Letters

Monitoring global health

Problems are primarily national

Editor—Murray et al urge for improved global reporting of health data.[1] They also highlight the difficulty of showing national decision makers that good health data can strongly support decision making. Why is this?

A reason may be that data are always subject to interpretation. The article by Murray et al is a case in point. They want to establish "an independent monitoring organisation," arguing that the World Health Organization is not fit to undertake the job because of tension between advocacy, monitoring, and evaluation. But evidence that it is this tension that leads to poor monitoring by WHO is weak, at best.

In reality, the problems of global health reporting are primarily national (and subnational). The fact that the sum of deaths claimed by different programmes is greater than the actual number of deaths reflects epidemiological methods and the current limitations in global health reporting, more than any WHO failure. The global burden of disease project was limited by these issues, but it was undertaken as effectively in WHO as in any other organisation.

Not only are there problems in capacity, understanding the value of surveillance, and coverage of health services. The reporting of health events can be politically sensitive or even economically damaging. It is therefore likely that political interference will continue (whoever collects the data) until governments can be shown that honesty pays. It is perhaps this failure that needs to be dealt with rather than setting up yet another organisation without a proper analysis of the reasons (and locus) for failures in global health reporting.

Osman David Mansoor *public health physician*
Public Health Consulting, 4/14 College Street,
Wellington, New Zealand
oz@phc.org.nz

Nick Wilson *senior lecturer*
Department of Public Health, Wellington School of
Medicine and Health Sciences, PO Box 7343,
Wellington South 6005, New Zealand

Competing interests: Both authors have worked for WHO.

1 Murray CJL, Lopez AD, Wibulpolprasert S. Monitoring global health: time for new solutions. *BMJ* 2004;329:1096-100. (6 November.)

WHO has mandate and expertise

Editor—In their critique of procedures of the World Health Organization for analysing and presenting health statistics, Murray et al make a series of misleading statements about monitoring and evaluation of tuberculosis.[1] Ironically, part of the reason that they can criticise WHO's tuberculosis statistics is that, by design, WHO is completely open about the process of gathering, analysing, and presenting data.

We refer to just three issues among many more.

Firstly, it is untrue that no affordable and feasible methods are currently available to assess tuberculosis in a community. China, India, and other countries have carried out a series of large scale population surveys of infection and disease that have shown, or have the potential to show, the impact of their tuberculosis control programmes.[2 3]

Secondly, after years of exposure to these statistics, Murray et al still do not seem to understand the meaning of basic indicators, such as case detection, and how they are used in planning and evaluation. These indicators are fully explained in our annual report.[4]

Thirdly, we reject absolutely the suggestion that WHO manipulates global tuberculosis statistics so as to advocate for the directly observed therapy, short course (DOTS) strategy, and fails to expose weaknesses in the data. With reference to Mozambique, the example chosen by Murray et al, our 2004 report clearly pointed out the strengths and weaknesses of the data.

WHO now routinely collects tuberculosis statistics from 200 countries, and the quality and diversity of the data on surveillance, planning, and financing are improving each year. We do not need another global health monitoring organisation that would dilute this effort and would do little to enable countries to use their data to correct their own problems. We need instead further international support for WHO and its established partners, which collectively have the mandate and expertise to carry out this work.

Christopher Dye *coordinator, Tuberculosis Monitoring and Evaluation*
dyec@who.int

Mario Raviglione *director*
Stop Tuberculosis Department, World Health
Organization, CH-1211 Geneva 27, Switzerland

Competing interests: Both authors work for WHO.

1 Murray CJL, Lopez AD, Wibulpolprasert S. Monitoring global health: time for new solutions. *BMJ* 2004;329:1096-100. (6 November.)
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Bottom up approach is more likely to be successful

Editor—Murray et al identify the need for better health information, but their solution is misguided.[1] How would their proposal for a richly funded "independent" organisation, primarily concerned with global monitoring be useful to countries?

Such top down, technocratic approaches emphasise global comparability at the expense of countries' ownership. Murray et al assume a priori that addressing the problems with global reporting will also fuel greater commitment among countries to strengthening national health information systems. This approach was used in the work of the World Health Organization that was led by Murray, on burden of disease, health system performance, and the world health survey. The results were an overemphasis on model building and global comparability, with tenuous links to empirical evidence and a notable absence of involvement from countries. WHO is now working to support the building of country information systems from the ground up while not neglecting its global monitoring role.

