

## Sickness certification system in the United Kingdom

### Doctors are indeed agents of social control

EDITOR—Doctors are agents of social control and get paid accordingly. And you'd better believe it because it ain't about to change.

A cold ain't a cold until you say it is. A person ain't fit to drive until you say they are, and nobody ain't fit to go back to work until you say they are.

Enter the patient. There are the driven folk, those without insight, who want you to look under the bonnet, twiddle a few knobs, and send them magically repaired back on their way. These are the people you encourage to take time off work because it's all you can do, and often they take no notice.

Then you have the amorphous dispossessed. Those who have to work and don't feel up to it; those who experience the drudgery of manual work when there is depression or pain; those out of work and under pressure to take jobs that are even worse than the ones they've lost. These people create the dialogue of uncertainty that is so accurately illustrated in Hussey et al's paper.<sup>1</sup>

In the face of this uncertainty we create terms and phrases that obfuscate. We write sick notes unthinkingly and inconsistently, doing so with good grace for those we like and more grudgingly for those who make us feel angry or uncomfortable.

There is anarchy in all this that we rather enjoy, but we do so irresponsibly. In one of the focus groups a doctor had written nothing in the space provided for diagnostic detail and boasted that in four months no one had taken him to task for it.

This is the point: there is no redress for anything you write, but imagine the chaos you can create for the honest employer, the small business with a shoestring workforce stripped of a couple of indispensable workers for two weeks.



GPs are in best position to issue sickness certificates

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Competing interests: None declared.

<sup>1</sup> Hussey S, Hoddinot P, Wilson P, Dowell J, Barbour R. Sickness certification system in the United Kingdom: qualitative study of the views of general practitioners in Scotland. *BMJ* 2004;328:88-91. (10 January)

### Maybe charging for certificates clarifies matters

EDITOR—It seems sick certificates stimulate the same concerns the world over,<sup>1</sup> I have worked in the United Kingdom, Australia, and now in Canada. Sick certificates (and their grander cousin, the "insurance form") particularly seem to challenge the relationship between patient and doctor because it is often a third party that demands them and not the patient. If we are honest with ourselves, how much is "time off work" part of the treatment plan for a patient? When providing certificates we are, as mentioned by one respondent, more often being policemen for employers, not doctors for our patients.

From another angle we also must be mindful of the potential harm we can do by providing a sick note "just because the patient demands it." We certainly don't provide benzodiazepines or opioids on the basis of the same premise. Any professional relationship that is based on fear of losing the patient or just "giving them what they demand" is dysfunctional and needs to be terminated anyway.

And what is my cop out solution? Here in Canada I am free to say to the patient that unfortunately their government medical cover does not include the cost of sick notes and there is a charge for them. (Actually, I believe the same applies in the United Kingdom, does it not?) Very quickly the certificates seem to become far less necessary when they are not free.

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### Medical certificates are challenging but essential part of job

EDITOR—No one is in a better position to issue a sickness certificate than a general practitioner.<sup>1</sup> He or she has the information

at hand and sometimes good knowledge of the patient. Independent examination would be an unmanageable system with constant requests for the general practitioner's opinion and records.

My role in sickness certification has made me realise that general practitioners are not patient advocates but an essential part of society's machine. People need somewhere to go when they are ill or believe themselves to be ill or even if they are swinging the lead. As general practitioners we are an essential part of the system that tries to ensure people are using the country's resources appropriately. The government drops our gatekeeping role at its peril.

The ability to negotiate a sick note and to know how to balance what is best for the patient—for example, perhaps not adopting the sick role—and what is best for the system is a huge responsibility and intellectually quite challenging if thought through in terms of the patient and society.

A lack of ability to confront patients is a deficiency in general practitioners' skills. The epidemic of illness behaviour and sick role adoption is partly our fault.

