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LETTERS

PETER MACDIARMID/GETTY

ASYLUM SEEKERS' HEALTH NEEDS

Inhumane starting point

Detention of "failed" asylum seekers for the administrative convenience of the UK Border Agency should only be for lawful removal from the UK and for the shortest possible time, but in practice it is indeterminate and can last for years.[1]

Many detainees are eventually found to have been inappropriately detained and are allowed to remain in the UK because they risk persecution in their own countries. Independent doctors often provide evidence that they were tortured or subjected to organised violence. Although doctors employed in immigration detention centres have a legal duty to inform the UK Border Agency of people they think have been tortured, they rarely do so adequately, and when they do the authorities usually ignore them.

The psychological harms of wrongful detention—mainly retraumatisation—are severe. The financial costs run to millions, but the Home Office refuses to audit and publish the data.

I have examined over 300 detainees as an independent doctor. I often find that doctors employed by the centre have not taken adequate histories or appropriately examined, diagnosed, treated, or referred their patients.

Patients who are referred are often not taken to hospital. When male patients do go to hospital, they are usually kept in chains and denied privacy, even when the doctor requests removal of restraints and confidentiality. Much of the problem lies in the false belief that detainees are unpleasant people who are lying for secondary gain. It is not possible to practise adequate or humane medicine from this starting point.

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Competing interests: FWA is the clinical adviser to the Medical Justice Network (www.medicaljustice.org.uk). He was reported to the GMC with a demand for disciplinary action by the management of a detention centre for giving potentially lifesaving medical advice to three detainees who were on hunger strike in protest against what they perceived to be denial of access to justice. The GMC found no case to answer, and all three patients were released.

1 McCartney M. Poor diagnosis for asylum seekers' health needs. *BMJ* 2010;341:c4106. (17 August.)

Cite this as: *BMJ* 2010;341:c4696

With what right do we detain?

McCartney highlights concern about the poor provision of mental health care for asylum seekers.[1] I found that rates of suicide and self harm are higher in this vulnerable group than in the UK prison population.[2]

In prison "first night" physical and psychological health assessments entail many detailed questions designed to identify those at risk of self harm or suicide. In immigration removal centres, however, only a limited set of questions is asked, often without an interpreter. For a quarter of detainees this assessment also happens between midnight and 6 am owing to frequent movement of detainees at night.

This initial health screening, a rule 35 report, is supposed to identify those with serious medical considerations as part of the government's commitment not to detain vulnerable groups of asylum seekers. However, a freedom of information request by the BBC showed that only seven of the 200 detainees with rule 35 reports lodged were released over 18 months during 2008-9. The Medical Foundation for the Care of Victims of Torture has seen many cases of torture survivors detained for lengthy periods after their reports were ignored whose claims were subsequently upheld in the courts.

An analysis of the training needs of staff in initial accommodation centres undertaken by the medical foundation uncovered many symptoms and signs of vicarious traumatisation. This was due to the high numbers of people disclosing traumatic experiences and showing heightened distress without any outlet for nurses and doctors to "offload" the stories. The nurses work in conflicting systems of clinical care with strict targets and timelines alongside repeated disclosure of torture and ill-treatment. The result is both heightened compassion and anger at the "system" or heightened cynicism and a "culture of disbelief."

If the rights of a vulnerable group of people to adequate health care and fair treatment cannot be met in immigration detention centres, with what right do we detain them at all?

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Competing interests: JRC works at the Medical Foundation for the Care of Victims of Torture.

1 McCartney M. Poor diagnosis for asylum seekers' health needs. *BMJ* 2010;341:c4106. (17 August.)
2 Cohen J. A study of suicide and self-harm in asylum seekers. *Journal of Forensic and Legal Medicine* 2008;15:235-44.

Cite this as: *BMJ* 2010;341:c4695

Transfer care to the NHS

The current unsatisfactory healthcare provision for immigration detainees[1] is likely to worsen with the proposed cutbacks in funding to the UK Border Agency. Hence full transfer to the NHS has to be accelerated, while noting the paradox that this group becomes entitled to full free NHS care only because of being detained. In the proposed new world, detainee health care looks right for central commissioning and could sit alongside prison medical services.

