Letters

No health safety net for failed asylum seekers and others in UK

EDITOR—Hall shows that current health rules, which deny some of the most vulnerable people in the United Kingdom essential medical care, flout international law.[1 2] Evidence is mounting of the impact the tougher restrictions on NHS entitlement are having on vulnerable migrants living in the UK.

Last month the Refugee Council published a report documenting 37 case studies of failed asylum seekers who were refused medical care that they needed.[3] Médecins du Monde UK is also witnessing secondary care being denied to failed asylum seekers and other vulnerable migrants through our healthcare initiative "Project: London." The number of pregnant women who have been refused antenatal care, unless they pay the full amount for the care in advance, is growing. This approach puts these women and their babies at great risk and ignores government guidance, which clearly states that maternity services should not be withheld if the woman is unable to pay in advance.

The women who came to "Project: London" or to the Refugee Council may represent a much larger group of women who do not know where to go for help. Such women, often vulnerable and afraid, may deliver their babies at home without any medical care. Médecins du Monde UK is most concerned about the potentially disastrous consequences for the health of these women and their babies.

These restrictions on access to NHS care are labelled as charges for overseas visitors. In reality, they affect people who are living here, including failed asylum seekers, visa overstayers, and anyone without regular status. Unlike in some other European countries, no safety net is in place to ensure that children, pregnant women, or those without resources to pay for private care can have access to health care. We know through Médecins du Monde's work across Europe that the Netherlands, for example, has a special fund to finance the health care of undocumented migrants, and that Belgium, France, and Spain have special state health insurance.

Hall is right to reiterate the NHS core principles and to underline that these restrictions on access to care constitute an abuse of a fundamental human right. A radical review of these unfair regulations cannot come soon enough.

For more information about "Project: London" contact Médecins du Monde's press office (michelle.hawkins@medecinsdumonde.org.uk).

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New immigration rules and future of maxillofacial surgery

EDITOR—Indian and other international dental graduates have filled the shortfall in senior house officer posts in oral and maxillofacial surgery for years, helping to handle the expansion in the number of senior house officers caused by the European Working Time Directive. Changes in the immigration rules and in the General Dental Council's policy may leave this small group of 20-30 dedicated clinicians stranded.

To become a consultant in oral and maxillofacial surgery takes around 18 years and requires UK registrable dental and medical qualifications. Most trainees start in dentistry then, after a few years of basic training (and membership of the Faculty of Dental Surgery), enter medical school. Following medicine, foundation years, basic surgical training, and membership of the Royal College of Surgeons, trainees start five years of higher surgical training. In other countries this training is a recognised continuum, but in the UK it is a self assembled package. For UK dental graduates the estimated cost of a second degree was £120 000 (€175 000; $220 000) in 1991.[1] In 2006 international dental graduates pay £20 000 a year for their medical degree. Even for a four year course, the total cost of a second degree in fees and lost wages for international dental graduates is probably more than £200 000.

The international qualifying examination allows an international dental graduate to join the UK dental register. It is oversubscribed and the General Dental Council has suspended it to new applicants. Any international dental graduate in oral and maxillofacial surgical training without an international qualifying examination will be unable to become a consultant without undertaking a UK dental degree in addition to their UK medical degree.

In Dundee and Liverpool our dentally qualified medical students are employed in part-time posts. This maintains contact and training with the specialty. We may not be able to continue this practice should a British or EEA (European Economic Area) citizen apply for the post, even if the competing applicant had not committed to medical school training.[2]

These few trainees deserve some exceptions to be made.

- If the immigration authorities could consider them to be within a training pathway it would help their visa status.
- If the General Dental Council could recognise their particular circumstances and allow them preferential access to the international qualifying exam it would be a fair reward for their commitment.
- A sense of fairness should be sufficient to prevent these individuals being dealt a hammer blow by these changes. To meet the planned consultant numbers, we cannot afford to disregard this group.[3]

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Female genital mutilation: whose problem, whose solution?

Mutilation or modification?

EDITOR—Conroy's editorial and the study by Elmusharaf et al contribute to a literature that has often tended to be long on polemic and short on data.[1 2] Conroy's recognition that our conceptions of what constitutes female genital mutilation need further thought is long overdue. As I have argued, a coherent response requires both that female genital alterations are considered in terms of

their sociocultural significances and that the full range of practices from around the globe are examined together.[3] This entails that responses to and definitions of mutilation recognise the increasing range of genital plastic surgeries and the use of body alterations, such as genital piercing. In addition, any attempt at reconceptualisation and reclassification should examine arguments from those claiming that in some instances male circumcision and intersex surgeries constitute genital mutilation.

