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## Is infestation with the common bedbug increasing?

EDITOR—In recent decades the common bedbug, *Cimex lectularius*, has been so scarce in the United Kingdom that new finds have been considered worthy of publication.<sup>1</sup> In 1998 specimens from only one infestation were submitted to Brighton Public Health Laboratory Service for identification, none having been submitted during the previous three years. From February to October 1999 specimens from four separate infestations were referred to the service; this suggests that bedbugs are becoming more common.

Interestingly, in all four examples there was circumstantial evidence to suggest the transfer of bugs in luggage or furnishings. One infestation occurred in a hospital residence, where two healthcare workers who occupied a room serially were bitten. Many healthcare workers who used the room arrived with luggage from overseas for short term work. Other infestations concerned a patient who was bitten after sleeping on a bed imported from the United States and patients bitten after arriving with luggage from Australia. A fourth infestation concerned a healthcare worker whose home became infested despite no recent history of travel, acquisition of furniture or furnishings, or report of infestation in neighbouring dwellings. The infestation was successfully treated with insecticides. Three months later the patient's parents, resident at a different location, were bitten, which suggests that bugs transferred with personal effects had taken three months to become apparent. Bedbugs can live for six months without feeding.<sup>2</sup>

Many doctors are unfamiliar with bedbugs (figure) and their bites. The bugs feed on sleeping patients and hide during the day. They are apparent only if a special search is made at night. Superficially they resemble lentils, being round and flat. Awareness of the possibility of infestation is important because otherwise patients may



David Schatz/Science Photo Library

Coming soon to a bed near you?

be misdiagnosed as having scabies or other skin conditions or may be dismissed as being parasitophobic.

As data on infestations are not systematically collected it is not possible to relate the increase in cases reported here to an overall trend, but it does raise the possibility of a real increase, which may be associated with international trade and travel. For patients presenting with nocturnally acquired bites or itchy rashes without obvious cause, bedbugs should be considered as a possible explanation and a search recommended. Infestation is managed by applying insecticides to their hiding places.

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## Use of hypericum as antidepressant

### Valid measure of antidepressant efficacy in primary care is needed

EDITOR—The study by Philipp et al comparing hypericum extract and imipramine or placebo seems to show that hypericum is as effective at treating moderate depression as imipramine.<sup>1</sup> This impression is strengthened by the design of the study, which is double blind, randomised, and placebo controlled, using a widely used medication as a comparator and using globally accepted depression scales including the Hamilton depression score. Linde and Berner, however, in the accompanying commentary question the efficacy of hypericum because of its use in comparatively large doses and its comparison with low doses of standard antidepressants.<sup>1</sup> They believe that these, together with the effect of unblinding on outcome, should be taken into account in the analysis of the results. The basis of this criticism is the lack of universal consensus on how the effects of antidepressant drugs should be measured in primary care. Difficulty arises because lower doses are often used to treat patients who may be less depressed than those seen in sec-

ondary care, and the treatments themselves may be more important as an adjunct to the interaction between doctor and patient than as a therapeutic intervention alone. Patients, too, may prefer to use treatment options that they see as more natural, including hypericum, and doctors are beginning to accept the importance of supporting patients' choices.<sup>2</sup> Linde and Berne do not consider that most general practitioners use 20 mg of fluoxetine when treating depressed patients, and few are prepared to increase the dose beyond this level. This reluctance is less likely to be present with a treatment that is seen as part of alternative medicine and less likely to produce side effects.

Further, in practice both patients and doctors know which medication has been prescribed, and the pragmatic nature of the trial conducted by Philipp et al reflects this, making the results more applicable to the situation in which the medication will be used. These difficulties in interpreting results of trials in general practice populations will be solved only when a primary care based system of measuring efficacy is developed that is relevant to this population and the treatment it receives.

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### Naturalistic studies are needed

EDITOR—Philipp et al address an important question in attempting to test the effectiveness of hypericum extract in treating mild to moderate depression in a primary care setting.<sup>1</sup> In the United Kingdom, general practitioners see and treat most depressive illness. Narrative experience of patients often illustrates that they have already tried, or intend to try, St John's wort or other products for their depression. For a general practitioner trying to practice evidence based mental health care, it is challenging to be able to answer the patient who asks whether St John's wort will work better than fluoxetine (or citalopram or whatever). Like many of my colleagues I welcome such research.

I have concerns, however, over the ultimate applicability of research findings to the natural world of primary care. The authors say that, since hypericum products

may vary considerably in composition, the results cannot be generalised to other extracts and also that the tested daily dosage of 1050 mg extract, which is equivalent to 6 g of the crude herb, is higher than that recommended. Given that patients who choose to treat their depression with hypericum products frequently buy the product directly over the counter, there is currently little control over or knowledge about the doses that are really taken by those who try this remedy. We need to establish the actual effective dose to be able to counsel our patients accordingly. Furthermore, the manufacturers and marketers who promote these various products should act in a responsible manner. Far too often the money spent on promoting a health product that is freely available over the counter is inversely proportional to the evidence of its efficacy. Let us hope for more quality research on the effectiveness of hypericum to enable us to give a clear message to our patients.

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### Use of placebo in depression trial was unethical

**EDITOR**—Although the trial on the use of hypericum extract for depression reported by Philipp et al is a valuable addition to the literature on St John's wort,<sup>1</sup> I believe it to be unethical. The Declaration of Helsinki is quite explicit that patients in a clinical trial should be given the best proved medical care. In the reported trial, some patients with depression were denied effective treatment with antidepressant medication as a result of being allocated to placebo. According to the authors, one of these patients attempted to commit suicide. Ethics committees should not approve such trials, and patients should not consent to take part in them.