The Care Quality Commission has newly acquired responsibility for health care in some detention centres, and healthcare providers will need to work with it to improve standards. The many issues include non-referral for secondary care or transfer or deportation before it can be taken up, and failure to complete treatment, including for serious infectious diseases. The difficulty of the job expected of healthcare staff in immigration removal centres also needs to be appreciated, including the many constraining rules.

The problem of mental ill health is not helped by the unclear demarcation of responsibilities between the UK Border Agency and the NHS for secondary mental health care. An increasing proportion of detainees are foreign national ex-prisoners awaiting deportation. The interaction between pre-existing mental illness, being convicted by a court, being judged fit for detention or deportation, and being incarcerated is complex. An added complication is the ability to dissemble severe mental illness.

The right answer may be not only to improve mental health services for detainees but also to stop detaining those who are mentally ill and to identify and treat early those mentally ill prisoners destined for deportation.

Detaining children is no longer considered appropriate. Perhaps the rest of the detention policy also warrants overhaul.

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Competing interests: HGP completed a health needs assessment on Colnbrook and Harmondsworth detention centres for Hillingdon Primary Care Trust in February 2010.

1 McCartney M. Poor diagnosis for asylum seekers' health needs. *BMJ* 2010;341:c4106. (17 August.)

Cite this as: *BMJ* 2010;341:c4694

Pregnant asylum seekers

McCartney mentioned Aspinall and Watters' report, which highlights poorer pregnancy outcomes among refugees.[1 2] Let there be no doubt about what poorer means: asylum seekers and refugees are more likely than the general population to die during pregnancy or childbirth.[3] Maternal health complications and neonatal deaths and complications are likely to be even more prevalent.

In 2003 the House of Commons Select Committee on Health gathered evidence on the poor access to health services for pregnant asylum seekers.[4] It noted that pregnant women were being detained in immigration centres, despite the government's policy that pregnant women should not usually be considered suitable for detention.

Some of the evidence came from qualitative research undertaken by the Maternity Alliance.[5] It found that the biggest challenge was knowing what kinds of services and support were available.

Pregnant women tend to be among the most vulnerable and so act as a key indicator for service provision—if their risk of poor health is increased, services for others are also likely to be seriously problematic.

Maternity Action (www.maternityaction.org.uk), a charity campaigning to end inequality and promote the health and wellbeing of all pregnant women and their partners and children, is developing training courses for midwives, with funding from Comic Relief, to improve care for women refugees and asylum seekers. However, without broader policy interventions (and their enforcement), the health and healthcare experiences of these groups are likely to remain poor.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c4691

REFERRAL MANAGEMENT CENTRES

Time for free flow of care

Training and paying general practitioners to work as the gatekeepers between primary and secondary care and then paying a second group of workers to second guess their work is silly.[1 2] If managers believe that general practitioners are not getting referrals right they should challenge their decision making. Most general practitioners in the UK refer less frequently than their international colleagues.

General practitioners have been the risk sink of the NHS for many years.[3] Their ability to manage this essential task for the cash limited NHS has been gradually reduced by increased pressures in the consulting room, particularly the worry about missing something important[4] and consequent career damage from claims for negligence, GMC action, and press reports. Although much guidance on specific diseases has been produced, no one has produced a guide on managing the symptom soup and comorbidity of daily general practice. No one has yet worked out how to answer the apparently simple question, "What is a good referral?"

The historical (and now increasingly anachronistic and unhelpful) division of primary care from secondary care was always an organisational rather than a medical or patient centred arrangement. Patients and their illnesses are mostly continuous, unlike the disjointed care system that tries to treat them as a series of itemised episodes. The more we move towards free flow of patients and information across interfaces of care the better the NHS will work for patients.

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Competing interests: PGD is an NHS GP who makes referrals every day, hopefully mostly accurately for sensible clinical reasons and to help patients get to where they need to go.