Bottom up approaches will not only generate data for country decision making but also produce the information needed by donors and international organisations for global monitoring. This is the underlying premise of the Health Metrics Network, a new global alliance aiming to increase the availability and use of sound data through the reform of country health information systems.

Examples abound of productive interaction between global monitoring and country information systems. Estimates of the

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Tuberculosis advocacy in Lima, Peru

AIDS epidemic are generated by countries themselves using standardised methods.[2 3] In addition to empowering countries and stimulating the use of data for health action, this approach shows the importance of solid surveillance systems to countries. Capacity building in countries is therefore producing not only better country data but also better global monitoring. It would be wise to build on the current momentum of partnership and collaboration led by the Health Metrics Network and WHO.

Ties Boerma *director, Measurement and Health Information Systems*
boermat@who.int

Carla Abou-Zahr *interim executive secretary, Health Metrics Network*
World Health Organization, 1245 Geneva, Switzerland

Competing interests: TB and CAZ work for WHO in Geneva and are involved in the Health Metrics Network.

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Cochrane Collaboration in developing world could be an answer

Editor—The need to develop and maintain a robust health information system that is free from political influence is undoubtedly important. The health promotion field of the Cochrane Collaboration has also recognised this need, identified priority areas of global importance, and is commissioning reviews.[1] The suggestion by Murray et al of an independent global organisation sounds similar to the ideals of the Cochrane Collaboration but seems to have a wider scope.[2]

One of the problems with such organisations is that these centres are usually based in a developed country—for example, most centres of the Cochrane Collaboration are located in the developed world. An alternative to creating a new body looking at health information could be to help support establishing regional or national centres of a collaboration in the developing world; rather than to have yet another organisation based in a developed country. In my view, this is more likely to contribute to the development of a robust global health information system.

Ilyas Mirza *consultant psychiatrist*
Naseberry Court, Chingford, London E4 9QJ
ilyasmirza@blueyonder.co.uk

Competing interests: IM has an active interest in setting up an independent centre for research evaluation and dissemination in South Asia.

1 Waters E, Doyle J. Systematic reviews of public health in developing countries are in train. *BMJ* 2004;328:585.
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Limitations and potential of country of birth as proxy for ethnic group

Editor—We agree with Jarman and Aylin that recording of ethnic group on death certificates needs to be improved in the United Kingdom.[1]

Currently, country of birth has been included in each UK census since 1841 and is a readily available and objective, although crude, method of ethnic group classification.[2] Indeed it remains a good proxy for ethnic group for the older age minority groups and is of intrinsic interest in separating environmental and genetic differences. However, it is no longer an appropriate proxy as it does not take account of the diversity of the country of origin of the individual; the number of white people born in countries, such as India, ruled by the British Empire; and children of migrants identified by this method as second generation immigrants. In the 2001 census half of the minority ethnic population was born outside the United Kingdom.

Further recording of country of birth on death certificates, which is reliant on an informant, may be less accurate than on the census, when the person is still alive to provide the information, leading to the possibility of numerator-denominator bias. Previous analyses of mortality by country of birth have grouped together countries for which this is a particular issue—South Asian countries[3]—but this approach obscures potentially important differences between countries of birth.[2 3 4]

Despite these limitations, we have documented the marked variations in mortality by age, sex, and ethnic group.[5] This resource is available online and provides a wide range of data both on the morbidity and mortality by ethnic group that is of use for commissioning services for these minority communities. However, there is an urgent need to address the recording of ethnic group data on death certificates to accurately determine and address the health inequalities between ethnic groups in the United Kingdom.

Paramjit S Gill *clinical senior lecturer*
University of Birmingham, Birmingham B15 2TT
p.s.gill@bham.ac.uk

Raj Bhopal *professor of public health*
Sarah Wild *senior lecturer*
Public Health Sciences Section, Division of Community Health Sciences, University of Edinburgh, Edinburgh EH8 9AG

Joe Kai *professor of primary care*
University of Nottingham, Graduate Medical School, Derby City General Hospital, Derby DE22 3DT

Competing interests: None declared.

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Specialised care for early psychosis

Like was not compared with like

Editor—Craig et al tried to evaluate early intervention services for psychosis empirically.[1] The results of the Lambeth Early Onset (LEO) trial may, however, be misrepresented, especially by those who think that early intervention services are a waste of valuable resources,[2] and be used to argue that resources should be directed to inadequately resourced routine services, the supposed comparison group in the LEO trial.

