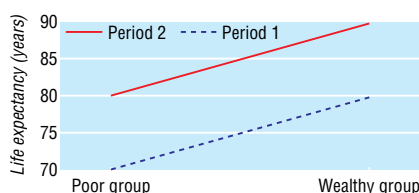


## Health inequalities under New Labour

### Relative rather than absolute gaps are important over time and place

EDITOR—We agree with Shaw et al that the method of measuring inequality in health outcomes used in setting the government targets is problematic (A Low, UKPHA (UK Public Health Association), 13th annual public health forum, Gateshead, April 2005).<sup>1</sup> However, the government's targets are based on reducing relative gaps in life expectancy and infant mortality.<sup>2</sup> The slope index of inequality (SII) used by Shaw et al measures absolute gaps.



Constant slope index of inequality (SII) means a greater rate of progress for the poor group

The distinction between absolute and relative gaps becomes important when comparisons are made over time. Increasing life expectancy over time with no change in the slope (constant SII) implies a faster rate of progress for those at the bottom of the scale than for those at the top. The figure shows a gain of 10 years of life expectancy for both groups; the rate of improvement for the poor group is 14% (10/70) and for the wealthy group 12.5% (10/80).

The interpretation of the SII is affected by increases or decreases in life expectancy over time. We therefore advocate the use of the relative index of inequality (RII) to compare magnitudes of inequality in health outcomes over time, as well as between different conditions and rates of service provision (A Low, UKPHA (UK Public Health Association), 13th annual public health forum, Gateshead, April 2005).<sup>3</sup>

We calculated the relative index of inequality for the data of Shaw et al by dividing the reported SII by the average life expectancy across all poverty groups. The absolute gap (SII) for both sexes from 1992-4 to 2001-3 is 4.3%, for men 3.8%, for women 4.0%. The relative gap (RII) is 2.0% for both sexes, 0.9% for men, and 2.2% for women. In this case the SII overestimates the magnitude of gap changes, because the

increasing general trend is not accounted for.

In similar calculations for the other official headline target of infant mortality the SIIs would underestimate the magnitude of gap changes, as infant mortality is on a general downward trend.

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- 1 Shaw M, Davey Smith G, Dorling D. Health inequalities and New Labour: how the promises compare with real progress. *BMJ* 2005;330:1016-21. (30 April).
- 2 Department of Health. Health inequalities—national targets on infant mortality and life expectancy—technical briefing (revised 2002). [www.dh.gov.uk/assetRoot/04/07/78/96/04077896.pdf](http://www.dh.gov.uk/assetRoot/04/07/78/96/04077896.pdf). (accessed 15 Apr 2005).
- 3 Low A, Low A. Measuring the gap: quantifying and comparing local health inequalities. *J Public Health* 2004;26:388-95.

### Difference in findings is due to geographical coverage

EDITOR—Shaw et al argue that any study that does not use the recently released, final revised population estimates will produce erroneous results, citing a paper by one of us (MB), which showed a narrowing of the life expectancy gap in England.<sup>1,2</sup>

How much do revisions to population estimates influence the conclusions and can this alone account for the apparently different conclusions in the two papers?

Bajekal used the unrevised population estimates from the 1991 census rolled forward, but this mainly produces a difference in scale rather than direction of trends from the use of revised figures. We found that the conclusions of Shaw et al would still have differed from those of Bajekal had they used unrevised populations.

Both studies examined differential trends in life expectancy between 10ths of

populations grouped by deprivation and covering almost the same period. We propose that the reason for the discrepancy in the two findings is due to geographical coverage (England *v* Great Britain) and the spatial level of analysis (ward *v* local authority).

Using the same data as Shaw et al, but for England alone, we see no change in the life expectancy gap between the local authorities with the highest and lowest life expectancy for men, and a relatively small increase in the gap for women (0.6 years) over the 1990s (table). Given that the width of the 95% confidence interval at local authority level is about one year, these results show that the life expectancy gap in England remained stable over the period.

Even within England, results from an analysis of wards will differ from those of local authorities. Differences in life expectancy and social deprivation between wards within most local authorities are considerable, and the socioeconomic composition of wards also changes over time. This will tend to make differences in life expectancy between local authorities both narrower and more stable over time than those for wards.