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### Department for Work and Pensions is trying to address challenges

EDITOR—Hussey et al produce similar findings to other recent studies about general practitioners' advice on fitness for work,<sup>1-3</sup> but in his editor's choice Smith concludes that much of this work is philosophically untenable. General practitioners have been poorly trained in this important and undoubtedly difficult aspect of their day to day work, a challenge that the Department for Work and Pensions is anxious to address.

Smith also perpetuates the myth that general practitioners are acting solely as agents for the department, presumably in the same way that they are agents of the NHS when they issue a prescription?

Advice on fitness to work is an integral part of the clinical management of patients of working age. The obligation to record the advice on a statement (such as Form Med 3) does not detract from the doctor's overriding concern for the best clinical outcome for the patient. Good professional practice may sometimes mean challenging the patient's view, much as a general practitioner may do

when requested to prescribe a drug. But it is an extremely narrow view of advocacy to believe that a skilled professional should simply accede to the patient's wishes without any negotiation.

The government has recognised the need for reforms in the area of incapacity for work, including many of the changes called for by Hussey et al.<sup>4,5</sup> Employers need to take greater ownership of managing absence and avoiding inappropriate medicalisation. But general practitioners' position in frontline health care inevitably means that they will remain a key source of advice and influence for working patients for the foreseeable future.

General practitioners' educators should urgently recognise the need for a change in thinking about this aspect of vocational training and continuing professional development. To support them in this task, the Department of Work and Pensions already provides a range of relevant training resources, evidence based guidance, online training, and a national network of medical officers ([www.dwp.gov.uk/medical](http://www.dwp.gov.uk/medical)).

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- Hussey S, Hoddinot P, Wilson P, Dowell J, Barbour R. Sickness certification system in the United Kingdom: qualitative study of the views of general practitioners in Scotland. *BMJ* 2004;328:88-91. (10 January.)
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## Public involvement in health care

### Every voice counts, not just that of patients

EDITOR—Section 11 of the Health and Social Care Act 2001 concerns "persons to whom ... services are being or may be provided." This means that more people than current patients have to be involved "directly or through representatives" about plans and services. Florin and Dixon's philosophising about the desirability of public involvement is therefore curious.<sup>1</sup>

User involvement in health and social care should lead to shared power and genuine partnerships, with no short cuts or quick fixes.<sup>2</sup> Investment in community development is needed for sustainable engagement, so that every voice can count, not just that of patients.<sup>3</sup>

Many users reject the role of a patient as inherently powerless. My experience in Wandsworth is that user participation groups in primary care practices can foster trust, responsibility, and partnership between users, practitioners, and managers.



Such small scale benefits are important. Supporting practice based participation can open new channels for compliance with section 11 requirements and create lasting structures of user involvement, reaching out into the community from general practices. Investment as well as good intentions will be needed to achieve that.

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- Florin D, Dixon J. Public involvement in health care. *BMJ* 2004;328:159-161. (17 January.)
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### Public involvement is needed at highest level

EDITOR—Florin and Dixon bring coherence and clarity to what has hitherto been a muddled debate.<sup>1</sup> Two things are worth adding.

Firstly, the more devolved and local public involvement in health policy development becomes the more the government's national strategy and targets become givens. The public was not involved in the British government's decision to focus on mortality and cure (which are easily measurable) at the expense of long term medical conditions that chiefly affect the quality of people's lives. But that focus has become a given that will dominate the development of local health policy. If governments wish to provide the sort of health care people want, public involvement in health strategy development is needed at the highest level.

Secondly, a tendency prevails to see public involvement as something separate from the rest of health policy development instead of an integral part of it. Dermatology is an exception.

The Action on Dermatology programme was established in 2000, chiefly in response to long waiting times. A task group was established to identify, develop, and disseminate good practice in the delivery of dermatology services. The task group consists of two or three representatives of the NHS Modernisation Agency, two consultant dermatologists, two dermatology nurse specialists, two general practitioners actively interested in dermatology, two patients' representatives, and a pharmacist. Everybody in the group has equal status. There is no

politically correct pandering to the patients' representatives (of whom I am one), but our views are weighed equally with those of others, and we are not "token patients."

