.)

Several studies have shown salmeterol to be more potent than salbutamol for systemic effects

EDITOR—In their editorial on spacer devices in the treatment of asthma Christopher O'Callaghan and Peter Barry suggest[1] that the finding of Smyth et al that salmeterol is some 10 times more potent than salbutamol for systemic effects may be because salbutamol was given as multiple actuations into a large volume spacer whereas salmeterol was given without a spacer.[2] The study by Smyth et al was not designed primarily to compare potency,[2] but because it suggested that salmeterol had more systemic effects than had been expected from studies in vitro we carried out two further studies, giving salmeterol and salbutamol by identical ways in each study.[3 4] Despite different study designs the two studies have given consistent findings showing that salmeterol is some 7-10 times more potent than salbutamol for systemic effects.

The fact that these findings were similar to those of Smyth et al suggests that the authors' conclusion that multiple actuations from an inhaler into a spacer before inhalation cause the same effect as one direct inhalation may not be true for β agonists. The gold standard for determining systemic drug activity has to be assessment of the drug's pharmacodynamic effects.

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2 Smyth ET, Pavord ID, Wong CS, Wisniewaki AFZ, Williams J, Tattersfield AE. Interaction and dose equivalence of salbutamol and salmeterol in patients with asthma. *BMJ* 1993;306:543-5.
3 Bennett JA, Smyth ET, Pavord ID, Wilding PJ, Tattersfield AE. Systemic effects of salbutamol and salmeterol in patients with asthma. *Thorax* 1994; 49:771-4.
4 Bennett JA, Tattersfield AE. Time course and relative dose potency of systemic effects from salmeterol and salbutamol in healthy subjects. *Thorax* 1997;52:458-64.

Integration of hepatitis B vaccination into national immunisation programmes

Delivering vaccine to infants at risk is complex

EDITOR—In their commentary on Pierre Van Damme and colleagues' paper Philip P Mortimer and Elizabeth Miller suggest a phased approach to the delivery of a childhood hepatitis B immunisation programme in Britain.[1] Initially this would involve stringent implementation of the current programme of universal antenatal screening and subsequent tracking and delivery of vaccine to infants at risk.

In April 1994 Lambeth, Southwark, and Lewisham Health Authority commissioned a community based computer assisted tracking system for following up infants at risk.[2] Existing community nursing and medical staff were trained in delivering the programme. Apart from covering the costs of the vaccine and of initial software, no new money was made available. Universal antenatal screening was operational by April 1995. The health authority covers an area of wide ethnic diversity (white 58.0%, West Indian 17.9%, African 12.5%, Asian 6.8%.). There are about 12 500 births a year; the prevalence of positivity for hepatitis B surface antigen on antenatal screening is 1%.[3]

In the first 34 months of the programme 403 infants enrolled. A completion rate of 83% (181/218) was achieved for the infants who could have completed the programme. Twenty two infants moved out of the area, 17 within Britain and five abroad. Fifteen infants were not traced. Only four children were from white British backgrounds; most were African (55%) or Chinese/Vietnamese (15%).

Miller and Mortimer fail to indicate the complexity of delivering vaccine to infants at risk. The most vulnerable ethnic groups have only limited awareness of hepatitis B; information available from occupational health and genitourinary medicine clinics is of limited relevance and has led to unnecessary anxiety and blame. Information specific to the programme and the natural course of transmission of the virus relevant to local ethnic groups is needed.

The authors' strategy fails to take into account the high mobility rates of babies from ethnic groups and does not address the needs of travelling infants who are not immune. Babies and children travelling to and staying with members of their extended family in areas where horizontal transmission rates are high need special consideration. A strategy for babies already enrolled in universal programmes in other countries who arrive in Britain and require further immunisation needs to be agreed. We are aware of 12 such infants, some of whom have had difficulties completing the programme in the primary care system.

Finally, although we have been able to deliver an effective hepatitis B service locally, we are aware of the patchy implementation of the current programme and the need for rigorous national monitoring if current strategies are to have credibility internationally.

