

deduced from this. Does the relative contribution of specific and non-specific factors to a treatment affect how we judge its clinical benefits? Perhaps it would be worth comparing the results obtained by the homoeopath in the trial with those obtained by a conventional general practitioner. This would help us to evaluate the comparative effectiveness of homoeopathy in practice.

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- 1 De Lange de Klerk ESM, Blommers J, Kuik DJ, Bezemer PD, Feenstra L. Effect of homoeopathic medicines on daily burden of symptoms in children with recurrent upper respiratory tract infections. *BMJ* 1994;309:1329-32. (19 November.)
- 2 Campbell ACH. Children with upper respiratory tract infection. *British Homoeopathic Journal* 1977;66:20-5.

### Power of study was not estimated

EDITOR,—E S M de Lange de Klerk and colleagues conclude that homoeopathy has little to add to the treatment of recurrent upper respiratory infections.<sup>1</sup> There is a flaw in this conclusion. The authors do not mention the possibility of a type 2 error, which occurs when the null hypothesis is incorrectly accepted when the alternative hypothesis is true. Why was there no estimation of the power of the study? The authors state that "the small difference in symptom score found in favour of the homoeopathic medicines was not significant." This may have been because the numbers of patients were not sufficient for a true difference between the two groups to be detected. I also question whether the provision of advice on nutrition is part of conventional treatment of recurrent upper respiratory infections. Dietary manipulation alone may be a powerful tool in the management of recurrent upper respiratory infections.

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- 1 De Lange de Klerk ESM, Blommers J, Kuik DJ, Bezemer PD, Feenstra L. Effect of homoeopathic medicines on daily burden of symptoms in children with recurrent upper respiratory tract infections. *BMJ* 1994;309:1329-32. (19 November.)

### Authors' reply

EDITOR,—The level of significance that we chose was, admittedly, an arbitrary cut off point. The difference in daily symptom score lingered around the 0.05 significance level. The estimate of the difference, however, was in our opinion—and to our disappointment—not clinically relevant. Even the clinical relevance of the upper limit of the 95% confidence interval of the difference in mean symptom scores over a year (0.83) must be questioned.

The power calculation for the trial was based on the outcome measure "change in wellbeing score."<sup>1</sup> After completion of the trial the confidence interval is what matters. The recorded difference in the change in wellbeing score was much smaller than expected.

Because the greater use of antibiotics in the placebo group might have reduced the difference in the symptom scores we did a combined analysis of the symptom score, use of antibiotics, and other interventions. This also gave only small differences between the two groups. The difference between the groups in the reduction in the use of antibiotics compared with the year before participation in the study did not approach significance ( $P=0.38$ ), and therefore its possible clinical relevance was not an issue for discussion in our paper.

The daily symptom scores were averaged over a year because the children suffered from symptoms half of the time and close monitoring gives more reliable data. Time trends were studied by compar-

ing differences over the last nine months as well as differences over the four quarters of the year separately. No time trend could be found. Adjustment for small differences in prognostic variables at the baseline reduced the difference in the mean daily symptom scores between the groups. As well as analysing mean daily symptom score, we analysed episodes of respiratory tract infection. The placebo group suffered an average of 8.4 episodes covering 47 days, with a mean daily symptom score of 14.1, while the treatment group suffered an average of 7.9 episodes covering 41 days, with a mean daily symptom score of 13.6 ( $P=0.5$ ).<sup>1</sup>

The parents of most of the children stated that their child's health had improved. This may have been due to growth and development as well as the whole treatment package. Our study, however, concerned the specific effects of individually chosen medicines. The homoeopathic doctor who prescribed these medicines studied at the Faculty of Homoeopathy (a long course), passed the examination for membership of the faculty with honours, and had had 10 years' experience in homoeopathic practice. Dietary advice was given to create optimal conditions for a positive effect of homoeopathic medicine.<sup>2</sup>

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- 1 De Lange de Klerk ESM. Effects of homoeopathic medicines on children with recurrent upper respiratory tract infections. Amsterdam, Vrije Universiteit, 1993. (PhD thesis.)
- 2 Hahnemann S. *Organon of Medicine*. 6th ed. Philadelphia: Boericke and Tafel, 1921, and 1977.