This inclusiveness and egalitarianism have made the programme so successful. Its findings were published and are now being developed further.<sup>2</sup> All parties found the programme's task group as a forum for the exchange of information and ideas so useful that it has been kept running, although funding ceased in March 2003.

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- Florin D, Dixon J. Public involvement in health care. *BMJ* 2004;328:159-161. (17 January.)
- NHS Modernisation Agency. *Action on Dermatology good practice guide*. London: NHS Modernisation Agency, 2003.

### Process needs to be transparent and open

EDITOR—Florin and Dixon raise important points about the need for clarity on the issue of increased public involvement in decision making in the NHS.<sup>1</sup> Two points are worth emphasising.

Firstly, the entire process could be reduced to a tickbox exercise in which trusts co-opt "tame" representatives to rubber stamp decisions.

Secondly, "professional" public representatives could emerge whose views are not necessarily representative of the public's and who turn up as public representatives on every committee and board.

The process by which the public is involved in making health service decisions needs to be transparent and open and may require extra effort, to ensure that the process is indeed inclusive.

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- Florin D, Dixon J. Public involvement in health care. *BMJ* 2004;328:159-161. (17 January.)

### Some things do count

EDITOR—Having retired and moved away from the area in which I worked I have become an increasing user of the NHS and find it impossible to get worthwhile information on which to make a balanced judgment about things that should be counted easily.

The informal local knowledge that was available and useful is no longer available to me. My general practitioner, who is excellent, knows only the local services and does not know what their results are.

I needed a hernia repair—but surgical results are not available. Local anaesthesia and day case surgery as your editorial recommends—no information available, and in particular, no warning that the surgeon has an unrealistic belief in the rapidity of onset of action of local anaesthetic. Need another hip replacement? No information

about results to help with the decision whether to travel back to London, or have surgery locally.

If we take public involvement in health care seriously, and if we believe in using industrial processes in health care, on which the same issues carries articles, this is not good enough. I have to disagree with Einstein and with McKee<sup>1</sup>—these things can and ought to be counted, and they do count.

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1 McKee M. Not everything that counts can be counted; not everything that can be counted counts. *BMJ* 2004;328:163. (17 January.)

## NHS Modernisation Agency's way to improve health care

**EDITOR**—As leaders in the NHS Modernisation Agency, we were delighted to see the paper by Young et al summarising three key approaches to improving manufacturing systems.<sup>1</sup> Improvement programmes in the agency have been adapting these approaches successfully to NHS healthcare systems for several years.<sup>2</sup>

We now refer to this body of knowledge as “clinical systems improvement.” At its heart is the graphical presentation of data and their analysis using statistical process control. Key measures are monitored to see whether changes to the system have made a notable impact and determine whether improvement has occurred before the change is rolled out. Data are presented in a format that is easily understood and statistically valid, which appeals particularly to doctors.

We have had success in applying these methods to improve emergency flows,<sup>3</sup> and reducing journey times in cancer care. Now we are learning to apply these methods across entire organisations. For example, in Nottingham City Trust elective admission rates have increased by 8% and cancelled admissions for surgery have been cut in half by improving the emergency pathway and reducing medical outliers.

The improvement partnership for hospitals is accumulating knowledge and experience from Modernisation Agency programmes ([www.modern.nhs.uk/iph](http://www.modern.nhs.uk/iph)).<sup>4</sup> We offer an ambitious learning programme to NHS trusts, support senior managers, and clinicians in reforming their local healthcare delivery systems.

Publication of our methods and results in journals such as the *BMJ* will help to spread awareness, encourage clinicians to be more involved in improving their own services, and stimulate fruitful discussion. Our vision is that staff in all healthcare organisations will have the capacity continuously to improve their own services on the basis of the priorities of their patients and that together we will improve the quality of healthcare in the NHS.

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1 Young T, Brailsford S, Connell C, Davies R, Harper P, Klein J. Using industrial processes to improve patient healthcare. *BMJ* 2004;328:162-4. (17 January.)