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1 Van Damme P, Kane M, Meheus A on behalf of the Viral Hepatitis Prevention Board. Integration of hepatitis B vaccination into national immunisation programmes. *BMJ* 1997;314:1033-7. [With commentary by P P Mortimer and E Milller.] (5 April.)
2 Nesbitt A, Jackson M. Community programme boasts initial success. *BMJ* 1995;310:400.
3 Chrystie I, Sumner D, Palmer S, Kenney A, Banatvala J. Screening of pregnant women for evidence of current hepatitis B infection; selective or universal? *Health Trends* 1992;24:13-5.

Alternative strategies must be considered before universal vaccination is adopted

EDITOR—The prevention of chronic infection is the main reason for aiming to control hepatitis B. Neonates and children have the highest risk of persistent infection.[1] Either option for control proposed in the article by Pierre Van Damme and colleagues and in the commentary on this article—universal screening or targeted vaccination—would require universal antenatal screening and vaccination of infants at risk to prevent vertical transmission occurring at birth.[2]

For the past 20 years universal antenatal screening for hepatitis B surface antigen has been in place in the Trent region, as advocated by Boxall.[1] To examine the effectiveness of this system we have undertaken an audit in Leicestershire of all women identified as being positive for hepatitis B surface antigen between 1986 and 1995 (161 women from an estimated 120 000 women with live births over this period). Only 70 infants met the criteria for vaccination that were used at the time (the guidelines have changed appreciably in latter years, with more babies being targeted for vaccination[3]).

Of the 70 infants, 47 (67%; 95% confidence interval 55% to 78%) had documented evidence of having received all three doses of vaccine. Seven infants were known to have received two doses and 13 one dose, and in only three were no doses were recorded. These figures are a minimum as some infants probably received vaccine but did not have this recorded. Possible mechanisms to improve the uptake of vaccine include the introduction of a specific nurse liaison service and a call-recall facility.

Additionally, our audit found documented evidence of contact tracing in only 22 cases. This highlights the need for improved notification to the consultant in communicable disease control so that he or she can coordinate the preventive action.

We agree with Philip P Mortimer and Elizabeth Miller's comments in their commentary on the article.[2] Most cases of hepatitis B in Britain occur in adults, and therefore reliance on the vaccination of infants will not lead to a reduction in cases for over 20 years. Alternative vaccination strategies need to be considered before universal vaccination is adopted, including the strengthening of those strategies currently in place, with attention to some of the improvements suggested above.

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1 Boxall EH. Antenatal screening for carriers of hepatitis B virus. *BMJ* 1995;311:1178-9.
2 Van Damme P, Kane M, Meheus A on behalf of the Viral Hepatitis Prevention Board. Integration of hepatitis B vaccination into national immunisation programmes. *BMJ* 1997;314:1033-7. [With commentary by P P Mortimer and E Miller.] (5 April.)
3 Department of Health. *Immunisation against infectious disease.* London: HMSO, 1996.

Treatment of postnatal depression

Two weeks of depression may not be long enough to exclude spontaneous recovery

EDITOR—In their study of the treatment of postnatal depression in primary care Louis Appleby and colleagues observed substantial improvement in patients' mood within one week.[1] They raised the important question of how to distinguish transient distress from more severe types of depressive disorder and they suggested that the presence of depressive symptoms for at least two weeks identified what they called true depression.

Findings from the Edinburgh primary care depression study suggest that this criterion may not be sufficient.[2] Freeman and I studied patients with major depression—that is, dysphoric mood accompanied by at least four biological features of depression for at least two weeks.[3] Randomised patients were interviewed by an independent rater immediately before they started treatment and within 72 hours of a diagnostic interview. Four patients satisfied the a priori definition of recovery even before they started treatment. The four patients who recovered had experienced depressive symptoms for at least two but not as long as four weeks.

The identification of factors that can be used to select depressed patients in primary care who require specific treatment to aid recovery is important but controversial. A major naturalistic study identified two associations with the likelihood of recovery from depression—namely, milder symptoms and a short duration of illness.[4] Our study found that the diagnosis of melancholia, a more severe form of major depression characterised by a pervasive loss of interest, identified patients with a poor prognosis after 16 weeks.[2] Most depressed patients in primary care do not have this more severe form of depression, and there is still the problem of how to prioritise treatment among other, non-melancholic, patients. The use of the duration of the index episode of depression merits further study. Our preliminary data suggested that symptoms lasting two weeks are not sufficient to exclude the possibility of rapid recovery without any specific treatment.

