small. In addition, forensic DNA testing requires analysis of the test results using population genetics—in contrast to research and diagnostic testing, in which conclusions are based only on known samples. In a debate over reliability in the *American Bar Association Journal*, the Castro defence attorneys asserted that the differences between diagnostic and forensic applications of DNA testing demand the development of additional forensic techniques.[3]

Legal and scientific critics of DNA testing as a forensic tool contend that it was rushed prematurely into court by the commercial DNA laboratories before the scientific community had agreed on standards to ensure reliability or on guidelines for interpretation. Even those who believe that forensic DNA testing is reliable agree on the urgent need for quality assurance to ensure that reliability. The United States Congress Office of Technology Assessment, for example, found that DNA tests are valid and reliable "when properly performed and interpreted."[4] Nevertheless, the office also called for the immediate establishment of standards for forensic applications of DNA testing—"the cornerstone of quality assurance"—to provide a benchmark against which to measure a particular test's reliability.[5]

In the United States various approaches to quality assurance are being considered, ranging from monitoring to regulation and from voluntary to mandatory. In Britain quality assurance is being looked at, but work is not being coordinated. The commercial DNA laboratories, which have been or are in the process of being accredited as meeting the quality standards for DNA paternity testing set by the British Standards Institution, are seeking or intend to seek certification by the institution for forensic DNA testing as well. The institution does not, however, set technical standards for such things as interpretation of data; rather, it certifies that the laboratory documents and follows its procedures.

The Forensic Science Service laboratories and the Metropolitan Police laboratory are pursuing accreditation of their procedures from the National Measurement Accreditation Service, a government regulatory body that certifies technical as well as operational standards. Its certification procedure for forensic laboratories is, however, not yet in place.

Professional organisations such as the International Society for Forensic Haemogenetics have made some recommendations and are in the process of developing voluntary guidelines for DNA analysis, including the crucial subject of interpreting test results. In the legal academic community the suggestion has been made that legislation is needed to lay down minimum standards and legal requirements for forensic DNA testing.[6]

DNA profiling raises all the issues about forensic science that are already under scrutiny in Britain. Because it is a new technique it also highlights the lack of a procedure by which the reliability of a novel forensic scientific technique can be assessed by the courts and standards set for its use. Many options are being considered, but action needs to be taken quickly to ensure that no grave miscarriage of justice occurs in a case in which DNA profiling evidence is used.

JANE SUFIAN

Attorney, Legal Aid Society,
New York City, USA

1 US Congress Office of Technology Assessment. *Genetic witness: forensic uses of DNA tests.* Washington, DC: US Government Printing Office, 1990:145-8. (OTA-BA-438.)
2 144 Misc 2d 956 (Sup Ct, Bronx Co, 1989).
3 Neufeld PJ, Scheck BC. No: less than meets the eye. *American Bar Association Journal* 1990 Sept:35.
4 US Congress Office of Technology Assessment. *Genetic witness: forensic uses of DNA tests.* Washington, DC: US Government Printing Office, 1990:59-60. (OTA-BA-438.)
5 US Congress Office of Technology Assessment. *Genetic witness: forensic uses of DNA tests.* Washington, DC: US Government Printing Office, 1990:82. (OTA-BA-438.)
6 White R. DNA profiling and problems for the defence in the criminal law with special reference to Northern Ireland. *Annex E to the 15th report of the Standing Advisory Commission on Human Rights, report for 1989/90, 1 April 1989-31 March 1990, House of Commons paper.* Dundee: University of Dundee, 1990:141-76 at 168-9. (HC[1989/90]459.)

Psychological therapy in the NHS

Providing a comprehensive service is more important than who leads it

Clinical psychology first emerged as a profession during the second world war, when psychologists started to treat psychologically traumatised war casualties. Not until the Trethowan committee reported in 1977, however, did it become fully recognised as an independent profession with a therapeutic contribution going beyond psychological testing.[1] A review of clinical psychology services in 1989 by the Management Advisory Service endorsed psychologists' perception of themselves as valuable, independent, scientifically informed practitioners who could show considerable flexibility in responding to the needs of individual patients and of evolving services.[2] But it did recognise that "independent" often meant that there was a lack of accountability to either managers or other professionals in the multidisciplinary team. The British Psychological Society has recently produced a policy statement suggesting how psychologists should work with other professionals to ensure that a comprehensive range of psychological therapies can be offered to all care groups.[3]

As the report recognises, the term "psychotherapy" is ambiguous (the report suggests using "psychological therapy" instead). At a specialist level psychotherapy may be used as a generic term or may be restricted to a particular method such as psychoanalytic psychotherapy or behavioural psychotherapy. Moreover, psychological therapies are practised at different levels, from that of the full time specialist psychologist or medical psychotherapist to the basic skills of good listening and empathic reflection required of all health professionals.

