

It is often junior doctors who decide, possibly without consciously recognising that they have thereby pre-empted organ donation. Moreover, even when a patient suitable for organ donation dies in an intensive care unit, in nearly one third of cases family representatives are unfortunately not able to agree that the person who has died had expressed no objection to organ retrieval after his or her death.³ Thus kidneys that could have given new life to others are lost with these patients.

Public opinion is strongly in favour of organ donation. A majority would approve of a change in legislation to allow organs to be removed after death unless the patient had registered an objection beforehand. In one recent survey 28% of a random sample carried a kidney donor card saying, "I would like to help someone to live after my death." (E Ward for the British Kidney Patient Association, 1993). How many of them realise that death must occur in an intensive care unit for their wishes to be fulfilled? Unless, that is, the removal of organs from non-heart beating donors can be shown to be both practical and worth while.

Two papers in this week's *BMJ* address the issues surrounding non-heart beating donors.^{4,5} A group in Leicester used in situ perfusion to reduce damage to the organs while preparations, including obtaining permission for removal, were made (p 575).⁴ A group from King's College Hospital removed the kidneys as soon after death as possible, having obtained prior permission in two thirds of cases from families and even from the donors themselves, who were dying of cerebral tumours in a hospice.⁵ Death in these cases may be gradual, resulting in damage to the organs, and the moment of asystole is not always detected precisely. In both hospitals the pressure on intensive care beds usually precluded elective ventilation solely for the purpose of organ retrieval.⁶ The authors in Leicester were particularly careful to obtain ethical approval, and publicised their protocol in the local press. No objections were raised.

Varty *et al* report that some kidneys were lost because of difficulties in placing the double balloon triple lumen catheters, and the number of authors of the paper suggests that the in vivo cooling technique used demanded a high level of input from skilled surgeons.⁴ Phillips *et al* compared the results of using non-heart beating donors with those of using conventional heart beating donors and report a higher mortality and lower graft survival with non-heart beating donors.⁵ As Varty *et al* also found, primary non-function was the rule, and oliguria could be prolonged even in grafts that eventually functioned satisfactorily.

The implantation of non-viable kidneys not only results in graft nephrectomy but also risks sensitising patients to future grafts. We need a rapidly performed test, perhaps histochemical, to prove tissue viability so as to avoid implanting kidneys that are never going to work. These and other published results make it mandatory to obtain informed consent from patients waiting for a renal transplant who are to be included in a programme using non-heart beating donors.

At a recent combined meeting of the Dutch and British transplantation societies the question of non-heart beating donors was formally debated, and a clear majority supported the belief that "non-beating heart donors make an important contribution to kidney organ donation." Another paper presented at the same meeting, however, suggested that there was still a large stock of potentially usable kidneys from donors whose hearts were still beating. The authors audited clinical decisions taken in the case of 163 potential donors out of 5200 deaths in 1992 in five hospitals in north west England (J Connolly *et al*, Joint Meeting of British and Dutch Transplantation Societies, London, 1993). Only three quarters of the potential donors were being ventilated at the time of death, the most common reason for non-ventilation being a poor prognosis; among those ventilated an inquiry about donation was recorded in only 64%. The authors concluded that this large group of potentially usable kidneys was not used because of the failure of medical staff to identify potential donors and to facilitate organ donation. The question was "Are we educating the right people?"

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1 United Kingdom Transplant Support Service Authority. *Report*. Bristol: UKTSSA, 1991, 1992, 1993.

2 Pallis C. Prognostic significance of a dead brain stem. *BMJ* 1983;286:1234.

3 Gore SM, Hinds CJ, Rutherford AJ. Organ donation from intensive care units in England. *BMJ* 1989;299:1193-7.

4 Varty K, Veitch PS, Morgan JDT, Kehindi EO, Donnelly PK, Bell PRF. Response to organ shortage: kidney retrieval programme using non-heart beating donors. *BMJ* 1994;308:575.

5 Phillips AO, Snowdon SA, Dean C, Hillis AN, Bewick M. Results of renal transplantation from non-heart beating cadaveric donors. *BMJ* 1994;308:575-6.

6 Feest TJ, Riad HN, Collins CH, Golby MGS, Nicholls AJ, Hamed SN. Protocol for increasing organ donation after cardiovascular death in a district general hospital. *Lancet* 1990;335:1133-5.