Such an endeavour would raise difficult ethical, legal, and medical issues on, for example, drawing distinctions between modifications and mutilations and the relevance (or irrelevance) of fully informed consent on the part of the (adult or child) patient on the receiving end. Also, the various cultural and religious defences of the practices would need to be re-examined and reassessed along with human rights and established health concerns. Some of these issues have already been explored.[4]

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Beyond this, although it is important to raise concerns about the "burgeoning industry" which sells the "cyborg porn babe" body, it is crucial also to be aware that this perspective risks both undermining the autonomy of women who buy the "products" and disregarding their perspectives.[5] It would be wrong simply to cast such women or (for want of a better term) "non-Western" women who have had genital alterations as victims.

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Psychological damage is immense

EDITOR—Conroy's concerns about cosmetic surgery in the West are understandable, but he seems to have missed the fundamental differences between it and the genital mutilation of children.[1] When a child is mutilated by adults the procedure constitutes a sexual assault in that the child does not understand what is happening, has no control over it, and does not consent to it. On the other hand, if adults choose, however misguidedly, to reconstruct their genitalia it is with knowledge and agreement. The effect on the psyche of the two processes is quite different.

I found that psychological trauma was correlated with several factors: feeling powerless to influence the event, lack of information given to the patient, the experience of physical pain, a perceived unsympathetic attitude on the part of the examiner, and a lack of clearly understood consent for the procedure.[2] Other forms of attack on women, such as rape, childhood sexual abuse, and sexual torture, also cause post-traumatic stress disorder.[3]

Conroy suggests that the "high social value" of female genital mutilation somehow means that it is not forced on unwilling young girls. However, social value is an adult concept whereas the child understands the experience only subjectively. A World Health Organization report states that for many girls genital mutilation is a major experience of fear, submission, inhibition, and suppression of feelings and thinking.[4] This experience becomes a vivid landmark in their mental development, the memory persisting throughout life. For some, nothing they have subsequently gone through, including pain and stress in pregnancy, has come close to the painful experience of genital mutilation. Their tension and tears reflect the magnitude of emotional pain they silently endure at all times; the resulting loss of confidence and trust in family and friends can affect the child-parent relationship and has implications for future intimate relationships between the adult and her own children.[4]

Victims of childhood abuse may idealise the trauma and become perpetrators to overcome their anxieties, thus ensuring transgenerational continuation of the practice.[5]

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East and West: worlds apart in cataract surgery

EDITOR—Allen describes cataract and its management in the developed and developing worlds.[1] Blindness due to cataract is a large problem in the mountainous northern parts of Pakistan, where I worked in the eye department at Ayub Teaching Hospital, Abbottabad, in the North West Frontier Province.

In a study conducted in the tribal areas of the province the prevalence of bilateral cataract blindness was 4.8% among the 1549 people examined.[2] Another population based cross sectional study in 1106 men and women aged 40 and older in a rural area in the province found that 1.9% of them were blind (visual acuity $<3/60$ in the better eye) and 2.4% had severe visual impairment (visual acuity $<6/60$-$3/60$).[3] The leading cause of blindness and low vision was cataract, which accounted for 66.6% cases of blindness.

Patients with cataract usually present late to the hospital because of a lack of awareness and resources. The governmental health services provided in the rural areas are also nominal and overburdened. With most patients being operated on for mature cataracts, visual acuity of 6/24 or better is usually not considered suitable for surgical intervention. This is in contrast to the practice in the United Kingdom, where patients with cataract are routinely being operated on with vision of 6/9 or even better. Owing to lack of equipment and training and the advanced stage of cataracts encountered, the preferred operation in many centres in Pakistan is still extracapsular cataract extraction. Many patients are unable to afford the high price of intraocular implants and so have plain cataract extraction, which leaves them aphakic.

Many non-governmental organisations and charities are working in the North West Frontier Province organising free eye camps. Ophthalmologists in the United Kingdom can help by volunteering to participate in such camps.

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1 Allen D, Vasavada A. Cataract and surgery for cataract. *BMJ* 2006;333:128-32. (15 July.)
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Test for quinolone resistance in typhoid fever

EDITOR—Bhutta summarised current issues in the diagnosis and treatment of typhoid fever.[1] We highlight the need for the use of appropriate laboratory methods to detect clinically significant quinolone resistance.