1 Mashta O. Costly referral management centres fail to deliver savings. *BMJ* 2010;341:c4351. (12 August.)
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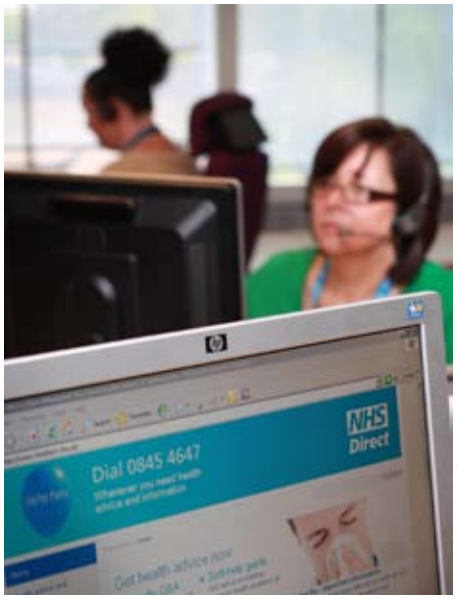
Cite this as: *BMJ* 2010;341:c4714

PROMOTING SELF CARE

NHS Direct plays a major role

Nazareth and Murray state that enhancing people's ability to self manage minor illness should be a priority for the NHS.[1] Although



PETER MACDIARMID/PA

they refer to NHS Direct's website they do not reference our work or its success in achieving this objective.

While we agree that further research on effectiveness of interventions to promote self care is needed, our data show that telephone based support from health advisers and nurses is effective. It helps patients, their families, and carers manage a wide range of minor and not so minor conditions themselves or with advice from local services, such as local pharmacies.

NHS Direct receives five million phone calls each year. Patients ask for advice about specific symptoms and call for general health advice or information on drugs. We deal with about 60% of calls without the need for onward referral. Follow-up surveys show that our patients would otherwise have sought advice or care from other healthcare sources.

In 2009-10, our core services saved 2.4 million appointments with GPs and other primary care services. They also prevented 1.6 million unnecessary ambulance journeys and visits to emergency departments. We estimate that NHS Direct saved the NHS £213m (€260m; $331m).

Our patients report a high level of satisfaction with our services—less than one call per 10 000 is a complaint. This remotely provided service that uses telephone and internet technologies and is available when and where the user wishes provides a key support in helping patients manage their minor or more serious illnesses.

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Tim Heymann reader in health management, Imperial College Business School

Competing interests: BG is an employee of NHS Direct; TH is a non-executive board member of NHS Direct.

1 Nazareth I, Murray E. Promoting self care for minor illness. *BMJ* 2010;340:c2913. (10 June.)

Cite this as: *BMJ* 2010;341:c4700

NICE ON BACTERIAL MENINGITIS

Vancomycin may not be necessary

The guidelines from the National Institute for Health and Clinical Excellence (NICE) on the empirical treatment of bacterial meningitis in children recommend intravenous ceftriaxone for children aged ≥3 months and cefotaxime plus ampicillin or amoxicillin for infants aged <3 months.[1 2] The *British National Formulary for Children* (*BNF-C*) recommends similar empirical treatment with cefotaxime or cefotaxime and ampicillin, respectively.[3] Whereas the *BNF-C* recommends the addition of vancomycin only for meningitis caused by pneumococci resistant to penicillin and cephalosporins, NICE recommends addition of vancomycin for children with suspected bacterial meningitis who have received antibiotics or travelled outside the UK in the preceding three months, these being regarded as risk factors for pneumococcal cephalosporin resistance.[4 5] This recommendation could lead to a disproportionate increase in prescribing of vancomycin if the prevalence of cephalosporin resistant pneumococci remains low.

We report the antibiotic susceptibility of pneumococci from children with meningitis in England and Wales from January 2001 to June 2010. We extracted data on cases of pneumococcal meningitis from the HPA surveillance database (LabBase2) and stratified them by age under 3 months and 3 months to 14 years.

There were 630 isolates from 86 infants and 544 children. None of the 53 isolates from infants with data on cephalosporin susceptibility were resistant; only two of the 273 isolates (0.7%) in older children had reduced cephalosporin susceptibility (one each in 2007 and 2008). None of the 63 isolates from infants and 14 of the 338 isolates (4.1%) from older children with susceptibility data were resistant to penicillin. No isolates were resistant to vancomycin.