Homosexuality and mental health services

Homosexuals shouldn't have to suffer their doctors' prejudice

By inviting us to "identify the particular needs of lesbians and gay men" the *Health of the Nation Key Areas Handbook on Mental Illness* touches on complex issues.¹ For ours is a deeply homophobic society: gay men and lesbian women face prejudice at home, school, work and even in death.^{2,4} They are assaulted by their families² and by strangers.⁵ The discrimination is pervasive: some is derived from statute law,⁶ black youngsters chant death threats at gay men in mimicry of a popular song,⁷ and in *BMA News Review* distributed to all general practitioners and BMA members, a doctor recently wrote: "Only a society flirting with self-destruction encourages such perversity and ruination. Under no circumstances ought

homosexuality be regarded as anything other than a destructive habit system."⁸ Similar prejudices were voiced by opponents of this week's parliamentary amendment to lower the age of consent for homosexual men.

Although intuitively one might expect such prejudice to have an adverse impact on the mental health of lesbians and gay men, this has proved hard to show.⁹ Historically, medicine and psychiatry defined homosexuality as a disease or homosexuals as disturbed. But rigorous research has failed to differentiate homosexual and heterosexual populations on the basis of personality or psychopathology.¹⁰ Ask not why homosexuals are unstable, but why they are not.

Most recent research into psychological distress in homosexuals has been performed in the context of HIV and AIDS. Important though this is, it fails to address the emotional needs of the gay community in general and of lesbian women in particular. What these studies have shown, however, is that distress may be mediated by such factors as life events,¹¹ social support,¹² and self esteem.¹³ These are mainstream concepts in models describing the social origin of mood disorders. Additional evidence exists, however, that prejudice and stigmatisation amplify the effects of adverse events.¹¹

But what if professions delivering health care prove to be homophobic? In a survey of attitudes in 1989 about one third of general practitioners felt uncomfortable with male homosexuals, considered them a danger to children, and thought that they should not be employed in schools. One in nine believed that homosexuality was an illness.¹⁴ In a Canadian study in 1991, one quarter of respondents from a psychiatric faculty identified themselves as prejudiced against homosexuals.¹⁵ Last year a British survey reported that only one in two clinical medical students thought that homosexual activity could form part of an acceptable lifestyle.¹⁶ Gay men and lesbian women may commonly feel that they have dealt with a prejudiced health professional; one in four respondents to an American survey in 1980 believed this.¹⁷

The perception of prejudice, of course, is not proof of its existence. But, as shown elsewhere in this issue by Lynn Rose (p 586),¹⁸ the two tend to coexist, and each is disabling. Rose's study of homophobia among doctors is welcome and begs the question of how a profession that fails to care for its peers can care for its clients.

A change in attitudes and practice is overdue. Firstly, the needs of lesbians and gay men should be explored within undergraduate and postgraduate medical education. Models for medical undergraduates and mental health professionals^{19 20} already exist, and evidence suggests that specific training is worthwhile.²¹

Secondly, points of contact should be established between service providers and the gay community, using existing resources within community mental health services and primary care. Gay or lesbian staff may or may not want to take on specific responsibilities. The costs of providing a poster, leaflet, or list of local groups are minimal. Thirdly, the

government must review its own agenda in the light of the recent Department of Health booklet identifying sexual orientation as a risk factor for suicide in adolescents.²²

Finally, the Royal College of Psychiatrists needs to formulate a substantive response to the 1993 position statement on homosexuality issued by the American Psychiatric Association: "Whereas homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities, the APA calls on all international health organizations, psychiatric organizations, and individual psychiatrists in other countries, to do all that is possible to decrease the stigma related to homosexuality wherever and whenever it may occur."²³