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### Active substances must be identified

**EDITOR**—The report by Philipp et al provides additional helpful confirmation that St John's wort offers potential benefits in the treatment of depression.<sup>1</sup> What is now needed, however, is not more clinical studies on raw extracts but isolation and characterisation of the active substance(s) and a determination of their

likely pharmacological site and mechanism of action, their pharmacokinetics, and their metabolic fate. This has been done in the case of numerous other useful medications of plant derivation, from opium to salicylates. It is the only way to evaluate the potency, stability, duration of action, toxicity, and potential for drug interactions of the active substance(s), whatever it or they are. If the past is any guide, this is also the only way to further and deepen our understanding of human health and disease and to show the way to better therapeutic agents.

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### The herbalist will see you now

**EDITOR**—Ambivalence among psychiatrists and general practitioners about herbal remedies will persist, despite the well designed trial of Philipp et al, which shows that hypericum (St John's wort) extract is comparable to imipramine in its effectiveness in treating depression.<sup>1</sup> Complementary and conventional treatments in psychiatry do clash, particularly in the English speaking world, not least because of attitudes and prejudices held by practitioners.<sup>2</sup> Nevertheless, we need to be familiar with such treatments because increasing numbers of our patients are attracted to them and may seek our advice. Illnesses such as serious depression are best treated by a competent doctor, irrespective of whether the treatment is conventional.

Hypericum extracts are effective in mild to moderate depression<sup>3</sup> and may also be effective in severe depression if titration above the usual dose is allowed. Their main advantage is their tolerability: side effects are even milder than those of the selective serotonin reuptake inhibitors, with notably less sexual dysfunction. Hypericum extracts seem to act like selective serotonin reuptake inhibitors in terms of possible interaction with monoamine oxidase inhibitors and (like most antidepressants) may provoke mania in patients with a bipolar tendency. It is important that appropriate cautions are given, in this case with regard to ingestion during pregnancy or in combination with monoamine oxidase inhibitors.

Some of the scepticism about hypericum arises from the many different preparations available, and Philipp et al emphasise that their findings cannot be generalised to other extracts. Standardisation is attempted by the more reputable suppliers, generally with respect to content of hypericin and pseudo-hypericin ("total hypericins"). Hypericins are weak inhibitors of monoamine oxidase A but now seem to be less important to antidepressant action than other constituents of the herb, notably hyperforin.<sup>4</sup> Consistent with the clinical profile of hypericum extracts, hyper-

forin enhances the synaptic availability of serotonin, as well as dopamine and noradrenaline.<sup>4</sup> Hypericins and hyperforin also differ in their relative concentrations across the growth cycle of the herb, the latter being far more abundant towards the end of flowering.<sup>5</sup> The conclusion is that current standardisation (with respect to hypericins) may correlate poorly with clinical potency (more likely due to hyperforin). This may explain the "modest" or "weak" results seen with some extracts and indicates the importance of further research and the urgent need for better standardisation. Steiner Arzneimittel (suppliers of the extract used by Philipp et al) specify the content of hyperforin as well as hypericin.

The efficacy, tolerability, and popular appeal of hypericum pose a challenge to conventional medicine. Doctors require an up to date, working knowledge of effective herbal treatments—otherwise we will be eschewed by patients we could benefit.

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### Safety in overdose needs to be established

**EDITOR**—The article by Philipp et al on the use of hypericum extract for depression and the accompanying commentary by Linde and Berner make it clear that the implications for the treatment of depression are serious,<sup>1</sup> and I think that the main deciding factor in its use will be its safety in overdose. Has this been looked at yet? This has been one of the most important factors to recommend the selective serotonin reuptake inhibitors and that without this advantage, sales of drugs such as fluoxetine may be affected adversely. I just question the comment that 20 mg of fluoxetine is a "comparatively low dose"; rather, I would think of this as a standard dose for depression and certainly not enough to undermine the study mentioned.<sup>2</sup> Finally, what is the current situation about prescribing extracts such as hypericum?

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**Authors' reply**

EDITOR—We appreciate the positive feedback in most of the comments on our trial, which we would like to emphasise is not really comparable to other hypericum studies since the three arm method has been applied for the first time. The growing evidence on the effectiveness of some, but not all, hypericum preparations in mildly and moderately depressed patients is promising in many respects but contains risks when professional advice is not sought. The accumulating reports on possible interactions of hypericum preparations have to be taken into account seriously in further pharmacological, clinical, and epidemiological research.<sup>1</sup>

The magnitude of the therapeutic effect of hypericum extract over placebo, which seemed to be questioned by Linde and Berner, corresponds to a Cohen's *d* (standardised mean difference) of 0.76 (after six weeks) and 0.81 (after eight weeks of treatment).<sup>2</sup> It is in line with effect sizes for placebo controlled hypericum studies (range of 0.5 to 1).<sup>3</sup> Thus, the superiority of hypericum extract STEI 300 over placebo is impressive. Hypericum should be tested against newer antidepressants as well, but preferably in three arm trials.

Thornter and also Walton correctly emphasise the need for more pragmatic or naturalistic trials like ours and point to the question of adequate evaluation of efficacy in trials with general practice populations. We believe that the undoubted merits of the HAMD scale should not hinder progress in developing a primary care based system of measuring antidepressive effects with other scales. By integrating self rating scales, our study approach already follows a promising alternative to psychiatric severity scales since we could show SDS and SF 36 scales to be sensitive for drug or placebo differences.

