tion. Secondly, inadequate resources will be as detrimental to outcomes as they are in an institutional setting. Finally, the local clinicians should determine the operational policies according to local needs; the special interests of the general practitioners; and the availability of specialist nurses, physiotherapists, and occupational therapists.

J W MYLES
Retired consultant orthopaedic surgeon
17 Audley Gate,
Peterborough PE3 9PG

G A PRYOR
Consultant orthopaedic surgeon
M PARKER
Orthopaedic research fellow
Peterborough District Hospital,
Peterborough PE3 6DA

J K ANAND
Community physician
68 Ledbury Road,
Peterborough PE3 9PJ

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Use of placebo in studies of postoperative vomiting is unethical

EDITOR,—Minerva refers to a paper quoting an incidence of postoperative vomiting of 22% despite the use of an antiemetic drug and describes this as "a depressingly high figure."[1 2] I agree, but I find even more depressing the fact that researchers in 1996, with the consent of ethics committees, should think it justifiable to use placebos in a study of this nature.

The incidence of postoperative nausea and vomiting, when no measures are taken to prevent them, has been known for at least 30 years and confirmed in numerous studies, as summarised in a fairly recent review article.[3] It averages about 30% but may be up to 80% or more in susceptible patients after certain operations. The paper to which Minerva refers confirmed this yet again. Similarly, ways of reducing the incidence of this complication are well known, the use of antiemetic drugs being only one. Scores of publications have shown small differences in the effectiveness of various drugs.

Significance may be increased by use of placebos, although an acceptable alternative is to use a known standard rather than a placebo for comparison. Statistically the study in question is flawed, as neither the anaesthetic techniques nor the operations were rigorously standardised. The study was carried out in 35 departments in eight countries—something that is hard to organise and impossible to supervise. Perhaps it is time for all journals to follow the example of the *BMJ* in requiring authors to describe their sources of funding and any conflict of interest.

I am sure that I am not the only anaesthetist (I retired 12 years ago) who has been able to reduce the incidence of postoperative vomiting to about 15%. This is still too high, although the figure includes many patients who vomit once during recovery of consciousness and then have no further trouble.

Sound statistics is one aspect, good patient care is another. What justification is there for the authors of this and similar papers to subject a predictably high proportion of their patients to a distressing complication to show, yet again, that a new drug is slightly better—or maybe, as these authors admit, slightly worse—than preceding ones? This is what I find depressing.

AILEEN K ADAMS
Retired consultant anaesthetist
12 Redwood Lodge,
Grange Road,
Cambridge CB3 9AR

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Efficacy of colchicine in familial Mediterranean fever is well established

EDITOR,—In their grand round on reactive systemic amyloidosis A R Allen and colleagues state that, while colchicine prevents the development of renal amyloidosis in familial Mediterranean fever, it does not abolish febrile attacks.[1] The latter remark is not true since three double blind clinical trials performed in the early 1970s showed that daily administration of 1-2 mg colchicine prevents febrile attacks in familial Mediterranean fever.[2-4] In a series of 350 children colchicine induced complete remission of the attacks in 64% of the patients and partial remission (a significant decrease in the frequency and severity of attacks) in 31%.[5] Moreover, colchicine can consistently abort attacks of familial Mediterranean fever if taken at the onset of symptoms.[6] Thus the efficacy of colchicine in familial Mediterranean fever is well established.

JOOST P H DRENTH
Resident in internal medicine
Department of Medicine,
University Hospital St Radboud,
6500 HB Nijmegen,
Netherlands

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Proposed academy of medicine

Proposal is a fudge between academy of medicine and of health

EDITOR,—I agree with Richard Smith that an academy of medicine is required[1]; I argued constantly for such an academy throughout my six years on the council of the Royal College of Obstetricians and Gynaecologists. What I am not certain about is whether it should be an academy of health (to include a broader constituency) or an academy of medicine. If it was an academy of medicine then it would, and should, be the official (non-trade union) voice of the medical profession. In such a scenario doctors should make decisions and resolutions, albeit with the benefit of advice from non-medical people, whether sociologists, journalists, or lawyers. Alternatively, an academy of health could be invoked, which would require a much broader constituency at the decision making level. The proposal in Smith's editorial seems something of a fudge between the two. As such, I would not support it; it would neither be a medical representative body nor (with three quarters of the members being doctors) satisfy legitimate aspirations of non-medical professionals.

The other issue on which Smith's editorial is silent is the principles governing membership of the academy and any governing body (council). In my opinion, at least half the posts would have to be filled by election so that a feeling of ownership could develop. The central body could include the presidents (and perhaps secretaries) of all the medical royal colleges. In this way the new body would sit above the royal colleges and act as a conduit by which the profession could have a dialogue with the government.

It would be interesting to know of any experience that other countries have had with such a body.

R J LILFORD
Director of research and development
NHS Executive,
Birmingham B16 9PA

1 Smith R. Does Britain need an academy of medicine? *BMJ* 1996;312:1374-5. (1 June.)

Academy of Medical Royal Colleges has its own, independent secretariat

EDITOR,—Richard Smith's editorial on the proposed academy of medicine for Britain contains a misstatement of fact that may lead to a misunderstanding of the role of the Academy of Medical Royal Colleges and its relations to the Royal Society of Medicine.[1] Furthermore, the Academy of Medical Royal Colleges was not party to the consultation paper on a possible academy of medicine in Britain.

During the past few years the Academy of Medical Royal Colleges (formerly the Conference of Medical Royal Colleges, founded in 1976) has been evolving to become more cohesive and effectively organised so that it can speak with a clear voice for the medical royal colleges and their faculties. More than two years ago the decision was made to take the steps necessary for this body to become a limited company and thereby acquire the legal status to rent premises and employ staff. In the course of this process the decision was made to change its name to the Academy of Medical Royal Colleges, to reflect more closely its roles in maintaining and enhancing postgraduate and continuing medical and dental education in the reformed NHS.

Another noteworthy development was our decision, in April, to invite the presidents of the Royal College of Physicians of Ireland and the Royal College of Surgeons in Ireland to join us as full members instead of having observer status. This recognises the longstanding collaboration between the colleges of the United Kingdom and Ireland on a number of issues and strengthens our voice in European medicine.

The chief executive of the Royal Society of Medicine does not "supply the conference with a home and a secretariat." The Academy of Medical Royal Colleges rents space from the Royal Society of Medicine and employs its own, independent secretariat. Nor can it be claimed that the chief executive has been involved in any way in the foundation of the Academy of Medical Royal Colleges.

FIONA CALDICOTT
Chairman
Academy of Medical Royal Colleges,
London W1M 8AE

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