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1 Appleby L, Warner R, Whitton A, Faragher B. A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression. *BMJ* 1997;314:932-6. (29 March.)
2 Scott AIF, Freeman CPL. Edinburgh primary care depression study: treatment outcome, patient satisfaction, and cost after 16 weeks. *BMJ* 1992;304:883-7.
3 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders.* 3rd ed. Washington: APA, 1980.
4 Keller MB, Lavori PW, Mueller TI, Endicott J, Coryell W, Hirschfeld RMA, et al. Time to recovery, chronicity, and levels of psychopathology in major depression. *Arch Gen Psychiatry* 1992;49:809-16.

Additional information would enhance value of study

EDITOR—The trial by Louis Appleby and colleagues of treatment in postnatal depression deserves further comment.[1]

Firstly, the wide recruitment criteria mean that many mild cases of depression were included; many women had apparently not sought medical help. Forty one of the 87 women in the study had a personal or family history of depression not related to pregnancy and 46 had a personal or family history of postnatal depression. We believe that postnatal depression and depressive illness at other times (for example, bipolar or unipolar depression) are different conditions and that the analysis should have tried to separate them—though of course some women may have both.

Secondly, mothers who were breast feeding were excluded because fluoxetine is contraindicated for them, so the trial results cannot be applied to them. It would be useful to know how many such mothers were among the 218 women excluded because they did not satisfy the entry requirements. Breast feeding may have stopped by six weeks or never started because of social pressure, low maternal instinct, or the mother tried and failed.

Thirdly, to give an estimate of the prognosis in the population studied it is useful to know how many women had recovered—that is, achieved a score on the clinical interview of <12, or a score on the Edinburgh postnatal depression scale of <10, or Hamilton scores of <8—in each of the four groups by the end of the study. In a separate letter, Appleby has kindly given us this information. Also deserving of follow up is what the women who took fluoxetine were told about continuing or stopping the drug at the end of the trial, and what they did.

Fourthly, we have learnt from Appleby that all counselling was done by one clinically untrained graduate psychologist under his supervision. His reason for using such an inexperienced person was to show that a non-specialist in mental health could deliver the counselling intervention. This seems to us an important achievement.

Lastly, the paper omitted to note that the trial was funded by Eli Lilly, which makes fluoxetine. Appleby has told us that the company's staff suggested only minor and helpful modifications to the protocol.

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1 Appleby L, Warner R, Whitton A, Faragher B. A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression. *BMJ* 1997;314:932-6. (29 March.)

Sri Lankan refugees

Ethnic cleansing is in progress

EDITOR—Life is not easy for Tamils in Sri Lanka, as claimed by the 14 Sri Lankan doctors in their letter.[1] Some of the authors' outrageous remarks need rebuttal. World media have no access to the Tamil areas; the international community is unaware of the extent to which Tamils are denied basic human rights in Sri Lanka.

Since the British left Ceylon in 1948 the multiethnic island has degenerated into a kind of hell. The revival of ancient racial hatred and denial of equality of opportunity have destroyed national unity. Tamils in the plantation districts were disenfranchised and thousands of them were repatriated without consent to India. No other country in the modern world has done anything similar. The Sinhala-only Act deprived minorities of linguistic rights. Tamil members of parliament were expelled from the legislature, and Tamils have not had fair elections or democratic rights since then.

Any passive Tamil dissent resulted in violence with the loss of thousands of Tamil lives and destruction of Tamil property. It was after 30 years of harassment and humiliation that Tamil militancy emerged. The current ethnic civil war is a reality. No one can condone the methods used by Tamil militants, especially the use of suicide squads. A more objectionable feature is the exercise of state terrorism against Tamils and indiscriminate aerial bombing and naval shelling of Tamil areas by government forces.