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Competing interests: None declared.

- 1 Shaw M, Davey Smith G, Dorling D. Health inequalities and New Labour: how the promises compare with real progress. *BMJ* 2005;330:1016-21. (30 April).
- 2 Bajekal M. Healthy life expectancy by area deprivation: magnitude and trends in England, 1994-1999. *Health Stat Q* 2005;25:18-27.

### Authors' reply

EDITOR—Low and Low highlight how the widening gap in mortality between areas in the United Kingdom should be measured. Earlier, concern was raised that the changing size of social class groups could lead to increases in differences between groups at the top and bottom of the social hierarchy (whether measured in relative or absolute

Local authority areas with the highest and lowest life expectancies (with 95% confidence intervals) at birth in England

	Men		Women	
	1992-4	2001-3	1992-4	2001-3
Life expectancy in years:				
Highest	78.0 (77.3 to 78.7) East Dorset	80.1 (79.3 to 80.8) East Dorset	83.1 (82.5 to 83.8) East Dorset	84.8 (84.3 to 85.4) Kensington and Chelsea
Lowest	69.7 (69.4 to 70.1) Manchester	71.8 (71.4 to 72.1) Manchester	76.5 (76.1 to 76.8) Manchester	77.6 (77.0 to 78.3) Blackburn with Darwen
Difference	8.3	8.3	6.6	7.2

Life expectancy in England by poverty, slope index of inequality, and difference between poorest and richest local authority districts, 1992-2003. Values are life expectancy differences in years

England	1992-1994	1995-1997	1998-2000	2001-2003
SII	3.65	3.77	3.83	3.98
Difference	7.47	7.04	7.38	7.54

terms) despite an overall reduction in inequalities.<sup>1</sup> Both the measure we used and that advocated by Low and Low were introduced to provide estimates of inequality that were not dependent on the size of the social groups used to categorise people.<sup>2</sup>

However, neither approach is the “correct” way of reporting these data. They reflect different aspects of the data, but both are valid. In epidemiology, relative risks are taken as better indices of aetiological effect, absolute differences as better indices of public health importance. We think inequalities in health are more relevant to public health policy than aetiology. However, which matters more to you, whether your life expectancy disadvantage has increased from 10 to 11 years or whether the relative improvement in your life expectancy is 0.8925?

Both Low and Low’s approach<sup>3</sup> and ours represent appropriate ways of measuring overall inequalities in mortality, rather than merely comparing the highest and lowest life expectancy areas, as Bajekal and Baker do. Consider whether inequalities in England between local authority districts (the geographical unit the government has chosen to assess the life expectancy inequality target) have risen over time, rather than in the UK as a whole, which we considered in our original paper. The table shows that when men and women are considered together, if only the absolute difference between the worst and best off areas is compared then it might seem that there is no trend.

However, in England the slope index of inequality (SII) has risen consistently over time and, compared with table 1 of our original paper, began lower and ended up higher than for the UK as a whole. Rising inequalities within England—in particular life expectancies rising most quickly where they were highest to begin with—are therefore driving rising inequalities in the UK as a whole. Whichever appropriate measure is used, trends in inequalities in life expectancy are rising in both the UK and (at an even greater pace) England.

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1 Stern J. Social mobility and the interpretation of social class mortality differentials. *J Soc Policy* 1983;12:27-49.  
2 Wagstaff A, Paci P, Van Doorslaer E. On the measurement of inequalities in health. *Soc Sci Med* 1991;33:545-57.  
3 Low A, Low A. Measuring the gap: quantifying and comparing local health inequalities. *J Public Health* 2004;26:388-95.

### Making allegations without due care is wrong

**EDITOR**—Dyer reported that parents wrongfully accused of child abuse cannot sue doctors.<sup>1</sup> When doctors are required to report abuse but are given unlimited immunity for reporting a suspicion of child abuse, over-reporting seems likely. The most serious problem arises when suspicions become formal diagnoses.

