Letters

Racism continues among doctors in Europe

EDITOR—Last year Ismail and Carnall highlighted the positive attitude of the British in bringing racism in the NHS to worldwide attention.[1] Similar coverage by *Deutsches Ärzteblatt*, the medical and political organ of the Bundesärztekammer (the German medical association) in Germany, would be unthinkable. Such discussions on race issues would be embarrassing.

I was a target of racial abuse from an overbearing consultant in a hospital in Nordrhein-Westphalia for about two years. He was fully supported by the hospital authorities; I was simply a non-white British citizen blowing a whistle. Hounded and harassed, I approached the Marburger Bund (the hospital doctors' trade union), of which I was a member; it is the largest association of doctors in Germany. I was told that although I was legally in the right in my attempts to get my fair share of private patients and medical insurance fees, it could not help me. Apparently it did not deal with racism problems.

As a member of the BMA, I referred my case to its international department for representation at the Standing Committee of European Doctors in Brussels. I explained the rejection by the Marburger Bund, but it was six months before the BMA replied decisively, in November 1995. It confirmed that the BMA's legal department was unable to help because "the Marburger Bund would be the appropriate body to do so."

And so I had to accept that the Marburger Bund is unable to seek redress for racial abuse and legally is not bound by its constitution to proceed to civil cases. I find it a moral scandal that I was ignored by the Marburger Bund and that the BMA's international department was unable to act. I wonder how the associations's legal department would respond to complaints of racism in the NHS by a non-white doctor from another country in the European Union—that would, hypothetically, be a similar case to mine.

"Equality strategies" in the European Union must be rethought. These become a farce when the union itself does not have antidiscriminatory laws because some hegemonic states do not like them. Britain and Germany should identify ethnicity first; not everything in life is based on race, the criterion on which the BMA and the Marburger Bund betrayed me as their member and as a British/European Union citizen.

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1 Esmail A, Carnall D. Tackling racism in the NHS. *BMJ* 1997;314:618-9.

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

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, whether typed or sent by email, should give each author's current appointment and full address. Letters sent by email should give a telephone and fax number when possible. We encourage you to declare any conflict of interest. Please send a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

We may post some letters submitted to us on the world wide web before we decide on publication in the paper version. We will assume that correspondents consent to this unless they specifically say no.

Letters will be edited and may be shortened.

More openness needed in palliative care

Deliberate shortening of life has no part in ethical medical practice

EDITOR—Corner's contribution to the euthanasia debate, in her Personal View, concerns me.[1] Surely palliative care physicians are—and need to be—perfectly clear in their response to requests for symptom control and euthanasia as to what is legally permissible and what they are attempting to do. A recent letter in the *Times* makes the position clear, and there is no intention or desire for "greyness" or obfuscation.[2]

The role of medicine in the care of patients whose disease is beyond the possibility of cure is to improve quality of life as far as medically possible (and to facilitate nursing, social, and spiritual support through involvement of the relevant professionals); it is not to deliberately shorten life or to drag out the dying process.[3] To that end we are able to prescribe or advise appropriate analgesics, including morphine, diamorphine, and other opioids; we can escalate the dose to the level that will control pain or add coanalgesics and other drugs to maximise this control.[4] By this means we are able to remove pain in the vast majority of patients and to relieve or reduce it to acceptable levels in the remainder. Our practice is with patients with cancer, AIDS, motor neurone disease, and a limited number of other progressive, incurable, and fatal illnesses, but the principles apply in the care of many other patients. Similar principles apply to the relief of other symptoms, such as nausea and vomiting (with antiemetics), dyspnoea (with bronchodilators, opioids, etc), and mental distress (with antidepressants, sedation, and other approaches).

Deliberate shortening of life—euthanasia—has no part in palliative care or ethical medical practice. The possible shortening of life that is occasionally consequent on appropriate prescribing of drugs to relieve pain, distress, or other symptoms does not need to be a consideration limiting proper palliation. I do not understand why these need to be regarded as "grey ethical principles" or "maintaining a climate of fear and secrecy," as Corner suggests. It is good that the report of the Select Committee on Medical Ethics,[5] the *BMJ*'s ABC series on palliative care, and Oliver's letter (among others) make clear and public the principles to which we adhere.

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1 Corner J. More openness needed in palliative care. *BMJ* 1997;315:1242. (8 November.)
2 Oliver D. Easing pain for the terminally ill. *Times* 1997 Nov 12.
3 National Council for Hospice and Specialist Palliative Care Services. *Definitions in specialist palliative care.* London: NCHSPCS, 1995.
4 O'Neill B, Fallon M. ABC of palliative care: principles of palliative care and pain control. *BMJ* 1997;315:801-4.
5 Select Committee on Medical Ethics. *Report.* London: HMSO, 1994.

Wider debate is needed about decisions made in care at end of patients' lives

EDITOR—Corner highlights several misconceptions encountered in the care of dying patients.[1]

Firstly, she seems to equate the ethical principle of "double effect" with euthanasia. There are, however, important differences between the two. In the case of double effect

the primary aim of giving a drug is to relieve distressing symptoms, and the death of the patient (should that occur) is unintentional. Euthanasia occurs when drugs are given with the aim of causing the patient's death. Corner states that "the easing of death, as an intentional double effect, is commonplace in palliative care." We are not aware of any evidence supporting this and believe it to be uncommon within specialist palliative care teams.

Secondly, the management of distressing symptoms involves the judicious use of drugs. This entails the correct choice of drug (such as an analgesic for pain or an anxiolytic for anxiety) and regular review to minimise toxicity and drug interactions. Corner's article was prompted by media coverage of the case of Annie Lindsell, a patient with motor neurone disease, but Ms Lindsell's general practitioner agreed to the careful use of drugs to control her symptoms, not for euthanasia.

Thirdly, Corner raises the issue of double effect and informed consent. Because double effect is relatively uncommon there is no compulsion for palliative care physicians to discuss these issues with the patient or family. We find, however, that patients and families often raise concerns relating to the use of drugs in the terminal phases of illness, and these issues are discussed openly.