The civil war can be ended only by reconciliation and working towards national unity. Sadly, the Colombo government is intent on crushing the Tamils militarily and eliminating any Tamil dissent. The burning by government forces of Jaffna's library and the military blockade of Tamil areas since 1983 indicate Colombo's intent. Ethnic cleansing is in progress; the situation in the north and east of Sri Lanka is similar to that in the former Yugoslavia. Political detainees were massacred in a Colombo prison some years ago. Since the military conquest of the Jaffna peninsula by government forces over 700 young Tamils have disappeared without trace. Thousands run away for their lives and to seek a living elsewhere.

The Refugee Council is to be commended for its humanitarian plea to the British government.[2] The 14 anonymous doctors, who made contemptuous remarks about Tamil "economic refugees," did not come to Britain to do medical missionary work.

The most pressing problem facing mankind is the worldwide refugee problem. This has to be solved by a concerted effort by the international community. All people should be safe, secure, and free to live their lives to their fullest potential in their country of birth.

S Pothalingam *Retired surgeon*
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1 Sri Lankan refugees are not at risk of persecution [letter]. *BMJ* 1997;314:905. (22 March.)
2 Bunce C. Psychiatrists plan network to help asylum seekers. *BMJ* 1997;314:535. (22 February.)

Tamils have become soft targets

EDITOR—The 14 authors of a letter question an independent assessment of the persecution of Sri Lankan refugees and wrongly accuse the authors of the assessment of echoing the propaganda of the Liberation Tigers of Tamil Elam.[1 2] The memories of the 14 doctors must be short, as they seem to have forgotten about the mutilated bodies of Tamils found in lakes, rivers, and the sea around Colombo and the harassment and humiliation by Sri Lankan authorities of many already repatriated.

I have recently returned to Britain from Sri Lanka. To say that outside the war zone the Tamils are living happily is far from the truth. Tamils in Sri Lanka live in fear of atrocities by armed forces and armed gangs. Tamils have become soft targets because the authorities repeatedly turn a blind eye. Innocent Tamils in Colombo are subjected to arbitrary arrest, detention, and humiliation. A relative of mine was arrested, detained, and degraded by having his head shaved. Details of his whereabouts and arrest were withheld from his family despite repeated inquiries.

The doctors also fail to understand that once people are accepted as refugees they are not allowed to travel to their country of origin. Most Tamils living outside Sri Lanka who are not refugees travel to Sri Lanka only to see their relatives or to attend weddings or funerals. There are better places to go on holiday, where one is not in fear for one's own safety.

From a Sri Lankan born British citizen living and working in Britain

1 Sri Lankan refugees are not at risk of persecution [letter]. *BMJ* 1997;314:905. (22 March.)
2 Bunce C. Psychiatrists plan network to help asylum seekers. *BMJ* 1997;314:535. (22 February.)

Comments are like those of white South Africans not so long ago

EDITOR—I am amazed to see the *BMJ* publish what is effectively a political statement and saddened to realise that the 14 signatories to this letter, undoubtedly all Sinhalese, have no insight into the problems in Sri Lanka.[1] While suggesting that they themselves are economic migrants to Britain, they have perhaps inadvertently given good reasons why it would be risky for Tamil doctors to return to Sri Lanka. Only Tamils can be suspected of having been "sent [to Britain] by the Tigers to raise funds" or detained "to prevent incidents in the future." One would then have to have immense faith in the Sri Lankan judicial system.

It was only because I am a Tamil that I was forcibly moved within my own country, penniless and in terror (just like almost every Tamil living outside the north and east), three times between 1971 and 1983; that I had to depend on the good will of my Sinhalese friends for safety; and that I had to give up my ambition of reaching the top of the medical ladder in Sri Lanka. To say that most Tamils "live quite happily outside the war zone" is to add insult to injury; all but those in employment are forced to live in congested cities, where the language is incomprehensible, cost of living atrocious, and fear of detention and physical harm ever present. This while their own homes are inaccessible or without amenities, if they have not been flattened by shelling.

Even though my first act after passing my postgraduate degree in Britain was to book my ticket home, I have not been able to pluck up courage to return to Sri Lanka for 14 years after my third spell as a refugee in my own country. I know of others who have travelled to Sri Lanka, but to call their visit a holiday is another travesty. We Sri Lankans have strong family bonds, and often the only way of meeting a parent or relative is to risk a trip.