The comparison in the LEO trial was not between a well funded specialist team and run down inner city services, but between a newly formed specialist team that was learning on the job and between well established and integrated community mental health teams. A randomised controlled trial of a developing team at its inception is the equivalent of conducting a clinical trial on a drug without first establishing its pharmacokinetic and pharmacodynamic properties.

ETHOS, the neighbouring early intervention service in southwest London, was set up in July 2001. The ETHOS team has taken three years to determine the key ingredients of effective biological and psychosocial interventions for its patients, the appropriate generic and specialist skill mix of the team, the duration of service provision, pathways into and out of care, and strategies for preventing relapse.

Despite all the problems entailed in developing and establishing a new service, the LEO trial shows some positive outcomes for patients receiving early intervention. It would be unfortunate therefore if the limited effectiveness of LEO intervention simply strengthens the prejudices of the nay-sayers and confirms the principle of dangerous precedent: nothing should ever be done for the first time.

Swaran P Singh *senior lecturer in mental health*
St George's Hospital Medical School, London SW17 0RE
s.singh@sghms.ac.uk

Competing interests: SPS has established and run the ETHOS early intervention in psychosis service.

1 Craig TKJ, Garety P, Power P, Rahaman N, Colbert S, Fornells-Ambrojo M, et al. The Lambeth early onset (LEO) team: randomised controlled trial of the effectiveness of specialised care for early psychosis. *BMJ* 2004;329:1067-9. (6 November.)
2 Pelosi AJ, Birchwood M. Is early intervention for psychosis a waste of valuable resources? *Br J Psychiatry* 2003;182:196-8.

More detail is needed

Editor—Craig et al evaluated the effectiveness of specialised care for early psychosis.[1] This is a good first step. What is different in the early intervention team work needs to be described more fully—for example, the frequency and regularity of appointments in assertive outreach and standard care.

People with schizophrenia benefit from a regimen that gives them something in the near future on which to anchor their inner thoughts, something to look forward to and reassemble "connecting" ability to outside expectation, rather than drifting. What is described is rather like a manifesto. Some idea of the numbers of people who were offered and took up cognitive behaviour therapy, vocational guidance, and particularly occupational activities that brought about "breaks" would be helpful.

CLAY PATRICK McBRIDE/PHOTONICA

David H Yates *retired psychiatrist*
Wadebridge, Cornwall PL27 7RE
david@jidgey.freeserve.co.uk

Competing interests: None declared.

1 Craig TKJ, Garety P, Power P, Rahaman N, Colbert S, Fornells-Ambrojo M, et al. The Lambeth early onset (LEO) team: randomised controlled trial of the effectiveness of specialised care for early psychosis. *BMJ* 2004;329:1067-9. (6 November.)

Author's reply

Editor—The Lambeth Early Onset (LEO) community team comprised experienced mental health professionals, most of whom had not previously worked in an early intervention service and were comparative novices at the interventions advocated by international experts. However, we contend that our pragmatic approach is precisely how many similar early intervention teams are being established, so that our results reflect the least that may be expected from these new services.

Although it may also have been better to have waited until the early intervention service was fully established, randomisation to non-specialist care would have been impossible to justify once the service had been running for two or three years—an observation that probably accounts for the dearth of relevant randomised controlled trials.

We will provide more detail on the process and outcomes of the LEO team later, but a few clarifications may be helpful. The work of the LEO community team differed from comparison sector teams mostly in terms of intensity. Patients in LEO were seen more frequently (an average of 13 visits in the first three months out of hospital compared with five for standard care).

Much of the effort was to help patients resume aspects of their life that had been disrupted by illness. Occupational and social activities were accorded as much importance as management of symptoms. Presumably as a result, LEO patients were more likely to continue drug treatment, with 50% still adherent at nine months compared with fewer than 30% in standard care. They spent twice as much of the follow up engaged in education or employment and had more satisfactory relationships with friends and family. Just over half of them took up offers of cognitive behaviour therapy for positive symptoms, and some family work was carried out in 40 LEO families, although this entailed mainly advice and support rather than formal therapy.

Tom K J Craig *professor of social and community psychiatry*
Institute of Psychiatry, London SE5 8AF
tcraig@iop.kcl.ac.uk

Competing interests: TKJC has received support for attending seminars and fees for speaking at conferences on early psychosis from Eli Lilly, AstraZeneca, Janssen-Cilag, and Novartis.

Computer assisted knee arthroplasty is here today

Editor—Gidwani et al summarise the orthopaedic options for painful arthritis of the knee.[1] As they say, computer assisted surgery is not standard practice for most orthopaedic surgeons in the United Kingdom. Many cite a lack of long term follow up data for this technique to justify their reluctance to embrace this technology.