While we agree with Corner that there should be more openness in palliative care, we also believe that her article highlights the need for wider education and debate about the complex decisions that are made in caring for patients at the end of their lives.

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1 Corner J. More openness needed in palliative care. *BMJ* 1997;315:1242. (8 November.)

Doctrine of double effect means that death is not intended

EDITOR—In her comment on the case of Annie Lindsell, a patient with motor neurone disease, Corner describes "the easing of death as an intentional double effect" as being commonplace in palliative care and general practice.[1] She calls on those working in palliative care to make clear its strategies regarding when "double effect is used with the view that death is a likely and welcome secondary consequence." She seems to jump from relief of symptoms, with the unintended risk of death, to intentional killing.

It is incorrect to refer to the doctrine of double effect in this way. The doctrine has several well defined safeguards that protect against such use. Firstly, the act in question has to be morally good or at least neutral. Secondly, the doctor's intention must be only the good effect; the bad effect can be foreseen but never intended. Thirdly, the bad effect must not be the means of achieving the good effect; so a patient's death must not be the means to relieve his or her distress. Finally, on balance, the good effect must outweigh the bad effect.[2]

Clearly, therefore, the doctrine of double effect should not be used to justify the statements given. It may well be that palliative care (and other specialties) needs to acknowledge that there are times when symptoms cannot be controlled and when intentionally ending life would be a welcome release; but if this is the case then the doctrine of double effect does not provide the justification. Instead, this would entail the acceptance of the principle of active euthanasia. To apply this clearly defined doctrine of double effect wrongly will lead only to hesitation in its use and unnecessary suffering for patients. The doctrine of double effect may well be used frequently, and, as death approaches, the risk from any procedure or treatment increases, but this does not mean that death is the intention.

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1 Corner J. More openness needed in palliative care. *BMJ* 1997;315:1242. (8 November.)
2 Beauchamp TL, Childress JF. *Principles of biomedical ethics.* New York. Oxford University Press, 1994:207.

Patient's sex does not affect use of thrombolysis

EDITOR—Wenger's review of the importance of coronary heart disease in American women is equally applicable to women in Britain.[1] Wenger points out that the prognosis is influenced by access to clinical interventions, and she suggests that underuse of thrombolysis in women may have a cascade effect on risk stratification.

Her assertion that patients who have had thrombolytic treatment seem more likely to undergo investigation is unreferenced. In addition, the study quoted as showing lower use of thrombolysis in women than men shows no sex difference when the 95% confidence intervals are examined.[2] One of us (RR) has undertaken an (as yet unpublished) critical appraisal of the international literature on the influence of patients' sex on the use of cardiac interventions, which showed that in nine of 11 studies the patient's sex did not affect use of thrombolysis. Five of these studies were conducted in Britain, of which four showed no independent effect of sex.

The cascade effect probably does occur, but later in the clinical management pathway. We recently performed a retrospective cohort study of 715 people admitted to five hospitals in inner London with acute chest pain. After differences in age, chest pain characteristics, comorbidity, and cardiac risk factors were controlled for, the patient's sex did not influence use of thrombolysis, but men were 70% more likely than women to undergo exercise testing (adjusted odds ratio = 1.72 (95% confidence interval 1.19 to 2.50)). This may be because exercise testing is less accurate in women than men.

Women were no more likely than men, however, to receive alternative non-invasive investigations (male to female adjusted odds ratio for isotope scanning 0.93 (0.54 to 1.61)). Similar findings were reported in a previous English study.[3] When women did undergo exercise testing, sex related differences in their subsequent management did not occur. This suggests that the cascade effect occurs at the level of non-invasive testing. Referral for angiography was mainly influenced by the results of the exercise test (positive result of exercise test, adjusted odds ratio = 7.59, $P < 0.05$). In turn, findings at angiography were the most important determinants of revascularisation, and sex did not exert a significant effect (male to female adjusted odds ratio for revascularisation after angiography = 1.37 (0.33 to 5.56)).

Taken together, these findings have different implications for the promotion of equitable access to cardiac services than might be drawn from the review article.

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1 Wenger KNK. Coronary heart disease: an older woman's major health risk. *BMJ* 1997;315:1085-90. (25 October.)
2 Jackson G. Coronary artery disease and women. *BMJ* 1994;309:226-7.
3 McLaughlin TJ, Soumerai SB, Willison DJ, Gurwitz JH, Borbas C, Guadagnoli E. Adherence to national guidelines for drug treatment of suspected acute myocardial infarction. *Arch Intern Med* 1996;156:799-805.
4 Spencer I, Unwin N, Pledger G. Hospital investigation of men and women treated for angina. *BMJ* 1995;310:1576.

Childhood insulin dependent diabetes: Oxford may not be representative

EDITOR—Gardner et al present results from the Oxford health region showing a considerable rise in the incidence of childhood insulin dependent diabetes since 1985, particularly among children under the age of 5.[1]

We have recently published similar data from Scotland, based on prospective registration of 2326 cases of insulin dependent diabetes in children aged under 15 during 1984-93 and with an estimated completeness of 98.6%.[2] We found an annual incidence of 23.9/100 000 per year, compared with the Oxford figure of 18.6/100 000 per year. The rate of increase in the group of children aged under 5 was consid-

Change in incidence of insulin dependent diabetes in children aged under 15 in Scotland, 1984-93

	Annual change (95% CI) (%)	
Age (years)	Oxford	Scotland
0-4	11 (6 to 15)	3 (0 to 7)
5-9	4 (0 to 7)	3 (1 to 6)
10-14	1 (–2 to 4)	0 (–2 to 2)
Overall	4 (2 to 6)	2 (1 to 3)

erably lower than that reported from Oxford, although rates of increase were comparable in the two older age groups (table). We could detect no evidence of a difference in rates of increase between age groups (Poisson regression $\chi^2 = 4.02$, df = 2; P = 0.13).

We conclude that the pronounced increase in the incidence of insulin dependent diabetes among the youngest children that was evident in Oxford may not be representative of the situation in Britain as a whole.