The concern of Vickers about using a placebo group might have been triggered by our own misleading case report of a suicide attempt. The patient was suffering from an acute episode of a recurrent moderate depressive disorder and had been treated with imipramine before the study started. She was unfortunately randomised to the placebo group. After some improvement during the first weeks her status deteriorated. Around week seven she urged the investigator to open the emergency envelope since she was having suicidal thoughts and wanted to find out whether an effective treatment was being administered. The patient then was immediately treated with imipramine. No actual suicide attempt took place. We believe that control of suicidal risk in our study was efficient and the positive decision of the ethics committees was justified on these grounds. In most countries, regulatory bodies give approval to a drug as an antidepressant only when it has been tested in placebo controlled studies.

The proposal by Gorski to isolate and characterise the active substance(s) of St. John's wort is theoretically a straightforward strategy. We know from previous pharmacological work, however, that the picture is

more complex.<sup>4</sup> Extracts of St John's wort contain several pharmacologically relevant substances (besides hypericin and hyperforin), and it has been shown that substances like procyanidins may contribute indirectly to the antidepressant effects.<sup>5</sup> Therefore we should concentrate our efforts towards the definition of well accepted ranges for all biologically relevant substances in St John's wort and study the potency, stability, duration of action, toxicity, and potential for drug interactions of such well characterised extracts. We hope that improved standardisation will lead to extracts with an even better relation between risks and benefits.

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## Article about Canadian guidelines on proton pump inhibitors was misleading

EDITOR—I am writing because AstraZeneca Canada objects to the fact that the *BMJ* did not ask the company for comment before publishing Shuchman's news article on guidelines about the prescription of proton pump inhibitors in Canada.<sup>1</sup> The article misleads readers on several counts.

Firstly, Shuchman writes of a letter that AstraZeneca sent to Dr Anne Holbrook; the letter was sent two years ago to Dr Holbrook as the chair of a government committee. The government of Ontario responded in April 1998 on her behalf and provided assurances that these guidelines would not contravene the Federal Food and Drugs Act.

Secondly, the guidelines have never been published by the government and to the best of our knowledge are currently being reviewed and updated.

Thirdly, AstraZeneca provided the committee with scientific information refuting the draft guidelines but did not receive any response to these concerns.

AstraZeneca Canada is not pursuing legal action against any doctor. AstraZeneca believes in, and champions the appropriate use of, all of its products. We support patient access to cost effective drugs that provide the best available treatment, freedom of product choice, and independent evaluations—

provided such evaluations are based on sound, peer reviewed scientific evidence.

AstraZeneca has never prevented any doctor or researcher from publishing or communicating the results of their studies. It has a passionate interest in—and a long history of supporting-independent, peer reviewed research that leads to the development of beneficial products for Canadians and patients around the world.

Two years ago we believed the provincial government might accept the draft recommendations from the Ontario Gastrointestinal Guideline Development Committee and implement drug class substitution in Ontario. In our view, this would contravene federal legislation. Health Canada has the primary responsibility to determine the safety and efficacy of prescription pharmaceutical products. For gastrointestinal illnesses there are three products in this class of drugs. Each product is a different chemical entity. Omeprazole has been approved by Health Canada for more indications than the other two products, and the drugs in this class are not "the same."

We have spoken to Dr Holbrook and apologised for misdirecting the letter through her, as chair of the advisory committee, instead of sending it to the ministry. We have also discussed our differences in the assessment of proton pump inhibitors by the committee and wish to move forward in the spirit of scientific debate.

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## Doctors and theologians

### There is abundance in religion but scarcity in the NHS

EDITOR—Neuberger compares the NHS with a theological institution.<sup>1</sup> However, a minister of religion draws on an abundant and freely and universally available source of love, morality, and strength. This abundance is celebrated every week in churches up and down the country and contrasts with the scarcity and poverty of earthly existence. God is not rationed.

As a doctor who is a Christian working in a secular organisation I have to deal with problems of earthly scarcity. The British public may believe that the NHS is the best health service in the world but this is a sign of ignorance of the wider world rather than of British brilliance. It is worth noting that very few countries follow our model of providing health care, and few of the rich neighbouring countries choose to spend as little on health as we do.

Today's doctor is no minister. To some extent we can give people solace as well as medicine. However, we cannot offer the best earthly cures to our patients. The service is rationed at all points as everyone knows.

As a doctor I have to work within a system in which the lack of resources severely hampers the efforts of doctors to practice good medicine for their patients. It is a system that leads to delays in diagnosis and treatment. The lawyers are profiting from this system with the result that scarcity in the NHS is becoming even worse.

Politically, the NHS is a sacred cow. Any threat to it is dealt with by finding scapegoats, such as underperforming doctors or "the forces of conservatism." Voices of compassionate sanity, such as Lord Winston,<sup>2</sup> are criticised vituperatively by the government.

The time has come for a radical and heretical look to be taken at the NHS. Is the present system really the best for our country? Can we as doctors really develop to our potential if the country refuses to invest in the practice of medicine? Can we deliver the standards that patients demand without investing in facilities and training for all health workers? I still retain some belief in the possibility of progress although it is more from hope than experience.

However, I hope no one is so deluded that they believe that any form of medicine can be a substitute for religious faith. Even a better, modernised NHS will only postpone the need to face up to the great questions of religious faith and purpose.

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2 Riddell M. The NS interview: Robert Winston. *New Statesman* 2000 Jan 17:14-5.