Given this low prevalence of cephalosporin resistance among pneumococci causing meningitis in England and Wales, we suggest that there is currently little evidence to recommend the risk based empirical addition of vancomycin for children with suspected bacterial meningitis. Vancomycin should be added only if pneumococci resistant to cephalosporin are isolated.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c4704

HOME *v* HOSPITAL BIRTH

Recent meta-analysis is misleading

Delamothe queries why the authors of an American meta-analysis on planned home and hospital birth shifted focus from perinatal mortality to neonatal mortality "despite having relevant data for these calculations on only 9% of their total sample."[1 2]

The authors found no difference in perinatal mortality between planned home and planned hospital births when they included the Dutch study, over 90% of their sample. Isolating the neonatal risk from the perinatal risk, they chose only studies that included both early (0-7 days) and late (8-28 days) neonatal mortality, conveniently excluding the Dutch study, which reported only early neonatal mortality.

In high resource countries two thirds to four fifths of neonatal deaths occur in the first seven days.[3] There is no reason to expect any difference in safety had the Dutch late neonatal mortality simply been reported or requested.

The high quality Dutch study was consequently displaced as the largest contributing study to the neonatal risk estimate by a study based on birth certificates. This American study does not meet the standards for home birth research that since the 1980s have required comparisons of home and hospital birth to stratify for whether the home births in the studies were planned and had a midwife or physician in attendance.[4]

Excluding the birth certificate study or including the Dutch study would have meant that the authors could not have concluded that less medical intervention or home birth creates higher neonatal risk. Rather, the more accurate conclusion of the meta-analysis would read, "planned home birth produces the same intrapartum and neonatal outcomes as planned hospital birth with far less intervention." Not so savoury for the international media but fairer for birthing women.

Given its shortcomings, this meta-analysis should be withdrawn.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c4699

MINIMUM ALCOHOL PRICE

Good supporting evidence exists

The Scottish government has been unable to reach consensus on minimum pricing for alcohol,[1] despite a recent UK Health Select Committee report highlighting that the drinks industry relies on hazardous drinking for around half of sales. This calls into question the assertion that increased taxation on alcohol would penalise responsible drinkers.[2]

Poorer populations have a greater disease burden per litre of alcohol than higher income populations, and setting a minimum price per unit of alcohol has more effect on heavier drinkers

MARCEL NIJHUIS/FOTOLIA

(more likely to be in lower social classes) than lighter drinkers.[2 3] Increasing the price of alcoholic drinks tends to have long term effects, with reduced consumption overall and heavier drinkers buying cheaper alternatives.[2] Price increases also raise the age at which young people start drinking, slowing their progression and reducing alcohol related harms.[4]

Attempts by government and the drinks industry to work together must go beyond token efforts, which see the government spending £17.6m (€21.5m; $27.3m) on educating the public about the harms of alcohol and industry spending £600-800m on promoting alcohol to that same public.[5] This may lead to reduced sales, but it is time that the admission was made that irresponsible drinking generates revenues but cripples society in the longer term. If a society's greatest asset is the health of its citizens then the implications of this truism must be felt in public health policy making for alcohol abuse in Scotland and elsewhere.

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Competing interests: None declared.

1 Mashta O. Scottish government considers alternatives to minimum alcohol price. *BMJ* 2010;341:c4285. (9 August.)
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Cite this as: *BMJ* 2010;341:c4701

SUICIDE AND EUTHANASIA PARADOX

A question of rights

MacCormick uses the Declaration of Human Rights to justify challenging patients' beliefs about their lives,[1] but this distorts the declaration's real purpose of protecting individuals' rights against abuse by others. Nicklinson's lawyers alluded to article 8, but two other articles are pertinent:

Article 18: Everyone has the right to freedom of thought, conscience or religion; this right includes freedom . . . to manifest his belief in practice and observance.

Article 19: Everyone has the right to freedom of opinion and expression; this includes freedom to hold opinions without interference.