In my practice, I regularly see charts in which the first person to raise a suspicion of abuse is considered to have made a definitive and incontrovertible diagnosis. Subsequent consultants echo it, and it is assumed to be fact. Except when a medical student sees the child, there is seldom the barest outline of a differential diagnosis anywhere in the record. Such failure to consider, and systematically exclude, alternative explanations for the child’s signs and symptoms represents tunnel vision and often precludes further investigation. It is poor medicine that would, in any other setting, be ample grounds for a negligence action.

At minimum, a standard of care should be formulated to include a differential diagnosis of the patient’s complaint, with reasons for excluding or making specific diagnoses. The standard of care should also include sufficient radiological and laboratory investigation before making definitive diagnoses of abusive injury. All doctors have a moral obligation to prevent child abuse. It is serious child abuse to remove a child from innocent, loving parents or to incarcerate caregivers on the basis of tunnel vision, and we have a moral obligation to prevent this form of abuse as well.

Craft’s concern about liability exposure for reporting suspected child abuse is understandable.<sup>1</sup> However, immunity from negligent acts should not be absolute and caregivers who have been unjustly harassed should have recourse. At present they do not.

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1 Dyer C. Parents wrongfully accused of child abuse cannot sue doctors. *BMJ* 2005;330:981. (30 April.)

### Pharmacogenetics and ethnically targeted therapies

#### Racial drugs need to be put in context

**EDITOR**—Rahemtulla and Bhopal focus on the heart failure drug BiDil to explore the “resurgence of the role of biology in concepts

of race and ethnicity.”<sup>1</sup> BiDil, a combination of two generic drugs (hydralazine and isosorbide dinitrate) that have been used for years to treat heart failure, is currently undergoing review by the US Food and Drug Administration for approval as the first ever drug with a race specific indication—to treat heart failure in African-Americans.

The authors assert that the major implication of BiDil is that differential responses to treatment between racial groups are attributed primarily to genetic differences. Unfortunately, this is precisely not the major medical implication of BiDil, but rather the major popular misreading of BiDil. The A-HeFT trials, on which the BiDil submission is based, enrolled only self identified African-Americans.<sup>2</sup> There was no comparison population, therefore the results say nothing about whether BiDil works differently or better in African-Americans than in anyone else. The trial results seem to show that BiDil works to treat heart failure—full stop.

The history of BiDil shows the race specific design of its clinical trial and marketing to be driven more by considerations of commerce than medicine. NitroMed, the corporate sponsor of the BiDil trials, holds at least two patents to BiDil. One is not race specific and covers the use of BiDil in the general population. This patent expires in 2007. The other is race specific; it does not expire until 2020.<sup>3</sup> NitroMed therefore has a vested interest in framing BiDil as a race specific drug—regardless of the limitations imposed by the actual evidence. In evaluating claims and counterclaims regarding relations between race and genetics, it is imperative that such background interests be brought to light.

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Competing interests: None declared.

1 Rahemtulla T, Bhopal R. Pharmacogenetics and ethnically targeted therapies. *BMJ* 2005;330:1036-7. (7 May)  
2 Taylor AL, Ziesche S, Yancy C, Carson P, D’Agostino R Jr, Ferdinand K, et al. Combination of isosorbide dinitrate and hydralazine in blacks with heart failure. *N Engl J Med* 2004;351:2049-57.  
3 Kahn J. How a drug becomes “ethnic”: law, commerce, and the production of racial categories in medicine. *Yale J Health Policy Law Ethics* 2004;4:1-46.

#### Authors’ reply

**EDITOR**—Kahn emphasises that the results of the BiDil trial do not show that black African-Americans are biologically different from white Americans. Although he makes this point by contrasting it with a partial quotation from our editorial, his emphasis is very close to the tenor of our argument as summarised in the closing sentence: “A historical perspective is likely to be helpful—claims of a biological basis to racial or ethnic variations in health and disease, including therapeutics, have proved to be overstated.”