### Doctors may stop believing in the NHS

**EDITOR**—It is all very well congregations losing their faith, as discussed by Neuberger in her editorial comparing the NHS with a theological institution.<sup>1</sup> However, priests have pride too. Many are fed up with trying to provide ever increasing miracles to an avaricious public while their church and "god" do not provide them with the resources.

The health service is its staff. Increasingly staff see little reason to continue believing in their church. Many priests and servers might prefer to work in a garage where the duties are clearly understood and adequate resources are available to do the job properly.

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## Caring for marginalised people

### Appropriate external intervention is needed

**EDITOR**—Medicine usually fails marginalised people, as Smith observed.<sup>1</sup> But it is not just medicine that fails them. Every technology invented so far has failed them and will continue to do so. Information and commu-

nication technologies have exacerbated the divide between rich and poor nations and have also further marginalised those who are already marginalised within nations.<sup>2</sup> Reverend Jesse Jackson has drawn attention to how these technologies have led to a deepening of the racial divide in the United States.<sup>3</sup>

In analysing papers published by medical researchers in India I found that much of the research carried out there has not been done in the areas in which it is most needed, such as respiratory diseases, diarrhoeal diseases, and ophthalmological disorders. A comparatively large amount of research is being carried out in the areas of cancer and cardiovascular diseases, although these are not significant causes of morbidity and mortality in India.<sup>4</sup>

The idea of paying special attention to "the poor and mean and lowly" has been emphasised throughout human history by noble souls like Jesus Christ and in recent times by Mahatma Gandhi and Mother Teresa. Yet it is something that is consistently forgotten by most of the rest of us.

Both human nature and technology need appropriate external intervention if they are to work in a manner that is beneficial to the mass of humanity. For Smith, the appropriate external intervention that can drive medicine in the right direction is found in "professional and political leadership, unceasing commitment from the top, a clear vision of what is needed, resources, and a strategic approach"; and the intervention that can correct human nature is for doctors to rediscover the religious underpinning of medicine "while operating in an increasingly secular world." I could not agree with Smith more.

In support of his case, Smith quotes from *Corinthians*. Gandhi said: "Recall the face of the poorest and the weakest man whom you have seen and ask yourself if the steps you contemplate are going to be of any use to him. Will he gain anything by it? Will it restore to him control over his own life and destiny?"

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### All doctors should be taught and tested

**EDITOR**—Smith drew attention to the mismatch between the health needs of people with learning disabilities and the response of the medical profession: "Unfortunately those who care for marginalised groups themselves become marginalised."<sup>1</sup>

Recruitment to the psychiatry of learning disability has always been low, except in parts of the country with dynamic, research oriented leaders. Despite the high level of skill required to practise psychiatry with

patients who have difficulties communicating and despite the scope for research, it is not a high status specialty.

I doubt that young doctors will flock to a specialty that Smith says is staffed by "people, often inspired by religious faith ... willing to devote themselves" and by "others ... who cannot find places in the more popular parts of medicine and who drift reluctantly" into caring for marginalised groups. These extreme reasons for choosing a career exist but most specialist registrars in the psychiatry of learning disability report that the main determinant of their choice was that they had had high quality training during their rotation as a senior house officer in psychiatry.<sup>2</sup> Young doctors rarely consider a career in this specialty until they discover how rewarding it is to develop skills (especially in communication) that few other doctors have.

All doctors should have good quality teaching on how to deliver general medical care to people with learning disabilities. All royal colleges should test the competence of doctors in their specialty to deliver medical care to people with learning disabilities. Candidates for postgraduate examinations should expect to fail if they are unable to demonstrate competence in delivering care to patients with learning disabilities. All medical schools and all royal colleges should teach and test these skills.

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### Leadership and strategy are needed to support those who provide care

**EDITOR**—I read Smith's editorial on providing medical care for marginalised people with relief.<sup>1</sup> For the past two years I have been struggling to set up a service for some of the marginalised groups identified in his editorial. As a service providing care for homeless people and travellers we have an excess of clients with addiction problems and with learning disabilities; we also treat refugees. These groups do get a poorer standard of care when they are treated within mainstream services. One of the root causes of this is an unwillingness or, more realistically, an inability to adapt services to the needs of members of these groups. This is why services such as ours have been set up, and although we do not have the resources that standard services do, we try to provide a user friendly service adapted to meet the needs of our patients. Although our patients receive an inferior service because we do not have the breadth of a modern general practice, members of marginalised groups do at least have access to some form of primary care, and things can only get better.

I have no religious motivation, just an overwhelming desire to see people treated

fairly and also the knowledge that what we are doing is cost effective both financially and socially. Perhaps I have become marginalised: I work half time in "ordinary general practice" and most of the work that I have done caring for marginalised people has been unpaid. However, my colleagues have supported me and the service has received limited funding from the local primary care group and the health authority, but it has been like swimming through treacle. Thus, I wholeheartedly back Smith's call for "professional and political leadership, unceasing commitment from the top, a clear vision of what is needed, resources, and a strategic approach." A decent service for marginalised people should not be dependent on mad buggers like me.

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## Doctors and complementary medicine

### "Deep model" that is probably true should be used

**EDITOR**—Leibovici suggests that, in the real world with limited resources, "a deep model of the physical world is essential for choosing hypotheses to be tested and for learning from failures."<sup>1</sup> This point is applicable to any area of research, but it makes the assumption that one's deep model of life/the physical universe/whatever is full and accurate. In turn, this implies a certainty we cannot possess. We cannot state that our deep model is certainly true, for it allows only for what we already know and not for what we have yet to learn or discover.