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1 Gardner SG, Bingley PJ, Sawtell PA, Weeks S, Gale EAM, the Bart's-Oxford Study Group. Rising incidence of insulin dependent diabetes in children aged under 5 years in the Oxford region: time trend analysis. *BMJ* 1997;315:713-7. (20 September.)
2 Rangasami JJ, Greenwood DC, McSporran B, Smail PJ, Patterson CC, Waugh NR on behalf of the Scottish Study Group for the Care of Young Diabetics. Rising incidence of type 1 diabetes in Scottish children, 1984-93. *Arch Dis Child* 1997;77:210-3.

Profiting from closure

Birmingham's consultation document is not a private finance initiative

EDITOR—In his editorial on the private finance initiative and the NHS, Price makes unwarranted assertions on the basis of incorrectly interpreting the content of Birmingham Health Authority's consultation documents on Birmingham's health care future.[1]

He says that this is a private finance initiative plan. It is not: it is a consultation document setting out the constraints on and options for development and offering a series of possible solutions. Price says: "Their solution involves reducing the hospital sector by half . . . ." The consultation document does not do this. It points out, however, that substantial numbers of patients stay one day or less and that at the other end of the scale a substantial number of bed days are taken up by a small proportion of patients. There are valid questions to ask about whether acute hospital facilities are well used in this way, but a halving of beds is not suggested. Price also asserts that the documents imply that capital spending will be used to drive out labour. The document neither says nor implies this. Indeed, the impact of doctor shortages and the pressing need to recruit in certain spheres, notably accident and emergency medicine and general practice, are discussed at length.

Price seems to be mainly interested in criticising the private finance initiative and to have contrived arguments to suit his purpose. He would have done better to read the documents properly. There is a clear and pressing need to rebuild obsolescent hospitals unworthy of England's second city and to enhance its general practice. Price does these needs no service.

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1 Price D. Profiting from closure: the private finance initiative. *BMJ* 1997;315:1479-80. (6 December.)

Author's reply

EDITOR—The Birmingham consultation document *is* a private finance initiative plan. "New PFI [private finance initiative] proposals," according to the document, "must fit into an overall agreed framework . . . . This is the framework which we are now developing together, through this process of consultation" (p 11).[1]

The document even specifies the desired scale of private investment—£250m over the next three years (p 11).[1] The consultation document *does* refer to reducing the size of the hospital sector by half: "There is an expectation [of] a significant reduction in total occupied space . . . . We would suggest a target figure of a 50% reduction [for] new-build schemes . . . in Trust plans" (p 62).[2] Moreover, the document says that "a large proportion of elective patients currently staying up to four nights in hospital could be treated without staying overnight" (p 43)[2] and that most patients staying more than seven nights could be in non-hospital settings (p 44).[2] This implies that less than 50% of the 1996-7 caseload will require inpatient stays in the future (p 41).[2] It is disingenuous to describe these claims as "valid questions" when £50m plus the cost of capital is to be taken out of the hospital sector to "emphasise the degree of change *required*" [my italics] (p 63).[2] It follows that capital investment is being used to shed labour from the hospital sector. Indeed, according to a senior official in the health authority, this is the main objective of the proposed capital investment (M Waterland, personal communication). It is not unusual for authorities to be reticent about the staffing element of their proposals. In Edinburgh, for example, it has so far proved impossible to get details and the Lothian Health Board is even making misleading statements to a government minister about its strategy (M Ford, letter to Alistair Darling MP, 17 December 1997). Public scrutiny of private initiative plans is proving exceptionally difficult.

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1 Birmingham Health Authority. *Birmingham's health care future? Consultation document.* Birmingham: Birmingham Health Authority, 1997.
2 Birmingham Health Authority. *Birmingham's health care future? New models of health care.* Birmingham: Birmingham Health Authority, 1997.

Informed consent in medical research: the ethics committee's view

EDITOR—Although, owing to circumstances beyond my control, considerable time has elapsed since the publication of clusters of letters commenting on the subject of informed consent in research,[1 2] I would still like to draw readers' attention to certain information on the granting of ethical approval by the Research Ethics Committee of the University of Natal for the study of Bhagwanjee et al.[3] While several of your correspondents seemed, either directly or by implication, to agree with the ethics committee's decision,[1] many others took issue with the decision on the basis of philosophical or procedural considerations, or both, which are obviously legitimate and worthy of respect, although the committee disagrees with them. However, the letter from Squire et al casts doubt on the legitimacy of the committee in terms of its membership,[1] and the letters from Ana[1] and from Mhlongo and Mdingi[2] contain outrageous and absolutely unjustifiable attacks on the integrity and concern for justice and for patients' welfare, not only of the researchers but of the whole ethics committee. The committee believes that these two letters should never have been published. For the record, all the patients in the trial were Africans, many of them Asian, white, or of mixed race.

The research ethics committee consists of the 10 members of the faculty's postgraduate committee, together with an internationally respected human rights lawyer, a social anthropologist widely known for her political and social activism, a general practitioner nominated by the non-academic medical profession, a senior member of the nursing profession, a forensic scientist, and an academic veterinarian.

The reasoning that led to the committee's approval of the research project was outlined in the commentaries by Bhagwanjee et al and by Seedat,[3] but it may be helpful to summarise it here. The concept of bioethics is structured on the basis of four principles: beneficence, non-maleficence, respect for people (and their autonomy), and justice (notably, social justice). None of these can ever be regarded as absolute, or even pre-eminent. Ethical dilemmas arise when, in particular circumstances, there is conflict between two (or more) of these ethical "imperatives." It is here that sensitive ethical thinking, rather than reflex absolutism, is required to balance and to judge between the claims of the competing imperatives.

The committee believed, probably rightly but perhaps wrongly, that the successful conduct of the trial required that patients' consent not be obtained. The committee further believed (and still believes) that the enormous importance to the community, and specifically to those who are HIV positive, of the information being sought in this study far outweighed the almost unmeasurably small harm that was done to the patients' autonomy. Before this

study, many intensive care units facing the unavoidable pressures of rationing regarded HIV positivity as a criterion for refusing admission. This policy has now been shown to be unjust and discriminatory.