As long as these rights don't harm others they provide a compelling reason why patients with capacity should be allowed to make decisions about their lives without coercion. They do not give patients a mandate to demand that someone else hastens their death, but the alternative could be to make the end of life less distressing.

MacCormick should try to appreciate the mindset of someone who has permanently lost "independence, physical ability and mental agility." He might try empathy rather than sympathy. However sincere his views, his right to impose them stops at himself. He should also refer to paragraphs 7 and 8 in the GMC's publication "Good Medical Practice."

Doctors cannot "insist" that a patient with capacity is mistaken in a belief that "their life has lost meaning, purpose and dignity." Prefacing such an insistence with the weasel word "respectfully" may even add insult to injury.

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Competing interests: None declared.

1 MacCormick IJ. Suicide and euthanasia paradox. *BMJ* 2010;341:c4291. (10 August.)

Cite this as: *BMJ* 2010;341:c4705

Between blind rebuttal and the knacker's bolt

MacCormick fails to distinguish between suicide as a result of psychiatric illness, an offhand statement ("I wish I could die"), or a rational decision made by someone with capacity who despite prolonged medical and psychological intervention "feels that, on balance, they would rather not carry on."[1]

Such patients can struggle to live with illness over many years. In these circumstances I would find it hard to disagree however "respectfully" with someone's belief that for them, life has lost "meaning, purpose and dignity."

Autonomy is perhaps the most important ethical principle that guides our practice, but nowhere is it mentioned in MacCormick's letter. We have a duty to facilitate a patient's autonomy to the greatest possible extent, regardless of how difficult or distasteful we find it. Clearly we are bound by the law, but a third way exists between blind rebuttal of a patient's feelings and the knacker's bolt: an acknowledgement of the validity of a carefully thought-out opinion. For those who have fruitlessly tried all possible alternatives, it may be sufficient merely to know that a place exists where they may find an end governed not by disease progression or the good intentions of medical staff, but peacefully, and on their own terms.

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Competing interests: None declared.

1 MacCormick IJ. Suicide and euthanasia paradox. *BMJ* 2010;341:c4291. (10 August.)

Cite this as: *BMJ* 2010;341:c4706

Author's reply

I didn't intend to sound insensitive or paternalistic, and had I been writing personally to Mr Nicklinson himself, or speaking to a patient, my language would have been different.[1-3]

However, it seems strange to consider that trying to persuade someone that they have dignity and value in themselves, and not just because they have some socially defined attribute, such as "independence," is "coercion," particularly if these beliefs are part of a world view driving suicidal ideation. My belief may conflict with a patient's "personal point of view," but insisting that dignity and value are inherent and do not depend on physical or mental ability is not unjustified or any more paternalistic than it would be to insist that human dignity does not depend on sex, race, or religion.

Instead of agreeing with someone that their life truly has lost meaning, purpose, or value, we can actively demonstrate the value and dignity that is inherent in them by working to treat the causes of their despair. This will not be simple, easy, or quick, and the causes may never be fully dealt with. However, in expressing our recognition of people's inherent value we can encourage them to value their own lives, whether or not they have the same physical ability or independence as the general population.

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Competing interests: None declared.

1 MacCormick IJ. Suicide and euthanasia paradox. *BMJ* 2010;341:c4291. (10 August.)
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Cite this as: *BMJ* 2010;341:c4707

DOCTOR SHORTAGES

Save lives

Judy Siegel-Itzkovich reports a fall in doctor numbers in Israel, from 3.7 to 3.4 doctors for every 1000 residents.[1] But chronic underfunding and the consequent doctor shortage may actually be good for the nation's health.

In June 2000, she reported from Jerusalem that a doctors' strike, supported by the Israel Medical Association (IMA), had led to a considerable drop in the death rate.[2] So the recent fall may well be something for the Israeli citizen to celebrate.

(For comparison, the UK has 2.2 doctors per 1000 head of population, Malawi has 0.02, and the world weighted average is 1.7.)

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Competing interests: None declared.

1 Siegel-Itzkovich J. Doctor shortage and chronic underfunding spark crisis in Israel's public hospitals. *BMJ* 2010;341:c4298. (9 August.)
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Cite this as: *BMJ* 2010;341:c4703