2 Silvester K. Chaos the enemy of quality. *Clinician in Management* 1997;6:9-13.

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## Health needs of women who have sex with women

### Maybe new subspecialty is needed

**EDITOR**—The editorial by Hughes and Evans discussed the health needs of women who have sex with women.<sup>1</sup> NHS services are predominantly targeted using white, heterosexual imagery. How non-white, non-heterosexual people relate to these images and whether they would still access a service that used imagery irrelevant to their cultural references are debatable. Work is needed, with local initiatives and voluntary sector groups in partnership, to develop appropriate campaigns and culturally relevant material to encourage equitable access.

Services also need to address the issue of cultural competency both in directly employed and contracted services. Diversity and equality are high on the NHS human resources agenda but have been slow to infiltrate the medical hierarchy. Research has shown perceived disapproval acts as a barrier to accessing care.<sup>2</sup> Targeted services for lesbian or bisexual women have illustrated the breadth of need for this group. A wider ranging agenda for diversity and equality and a strong move by both medical and nursing colleges and education would



Relevant materials are needed to encourage equitable access for women who have sex with women

help instil confidence that, when seeing a health professional, sexuality will be recognised and not ignored or rejected.

Perceptions of prejudice are embossed during adolescence and childhood and the establishment of children's trusts and the dissolution of section 28 offer opportunities to establish a new status quo. Local strategic partnerships and the rise of health inequalities demand that this population of need is neither neglected nor ignored.

The United States has consultants of lesbian and gay public health. Perhaps in the United Kingdom we should look at developing a new subspecialty in public health for this new age of cultural awareness?

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1 Hughes C, Evans A. Health needs of women who have sex with women. *BMJ* 2003;327:939-40. (25 October.)

2 Wilton T, Kaufmann T. Lesbian's mothers' experience of maternity care in the UK. *Midwifery* 2001;17:203-11.

### Methodological assumptions underlying conclusions should have been questioned

**EDITOR**—The health needs of lesbian women clearly deserve more attention. I strongly agree with Hughes and Evans's statements about the importance for healthcare providers to understand that lesbianism is within the normal range of sexual behaviour and to reduce perceived and actual prejudice in medical settings.<sup>1</sup>

However, the editorial seems to neglect some essential methodological problems related to the epidemiology of lesbian health by listing conditions where lesbians are supposedly at special risk.

The Solarz report from the Institute of Medicine reviewed empirical research about physical and mental health in lesbian women.<sup>2</sup> The report concludes that they are vulnerable for the consequences of specific psychosocial pressure related to marginalisation, and that the healthcare system does not provide sufficiently culture sensitive care for women who have sex with women. Apart from this, no conclusions can yet be drawn about the relative risk or prevalence of breast cancer and other disorders in lesbian women. So long as representative population based samples are not available, where people give an honest answer to the question of sexual orientation, quantitative comparisons between lesbian and heterosexual women cannot be accomplished or justified.<sup>2</sup>

I am surprised that the *BMJ* did not question the methodological assumptions underlying the epidemiological conclusions drawn from the studies referred to in this editorial. More research is needed within this field, rather than re-forwarding epidemiological myths about the health of lesbian women.

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- 1 Hughes C, Evans A. Health needs of women who have sex with women. *BMJ* 2003;327:939-40. (25 October 2003.)
- 2 Solarz AL, ed. *Lesbian health—current assessment and directions for the future*. Washington DC, National Academy Press: 1999.

**Evidence is lacking that women who have sex with women are high risk group for cancer**

EDITOR—As pointed out by Hughes and Evans, the healthcare needs of women who have sex with women are an underprioritised area of research and public attention.<sup>1</sup> The statement, however, that these women represent a group at greater risk of developing particular cancers than their heterosexual counterparts lacks empirical support in the literature.

In what seems to be the only population based cohort study on the subject, little support was found for this widely and long held belief.<sup>2</sup> Findings among 1614 Danish women who registered in homosexual partnerships in Denmark during 1989-97 and who were followed up for cancer over 6656 woman years showed that being part of a registered homosexual partnership is not associated with increased risk of cancer at any site.