These ambiguities are compounded by the lack of formal planning for psychological therapy services in most districts and the fact that these services can be provided by more than one type of professional. Many, although not all, medical psychotherapists see themselves as providing a generic service in conjunction with colleagues in other disciplines. Ideally such a service would cover the whole range of treatments across the age range from childhood to old age as well as providing continuing supervision, training, and support for other staff. In practice some consultant psychotherapists have concentrated primarily on developing psychoanalytic psychotherapy services, leaving medical psychotherapy open to the accusation that it is partisan.

In promoting the ideal of a full range of psychological therapies available throughout the NHS the British Psychological Society considers that "clinical psychologists have a clear breadth and flexibility which enables them to provide comprehensive assessment and a far greater choice in the selection and delivery of psychological therapies."[3] In some ways this is disingenuous. The claim that all 2000 or so clinical

psychologists want to be seen as expert in the whole range of psychological treatments is not credible; indeed, the statement later recognises the range of managerial and clinical skills necessary within a clinical psychology department, not necessarily within one individual.

In the current climate of managerial uncertainty within the NHS there is much scope for internecine battles to block effective service developments. But it would be unfortunate if the territorial claims of doctors and psychologists obscured their common ground. Both the British Psychological Society and the Royal College of Psychiatrists agree that they must take a lead with managers in representing the need for comprehensive psychological therapy services across Britain,[3,4] where there are currently large discrepancies between regions.[4] Only if purchasers insist on an integrated approach to assessment and care will the major players, including psychologists and medical psychotherapists, cooperate in a planned approach to providing services. Purchasers must insist too that a comprehensive range of behavioural, psychodynamic, and systemic treatments is available, not just those of one school. The British Psychological Society's policy statement should be welcomed for not ducking the issue of competing claims for leadership but also for subsuming that competition within a broader debate about improving the quality and accessibility of psychological treatments within the NHS.

FRANK MARGISON

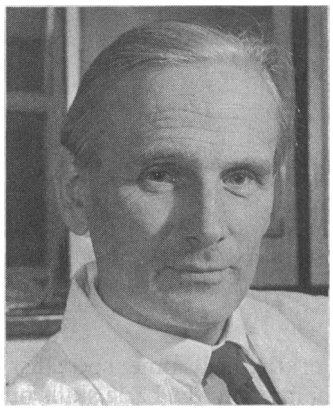
Consultant Psychotherapist,
Manchester Royal Infirmary,
Gaskell House, Manchester M13 0EU

1 Trethowan WH. *The role of psychologists in the health services: report of the sub-committee*. London: HMSO, 1977.
2 Management Advisory Service and Manpower Planning Advisory Group. *Review of clinical psychology services*. Cheltenham: Management Advisory Service to the NHS, 1989.
3 British Psychological Society Division of Clinical Psychology. *Psychological therapy services: the need for organisational change*. Leicester: British Psychological Society, 1990.
4 Royal College of Psychiatrists. The future of psychotherapy services. *Psychiatric Bulletin* 1991;15: 174-9.

Charles Fletcher at 80

Happy birthday—and sorry

Who now would believe the outcry by doctors in 1949 when the young Charles Fletcher first suggested that patients should be given pamphlets explaining the causes of their illnesses and what to do about them? According to the journalist Chapman Pincher, six out of 10 doctors chosen at random condemned the scheme: "It is a serious break with medical tradition and will lead to dangerous abuse," said one anonymous critic. "The next thing will be medical advice by post."



In fact, almost the next thing in Fletcher's continuing campaign to get doctors to tell patients what they were doing was his vigorous support for a series of BBC television programmes, *Your Life in Their Hands*, which included film of operations. On this occasion the main attack came from the *BMJ*, which published leading articles on four successive weeks arguing that giving patients information about disease was harmful. Fletcher was not shaken by these attacks; he went on to combine his academic work with frequent appearances on television.

By 1972 the concept of doctors talking to patients had become sufficiently respectable for it to be the subject of a Rock Carling lecture, in which Fletcher argued his case and laid down some principles; modern communication experts might do well to remember that "the purpose of communication is not just to deliver a message but to effect a change in the recipient in respect of his knowledge, his attitude, or, eventually, his behaviour."

Charles Fletcher was, perhaps, lucky to be in the right place—Oxford—at the right time—1941—to be the first clinician to give a patient penicillin. His later career owed little to chance. His work as director of the Medical Research Council Pneumoconiosis Research Unit established important principles, especially with regard to the interpretation of chest *x* ray films. He continued his interest in chest disease at the Royal Postgraduate Medical School in London, where he became professor of clinical epidemiology. He was secretary of the working party set up by the Royal College of Physicians of London to study atmospheric pollution, smoking, and health, and the college's report on smoking became an overnight best seller.

Always something of a showman, he has never concealed his diabetes, checking his blood sugar and injecting insulin while continuing whatever task was in hand—and in so doing showing other people with diabetes how little the disease need affect them.

In retirement Fletcher has maintained many of his interests but communication with patients has been foremost; he has tried to persuade his colleagues of its importance and the central part it should play in medical education. After more than 40 years of effort these ideas have become respectable and mainstream, and we hope that in his 80th year the *BMJ* may say to this pioneer "We're sorry, we were wrong."

TONY SMITH

Associate editor, *BMJ*