History is littered with examples of deep models that were later found to be inaccurate or incomplete. In Galileo's time, a deep model held by senior Catholic clergy was that the earth was the centre of the universe. Later, use of an extremely accurate, reliable timepiece to measure longitude at sea for the first time was long delayed because the experts to whom the timepiece was presented held the deep model that no mechanical clock could possibly be sufficiently accurate for this purpose. Modern nuclear physics has probably turned much of the previously held scientific deep model on its head.

The discovery of penicillin may have owed much to Fleming holding a slightly different deep model from that of his peers—one that resulted in him being open to the possibility that mould was not simply a domestic and laboratory nuisance. And modern day psychotherapy aims to help people identify and correct errors in their own deep model of life.

It is more valid to consider that our deep model of the physical world is probably (perhaps very probably) true. Such an approach will allow for a degree of caution

in decisions on where and how to use our resources in medical (or indeed any other) research, and in evaluating the results. It should also allow for the open mindedness needed when an unexpected and possibly major discovery is in front of our eyes.

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1 Leibovici L. Alternative (complementary) medicine: a cuckoo in the nest of empiricist reed warblers. *BMJ* 1999;319:1629-33 (with commentary by R B Haynes). (18-25 December.)

### Are medical dinosaurs heading for extinction?

**EDITOR**—Modern medical dinosaurs like Leibovici seem doomed to face a similar fate to that faced by the original dinosaurs when they became extinct.<sup>1</sup> Medicine is undergoing rapid change under the impact of complementary treatments and the patients who demand them. How can doctors be more answerable to science than to their patients?

Leibovici dismisses the abundant evidence in favour of complementary medicine. Admittedly, there is an abundance of the "wrong type" and a dearth of the "right type" to impress clinicians who insist on what is right and wrong. Dictators so detest competition, yet competition is the dynamo of change. Medicine is changing, and complementary medicine is a form of competition.

Branded an unacceptable medical heresy in the 1850s, complementary medicine has lived in the shadows of science as a professional outcast. Now it returns with public support, and the medical majority has become uncomfortable once again. A threat to clinicians' monopoly of power and a challenge to the entrenched dogmas of medical science, it demands to be accommodated.

Leibovici uses the term "politically dominant" carelessly. In countries such as India and China it is not true that only scientific medicine is endorsed by governments. Ayurvedic medicine and homoeopathy are popular in India. In China acupuncture and Chinese herbal medicine coexist equally with allopathy. If we are moving into an age of medical pluralism we should ask: on what basis can politicians repeatedly endorse scientific medicine yet deny endorsement to complementary medicine?

Patients are consulting complementary therapists in increasing numbers. Scientific medicine dominates all medical beliefs and practices, power, finances, research funding, and legal and political muscle. That dominance is being eroded as complementary medicine therapists use public pressure to remould outdated power structures into more pluralistic power sharing. Such a medical metamorphosis will lead to clinicians sharing power, ideas, and patients. If India and China can do it then why not everywhere?

Patients demand complementary medicine—safe and natural medicine—available everywhere. Whether it is philosophically acceptable or efficacious is irrelevant,

as is empiricism. Being ultimately answerable to the public it serves, medicine must adapt and supply these demands; complementary medicine is here to stay. Clinicians' chief benefactors are not scientists or philosophers or, indeed, professors of medicine but patients. Clinicians will ignore their patients at their peril or suffer the same fate as the dinosaurs.

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1 Leibovici L. Alternative (complementary) medicine: a cuckoo in the nest of empiricist reed warblers. *BMJ* 1999;319:1629-32 (with commentary by R B Haynes). (18-25 December.)

### Author's reply

**EDITOR**—I agree completely with Norrie's definition. The deep model that we use should be regarded as probably true until proved otherwise. The potential to falsify our model or a part of it should be the essential part of any experiment. The problem with hypotheses that cannot be accommodated even at the far fringes of our model is exactly that: experimenting with them does not have this potential.

The instant when a model stops being a flexible tool for advancement and becomes a harmful dogma is difficult to define. To advocate the use of deep models I should be able to show that my use of the term excludes notorious examples from the past: the defence of the geocentric model by the Catholic church, Lysenko's genetics, race theories. The willingness to admit that our model is probably true until proved otherwise, and that nothing in it is sacred, is probably the best defence. However, to falsify the model we must use one.

Morrell's main point seems to be that modalities of treatment should not be tested by efficacy and philosophical (and moral) acceptance but by some sort of public acclaim. I would guess that not only I but most of my patients and colleagues will opt for evidence of efficacy and efficiency and for the treatment being acceptable to the patient and the provider of medical care.

I was always partial to dinosaurs. I hope that Morrell will assign me the role of a brontosaurus, gently browsing the ferns, unaware of the threatening asteroid and the shrew-like mammals waiting behind the scenes tens of millions of years in the future.

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### Surgeons should have to demonstrate competence as pilots do

**EDITOR**—As a private pilot, I have often said that the arrangements for pilots not only to train but to continue to show their competence are far more stringent than

those for surgeons.<sup>1</sup> The issue of public confidence is similar for both groups, so major differences are hard to explain. Pilots regularly have inspectors supervising and checking their work; the checks include how well the teamwork operates on the flight deck. This is accepted practice, and it could be argued that similar provisions should apply in the operating theatre.

New European licensing arrangements require even part time private pilots to keep in practice, otherwise they cannot take passengers. Should surgeons be required to stay in practice for certain operations or not carry out the operation until they have been supervised and shown that they are up to date?

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1 Woodman R. Surgeons should train like pilots. *BMJ* 1999;319 (News extra 13 November; www.bmj.com/cgi/content/full/319/7220/1312/f).