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1 Informed consent in medical research [letters]. *BMJ* 1997;314:1477-83. (17 May.)
2 Informed consent [letters]. *BMJ* 1997;315:247-54. (26 July.)
3 Bhagwanjee S, Muckart DJJ, Jeena PM, Moodley P. Does HIV status influence outcome of patients admitted to a surgical care unit? A prospective double blind study (with commentaries by R Kale, S Bhagwanjee et al, and YK Seedat). *BMJ* 1997;314:1077-84. (12 April.)

Two actions are possible for doctors wanting to promote human welfare in Africa

EDITOR—Logie and Benatar paint a depressing but accurate picture of the effects of poverty (exacerbated by the trade and aid policies of the rich nations of the world) on health and health care for the vast majority of sub-Saharan Africans.[1] Although they end on a note of cautious optimism, thanks to the World Bank's new found commitment to alleviating poverty and the Highly Indebted Poor Countries Initiative, this may leave ordinary doctors in Britain feeling helpless in engaging with these desperately important but distant problems.

Nathanson suggests that humanitarian action is the duty of all doctors.[2] I would like to suggest two ways in which anybody can be "actively engaged in promoting human welfare and social reforms," which should both have a direct effect on the suffering in Africa discussed by Logie and Benatar. The first is to sign the petition being organised by "Jubilee 2000," a broadly based coalition of non-government organisations and churches. This proposal goes far beyond the limited Highly Indebted Poor Countries Initiative and suggests celebrating the millenium by writing off all the unpayable debt owed by the poorest countries to the G7 industrialised countries. This would make a huge difference to their ability to fund effective health services and safe water supplies. Further details are available from the campaigns team, Christian Aid, PO Box 100, London SE1 7RT.

The second action that is possible concerns the little known multilateral agreement on investment, which is being negotiated in the "rich nations club," the Organisation for Economic Cooperation and Development, and is due to be signed at the end of April. The main goal of this agreement is to improve investment opportunities for multinational corporations, and it achieves this by forbidding both discrimination between domestic and foreign investment and the imposition of any "performance requirements" on foreign investors. In the Third World this will make the development of appropriate and diversified industries impossible; environmental and labour will become unsustainable; and people will remain an easily exploitable source of sweat shop labour, with obvious detrimental effects on health. The agreement will allow multinationals to sue national and local government, which could cut into spending on health and social services. MPs must be told that this agreement is unacceptable. More details are available from the World Development Movement, 25 Beehive Place, London SW9 7QR

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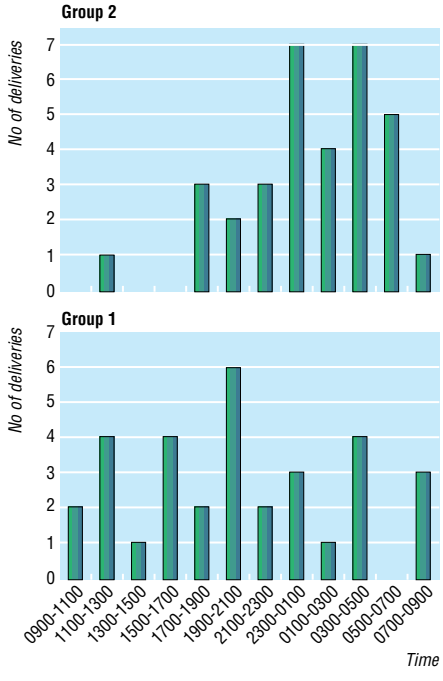
1 Logie D, Benatar S. Africa in the 21st century: can despair be turned into hope? *BMJ* 1997;315:1444-6. (29 November.)
2 Nathanson V Humanitarian action: the duty of all doctors. *BMJ* 1997;315:1389-90. (29 November.)

Timing of initiation of induction of labour can affect out of hours work

EDITOR—The new deal for junior doctors' hours[1] and the recommendations from the report of a confidential enquiry into perioperative deaths[2] put pressure on all specialties to reduce the out of hours workload, particularly out of hours operating. One specialty in which it remains difficult to achieve this is obstetrics, as the timing of labour is generally beyond the control of doctors. As a result, junior obstetricians and midwives remain busy throughout the 24 hours.

The one area in which a degree of control is possible is induction of labour. In our own unit, women scheduled for induction of labour were admitted to the delivery unit on the morning of induction, irrespective of their cervical score. As a result, over nine tenths of women whose labour was induced were delivering between 5 pm and 9 am. In March last year the induction protocol was altered so that women with an unfavourable cervix were admitted the day before induction and received the first dose of prostaglandin E_2 late in the afternoon. They were then left overnight and reassessed the next morning.



Distribution of time of delivery in pregnant women primed on day before day of induction of labour (group 1) and women induced in morning (group 2)

A case-control study was performed, in which 32 women admitted the day before induction for overnight cervical ripening (group 1) were matched with 33 women admitted on the day of induction as in the previous protocol (group 2). All were primigravidas with a singleton pregnancy and a cephalic presentation who were being induced for prolonged pregnancy. The number of caesarean sections (6/32 *v* 7/33, $P = 0.94$) and the number of operative vaginal deliveries (11/32 *v* 10/33; $P = 1.0$) did not differ significantly between the two groups. There were, however, significantly fewer out of hours deliveries in group 1 than group 2 (21/32 *v* 32/33; $P < 0.01$) (figure). When the timing of caesarean section was looked at, there was no significant difference in the overall number of sections performed out of hours, but the number performed between midnight and 9 am was significantly reduced in group 1 (1/6 *v* 6/7; $P < 0.05$).

These findings suggest that instituting a protocol of cervical ripening in the low risk population on the afternoon before planned induction of labour may significantly reduce the overall number of deliveries occurring out of hours, along with the number of emergency caesarean sections performed between midnight and 9 am. This will help obstetrics units to comply with the new deal and the recommendation of the confidential enquiry into perioperative deaths.

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1 NHS Management Executive. *Junior doctors: the new deal.* London: NHSME, 1991.
2 Buck N, Devlin HB, Lunn JN. *The report of a confidential enquiry into perioperative deaths.* London: Nuffield Provincial Hospitals Trust and King Edward's Hospital Fund for London, 1987.