Cancer risks may well differ between women who have sex with women who formally register their relationship and those who do not register, as well as between women who have sex with women who live in countries like Denmark, with a comparatively liberal attitude to the broad and expanding spectrum of sexual relationships between consenting adults, and those living in areas with less tolerant attitudes. Therefore, although not supported by available empirical evidence from population based data, high risk groups of women who have sex with women may exist.

At our current level of understanding, however, no convincing empirical evidence maintains that these women in general are a high risk group for cancer. If high risk groups of women who have sex with women exist, this must be due to factors that increase cancer risk independently of sexual preference, fantasies, behaviour, or identity.

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- 1 Hughes C, Evans A. Health needs of women who have sex with women. *BMJ* 2003;327:939-40. (25 October 2003.)
- 2 Frisch M, Smith E, Grulich A, Johansen C. Cancer in a population-based cohort of men and women in registered homosexual partnerships. *Am J Epidemiol* 2003;157:966-72.

**Cervical screening is offered without asking for sexual preferences**

EDITOR—With reference to the editorial by Hughes and Evans, we emphasise that the NHS cervical screening programme offers cervical screening to all women without inquiring about their sexual behaviour.<sup>1</sup>

We agree that many women who have sex with women have, at some time, also had a sexual relationship with a man, and their risk is no less than for the majority of the population. Women who have never been

sexually active with a man are equally entitled to cervical screening and may wish to discuss their situation with their general practitioner or sexual health adviser before making an informed decision about whether to participate in the programme or not.

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**Authors' reply**

EDITOR—We thank everyone who contributed to the rapid response debate on *bmj.com*.<sup>1</sup> Many of the responses related to homophobia in medicine. The editorial was designed to raise awareness of the healthcare needs of women who have sex with women rather than to stimulate a debate about the morality of homosexuality.

Varney's comments on accessibility and appropriateness of care provided by an informed clinical workforce are apposite.

Malterud expressed justified concern about the appropriateness of the conclusions we drew using the restricted epidemiological data available. We agree that epidemiological data concerning sexuality and health outcomes are difficult to gather and interpret.

We are pleased Frisch brought attention to a Danish study that was not published at the time of our submission and is the only population based study in this area listed in Medline. It shows that women who have sex with women are not at higher risk of cancers than heterosexual women.<sup>2</sup> We note the study's limitations in monitoring a self selected homosexual population in registered partnerships only, of relatively young age, and with short follow up. We also note the small numbers of incident cancers with which the statistical analyses were made and think it would be dangerous to draw unequivocal conclusions from a single paper.

The literature available presents evidence that women who have sex with women have increased risk factors for a variety of conditions. We look forward to the publication of further direct evidence that assesses the population impact of these risks and helps improve the standard of care for this important minority group.

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- 2 Frisch M, Smith E, Grulich A, Johansen C. Cancer in a population-based cohort of men and women in registered homosexual partnerships. *Am J Epidemiol* 2003;157:966-72.

**Health risks of overseas travel**

**Ignorance and complacency prevail about infectious diseases**

EDITOR—Dobson comments on an article that is to appear in *Travel Medicine and Infectious Disease*, in which the researchers call for more education about the prevention of malaria and other infectious diseases.<sup>1 2</sup>

We recently returned from the Rio Negro area, 40 km from Manaus city in the Amazon, Brazil. During the first trimester of 2003 Manaus experienced an 815% increase in cases of malaria compared with the same period in 2002.<sup>3</sup> This means 223 new cases daily, and close to 17 000 notifications for the trimester.<sup>3</sup>

Despite this increase, most Americans and Europeans whom we met did not take malaria prophylaxis. Also, most were not vaccinated against yellow fever or hepatitis A. Many found it ridiculous that we were taking Malarone (atovaquone plus proguanil) and had received vaccines before we travelled.