However, navigated arthroplasty surgery has been widely validated in the orthopaedic literature.[2 3] Lower limb mechanical alignment is one of the principal factors determining the survival of a total knee arthroplasty. As many as 10-15% of all knee prostheses ultimately require revision, many because of poor quality placement of the prosthetic components.[4] The failure rate of poorly aligned implants is more than twice that of well aligned implants.[5]

The main reason for poor alignment arises from the difficulty of using anatomical reference points, and human judgment alone cannot ensure reproducible alignment. Mechanical alignment outcomes obtained using computer assisted surgery have consistently been superior to those obtained using traditional alignment methods.[2 3] Most data on survival of total knee arthroplasties originate from centres specialising in such surgery and therefore do not reflect the normal Gaussian spread of outcome obtained throughout the country.

Computer assisted arthroplasty narrows the spread of alignment and so improves the long term outcome of such surgery. Interestingly, few orthopaedic surgeons formally assess postoperative mechanical alignment by lower limb alignment films or computer tomography. Despite their inability to assess their outcomes, many would state that their technique does not require modification. We think this shows a lack of insight which must be addressed to maximise the survival of arthroplasties.

Graeme Holt *specialist registrar, trauma and orthopaedic surgery*
graemeholt@btinternet.com
A G Gregori *consultant trauma and orthopaedic surgeon*
Hairmyres Hospital, East Kilbride, Glasgow G75 8RG

Competing interests: None declared.

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Preventing and treating hepatitis B infection

Immunisation is most important strategy to control hepatitis B

Editor—The immunisation advice in the hepatitis B review by Aggarwal and Ranjan is potentially misleading.[1]

Firstly, recommending three doses at 0, 1, and 6 months is unnecessarily limiting; delaying the third dose can lead to lower compliance. Hepatitis B vaccine has been shown to be immunogenic when a wide range of schedules is used.[2] Although increasing the time between the second and third doses leads to higher antibody concentrations, it seems to be the immune memory rather than antibody concentrations that is of primary importance. A two dose schedule was approved for adolescents in the United States in 1999; it has also been suggested as being adequate for infants.[3]

Secondly, the importance of hepatitis B immune globulin is overstated. It provides comparatively little additional protection to immunisation in preventing infection in infants of HBeAg positive mothers.[4,5]

Thirdly, although recommending giving vaccine to infants of HBeAg positive mothers as soon as possible after birth is reasonable, the data are limited on the precise timing. A dose of hepatitis B vaccine given with immunisation leads to higher protection (70% to 95%) than if given after one week (50% to 57%),[2 w1-w3] but one study found protective efficacy of 75% for those who received vaccine alone in week two.[w4]

As the authors note, immunisation is the most important strategy in controlling hepatitis B.

Osman David Mansoor *public health physician*
Public Health Consulting, 4/14 College Street,
Wellington, New Zealand
oz@phc.org.nz

Nick Wilson *senior lecturer*
Department of Public Health Wellington, School of Medicine and Health Sciences, PO Box 7343,
Wellington South 6005, New Zealand

Competing interests: None declared.

1 Aggarwal R, Ranjan P. Preventing and treating hepatitis B infection. *BMJ* 2004;329:1080-6. (6 November.)
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References w1-w4 are available on bmj.com

High risk groups are still not being vaccinated

Editor—Aggarwal and Ranjan highlighted the global burden of hepatitis B and say that vaccination is the mainstay of prevention.[1] They also describe the vaccination's lifelong efficacy and cost effectiveness. With such a clear evidence base and the recognition that certain high risk groups—such as injecting drug users—must be vaccinated, the availability of vaccination services to this population is disappointing.

In a recent national survey of all UK drug treatment agencies, only a quarter of drug services routinely provided hepatitis testing and vaccination for hepatitis B, and a quarter did not offer this service at all.[2] Often associated with equally limited access to hepatitis C testing, the absence of such service provision not only needlessly exposes vulnerable individuals to preventable risk but also denies the chance for positive behavioural change that can be seen in those who are made aware of their viral status.

The authors say that, in preference to universal neonatal vaccination adopted in countries with higher prevalence, a policy of selective immunisation of high risk groups has been implemented in the United Kingdom. However, a large proportion of injecting drug users in contact with treatment agencies who should thus be ideally placed to access and receive such interventions clearly do not. The continued failure to institute such health and cost effective evidence based interventions to a marginalised and high risk group is unacceptable and inconsistent with UK policy and the expectation of reasonable public health care and harm reduction.