Enhancing patients' compliance

Electronic monitoring approaches should be more widely used

EDITOR—Giuffrida and Torgerson's paper focuses attention on a problem that is widely recognised but largely ignored—namely, compliance.[1] Any measure that seeks to improve compliance with a prescribed regimen should be encouraged. As the authors concede in their introduction, however, the main challenge is identifying the patients whose compliance is considered to be inadequate.

Assessment of compliance should focus on the individual patient, and thus any approach that is targeted in a general manner at unselected populations is unlikely to be cost effective. The fundamental problem is that the prescribing clinician is unable to readily identify inadequate compliers and to distinguish them from poor responders or non-responders. This is not surprising as there is considerable evidence to indicate that compliance with a treatment regimen is not determined by age, sex, income, social status, level of educational achievement, or any other readily determinable factor. Thus before considering financial incentives to improve compliance we need to identify a reliable method to identify which patients to target.

It is now generally accepted that counts of returned tablets and patients' diaries are inadequate methods of assessing compliance and generally overestimate consumption of drugs.[2] Measurement of drug concentrations in blood, urine, or saliva may provide a limited insight into compliance but is relatively expensive, not instantaneous, and often misleading as, for many drugs, improvement in compliance immediately before a clinic visit will mask a potential underlying problem.

Electronic monitoring approaches, which depend on the use of devices incorporated into the drug dispensing system (that is, electronic caps on drug containers or electronic recording devices incorporated into inhalers),[3] are not entirely foolproof but are vastly superior to any other available monitoring approach. In addition, these devices offer the opportunity to extend our understanding of compliance in an individual patient from simply being a yes/no or adequate/inadequate phenomenon to one that recognises that compliance has dimensions of both time and quantity. To date such devices have proved to be too expensive for application in routine patient care. Undoubtedly, however, with more widespread use, economies of scale in production and cost would apply. This would allow greater emphasis to be placed on monitoring compliance, and a more rational approach could then be adopted to identify individual patients who are most likely to derive benefit from interventions designed to improve compliance.

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1 Giuffrida A, Torgersen TJ. Should we pay the patient? Review of financial incentives to enhance patient compliance. *BMJ* 1997;315:703-7. (20 September.)
2 Pullar T, Kumar S, Tindall H, Feely M. Time to stop counting tablets? *Clin Pharmacol Ther* 1989;46:163-8.
3 Cramer JA. Microelectronic systems for monitoring and enhancing patient compliance with medication regimens. *Drugs* 1995;49:321-7.

Financial inducements are equivalent to coercion

EDITOR—What is happening to health care? We in Britain are shocked when we look back at the sterilisation of Swedish women without consent.[1] Yet a paper in the *BMJ* describes a systematic review of studies of financial inducements to patients without mention of autonomy or coercion.[2] Giuffrida and Torgerson seem to draw no distinction between two very different situations. One is where an individual is offered personal advice, treatment, or preventive interventions for the benefit of that individual alone. The other is where, for reasons of public protection, enforced management is contemplated because, for example, an untreated patient with tuberculosis threatens the safety of others. The liberty of one person is disregarded because of the risk to others. Giuffrida and Torgerson simplistically imply that coercion by means of payment or gifts can always be justified because it is for the patient's own good, as well as for the good of society at large. Presumably the same arguments were used for ignoring the need for consent by the Swedish women.

There are many ways whereby we try to make services accessible and easy to use, and room for improvement exists. We try to minimise financial obstacles by providing free health care and by reimbursing travelling expenses for those with low income. Here in Bristol we have our share of problems in communicable disease control. Kindness and sympathy, home visits, the offer of a change of hospital team, and the offer of being taken to hospital by a member of staff whom the patient trusts often succeed in ensuring that patients do not endanger others by refusing treatment. In some cultural groups, particularly our Somali population, the usual approach often fails. We have contemplated using financial incentives but have decided to try even harder with a supportive approach.

It is unacceptable to assume that coercion can be justified solely for an individual's own good or for any supposed economic benefit to society. The way people feel about, and benefit from, health care involves far more than the specific remedies with which they are treated.[3] People must be supported in deciding for themselves whether the benefits they may receive from a specific remedy or preventive intervention outweigh any side effects they experience or any possible adverse consequences they may worry about. If benefits to the patient are so self evident, why are payments or gifts thought to be necessary?

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2 Giuffrida A, Torgerson DJ. Should we pay the patient? Review of financial incentives to enhance patient compliance. *BMJ* 1997;315:703-7. (20 September.)
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Authors' reply

EDITOR—Meredith is correct that blanket use of any method of improving compliance is unlikely to be cost effective; the studies in our review, however, were conducted among selected or uncommon groups of patients (for example, homeless people with tuberculosis).

We are surprised that Raffle and Morgan think that we advocated coercion to make patients comply with treatment. While we would have liked to discuss in more depth some of the issues that our review raised, we did not have space to do so. Also, linking our review with enforced sterilisation of Swedish women is somewhat extreme. We would not support the use of coercion; in our view, however, financial incentives are not coercive. Financial incentives allow more choice and autonomy than does having a healthcare worker try verbally to "persuade" (intimidate?) a patient to attend hospital. To some people, having a member of hospital staff arrive outside their home to take them into hospital might be deemed more coercive than the simple offer of a small payment.

We are pleased to learn that Raffle and Morgan have a supportive service for those patients who need treatment with minimal barriers to access. As these authors admit, however, their methods fail among some groups of patients. Treatment failure among patients with an infectious disease means that their children, spouses, friends, and other members of the public are at risk of infection. Whose autonomy is now threatened? In addition, the methods used by Raffle and Morgan are probably relatively expensive, and it might be more cost effective and equitable to pay patients to attend. Assuming that it takes an hour of a health worker's time to travel to and collect a patient, this would cost at least £15—a far greater sum than was shown to be effective in one of the studies identified in our review.[1] Rather than pay this money to a middle class professional healthcare worker, some might deem it to be a fairer use of our taxes to pay someone who is ill and poor and cannot afford the decent diet to fight the very disease that is being treated.