I am against violence, whether by the Tigers or by the Sinhalese armed forces and thugs. I have genuine affection for the Sinhalese people because I have lived and worked among them. But Sinhalese people who say how good it is for Tamils in Sri Lanka are like the white South Africans of not so long ago: we know how good apartheid was for the black people.

From a Sri Lankan working in Britain

1 Sri Lankan refugees are not at risk of persecution [letter]. *BMJ* 1997;314:905. (22 March.)

Refugee Council's assessment of human rights situation in Sri Lanka is accurate

EDITOR—The letter written by 14 Sri Lankan doctors working in Britain repeats the fallacy given currency by the Home Office—namely, that Tamils seeking asylum in Britain would not be at risk if returned to Sri Lanka, or at least could live safely in Colombo, and therefore they cannot be in need of political asylum.[1] Despite the letter's assertion that these Tamils are merely "economic refugees," there are many genuine asylum seekers who rightly fear persecution, including torture, at home. The numerous asylum seekers we have seen in recent months at the Medical Foundation for the Care of Victims of Torture, often showing evidence of gross abuse, leave us in no doubt that the Refugee Council's assessment of the current human rights situation in Sri Lanka is accurate.[2]

The letter states that thousands of Tamils live safely outside the war zone, but that does not mean that there are none at grave risk of persecution and torture. No doubt Sri Lanka is safe for some businessmen, professionals, and politicians. But the situation is very different for young men, many of whom have been picked up on suspicion by the security forces, interrogated ruthlessly, and then released, only to be captured and tortured in turn by the Tigers, who accuse them of being police informers. They thus become unacceptable to people on both sides in the conflict and unsafe anywhere on the island.

The 14 Sri Lankan doctors argue that those Tamils who are detained in Sri Lanka are so treated "purely to protect the lives of innocent civilians of all communities, including Tamils." But this argument is used to support the large scale and arbitrary detention of Tamil youths, whether or not they are involved in activities of the Tamil Tigers. It is unacceptable to detain people without due process of law. It is unlawful to torture detainees. Yet this is the reality in Sri Lanka, documented by the Refugee Council and confirmed by the scores of cases that we have examined in London.

The Home Office has a responsibility under international law to investigate each case individually and fully without preconceived ideas, to identify all deserving cases, and not to dismiss applicants for asylum as "bogus applicants."

Duncan Forrest *Clinician*
Gill Hinshelwood *Physician*
Michael Peel *Volunteer*
Gordon Barclay *Volunteer*
Derek Summerfield *Psychiatrist*
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1 Sri Lankan refugees are not at risk of persecution [letter]. *BMJ* 1997;314:905. (22 March).
2 Bunce C. Psychiatrists plan network to help asylum seekers. *BMJ* 1997;314:535. (22 February.)

Government denies legitimate rights of minorities

EDITOR—The claim by 14 doctors that Tamils live happily in southern Sri Lanka is fallacious.[1] The Refugee Council is the premier refugee organisation in Britain. The council's report followed a mission to Sri Lanka and wide ranging discussions.[2] The British Home Office has granted humanitarian leave to remain to over 14 000 Tamils, thus recognising that many Tamils need protection.

The current crisis was precipitated by Sri Lankan governments denying the legitimate rights of minorities. In its 1996 report the United States Department of State says that Sri Lankan security forces were responsible for extrajudicial killings, disappearances, and torture and that detentions and mass arrests increased.[3]

The Sri Lankan Supreme Court has ordered the release of a number of Tamils illegally held in prisons. Currently over 300

Tamils have remained in custody for over two years and many for over four years without trial under emergency regulations and the Prevention of Terrorism Act, which enable the authorities to prolong detention. Safeguards provided by the regulations have been breached by the security forces and government officials, including the defence secretary, according to a decision of the Supreme Court in December 1996. Supreme Court judge P Ramanathan said last November that, despite judicial orders against law enforcement officers, torture continued unabated in police stations.

Amnesty International has continually documented human rights violations against Tamils and has often pointed out that impunity remains a major concern. An example is the abduction and murder of over 35 Tamils in the Colombo headquarters of the police special task force. In March a Colombo judge dismissed the case on the grounds that the attorney general and the 24 police officers accused in the case were not present in court, and declared that the absence of the attorney general was an obstruction of justice. The government agent in Jaffna has received over 500 complaints of disappearances since the army captured the peninsula in early 1996, and a number of soldiers have been detained for rape and murder of Tamil women.