Differences, if any, between ethnic groups may be attributable to non-genetic factors, although genetic differences cannot be ruled out. Kahn’s view is that the attention that BiDil has drawn to biological differences between populations is the major popular misreading of BiDil.<sup>1</sup> The trialists

data placed a great deal of emphasis on physiological particularities of black Americans,<sup>2</sup> and if Kahn's viewpoint is correct then the popular misreading arises from a scientific one. There is great interest in ethnic variations in drug response (described as ethno-pharmacology, not to be confused with the discipline of the same name studying the therapeutic properties of traditional plants and remedies). Scholars in the field of race and ethnicity should follow this development. If genetic factors are found to be important in causing variations in drug response between populations then the concepts of race and ethnicity will need redefinition.

Kahn points to the commercial interests at stake. We are not in a position to comment, although we are impressed by the depth of his argument.<sup>1</sup> The trialists ought to answer directly.<sup>2</sup> Yogendra also points to the incentives of the marketplace.<sup>3</sup> We were amused and educated by Hughes' quotation from Paracelsus showing that this debate was alive about 500 years ago.<sup>4</sup>

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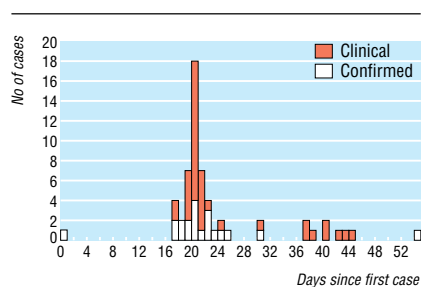
Competing interests: RSB was an invited speaker at the 8th world congress on clinical pharmacology and therapeutics, giving a presentation on concepts of ethnicity and race, and his expenses were met by both the congress and the James Lance GlaxoSmithKline Medicines Research Unit in Sydney.

- 1 Kahn J. How a drug becomes "ethnic": law, commerce, and the production of racial categories in medicine. *Yale J Health Policy Law Ethics* 2004;4:1-46.
- 2 Taylor AL, Ziesche S, Yancy C, Carson P, D'Agostino R, Ferdinand K, et al. Combination of isosorbide dinitrate and hydralazine in blacks with heart failure. *N Engl J Med* 2004;351:2049-57.
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## Younger teenagers are also at risk of mumps outbreaks

EDITOR—Savage et al provide a useful summary of the mumps outbreaks in England and Wales during 2004.<sup>1</sup> In their study, the population most susceptible to mumps were born between 1983 and 1986. They recommended reviewing the measles, mumps, and rubella (MMR) vaccination status of all school leavers.

A recent outbreak in a Scottish boarding school (October 2004) shows that younger teenagers are also at risk of mumps because of incomplete vaccination (figure). Fifty nine pupils at the school (10%) were reported as having mumps, of which 20 cases (34%) were confirmed virologically. All confirmed cases were born in 1987-91. Eleven reported cases (19%) were unvaccinated, and 34 (58%) had received only one dose of MMR. The school



Mumps outbreak curve (n=58 as date of onset not known for one case)

has a high proportion of boarders, some from countries that do not include MMR vaccine in their immunisation schedule.

The findings from this school outbreak are consistent with advice in Scotland that incompletely vaccinated children and young people aged 13-25 (born between 1979 and 1991) should be considered for opportunistic MMR vaccination.<sup>2</sup>

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Competing interests: None declared.

- 1 Savage E, Ramsay M, White J, Beard S, Lawson H, Hunjan R, et al. Mumps outbreaks across England and Wales in 2004: observational study. *BMJ* 2005;330:1119-20. (14 May.)
- 2 Chief Medical Officer. Letter. Mumps outbreaks in Scotland: offer of MMR to high risk individuals in high risk settings. 2004. [www.showscot.nhs.uk/sehdc/cmo/DC20040804mumps.pdf](http://www.showscot.nhs.uk/sehdc/cmo/DC20040804mumps.pdf) (accessed 7 Jun 2005).

## Patients' written consent when photographed could suffice for journals

EDITOR—We agree with Groves and Croot that consent for publication of images is a necessary legal requirement.<sup>1</sup> Nevertheless, we think that the best option may not always be for the journal to obtain consent.

We often take photographs in our consulting room because they have a lot of uses, publication being just one.<sup>2</sup> When we take a photograph of a patient, we do not usually know its final use at that time. We may not have another opportunity to ask the patient to give his or her consent to publication in a journal if we want to use the photograph.