Finally, in this era of evidenced based medicine, we assume that the strategies to maximise compliance used by Raffle and Morgan have been shown to be effective (and cost effective) in randomised controlled trials.

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1 Pilote L, Tulsky JP, Zolopa AR, Hahn JA, Schecter GF, Moss AR. Tuberculosis prophylaxis in the homeless. *Arch Intern Med* 1996;156:161-5.

The anguish of teenage mental illness

EDITOR—As the consultants responsible for the inpatient adolescent psychiatry unit featured in the Channel 4 documentary *The Madness of Children* we share the concerns expressed by Pearce about the programme's stigmatising title, its muddling of "extensions of normal behaviours and feelings" with specific mental illnesses, and its overemphasis on the use of drugs without

reference to specific indications or accompanying psychotherapeutic interventions.[1]

Allowing the media to portray medical practice is fraught with difficulties. A large amount of material is distilled into a few moments, with consequent risks of condensation, of misinterpretation, and of conscious or unconscious bias. Editorial control rarely rests with the clinicians concerned, and the final version may not be representative or fully accurate in all its parts. Against these caveats is the opportunity to carry a public education message to a far wider audience than is usually possible. When we were approached by Channel 4 we judged that the potential benefits outweighed the risks, and on balance we still hold that view.

Pearce, however, raises two aspects of the individual care of young people while inpatients: a 13 year old girl smoking in the unit, and the seeming lack of use of newer atypical antipsychotic agents. Although we cannot discuss individual care plans, we wish to respond to these two very public adverse criticisms.

The unit greatly emphasises health promotion and the development of healthy lifestyles. Young people are strongly discouraged from smoking and are only allowed to do so in one designated area and with express parental permission. We consider that an outright ban in inpatients in this age group would be likely to cause more health loss than health gain by creating greater difficulties in therapeutic engagement.

Our treatment of psychotic disorders includes using newer antipsychotic drugs when indicated, and we have recently treated patients with risperidone, olanzapine, and clozapine. Occasionally, young people are transferred to our service from other psychiatric settings and we will ensure that treatment started elsewhere is given an adequate trial, even when it may not have been our first choice. Pearce will be aware of the concerns expressed by purchasers and managers of provider units at the cost implications of switching to routine firstline use of the newer agents. We share his unstated view that the benefits gained may in fact justify the extra costs entailed.

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1 Pearce J. The anguish of teenage mental illness. *BMJ* 1997;315:494. (23 August.)

Agencies need to work together on general practitioner staffing

EDITOR—The general findings of the paper by Taylor and Leese on the recruitment of general practitioners[1] are in accord with those of the Medical Practices Committee's pilot study of recruitment to partnership vacancies of 1994 and its recruitment surveys of 1995 and 1996.[2 3] Over the past three years these studies have shown a progressive difficulty in recruiting good quality general practitioners, an observation reflected in the recent increase in requests to the committee for extension of time to find a partner. None the less, the findings of Taylor and Leese differ from the observations of the committee. This difference may have arisen for two reasons.

Firstly, Donald and Leese did not use the 1995 and 1996 statistical data,[2 3] which show important trends that were not apparent in their paper.

Secondly, they did not deal with the important effect of changes in general practitioner staffing on average list size per whole time equivalent principal. Indeed, such is the importance of the continuing trend towards part time working that average list sizes per general practitioner continue to decrease while average list sizes for whole time equivalent general practitioners have remained static for the past five years. There are also worrying trends in the number of qualified doctors available for recruitment. For instance, the total number of vocational training certificates has fallen year by year, from 2120 in 1990-1 to 1936 in 1995-6. Other factors affecting potential requirements for general practitioners (as yet unquantified) include the implications of shifting a greater proportion of medical undergraduate training into general practice; the effect of continued efforts to reduce individual excessively high practice list sizes; the effect of the General Medical Council's new performance procedures; the staffing requirements of new "models of care" identified in Taylor and Leese's paper, for which much of the workforce will come from the existing pool of general practitioners; and the possible workload implications of the primary care led NHS.

The Medical Practices Committee has been working increasingly closely with health authorities to achieve a more equitable distribution of existing staff. The potential problems with medical staffing identified here and in Taylor and Leese's paper underline the need to continue the close collaboration between the committee, health authorities, general practitioner representatives, and the NHS Executive to develop policies for planning general practitioner staffing.

Only by building up an accurate national picture of practices that reflects the adequacy of medical staffing and incorporates both local and national elements can the available doctors be most appropriately distributed throughout England and Wales.

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1 Taylor DH, Leese B. Recruitment, retention, and time commitment change of general practitioners in England and Wales, 1990-94: a retrospective study. *BMJ* 1997;314:1806-10. (21 June.)
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Managing pain in hospital

Protocol must not take precedence over clinical judgment and compassion

EDITOR—Savage's personal experiences of the preoperative periods after dislocations of a prosthetic hip are an indictment of several aspects of current medical teaching in Britain.[1] She is right in her comment about British doctors being frightened of opiates. There are two factors. The irrational fear is not of addiction but of respiratory depression. The general medical and nursing population does not seem to appreciate that apnoea does not suddenly develop when an opiate threshold has been reached but that the respiratory rate slows gradually with increasing doses of opiate. My prescription for 10 mg morphine intramuscularly to be given every one to four hours as required for postoperative analgesia was regularly changed by the resident doctor, without my being informed, to 10 mg morphine four hourly, at the instigation of one night sister. When challenged she said that hourly was not safe, but she was apparently quite happy if patient controlled analgesia was being used, even though this can deliver 12 mg morphine an hour.

The other point is that opiate induced respiratory depression is easily and rapidly reversed by intravenous nalorphine. Intravenous opiate titrated in incremental doses is the fastest, safest, and most effective method of producing analgesia, and the respiratory rate can be easily monitored. Analgesia can also be topped up before any potentially painful incident. Surely any department that claims to deal with accidents and emergencies should always have staff on duty who can insert an intravenous cannula and give immediate and adequate intravenous analgesia for all patients (the majority) in whom it is not contraindicated.