As doctors, we are extremely concerned by the government's economic blockade of the northern Vanni area, where 450 000 Tamil refugees live without adequate food, medicine, and other basic needs. In the two hospitals functioning in the area 110 people died in December alone because of lack of medicine and medical equipment.

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And 99 other Sri Lankan doctors

1 Sri Lankan refugees are not at risk of persecution [letter]. *BMJ* 1997;314:905. (22 March.)
2 Bunce C. Psychiatrists plan network to help asylum seekers. *BMJ* 1997;314:535. (22 February.)
3 US Department of State. *Sri Lanka country report on human rights practices for 1996.* Washington: USDS, 1997.

Tamils are victims of unjust politics, not economic refugees

EDITOR—"A physician and a priest ought not to belong to any particular nation, and be divested of all political opinion." (Napoleon Bonaparte, 1769-1817)

The 14 Sri Lankan doctors working in Britain make remarks that have irritated and upset many of the Tamil medical fraternity in Britain.[1] We are surprised that the *BMJ* should publish such a politically biased view. We wish to set the record straight.

Since 1956 there has been civil unrest in Sri Lanka. The world witnessed the pogroms and genocidal activities of the Sri Lankan government in 1958, 1977, and 1983 and the army occupation of predominantly Tamil areas, where terrorism and atrocities by the army continue. Tamil youths took up arms to defend themselves against this state sponsored terrorism. The state has also withheld medicine, food, and other essentials to the northeast since 1990. Who can deny that Sri Lanka is a police state masquerading as a democracy?

Are the areas in the south safe, as claimed by these doctors? Could any Sri Lankan government afford to have another pogrom as seen in 1983 in its capital city, Colombo? The Sinhala community depends on the many Tamils living in Colombo, who pay exorbitant rents. The government cannot upset this black economy. These Tamils who have sought sanctuary in the south have left behind their own homes in the north and east of the island because of army atrocities. Many thousands are refugees in their own country without proper shelter, food, and medicine. Many thousands of Tamils of all ages languish in jails without trial despite having committed no crime. Why should the Refugee Council's report be untrue?[2]

In the past four decades the Tamils have been forced to migrate from Sri Lanka for their own safety because of the repeated political and civil unrest. Tamils have dispersed across the globe. Since 1983 mass exodus on a unprecedented scale has taken place. We are not economic refugees, we are the victims of unjust politics in Sri Lanka. Since independence the Tamils have systematically been denied all basic rights of being equal citizens in their country of birth. At best these 14 doctors living in Britain are the real economic refugees.

V Rajayogeswaran *Chairman, Medical Institute of Tamils*
80 Tyron Way, Sidcup, Kent DA14 6AZ

And 11 other Sri Lankan doctors

1 Sri Lankan refugees are not at risk of persecution [letter]. *BMJ* 1997;314:905. (22 March.)
2 Bunce C. Psychiatrists plan network to help asylum seekers. *BMJ* 1997;314:535. (22 February.)

⁂This correspondence is now closed.—EDITOR

Let them eat asparagus

EDITOR—Through the letterboxes of residents of East Fife recently dropped a booklet entitled *Eating for Health* published by the Health Education Board for Scotland.[1] Tucked into the booklet was a letter from Lord James Douglas-Hamilton, minister of state at the Scottish Office, exhorting us all to read and digest the contents. The booklet gives advice about healthy eating—we should all eat more bread, cereals, fruit, and vegetables. (It does not mention wine.) It cautions against foods with high fat and sugar contents, and it suggests avoiding biscuits, cakes, chocolate, crisps, and chips (except on special occasions). On the first page the booklet states that eating more healthily does not mean spending more on food. The cover of the booklet features an orange, a leek, a baby sweetcorn, two twists of pasta, and an asparagus spear.

Interestingly, asparagus was on special offer in Tesco in St Andrews at the same time: 300 g for £1.99. By a strange coincidence a packet of biscuits (ginger nuts) costing 61p also weighs 300 g. Comparison of the nutritional content of these two foods using data listed on the packets is shown in the table.