Adam R Winstock *area clinical director*
Drug Health Services, South Western Sydney Area Health Service, PO Box 39, Liverpool BC,
NSW 1871, Australia
Adam.Winstock@swsahs.nsw.gov.au

Competing interests: None declared.

1 Aggarwal R, Ranjan P. Preventing and treating hepatitis B infection. *BMJ* 2004;329:1080-6. (6 November.)
2 Winstock AR, Sheridan J, Lovell S, Farrell M, Strang J. National survey of hepatitis testing and vaccination services provided by drug services in England and Wales. *Eur J Clin Microbiol Infect Dis* 2000;19:823-8.

Authors' reply

Editor—We agree with Mansoor and Wilson that hepatitis B vaccine has considerable efficacy even when the recommended schedule is not strictly adhered to. Two doses are possibly as effective as three doses, and the time interval between the second and the third doses may be unimportant.

Similarly, among infants born to HbeAg positive mothers, delayed administration of the vaccine or administration of vaccine alone without hepatitis B immunoglobulin seems to have considerable efficacy; however, whether this equals the efficacy of the recommended measures remains unclear. Our brief was to summarise the current standard recommendations and these remain unchanged despite the recent data.

As pointed out by Winstock, selective immunisation strategies aimed at high risk adolescents and adults do not work. We therefore believe that it may be wise to implement universal hepatitis B immunisation even in regions with low endemicity.

Rakesh Aggarwal *additional professor*
Piyush Ranjan *senior research associate*
Department of Gastroenterology, Sanjay Gandhi Postgraduate Institute of Medical Sciences,
Lucknow 226014, India
rakesh@sgpgi.ac.in

Competing interests: None declared.

A prisoner of conscience in Vietnam

Editor—In Vietnam, freedom of expression is limited, and this restriction has an impact on health services. Nguyen Dan Que has spent nearly half his professional life in prison for peaceful protest. He is an internationally trained doctor, capable of making a valuable contribution to his country's health service.

Dr Que studied medicine at Saigon University and joined the teaching staff of the university's medical school. He specialised in thyroid diseases and diabetes and in 1968-72 carried out research in Paris, Brussels, and London under the sponsorship of the World Health Organization. In 1974 he returned to Vietnam to join the Saigon University Faculty of Medicine. In 1975 he became director of Cho-Ray Hospital in Ho Chi Minh City. He soon became disillusioned with the new government's healthcare policies and expressed criticisms openly; he was dismissed as hospital director.

In February 1978 Dr Que was arrested and imprisoned without trial, under harsh conditions, for 10 years. He was adopted as a prisoner of conscience by Amnesty International and released in 1988. He was prevented from practising medicine. He refused to emigrate despite being invited to do so by the authorities. He became the first member of Amnesty International in Vietnam. In 1990, inspired by the democratic movements in eastern Europe, Dr Que founded the "high tide of humanism" movement (*Cao Trao Nhan Ban*), a non-violent movement for human rights. Its manifesto called on people in Vietnam and abroad to sign a petition demanding non-violent political, social, and economic change for Vietnam.

As a result he was arrested and in November 1991 tried for, among other things, planning to overthrow the government and being a member of Amnesty International. He was sentenced to 20 years' imprisonment and five years' house arrest. He was long kept in solitary confinement and developed hypertension and a duodenal ulcer. Perhaps as a result of international campaigning he was released under a special amnesty in September 1998.

After his release, Dr Que faced constant surveillance amounting to harassment, including having his phone and access to the internet cut on numerous occasions. On 17 March 2003, he was arrested again, reportedly while on his way to an internet cafe. He was sentenced after a grossly unfair trial, despite a wave of international protest, to two and a half years' imprisonment.

His health has reportedly worsened in prison. He requires drug treatment for hypertension and has a bleeding peptic ulcer and kidney stones. Drug treatment is reportedly delivered to prison, but it is not known whether he receives it or any other medical care.

The Health Professionals' Network of Amnesty International is calling for support for Dr Que. Only intensive international campaigning can help him receive medical treatment and his release.

Duncan Forrest *editor, Amnesty International UK Health Professionals' Network Newsletter*
Health Professionals' Network, Amnesty International, London EC1R 4RE

Duncan Forrest died on 4 December 2004. An obituary will be published in the *BMJ* soon. The contact for this letter is Natalie Smith, coordinator, UK Health Professionals' Network, Amnesty International, London EC1R 4RE (natalie.smith@amnesty.org.uk).