## Deaths attributed to haemochromatosis are rare in Britain

**EDITOR**—The conclusion of the letter by Allen and Williamson is based on speculation.<sup>1</sup> They state that at least half of the individuals who are homozygous for the C282Y mutation of the HFE gene will develop symptoms and signs of haemochromatosis, but they do not give a reference for this statement. The true figure in the British population is probably considerably less than half.

The redefining of abnormal biochemistry or genetics as disease has created the illusion of an epidemic: haemochromatosis is a rare disease in Britain. If it were not, many of the large number of individuals who are homozygous for the C282Y gene would be attending clinics that treat liver disease, cardiomyopathy, arthritis, and diabetes; however, this does not seem to be the case.

The most obvious source of evidence indicating the incidence of haemochromatosis as a true disease among individuals who are homozygous for the C282Y gene is the number of deaths nationwide attributed to iron overload compared with the estimated total number of people who are homozygous for the C282Y gene. There are 700 000 deaths in Britain annually and about 1 in 250 of these is expected to be of someone who is homozygous for the C282Y gene, giving a total of 2900 of these people a year. However, deaths attributed to haemochromatosis are rare in Britain. In the United States only 1.7 per 10 000 death certificates mention haemochromatosis.<sup>2</sup>

Studies looking for undiagnosed haemochromatosis in cohorts of patients with diseases that can be caused by haemochromatosis have found some cases, but only a tiny fraction of the total number of C282Y homozygotes in the population.<sup>3,4</sup> The hypothesis that most C282Y homozygotes do not develop serious disease as a

result of their genotype is supported by the observation that an elderly male population was not depleted of C282Y homozygotes.<sup>5</sup>

Clearly, the deaths that do result from haemochromatosis are tragic because they are probably preventable by screening and treatment. Screening, particularly if targeted at males and relatives of C282Y carriers, might be justified on a cost per life saved, even if fewer than 5% of individuals who are homozygous for the C282Y gene develop disease related to haemochromatosis. However, making unproved assumptions about the clinical importance of a genetic lesion or believing without question that medical intervention will save lives does not achieve the maximum benefit from limited resources.

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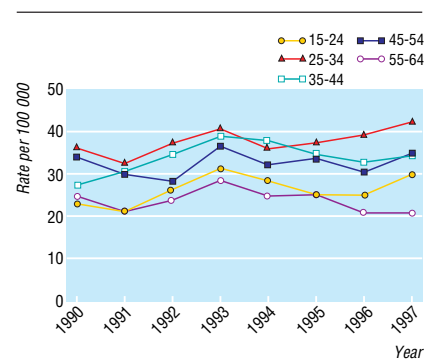
## Differences in suicide rates may be even more pronounced

**EDITOR**—Yamey reports on the decline in suicide rates among men and women in England and Wales in the 1990s.<sup>1</sup> Suicide rates in Scotland diverged from those in England and Wales in the late 1970s and early 1980s, with a more rapid increase in rates among men and no clear trend in rates among women.<sup>2</sup> A review of suicide and undetermined death rates in Scotland indicates that rates among men in these countries have continued to separate in the 1990s.

Age specific rates among Scottish women, not shown here, have shown slight increases or have remained the same, except in some older age groups where there have been slight decreases. Rates among men in Scotland (figure) give little indication of the declines noted in England and Wales. Compared with 1990, suicide rates among men in 1997 had increased in Scotland in all age groups up to and including 45-54 years.

Similar trends in methods used by men have occurred in Scotland, but the size of the changes differs from England and Wales. Rates of suicide by hanging and strangulation in men increased by 60% between 1990 and 1997, whereas deaths by other causes fell by around 40%. Deaths by solid and liquid substances showed little change over the period as a whole.

Squires et al have said that overall suicide rates may be influenced by a reclassification of deaths previously classified as undetermined cause to dependent and non-dependent use



Suicide and undetermined death rates for men in Scotland 1990-7 by age group (ICD-9 diagnostic codes E950-E959 or E980-E989 coded as primary cause)

of drugs.<sup>3</sup> If this is the case the differences between the countries may be even more marked than we have indicated.

Although trends in causes of death are largely similar to England and Wales, the absolute rates are different. This may be related to differential improvements in social circumstances in Scotland and England, but cultural differences between the two may also be important. Qualitative, as well as quantitative, research will be required to tease out the reasons for these striking differences.

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## Scottish group is developing guideline for managing pregnant women with epilepsy

**EDITOR**—We endorse Wiebe's call for more systematic implementation of evidence based guidelines for women with epilepsy.<sup>1</sup> We have been developing this approach in Scotland with a closely related national guideline published in 1997, "Management of pregnant women with epilepsy" (available via www.show.scot.nhs.uk/sign/sogap1.htm). This guideline was developed by a multidisciplinary group in accordance with rigorous methodology recommended by the Scottish Intercollegiate Guidelines Network. Individual recommendations in the guideline were graded according to the strength of available evidence. Although the guideline is due for review, many of its recommendations remain pertinent to current practice.

Publication and dissemination were under the auspices of the Scottish Programme for Clinical Effectiveness in Reproductive Health, a national initiative endorsed by the Scottish branches of the Royal

Colleges of Obstetricians and Gynaecologists and of Midwives. The guideline was disseminated by means of an interactive educational meeting attended by medical and midwifery representatives from all Scottish maternity units and by postal circulation to relevant medical and midwifery staff (including both hospital and community based practitioners).