We have our own consent form and use it as another official document. We think that if this document is similar in content to that of medical journals,<sup>3,4</sup> journals should accept it for two main reasons. Firstly, we may never see the patient again to sign the consent form when the journal asks us for it, even if the image is essential for publication. Secondly, our policy helps to allow photographs taken in countries where English is

not spoken to be published in international journals. Our patients usually do not speak English, so they cannot legally sign a legal document they cannot understand.

Biomedical journals should be flexible and accept different consent forms from their own. We coordinate Fotomedica, a medical digital image website ([www.fotomedica.com](http://www.fotomedica.com)), which is freely accessible to all. We do not use pictures with recognisable faces, and we always erase the name of the patient on radiograms. Sometimes we use image programs to improve the image.

We recommend obtaining consent at the same time the photograph is taken, because patients, unlike the postman, don't always ring twice.

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- 1 Groves T, Croot J. Using pictures in the *BMJ*. *BMJ* 2005;330:916. (23 April.)
- 2 Soler-González J, Martínez M, Riba D, Rodríguez-Rosich A. Authorization to use photography images in primary care education. *Aten Primaria* (in press).
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## Detecting cheating in written medical examinations

### Self regulation may be way forward

EDITOR—McManus et al suggest a promising initial step towards identifying occurrences of potential academic dishonesty.<sup>1</sup> A computer program, however, should not be seen as the final decision or a solution to the problem, although it is an effective tool.

Objections may be raised to the purely statistical and circumstantial nature of the method, but it mirrors the qualitative, side by side comparison of exams by an administrator—except that it is objective and has a high throughput. To say that focusing efforts at preventing cheating is more important than expending resources on penalising it is a weak attempt to remove a fundamental academic responsibility from students.

The computer program may prove effective in identifying potential cheats, but the burden of regulation should be placed on students. Some schools have successful and traditional "honour codes," in which issues of academic integrity are dealt with directly by representatives of the student body. Along with building substantial solidarity and students' pride in academic honour, the degree of cheating seems to be much less than in other systems; self regulation is also an effective method of catching those who do try to cheat. Furthermore, student wide accordance on academic integrity tends to support aggressive action against cheating, based on student defined levels of certainty. When coupled with appropriate and public punishments, this can help

reintegrate and strengthen the bond between honour, academics, and medicine. Doctors are increasingly under public scrutiny; maintaining the reputation of the profession in the future is a process that begins in the halls of learning now.

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1 McManus IC, Lissauer T, Williams SE. Detecting cheating in written medical examinations by statistical analysis of similarity of answers: pilot study. *BMJ* 2005;330:1064-6. (7 May.)

**Teach, and students may learn something**

EDITOR—I find the research on detecting cheating in written medical examinations disturbing.<sup>1</sup> That educationalists have to find the time to look at how to catch people out—rather than spending it improving teaching and examination methods and making the whole process less painful, or even enjoyable—is a shame.

Some bad eggs may take great enjoyment in “getting one over” on the examiners—but surely cheating is nothing other than the acute stress response to the exam system in place?

Seating candidates far apart is sensible, but talk of cameras, etc, does not strike me as sensible. The methods used to examine doctors should be looked at more closely and changed. Most college examinations remain archaic and often unkind. No other profession or even job requires such a long process of examination of its members.

And these candidates who allegedly have cheated—well, they may actually be great doctors who are just functioning badly on the day. I am not suggesting that cheating should be considered anything but wrong—but perhaps the system that brought the candidate to do it is what is wrong.

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**Summary of responses**



The learning in practice paper by McManus et al provoked a divided and global response.<sup>1</sup> Several respondents pleaded that prevention was better than cure, and putting measures in place to stop cheating is the way forward. Ways in which this could be done include adjusting seating arrangements, reducing numbers of participants, modifying types of questions (more unpredictable), setting tighter timeframes, and instilling the right values into students.