Medical students and nurses are continually told that they must not give opiates in case it obscures the diagnosis. This is part of routine protocol even though it may be relevant in only few cases. The insistence on getting electrocardiography and blood tests done before proceeding with anaesthesia is another example of a ridiculous, medico-legal driven, protocol. All patients over 50 are expected to have electrocardiography; this would apply to a 60 year old regular hill runner even if the injury was a broken ankle sustained at the end of a 24 km hill race. In Savage's case, knowledge of the haemoglobin concentration was irrelevant for the proposed procedure and the results of electrocardiography were relevant only if there was a history of heart problems. Protocol seems to have taken priority over clinical judgment and compassion.

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1 Savage A. Dislocations in the European Union. *BMJ* 1997;315:375-6. (9 August.)

Only one fifth of A&E departments were found to have pain control policy for children

EDITOR—In her Personal View, Savage states that consultants in accident and emergency should work out a protocol for analgesia.[1] We agree that the issue of pain management needs to be addressed, and we have specifically looked at difficulties with pain management in children.

We carried out a postal survey of current pain management in 26 accident and emergency departments in the South West and Wessex regions, of which 20 (77%) replied. At the time of our study 16 departments had no pain control policy for children and 18 had no standards to allow audit. In only seven departments was pain routinely assessed and recorded, and in only 10 were medical and nursing staff given formal training in pain management.

We subsequently introduced clinical guidelines into our local accident and emergency department, set standards, and provided training for staff with the aim of improving pain management in children. A pain score should be recorded at triage and appropriate management instigated, which should include psychological techniques such as blowing bubbles as well as analgesia. The response should be recorded at 60 minutes (or at discharge if this is sooner), and if there is no specific improvement in the pain score then treatment should be reassessed. An audit cycle is being established to monitor the effectiveness of the pain protocol and to highlight issues for which further training is required.

We appreciate that carrying out consistent and appropriate pain management within the constraints of a busy accident and emergency department is difficult. Performance in pain management can only be improved, however, by setting clinical standards and carrying out regular audit.

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1 Savage A. Dislocations in the European Union. *BMJ* 1997;315:375. (9 August.)

Corticosteroids in acute traumatic brain injury

EDITOR—The findings of the systematic review of randomised controlled trials of corticosteroids in acute traumatic brain injury[1] are in keeping with the conclusions reached by the Committee for Guidelines for the Management of Severe Head Injury, based in the United States. They indicate that the available evidence does not show a benefit of corticosteroids in acute severe traumatic brain injury.[2] The guidelines committee therefore recommended that corticosteroids should not be given routinely to patients with severe head injury.

We are puzzled why the authors state that considerable uncertainty remains over the effect of corticosteroids and recommend that a trial requiring 20 000 participants is justified. The meta-analysis showed that the odds ratio for death was 0.91, corresponding to a pooled absolute risk reduction for death in head injured patients treated with steroids of 1.8%, which was far from being significant. Moreover, the subgroup analysis, which analysed trials with only the highest quality of concealment of allocation (blinding), showed that the pooled odds ratios were even closer to unity (indicating no effect) and again not significant (summary odds ratio = 1.07 for death and 0.97 for death or disability). In essence, therefore, the pooled odds ratio for all of the trials as well as that for the trials with the best randomisation protocols all have relative risks for death and death or disability close to 1. Thus the meta-analysis provides no justification for the authors' conclusion that a larger trial is warranted.

A larger trial conducted recently to evaluate the effect of the 21-amino steroid tirilazad on the outcome in severely head injured patients showed that it conferred no overall benefit.[3 4] Subgroup analysis showed that male patients with subarachnoid haemorrhage present on initial computed tomography fared slightly better than the other patients. This trial had obvious advantages over the meta-analysis by being standardised for type of steroid, dose, duration of treatment, interval from injury to treatment, entry criterion, standardised assessment measures, and data management.

On the basis of both the meta-analysis and the trial of tirilazad, we disagree with the authors' recommendation for a trial to detect possible effects of steroids in head injured patients. About 40 000 patients would be needed to detect the observed 1.8% difference in death rates. Current trials of drugs thought to affect mechanisms of brain damage in head injured patients are designed to detect a 10% effect. A trial of 20 000-40 000 patients to detect a small reduction in mortality with steroids would divert resources and patients away from trials of compounds that may have more promise in improving outcome in head injured patients.

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4 Doppenberg EMR, Bullock R: Clinical neuro-protection trials in severe traumatic brain injury: lessons from previous studies. *J Neurotrauma* 1997;14:71-80.

Authors' reply

EDITOR—We agree with Newell et al that the available evidence does not reliably show a benefit from using corticosteroids in severe head injury. As they point out, the risk of death in the group treated with corticosteroids seems to be about 2% lower than that in the control group (95% confidence interval −6% to 2%). While this is compatible with no benefit from steroids, it is also compatible with a small benefit. Worldwide, several million people are treated each year for severe head injury, of whom over one million die and a similar number are disabled.[1] If a treatment as widely practicable as corticosteroids could reduce the risk of death by "only" 2% and the risk of disability by a similar amount, treatment of 100 000 patients would avoid 2000 deaths and prevent 2000 disabilities. Such a benefit would be impossible to show reliably without large scale randomised evidence.

Newell et al say that trials are usually designed to detect reductions in the risk of death of ⩾10%. Unfortunately, this will inevitably mean that moderate but clinically important effects, both beneficial and harmful, are missed. Indeed, the reason that the Brain Trauma Foundation's guidelines committee, of which Newell et al were members, was unable to recommend treatment standards for 11 of the 14 topics reviewed is that previous trials have been too small to reliably confirm or refute important treatment effects.

Newell et al are concerned that a trial large enough to detect a moderate effect of corticosteroids would "divert resources and patients away from trials of compounds that may have more promise." Corticosteroids are given in more than half of cases in two thirds of trauma units in the United States.[2] It seems more sensible to marshal this clinical heterogeneity in a scientifically defensible manner by conducting a randomised trial than to continue with such uncontrolled experimentation. Bearing in mind the numbers who sustain head injury each year, we are intrigued by the notion that there might be insufficient people to participate in relatively small trials of compounds that may have more promise. If such a high proportion of patients with head injury did participate in clinical trials one might expect that there would be less uncertainty about the effectiveness of interventions.