## The health of leaders

### Should they have occupational health screening?

EDITOR,—Psychiatrists and psychologists are not always natural allies, yet I believe that Ian Robertson was correct to draw attention to Churchill's habitual alcohol consumption.<sup>1</sup> He is not the first to have done so. L'Etang wrote extensively on the physical and mental incapacities of many great figures in history and commented in particular on Churchill's alcohol intake, quoting from respected sources.<sup>2</sup> Like all truly great people, however, Churchill rose above his personal weaknesses when it really mattered. Yes, he made mistakes, as at Gallipoli, but in all crucial decisions Churchill's judgment, with or without alcohol, was right. He insisted that we keep our fighter squadrons in reserve to face the Germans after the fall of France became inevitable. He worked tirelessly to bring the United States into the war on our side, so ensuring eventual allied victory. The fact that he probably drank  $\geq 80$  units of alcohol a week should not be taken out of context.

The debate on Churchill's achievements has tended to obscure the real question that Robertson asked—namely, should leaders undergo occupational health screening like the rest of us? I believe that this could have unforeseen consequences, possibly to the detriment of human destiny. As Shakespeare said, "Some men are born great, some achieve greatness, and some have

greatness thrust upon them." The vast majority of people live out their lives in mediocrity. A nation does not have an inexhaustible supply of highly talented individuals in any particular field. A policy to screen out from this pool of talent any person with worrisome health problems could lose as much as it gains. Nelson's victory at Trafalgar secured control of the sea for Britain for the rest of the century. How many modern sea commanders are without one arm and one eye? In today's navy I doubt whether Nelson would have been allowed to command an office in a run down naval dockyard earmarked for closure. What, I wonder, would a modern occupational health assessment have made of the deaf Beethoven?

As any historian knows, great events can turn on the smallest quirk of fate. Great discoveries are made by only a few. Human destiny relies on these people being in the right place at the right time. We should be careful that in our eagerness to prevent mishap we do not also discard good fortune and success, which can come from unlikely sources.

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- 1 Robertson I. Drunk in charge. *BMJ* 1994;309:1237. (5 November.)

- 2 L'Etang H. *Fit to lead?* London: William Heinemann Medical, 1980.

## Churchill's biographers disagree over alcohol consumption

EDITOR,—Ian Robertson offers his "sincere apologies" for his "gross error" in describing Churchill as often being dead drunk but then seems to be trying to buttress his "pseudo memory" by selective quotations from biographers known to be unsympathetic to their subject.<sup>1</sup> He might also have quoted Gilbert: "Winston's whisky was very much a whisky and soda. It was really a mouthwash. He used to get frightfully cross if it was too strong;" "He was remarkably moderate. He certainly drank the weakest whisky-and-sodas that I have ever known. . . . In truth in his normal drink the whisky only faintly tinged the soda."<sup>2</sup> These observations from close associates do not suggest that Churchill was addicted to alcohol.

In my view this further article is more illuminating of Robertson's bias and lack of scholarship than of Churchill's problem drinking (if any).

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- 1 Robertson I. Interpreting problems. *BMJ* 1994;309:1519. (3 December.)

- 2 Gilbert M. *Finest hour*. London: Heinemann, 1983:336.

## Use of personal records for research purposes

### Identification numbers help maintain confidentiality

EDITOR,—We agree with Nicholas Wald and colleagues that access to medical records is needed for research purposes,<sup>1</sup> but computerised record linkage does not necessarily entail the identification of people by name. The allocation of a unique identification number to each resident, as is currently the case in jurisdictions such as Saskatchewan,<sup>2</sup> provides a robust method for linking relevant records about a person from different databases while minimising problems of confidentiality.<sup>3,4</sup>

Developments in computer applications over the past 30 years have emphasised their value in medicine,<sup>5</sup> and the recent trends towards managed