The local guides argued that malaria prophylaxis was unnecessary on the Rio Negro since mosquitoes do not thrive in the acidic waters of this part of the river. They were clearly well educated in biology and infectious diseases but apparently forgot that all tourists need to travel through high risk areas to reach the Rio Negro delta.

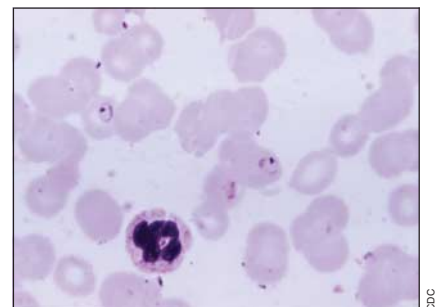
Many young Europeans and Americans seem not to be used to taking responsibility for their own health. Decades of well functioning public health systems, vaccination programmes, easy access to "high tech" health services, etc, seem to leave young people naive and ignorant about infectious diseases.

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- 1 Dobson R. Survey highlights health risks of overseas travel. *BMJ* 2004;328:7. (3 January.)
- 2 Roberts MTM, Lever AML. An analysis of imported infections over a 5-year period at a teaching hospital in the United Kingdom. *Travel Med Infect Dis* (in press).
- 3 Brasil K. Casos de malária em Manaus crescem 815% no primeiro trimestre. (Folha online). [www1.folha.uol.com.br/folha/cotidiano/ult95u73155.shtml](http://www1.folha.uol.com.br/folha/cotidiano/ult95u73155.shtml) (accessed 20 Jan 2004).



### Perhaps treatment on return home should depend on having taken drug prophylaxis

EDITOR—In his news item Dobson highlights the health risks of overseas travel.<sup>1</sup> I find that most of my patients who travel to malarial areas without taking prophylaxis don't do so for the following reasons.

Firstly, they don't believe they are susceptible, having lived in a malarial area for years.

Secondly, they haven't sought advice.

Thirdly, they know they ought to take it but are not willing to pay for it, although the cost of prophylaxis is a fraction of the cost of the holiday.

Fourthly, they believe that they can avoid being bitten.

Finally, very occasionally, they have travelled at very short notice. Adequate prophylaxis at the airport might therefore be helpful 24 hours a day; it could even be a condition of boarding the aeroplane that passengers have adequate and appropriate drug treatment with them.

I suggest that patients returning from abroad with preventable illnesses such as malaria are treated in the NHS only on the production of a receipt proving that they at least bought or were given the appropriate drugs for themselves and all members of their families who travelled with them.

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## Validity of Canadian studies

### Author's response

EDITOR—My detailed response to the news report by White on the validity of my studies is available on [bmj.com](http://bmj.com).<sup>1 2</sup>

The report contains several inaccuracies. The typographic error of writing SE instead of SD had already been acknowledged. We did not ask the subjects to remember and recount 50 digits. I provided detailed responses to all the comments of Roberts and Sternberg. However, Meguid (the editor) took the unfair step of sending my response to them and they modified their commentary and added a figure that I did not see before publication.

In science there is scope for different methods of analyses. It is impossible to conduct statistical analyses from our published paper of the kind claimed by Roberts. Repeated requests to Roberts, Sternberg, and Meguid about their funding and honorariums have not yielded a response.

President Meisen of Memorial University and his advisers looked at my manuscript; all information was provided. He wrote to Smith, editor of the *BMJ*: "I am satisfied that there has been no wrongdoing by Dr Chandra. I urge you to draw the same conclusions." Meisen said that I had promptly and thoroughly responded to all his queries.

Strawbridge's comments are at variance with his president's conclusions. His assertion that "a very large proportion of Chandra's work is in a journal he edits" is wrong; only 11 out of 190 articles were published in *Nutrition Research*. He does not say why the university has not investigated the criminal offence of the breaking open of my office and cabinets. A nurse's recorded statement that "she had tucked away" my research files that are still missing was not followed up.