Some pointed out that sophisticated computer programs may detect certain forms of cheating but not all (McManus et al looked only at multiple choice questions)—and programs and statistics can only ever confirm cheating, not prove it. One

respondent even suggested that modern technology may actually encourage people to cheat by making it easier to do so.

A draconian approach was advocated by a minority: cheats should be fully investigated, and the information acted on. The general tenor was, however, that the causes for cheating needed to be identified because blaming the students seemed, ahem, a cheat's way out.

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Competing interests: None declared.

1 Electronic responses. Detecting cheating in written medical examinations by statistical analysis of similarity of answers. <http://bmj.bmjournals.com/cgi/eletters/330/7499/1064> (accessed 17 Jun 2005).

**A testing time for ethical standards**

EDITOR—The General Medical Council's recognition that “fitness to practise” is a life-long issue is welcome.<sup>1</sup> In the recent GMC conference *Medical Education: From Here to Where?* Janet Smith reflected on the homicidal general practitioner Alan Shipman. According to one summary she said: “Medical students who fail to demonstrate ethical sense should not be allowed to qualify.” She proposed the GMC intervene more in medical schools because ethics “have to be planted right at the beginning.”<sup>2</sup>

Young people's social or antisocial development gives me daily food for thought. A sense of personal responsibility, respect for others, openness to reflection on past behaviour, and especially that moral compass of a duty to all who depend on you, are lifelong assets in any profession. Alas, most evidence shows that these assets develop before age 11, with a little evidence that young offenders might still acquire reflection in their teens.

On what evidence can medical schools “plant” ethical principles anew in students aged 20 and older? I observed, especially as a moral tutor, that higher education can teach some students better concealment of bad behaviours (vandalism, substance misuse, interpersonal violence): our highly intelligent students do not want to be “weeded out.”<sup>3</sup>

In the pragmatic code for social workers, educators have a “responsibility” to “inform students of their ethical responsibilities to agencies, supervisors and service users.”<sup>3</sup> When fostering knowledge of ethics, educators should be “emphasising the relevance of this knowledge to their practice.”<sup>3</sup> Medical educators developing ethics curriculums may find courses such as the Society of Apothecaries' “Ethics and philosophy of healthcare” helpful. What the public depend on is ethical practice. For adult learners this is best judged through reflection with a peer group. The *UK Clinical Ethics Network* could provide the foundation for this process.<sup>4</sup>

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1 Kmietowicz Z. GMC gives evidence to inquiry. *BMJ* 2005;330:1044. (7 May.)  
2 Boseley S. Ethics test “a must” for student doctors. *Guardian* 2005 May 10: 9. (Reporting a speech by Dame Janet Smith.)  
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4 Ethox Centre. *Report 2002-2004*. Oxford: Departments of Public Health and Primary Care, 2005.

**Shaving can be safer head lice treatment than insecticides**

EDITOR—Sladden and Johnson reviewed common skin infections in children.<sup>1</sup> The life cycle of head lice (*Pediculosis capitis*) was well described and is similar to that of pubic lice. I worked in chronic emergencies in Somalia in 1993 and Sudan 1996-7 among internally displaced populations and in the nomadic Karimajong of Uganda in 1998-9, whose poor hygiene would have been a good breeding ground for head lice. However, head lice were never a clinical problem because these populations know how to interrupt its lifecycle: they shave off their hair, the only place where the eggs (nits) are anchored and glued close to the skin. Lice outside the hair are not transmissible and do not cause infestation.

I recall massive poisoning and some deaths in one institution for mentally handicapped children in Uganda in the 1970s because children licked their hair after it had been treated with insecticide. In March 2005 I mentioned to colleagues that hair shaving is a good way to get rid of pubic and head lice, but they disagreed and preferred treatment with insecticide, with all its attendant poisonous risks. Shaving off hair has become a fashion propagated by famous sports stars in many communities. It was and is common practice for schools, military, and prisons to encourage short hair or shaving. In my consultations for postnatal, family planning, and genitourinary medicine, most patients, especially the women, have cleanly shaven pubic hair.

None of the major websites—the US Centers for Disease Control and Prevention, the National Institutes for Health, and the World Health Organization—mentions shaving in their advice on treatment and control sections. I wonder why.

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