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- 1 *Health of the nation and key areas handbook mental illness*. London: Department of Health, 1993.
- 2 Harry J. Parental physical abuse and sexual orientation in males. *Arch Sex Behav* 1989;18:251-61.
- 3 Remafedi G. Male homosexuality: the adolescent's perspective. *Pediatrics* 1987;79:326-30.
- 4 Nichols SE. Psychosocial reactions of persons with the acquired immunodeficiency syndrome. *Ann Intern Med* 1985;103:765-7.
- 5 Violence figures "tip of iceberg." *Pink Paper* 1993;303 (Nov 12):2.
- 6 Tatchell P. *Out in Europe*. London: Channel 4 Television and Rouge Magazine, 1990.
- 7 Sanderson T. Pecking order of oppression. *Gay Times* 1993 (Nov):15.
- 8 Gardner G. Should the age of consent for gays be lowered to 16? *BMA News Review* 1993;19 (Nov):23.
- 9 Weinberg MS, Williams CJ. *Male homosexuals their problems and adaptations*. New York: Oxford University Press, 1974.
- 10 Gonsiorek JC. Results of psychological testing on homosexual populations. *American Behavioral Scientist* 1982;25:385-96.
- 11 Ross MW. The relationship between life events and mental health in homosexual men. *J Clin Psychol* 1990;46:402-11.
- 12 Lackner JB, Joseph JG, Ostrow DG, Kessler RC, Eshleman S, Wortman CB, et al. A longitudinal study of psychological distress in a cohort of gay men. *J Nerv Ment Dis* 1993;181:4-12.
- 13 Nicholson WD, Long BC. Self-esteem, social support, internalized homophobia and coping strategies of HIV+ve gay men. *J Consult Clin Psychol* 1990;58:873-6.
- 14 Bhugra D. Doctors' attitudes to male homosexuality: a survey. *Psychiatric Bulletin* 1989;13:426-8.
- 15 Chaimowitz GA. Homophobia among psychiatric residents, family practice residents and psychiatric faculty. *Can J Psychiatry* 1991;36:206-9.
- 16 Evans JK, Bingham JS, Pratt K, Carne CA. Attitudes of medical students to HIV and AIDS. *Gemturin Med* 1993;69:377-80.
- 17 Dardick L, Grady KE. Openness between gay persons and health professionals. *Ann Intern Med* 1980;93:115-9.
- 18 Rose L. Homophobia among doctors. *BMJ* 1994;308:586-7.
- 19 Wallick MM, Cambre KM, Townsend MH. How the topic of homosexuality is taught at US medical schools. *Acad Med* 1992;67:601-3.
- 20 Murphy BC. Educating mental health professionals about gay and lesbian issues. *J Homosex* 1992;22:229-46.
- 21 Hellman RE, Stanton M, Lee J, Tytun A, Vachon R. Treatment of homosexual alcoholics in government funded agencies: provider training and attitudes. *Hosp Community Psychiatry* 1989;40:1163-8.
- 22 Department of Health. *Mental illness: sometimes I don't think I can go on any more*. London: DoH, 1993.
- 23 American Psychiatric Association. Position statement on homosexuality. *Am J Psychiatry* 1993;150:4.

Cutaneous T cell lymphomas

Well designed randomised trials of both topical and systemic treatments are needed

Mycosis fungoides and the Sézary syndrome, together known as the cutaneous T cell lymphomas,^{1,2} are low grade non-Hodgkin's lymphomas with a mature helper T cell phenotype and monoclonal rearrangements of the T cell receptor genes. They should not be confused with intermediate and high grade non-Hodgkin's lymphomas of T cell origin affecting the skin—which, confusingly, are also sometimes referred to as cutaneous T cell lymphomas. In the United States there are between 500 and 1000 new cases a year—compared with 49 000 new cases of non-Hodgkin's lymphoma³—and their incidence is increasing.

The aetiology of mycosis fungoides and the Sézary syndrome is unknown, though several putative retroviruses and environmental factors have been implicated.^{1,2} There are also many difficulties in determining treatment because many reviews of published studies do not use a standard staging classification, although a TNM and blood based staging

system has been widely adopted in recent years⁴; many studies do not use standard response criteria and have too few patients to draw meaningful conclusions; and there are few randomised studies comparing different approaches to treatment.

Nearly all patients have symptoms from their skin lesions, which may itch and cause pain, infection, bleeding, or disfigurement. Topical treatments, both chemotherapy and radiotherapy, are therefore the mainstay of treatment.

Radiotherapy was shown to clear the cutaneous lesions in the early 1900s, and it is still useful palliation for advanced tumours and ulcers. Electron beam therapy proved a real advance and could be used to treat the entire skin surface. In a large series from Stanford University in the 1970s total skin electron beam therapy led to complete resolution of all skin lesions in 84% of patients.⁵ Most of these patients who responded relapsed over the ensuing three years, but a fifth remained free of lesions for five to 10 years or more. The