Biscuits provide over 9743 kJ per £1 spent, whereas asparagus spears, tasty as they are, can offer only about 159 kJ per £1 spent (barely enough to cover the effort of eating them). The balance sheet for protein is similarly in favour of biscuits: 27 g of protein per £1 spent on biscuits, compared with 4 g per £1 spent on asparagus.

In terms of value for money the biscuits win hands down; this is probably why so many people buy them. The real issue here is poverty and shows the lack of understanding and insensitivity of policymakers towards the problems of ordinary people in the United Kingdom. The message seems to be "let them eat asparagus."

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1 Health Education Board for Scotland. *Eating for health.* Edinburgh: Scottish Office, 1997.

Comparison of nutritional content of 300 g asparagus and 300 g packet of biscuits

	Energy (kJ)	Protein (g)	Fibre (g)	Fat (g)	Carbohydrate (g)
Asparagus	318	8.7	5.1	1.8	6.0
Biscuits	5943	16.8	5.1	49.5	225.0

Surgical training

Training must be of highest possible quality

EDITOR—T J Crofts and colleagues articulate many of the concerns of surgical trainees.[1] The outcome of surgical training is a function of both the quality and the quantity of the training. Concern about surgical training tends to concentrate on the quantity of training, particularly the shortened training period and reduced hours of work. If these are considered in isolation it is easy to become alarmed by the prospect of underqualified surgeons coming off the production line. The changes brought about with the introduction of the specialist registrar grade and the new deal must be accompanied by an improvement in the quality of surgical training. Without adequate funding and an increase in the number of consultants the experiment will fail.

The indicator operations listed by Croft and colleagues are mostly elective procedures. A one in two rota would not rectify the potential deficit in the number required for training. To correct the 60% cut in surgical training by dramatically increasing the

length of training is neither practicable nor desirable. What the authors have shown is that in their training scheme they are unable to train their existing trainees adequately. If suitable changes cannot be made within the hospitals in Lothian perhaps the number of trainees should be reduced. Trainees cannot afford to spend a year in a post that does not offer sufficient exposure to training. The suggested numbers of operations were derived from questionnaires that elicited low response rates, and possibly the respondents were unrepresentative.

Trainees and trainers should aim to increase the number of operations performed with help that are logged in their logbook. Trainees performing parts of operations under supervision can gain quality, safe training without unduly prolonging the procedure—for example, in the early stages of training in laparoscopic cholecystectomy a trainee might concentrate on establishing a pneumoperitoneum and dissecting out the gall bladder.

We must consider what we are training general surgeons to become. Previously, most general surgeons would have had a special interest and broad experience in all the subspecialties. In the future, trainees will not have this breadth of experience at the end of their training. This has important implications in both the organisation of training schemes and the provision of consultant services in the future.

The new deal and the specialist registrar grade are here to stay. We should ensure that training is of the highest possible quality and is focused to provide the specialists that our patients are rightly beginning to demand.

Dermot C O'Riordan *President*
Nick Shaper *Honorary secretary*
Association of Surgeons in Training, London WC2A 3PN

1 Crofts TJ, Griffiths JMT, Sharma S, Wygrala J, Aitken RJ. Surgical training: an objective assessment of recent changes for a single health board. *BMJ* 1997;314:891-5. (22 March.)

Structured training is now being used

EDITOR—We are writing from the Royal College of Surgeons of Edinburgh in response to T J Crofts and colleagues' contribution to the debate about the scope for performing elective operations in basic and higher general surgical training.[1] The college agrees that maintaining high standards of training is a priority. Discussions should be based on a realistic appraisal of training opportunities to minimise frustration among trainees and trainers while satisfying service demands. Most general surgical trainees work a rota with at least three elective operating theatre sessions a week. Maximising training opportunities demands innovative approaches.

It is no longer realistic to accept the conventional logbook as the principal measure of operative experience or competence. We have developed the concept of structured training, breaking down operations into logical components (incision, exposure, procedure, and closure) and assessing competence in each part. Training will proceed on the basis of competence being recorded in all component parts of an operation before the trainee performs the full procedure.