Dissemination was complemented by an audit exercise that assessed obstetricians' baseline compliance with the guideline recommendations before their dissemination and any changes in practice after their dissemination. We will report the findings of this audit of self reported practice later. Recognising that self reports overestimate actual compliance with clinical practice recommendations,<sup>2</sup> we attempted to evaluate the impact of the guideline by looking at case notes. However, we had to abandon this because eligible cases could not be identified with sufficient accuracy via routine information systems or pharmacy records.

We welcome this opportunity to draw attention to our Scottish guideline, which was not identified through the search undertaken by Wiebe. We would also emphasise the efforts made to support implementation of this guideline by the sort of multifaceted approach that Wiebe advocated in the editorial. The methodology for guideline development is now well established, but identifying optimal methods for implementation is critically important.

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1 Wiebe S. Managing women with epilepsy. *BMJ* 2000;320:3-4. (1 January.)

2 Eccles M, Ford GA, Duggan S, Steen N. Are postal questionnaire surveys of reported activity valid? An exploration using general practitioner management of hypertension in older people. *Br J Gen Pract* 1999;49:35-8.

## Waiting time for cardiac surgery in Scotland is relatively short

EDITOR—According to the results of Pell et al's study,<sup>1</sup> the main reason why patients from lower socioeconomic groups are disadvantaged is because their cases are characterised as urgent less frequently than are those of affluent patients. Theoretically this effect is maximised the longer the waiting time; when waiting time is relatively short the effect is attenuated.

The authors, who work in Scotland, give a mean overall waiting time of 143.7-158.2 days (depending on the age group); this is relatively short compared with waiting times

for heart surgery in England, which commonly exceed 12 and sometimes 18 months. For this reason one would expect a much greater differential in the waiting time between socioeconomic groups in England than the one evidenced in Scotland. Hence the true level of inequalities in waiting times for heart surgery in the United Kingdom is likely to exceed the one calculated in this study.

Prolonged waiting for lifesaving surgery, not surprisingly, is associated with risks. According to one recent study, a median waiting time of about 146 days for coronary artery bypass grafting was associated with general mortality of 2.6% a year, or 0.28% per month of waiting.<sup>2</sup>

Hart's criticism of therapeutic nihilism in his commentary on Pell et al's paper is entirely appropriate. Unfortunately, according to the present dogma health care is not a matter of health, merely a matter of political demagoguery and media sensationalism. Whoever believes that this is the case should pay attention to this article.

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1 Pell PJ, Pell ACJ, Norrie J, Ford I, Cobbe SM. Effect of socioeconomic deprivation on waiting time for cardiac surgery: retrospective cohort study [commentary by J T Hart]. *BMJ* 2000;320:15-9. (1 January.)

2 Seddon ME, French JK, Amos DJ, Ramanathan K, McLaughlin SC, White HD. Waiting time and prioritisation for coronary artery bypass surgery in New Zealand. *Heart* 1999;81:586-92.

## More work is needed to explain why patients ask for amputation of healthy limbs

EDITOR—Dyer reports that a surgeon in Scotland amputated the legs of two psychologically disturbed men who had nothing physically wrong with the limbs.<sup>1</sup> There are several discrete groups of patients requiring such amputation, the most relevant being the group with a mismatch between their actual and perceived body schema. We have studied the psychological processes of seven such patients and have had correspondence with three others. We have used standardised mental health instruments and a technique to explore the expected self image with and without an amputation in relation to liked and disliked aspects of the self and partners.

The results of this assessment indicated that these patients do not have any known psychiatric illness and are a different group from people who fantasise about limb loss as an aid to sexual arousal. They seem to have some similarities to transsexuals, whose main concern is with body shape and gender identity.<sup>2</sup> The conviction has been there since childhood that the body does not have the right appearance to match its cortical representation, and the limb seems not to belong. This is not the same as body dysmorphic disorder, in which the limb is regarded as

ugly; it is regarded as normal but is in some way surplus to the perception of the complete body. As was stated in Dyer's article, patients who have had surgery have reported a better quality of life once the effort involved in seeking a solution is removed.

The patients that we have studied have also been assessed by two psychiatrists and in some cases have previously undergone extensive psychiatric treatment. This has not influenced the perceived discrepancy between the physical and mental representation of the body.

Perceived reduplication of normal limbs may occur in some neurological conditions,<sup>3</sup> and people with congenital limb deficiency may experience phantom sensations in the absent limbs.<sup>4</sup> Clearly, therefore, the phantom and the physical body do not always have complete correspondence. In patients requesting amputation to correct a perceived abnormality the opposite situation may have occurred: the physical limb has developed but the sensory awareness of it is lacking in some important respect. Thus it becomes not a psychiatric but a neuro-psychological problem. Further research may enable us to explain this more fully.

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1 Dyer C. Surgeon amputated healthy legs. *BMJ* 2000;320:332. (5 February.)

2 Money J, Ehrhardt A. *Man and woman, boy and girl*. Baltimore: Johns Hopkins University Press, 1972.

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## Openness is fine but deferred responsibility is not

EDITOR—In his Editor's Choice in the issue of 11 December Smith makes straightforward comments on bringing patients and the press into the process of health care.<sup>1</sup> If they understood more of the practicalities of, say, cardiac surgery they might appreciate the difficulties a bit better. Few doctors have any problems with this.

What is important is that we don't abrogate the professional responsibility that the general public (those without benefit of PhDs or careers in the law or media) rightly expect from a medical doctor. The government and our society invest vast sums in medical training and, increasingly, in monitoring medical activity. They have a right to expect rounded professionals with an ability to make informed judgments both right and wrong. It is important to achieve a balance with openness involving retained leadership and informed decision making on the part of a practising doctor. This need not be—but could easily be—compromised by openness unless the principle is indefensibly used as a shield to avoid making difficult clinical decisions.