Quinolone resistant isolates of *Salmonella enterica* serovar *Typhi have reduced susceptibility to ciprofloxacin, with minimum inhibitory concentrations between 0.1 mg/l and 1 mg/l compared with wild type strains (<0.1 mg/l). The currently agreed definition for resistance is a minimum inhibitory concentration >1 mg/l, and such isolates are therefore reported as being susceptible to ciprofloxacin*

by disc sensitivity testing,[2] although systemic infections with these isolates respond poorly to ciprofloxacin and ofloxacin.[3 4] These strains are invariably resistant to nalidixic acid, which is an important laboratory marker for treatment failure.[2 5]

This problem is illustrated by two recent cases of typhoid fever. Each isolate of *S typhi* was reported as susceptible to ciprofloxacin by the British Society for Antimicrobial Chemotherapy method.[2] However, both patients remained feverish and unwell after seven days' treatment with oral ciprofloxacin. After changing to intravenous ceftriaxone, symptoms quickly resolved, and both patients recovered. Subsequent testing showed that both isolates were resistant to nalidixic acid and had reduced susceptibility to ciprofloxacin (minimum inhibitory concentration 0.94 mg/l and 0.25 mg/l, respectively).

It is critical that microbiology laboratories test all *S typhi* isolates on primary isolation for susceptibility to nalidixic acid, in addition to ciprofloxacin and other appropriate antimicrobials.[2 5] Fluoroquinolones should not be used to treat nalidixic acid (quinolone) resistant systemic infections, and in typhoid and paratyphoid fever the choice of treatment for infection with these isolates is not straightforward. Many are also resistant to chloramphenicol, ampicillin and co-trimoxazole. Third generation cephalosporins and azithromycin have proved effective in endemic areas.[1 4]

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Local ethics committees and specialised research

EDITOR—In the mid-1960s a report by the Royal College of Physicians proposed setting up committees to consider the ethics of clinical research studies.[1] Although most doctors find the process of applying for research ethics approval taxing,[2] and its processing even more overwhelming,[3] they would also agree that independent assessment of a research project is an essential part of performing research.

Local research ethics committees have participated in the process of assessment of medical research for over 15 years. A report by Maskell et al found notable variation of practice depending on the individual committee.[4]

We assessed the expertise of the local research ethics committees in assessing a specialised field of research. Some committee members might not have the required expertise to make decisions in the field of research they have been asked to decide on. We interviewed by telephone 27 local research ethics committees that have been involved in processing applications for ophthalmic related research in London. The overall response rate was 88.8% (24 out of 27), with 11.2% (3 out of 27) refusing to answer questions over the phone.

When asked about the frequency of meetings, all respondents stated meeting once a month according to the guidelines of the Central Office for Research Committees (COREC). However Maskell et al suggested a wide variation in the practice of local research ethics committees, ranging from weekly to bimonthly meetings.[4]

When inquiring about the status of panel members, only three of the 24 local research ethics committees had an ophthalmologist on the panel when considering ophthalmic related research. A third said that they had refused an application without consulting an external ophthalmic expert when they thought that the application did not meet the criteria for ethics approval.

Ethics approval is now a compulsory part of any research. When an expert is not available and an application is likely to be rejected, we think that an external expert should be consulted if none of the panel members has any experience in that particular field of research.

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Opting in or out of electronic patient records

National clinical leads of Connecting for Health respond

EDITOR—We as the national clinical leads are concerned that a conflation of issues has clouded the principles in the opt in or opt out debate.[1] We believe that patients' clinical information must be appropriately protected. It should be shared with clinicians who genuinely need to know—and no


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further. Patients may not want some information shared beyond the clinician to whom they have entrusted it.

There is continuing discussion and debate in NHS Connecting for Health and the clinical professions on how best to control access to sensitive data while ensuring that security systems are not so complex as to be impractical.

Moving to an opt in for consent (individual expressed consent) will not, however, influence whether access controls work, whether patients can limit their participation, or whether individual doctors personally wish to prevent their own health information being made available more widely.

The pivotal issue in this debate is whether all patients should be asked for their consent to the potential sharing of their information in advance or whether they should all be informed in advance and their consent assumed unless they say otherwise.

The Department of Health, on the advice of the Care Records Development Board and on the basis of research it has undertaken with the public, supports the implied consent model (opt out). The proviso that there must be a public information campaign advising the population of the shared care record and advising them of their ability to limit their participation is of course key to the information commissioner's agreement with this strategy.

The national programme for information technology has been criticised for delays in delivering the shared care record. Much of the delay has been appropriate—it is better to hear and consider all views than to rush ahead. However, further delay would not be acceptable to patients who are frustrated continually and put at risk by their records being unavailable to those caring for them, colleagues who are impatient for the delivery of the shared care record, tax payers, and parliament.

In conclusion

- Data must be fit for sharing
- Records should be accurate and available only to those who are caring for the patient
- There must be opportunity for all citizens to be properly informed and to withhold sensitive information from sharing
- All lessons must be learnt from implementation in the first areas to pilot these arrangements.