I stand by my research. I am confident the conclusions of our study will be confirmed.

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Competing interests: RKC holds a patent for a multinutrient but has not derived any financial gain from it.

- 1 White C. Three journals raise doubts on validity of Canadian journals. *BMJ* 2004;328:67. (10 January.)
- 2 Chandra RK. Nutrient supplements and health. Electronic response to: Three journals raise doubts on validity of Canadian studies. [bmj.com](http://bmj.bmjournals.com/cgi/eletters/328/7431/67#47651) 2003. <http://bmj.bmjournals.com/cgi/eletters/328/7431/67#47651> (accessed 31 Jan 2004).

### Response of editor of *BMJ*

EDITOR—We were wrong to suggest that Chandra's paper showed that participants could remember 50 digits,<sup>1</sup> and a correction has been published.<sup>2</sup>

In his rapid response to White's news article Chandra quotes Professor Meisen's letter at length,<sup>3</sup> but that letter was dated 2 April 2001. In response to that letter I went back to our reviewers and consulted our ethics committee. We remained convinced that there were major problems with Chandra's paper, and so I wrote back on 30 November 2001 and asked the university to clarify what form its investigation had taken. In particular I wanted to know if the university had examined the raw data of the study.

Meisen wrote back on 3 January 2002 to say that university had not asked to see the raw data. He acknowledged that we had raised new issues and said that the university would review them and get back to us.

As I didn't hear further, I wrote again to the university. On 19 August 2002 I received a letter from Profes-

sor Strawbridge, director of faculty relations, in which he said that Chandra had resigned. Nevertheless, the university expected Chandra to respond.

On 12 November 2002 I received a further letter from Strawbridge, explaining that Chandra could not help with queries

because in his words "all my papers are in storage and some pertaining to this study were mislaid..." Chandra provided an address in Switzerland.

Chandra has not given an adequate answer to important questions about his work. Major doubts about all of his work will persist until he cooperates with the university—and perhaps some independent experts—in a full inquiry.

**Richard Smith** *editor*  
*BMJ*

Competing interests: RS is the editor of the *BMJ* and accountable for all it contains.

- 1 White C. Three journals raise doubts on validity of Canadian studies. *BMJ* 2004;328:67. (10 January.)
- 2 Corrections and clarifications. Three journals raise doubts on validity of Canadian studies. *BMJ* 2004;328:257. (31 January.)
- 3 Chandra RK. Nutrient supplements and health. Electronic response to: Three journals raise doubts on validity of Canadian studies. [bmj.com](http://bmj.bmjournals.com/cgi/eletters/328/7431/67#47651) 2003. <http://bmj.bmjournals.com/cgi/eletters/328/7431/67#47651> (accessed 31 Jan 2004).

### Response of editor in chief of *Nutrition*

EDITOR—Concerning the Chandra debate<sup>1</sup>: if Chandra were to provide the details of the study methodology and the original data as requested by his critics, wouldn't the debate end?

The scientific process encompasses (a) the careful conduct of the researcher and his or her team, or both, and the acquisition of credible data; (b) the description of the research in a manuscript, with presentation of the data and logical interpretation, such that fellow scientists can reproduce the data; (c) a peer review system of the manuscript before publication; (d) the scrutiny of the data by readers of the paper after publication; and (e) the independent reproducibility of the data on the basis of the methods reported in the paper in the long term.

In the past *Nutrition's* readers have occasionally raised issues based on (d), and these have always been satisfactorily resolved by open discussion and, if necessary to satisfy statistical concerns, by disclosure of the data.

With regard to Chandra's study, the controversy over the veracity of the data could have been resolved at an early stage, and can still be easily resolved were Chandra to provide the details of the study methods and the original data to his critics. Until now, despite contrary claims, he has failed to provide specific answers to questions about the methods or access to the data. Why?

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Competing interests: MMM has no financial or intellectual conflict of interest.

- 1 White C. Three journals raise doubts on validity of Canadian studies. *BMJ* 2004;328:67. (10 January.)

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