The college is pursuing the concept of structured training for surgical trainees by identifying key operations and their component parts. Before an operating session the trainer and trainee agree on what the trainee will undertake. The rest of the operation is performed by the trainer, so that the service demands are met. The principles identified apply equally to basic and higher surgical training. On the basis of the key training operations available in an individual unit it will be possible for basic or higher surgical trainees and their trainers to agree, prospectively, what operative experience and level of competence can realistically be achieved in a six or 12 month attachment.

The Royal College of Surgeons of Edinburgh has been in the forefront of recognising the priority of ensuring excellence among trainers to maximise training opportunities. In conjunction with its sister colleges it has promoted courses on "training the trainer" since 1995.[2]

The numbers of procedures identified by Crofts and colleagues as necessary to train a general surgeon merit careful interpretation rather than despair. A positive approach to structured training and training the trainers will help meet the challenges.

Robert Shields *President*
D A D Macleod *Chairman, training committee*
R W Porter *Director of education and training*
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1 Crofts TJ, Griffiths JMT, Sharma S, Wygrala J, Aitken RJ. Surgical training: an objective assessment of recent changes for a single health board. *BMJ* 1997;314:891-5. (22 March.)
2 Bulstrode C. Education for educating surgeons. *BMJ* 1996;312:326-7.

Save our service

On 14 June we published, as an article, a letter that Peter Richards and Michael Gumpel sent to Frank Dobson, the new secretary of state for health. Here we publish the reply from the NHS Executive and Richards and Gumpel's response.

Reply from the NHS Executive

Dear Professor Richards and Dr Gumpel,
Thank you for your letter to the secretary of state concerning difficulties in acute hospital services.[1] I have been asked to reply.

The government readily acknowledges the pressures in the system, which are caused by very tight financial controls and increasing demand on hospitals from urgent and emergency cases. In dealing with this your letter does, as you indicate, raise national policy issues. I do not think that it is practical to respond in detail to the various points you raised, but I can assure you that these issues, which clearly affect all hospitals in England, are under active discussion currently in the wide ranging review of the health service which is being led by ministers.

Your letter lists many of the excellent initiatives undertaken by Northwick Park to improve efficiency and save money to improve care for patients, and I expect that you are aware that the regional office of the NHS Executive appreciates the efforts of the trust and its medical team for its work in these areas. At the same time, although the absolute priority is for hospitals to treat patients who are admitted as emergency or urgent cases, the NHS has a responsibility also for patients on waiting lists for non-urgent and routine surgery.

The regional office of the NHS Executive also acknowledges the spirit of cooperation that is growing locally between acute and community trusts (including the Wellhouse, Northwick Park, the Royal Free, Central Middlesex, and Barnet Healthcare) as doctors and managers look at the needs for health care of the whole population, together with general practitioners from all the areas using these hospitals. This is undoubtedly the way forward.

Tony Bennett *Business manager, briefing and parliamentary unit*
NHS Executive (North Thames), Department of Health, London W2 3QR

1 Richards P, Gumpel M. Save our service. *BMJ* 1997; 314:1756-8. (14 June.)

Response to the NHS Executive's response

Dear Secretary of State,
Our letter to you (published in the *BMJ* on 14 June) was an opportunity for you to demonstrate your leadership, your commitment to a rational sharing of responsibility, and your determination to move towards a partnership of open accountability between NHS management and doctors. The interest created by our letter showed public concern. Both the public and the profession will judge the inspiration of your response.

We thought that you were waiting to explain that the £1.2 billion identified in the budget for the NHS next year (which we take to be recurrent funding) will go a long way towards eliminating the damaging and inequitable "efficiency" levy. Also, we expected you to take some credit for the steps that the government has announced to simplify and speed up the private finance initiative process to attract private capital into the NHS on mutually acceptable terms. Were you too modest? Sadly, we conclude that the delay simply represents the standard cascade time of a message from you to a regional outpost: all part of the central buck-passing bureaucracy that you are committed to pruning to provide bandages and butter to see the acute hospital services through the long hard winter ahead.

Peter Richards *Medical director*
Michael Gumpel *Chairman, medical staff committee*
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