Demanding, however, that every citizen must register their opt in after having obtained their full consent does not reflect

what the public expects, is impractical, and would fail to deliver the benefits of the investment that tax payers have made.

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1 Correspondence. To opt in or opt out of electronic patient records? *BMJ* 2006;333:146-7. (15 July.)

Debate has missed the boat

EDITOR—Clearly patient confidentiality is a concern, but should it outweigh the benefits of a fully computerised patient record?[1] Time waiting for old notes, trying to contact general practitioners, and inaccurate medical histories or prescription lists would quickly become a thing of the past. Most importantly a legible, accessible record shared by all professionals concerned with patients' care would improve communication.

Can it really be so difficult to keep sensitive information secure when banks and governments maintain much larger databases of information without significant compromise? General practitioners use more and more computerised systems without great difficulty, not to mention other countries, from which we could buy off-the-shelf solutions.

If security is an issue, why not let patients themselves decide (in the same way that people need not do internet banking, use a credit card, etc).

Perhaps more worrying, though less debated, is the amount of patient information kept on scraps of paper (patient handover lists) which are discarded or forgotten without being shredded.

Finally, with the advent of modernising medical careers, computer savvy doctors use memory sticks to store interesting x rays, case presentations, etc, which is surely less secure than having a hospital system.

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1 Correspondence. To opt in or opt out of electronic patient records? *BMJ* 2006;333:146-7. (15 July.)

Proposal: two part payment scheme for live kidney donors

EDITOR—Roff contributes to the debate over whether payment should be offered for kidney donors by citing various examples that dispel the myth that the value of life and limb cannot be put into monetary terms.[1] We assume the acceptance of the general principle of payment and propose a two part payment scheme that maximises the incentive for organs to be donated but at the same time preserves an element of the gift relationship in the transaction. This, like other methods of payment previously proposed, would entail the purchase of organs by the state and their allocation free of charge to patients on the basis of existing algorithms.[2 3]

The first part of the scheme would be a fixed base payment financed directly by government. In principle, the cost savings associated with transplant v dialysis would indicate an upper limit to an amount that could be paid—one estimate is $90 000.[4]

The second part of this scheme would be a payment from a top-up pool established through private donations. This payment would be calculated and paid at the end of each year—for example, if, in a given year, £5m were collected and 500 kidneys donated, each donor would be allocated a top-up payment of £10 000.

By tapping into both government and community willingness to pay, we believe that this scheme maximises the economic incentive for donors. It also promotes altruism by opening up the market to donations from people who may not otherwise have been able or willing to donate their own organs. It would also potentially take people off costly dialysis treatment and improve quality of life.

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Royal college denies rewriting child protection history

EDITOR—We were surprised to read the article by Gornall on the *Child Protection Companion*, a handbook from the Royal College of Paediatrics and Child Health.[1 2] In view of the accusations and the unwarranted reference to Stalin we would have expected to be given the chance to respond at the time.

The Royal College of Paediatrics and Child Health strongly supports the work of Professors Meadow and Southall. It forms an important part of the evidence on which we base our recommendations for practice in this field.

The *Companion* was produced as a handbook to guide general paediatricians in protecting children. It was never meant to be a fully referenced textbook on child protection. At no stage was there any attempt to rewrite history.

There are 22 references to the work of Professors Meadow and Southall given via reports published by the Department of Health and the college, which are available on websites and are the easiest way for general paediatricians to access them.

Fabricated or induced illness is an important but uncommon issue faced by general paediatricians. Chapter 6, referred to by Gornall, contains 15 sections on aspects of maltreatment, and fabricated or induced illness is one. The majority of references are not relevant to fabricated or induced illness.

The section on covert video surveillance is appropriately succinct—given the rarity with which this will be contemplated. It gives essential information for use by general paediatricians.

Gornall refers to discontent in the royal college members' discussion group. We have 9000 members and so far there have been only three replies to the original email expressing concern about the *Companion*.

The training course on child protection is a separate piece of work aimed at the most junior trainees. It focuses on commonly encountered child protection issues but nevertheless the materials refer to the work of Professors Meadow and Southall.

It is not the role of any royal college to comment publicly on individuals. Much public and behind the scenes work has been done by Professor Sir Alan Craft and Professor Sir David Hall to support paediatricians in protecting children. We have not changed our stance.

We strongly support Gornall's concern for expert witnesses. Complaints made to the General Medical Council result all too easily in lengthy processes, during which doctors find their careers and their lives blighted. These must be reformed. We must be fair to complainants but we must be fair to doctors too.

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Competing interests: None declared.

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