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1 Alexander E Jr. Global spine and head injury prevention project (SHIP). *Surg Neurol* 1992;38:478-9.
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Consent for transfusion

Leaflet on risks is available

EDITOR—Williams elegantly summarised the difficult issues surrounding consent for transfusion, pointing out that true (valid) consent must be based on adequate information that the patient can understand. What information should be presented and by whom is problematical.

Many patients, particularly in elective surgery, are unaware that their treatment will include transfusion. A considerable proportion of those who have been given a transfusion are unaware that this has occurred (unpublished data). In emergencies it may be impossible to explain that a transfusion is needed. Nevertheless, the information should be given later and included in the discharge summary. Often, neither the patient nor the general practitioner is aware that a transfusion has taken place.

There is much misinformation about the risks of blood transfusion. Patient concerns often centre around remote risk, such as transmission of HIV. Clinical staff may also be unaware of the real, important, risks. We support Williams's proposal for nurse specialists in transfusion, who would be the source of information for patients who are about to receive, or have received, transfusion, thus reducing the number of sources of information (and misinformation) currently available to patients.

The need for consistent, reliable, and accurate information about transfusion has been recognised. Within the London and South East zone of the National Blood Service an information leaflet was designed, primarily for patients about to undergo elective procedures that might include the use of transfusion. Common risks and side effects of transfusion are described; some less common risks are put into context by comparision with risks of normal everyday activities. Clinical staff will find the leaflet valuable to update their own knowledge about the real risks of transfusion. After field testing with a variety of patients in different hospitals and revision to take account of comments, the final version was approved by the Zonal Blood User Group and offered as a resource for hospitals in London and south east England. Meanwhile, this initiative was widened to include the whole of England. We believe that this approach will go some way towards ensuring that consistent and reliable information is available to patients. This is, after all, crucial to the issue of involving patients in decisions about their care.

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1 Williams FG. Consent for transfusion. *BMJ* 1997;315: 380-1. (16 August.)

Many transfusions are initiated by anaesthetists

EDITOR—Williams, commenting on the need to obtain consent for blood tranfusion, suggested that the administration of blood products, along with the obtaining of consent, could be delegated to specially trained nurses.

A survey undertaken by the Committee on Blood and Blood Products of the American Society of Anesthesiologists reported that in the United States more than half of all blood and blood products were given by anaesthetists.[2] Although changes in practice in recent years may have altered these findings somewhat, it is likely that a very substantial proportion of blood transfusions given in the United Kingdom are initiated by anaesthetists. It is clear, therefore, that the perioperative period should be an important focus for strategies aimed at reducing unnecessary use of blood and blood products. Published guidelines on treatment with blood components may help anaesthetic and surgical teams to manage transfusion appropriately.[3]

The responsibility for blood transfusion in the perioperative period should remain with the anaesthetist and surgeon—it is impractical and undesirable to consider delegating this to another group. Consent for transfusion, after a discussion of the likelihood of blood transfusion and the risks and benefits, should be documented along with consent for surgery and anaesthesia by the relevant members of the medical team. Strategies aimed at reducing intraoperative blood loss, such as induced hypotension or acute normovolaemic haemodilution, have associated risks, and these should also be discussed with the patient. Anaesthetists and surgeons should remain educated in the appropriate use of blood products, strategies to reduce intraoperative blood requirements, and methods for monitoring the need for transfusion.

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1 Williams FG. Consent for transfusion. *BMJ* 1997;315: 380-1. (16 August.)
2 Stehling LC, Ellison N, Faust RJ, Grotta AW, Moyers JR. A survey of transfusion practices among anesthesiologists. *Vox Sanguinis* 1987;52:60-2.
3 American Society of Anesthesiologists Task Force on Blood Component Therapy. Practice guidelines for blood component therapy. *Anesthesiology* 1996;84: 732-47.

Blood is dangerous

EDITOR—Williams' editorial reviews the issue of consent to blood transfusion,[1] which has been a topic of longstanding concern to accident and emergency specialists. However, his account does not cover the special problems surrounding emergency transfusion.

In accident and emergency departments, the capacity of patients to consent to blood transfusion is often inversely related to the severity of their clinical condition. In the past, doctors have acted in what they believe to be the best interests of the patient by starting a transfusion when the clinical condition indicates that one is necessary.

A recent case in Hong Kong has brought home to everyone the danger of emergency blood transfusion, and the fact that "acting in the patient's best interests" involves more responsibility than simply making the treatment decision. A road traffic accident victim (blood group O) was inadvertently given two units of group A and two units of group B blood, after an apparent mix up during the transfer of two patients from an accident and emergency department to an intensive care unit. The severely injured patient subsequently died, and an investigation has been started. Press interest has snowballed to include reporting of progressively more clinical mishaps (termed "blunders" by the press) almost daily. The issues raised went beyond the individual case and touched on a crisis of public confidence in the medical profession.

Blood should be treated as a dangerous drug. This life saving resource becomes as dangerous and life threatening as a loaded firearm in untrained hands. One slip in handling procedures may result in similar consequences for the life of the patient. The duty of care does not diminish, even in an emergency.

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1 Williams FG. Consent for transfusion. *BMJ* 1997;315: 380-1. (16 August.)

"Poor historians" are often found to have cognitive impairment

EDITOR—I note that the man whose radiograph was shown recently in Minerva is described as a poor historian.[1] But the historian is the person who records the history, and the temptation to use this lamentable phrase should be avoided as it reflects more on the doctor than on the patient.

Geriatricians view history taking as part of the physical examination of intellectual function. Failure to make progress here should alert the clinician to the possibility that the patient has dementia, rather than precipitate a reflex inscription in the notes. Unfortunately, "poor historian" in a patient's record often signifies that the clinician has missed the patient's cognitive impairment.

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1 Delap T, Jones S. Minerva. BMJ 1997;315:892. (4 October.)