As with many things in life, it is the balance of probabilities in clinical practice that matters, not the absolutist principle of openness.

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1 Editor's choice. Openness: a virtue whose time has come. *BMJ* 1999;319 (7224), (11 December.)

## Could the GMC institute an appeal procedure?

EDITOR—As Bliss's Personal View shows, doctors accused of medical misconduct would often fare better if arraigned before a court than before the General Medical Council (GMC).<sup>1</sup> Part of the reason may be that the GMC's tribunals, though usually and largely composed of non-specialists in the field of accusation, have at times ignored even unanimous independent medical expert opinion given before them. In addition, legal matters are decided by binding adjudication of the legal adviser to the tribunal, even when vigorously challenged on legal grounds. But most importantly of all, there is no appeal against the tribunal's (that is, the GMC's) decision, except by appeal to the Privy Council, a legal body that (apart from other considerations) would not and has not interfered with the GMC's medical findings and only rarely with its decision on legal matters.

This is surely not "natural justice" when in almost every case the professional standing and the livelihood of the accused are at stake. Is there no way in which the GMC can institute an appeal procedure? If this is at present impossible because of the legal status of the GMC and its adjudications, can

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it be altered? It is especially important because the nature of accusations against members of the medical profession seems to be changing. Is this a job for the BMA and/or the royal colleges?

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1 Bliss MR. Is an apology called for? *BMJ* 2000;320:67. (1 January.)

## Unlike GMC, GP did not follow line of political correctness

EDITOR—Have I missed something? Dyer reports that a doctor has been severely reprimanded for requesting blood tests for AIDS, a disease known to cause the symptoms and signs that the patients had.<sup>1</sup> It would seem that a considered decision was made by a caring doctor; knowing that to follow the line of political correctness would cause great harm in terms of anxieties raised, and being aware that a positive result was extremely unlikely, he decided not to inform the patients unless the results proved positive, at which time counselling could take place.

His colleagues, for motives that I cannot begin to imagine, invited the patients to "be counselled" to prepare them for receiving a negative result of an HIV test and complained to the General Medical Council. The council falls over the tripwire of political correctness and appals jobbing general practitioners like myself yet again.

At least it would seem that the council has not succeeded this time in driving a general practitioner out of the profession, but many of us are still waiting for the apology demanded for a previous decision.<sup>2</sup>

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1 Dyer C. GP reprimanded for testing patients for HIV without consent. *BMJ* 2000;320:135. (15 January.)

2 Bliss MR. Is an apology called for? *BMJ* 2000;320:67. (1 January.)

## Drivers who take insulin must tell Driver and Vehicle Licensing Agency

EDITOR—The DIGAMI study (diabetes mellitus insulin glucose infusion in acute myocardial infarction) suggested that insulin treatment at the time of myocardial infarction offered some improvement in mortality, particularly in patients not previously treated with insulin.<sup>1</sup> As a result of this study insulin has been started acutely after myocardial infarction in many such patients.

Any patient who starts taking insulin is legally obliged to inform the Driver and Vehicle Licensing Agency, and the standard advice is that he or she should not drive for at least a month. As many patients are advised not to drive for at least this period after infarction there may be no immediate concern. Many of these patients are, however, treated with insulin for several

months, and some of them seem to be unaware of their obligations regarding driving.

We would urge that all patients who are advised to start taking insulin are referred quickly for expert diabetological advice; in particular, they should be advised about their legal obligation as regards informing the Driver and Vehicle Licensing Agency. There is a risk of hypoglycaemia, and this risk would be diminished by early referral for expert advice on stabilisation and adjustment of insulin doses.

**N Essex** *member*  
**P J Watkins** *chairman*  
**J Durston** *senior medical adviser*  
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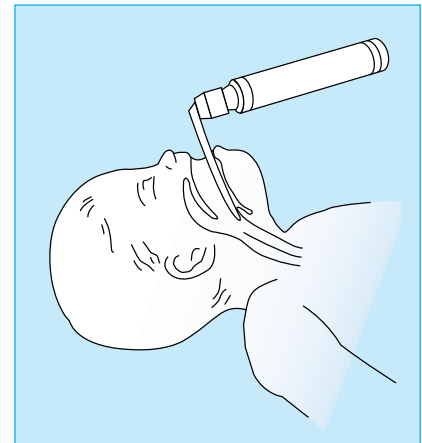
On behalf of the Honorary Medical Advisory Panel on Driving and Diabetes Mellitus

1 Malmberg K for the DIGAMI (Diabetes Mellitus Insulin Glucose Infusion in Acute Myocardial Infarction) Study Group. Prospective randomised study of intensive insulin treatment on long term survival after acute myocardial infarction in patients with diabetes mellitus. *BMJ* 1997;314: 1512-5.

### Corrections

#### *Care of the newborn in the delivery room*

We apologise for publishing an anatomically incorrect figure for the letter by C Deakin (1 April, p 937) and for asking Patricia Hamilton to base her reply on it. The correct figure is reproduced below.



Orotracheal intubation using straightblade laryngoscope

#### *How much to do at the accident scene?*

An editorial error occurred in the title for the second letter in this cluster by Charles D Deakin (8 April, p 1006). The title should have read: "Anaesthetic skills are required for pre-hospital management of the airway in major trauma" [not, "Anaesthetists are best people to provide prehospital airway management," as published].

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