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LETTERS

CARE OF REFUSED ASYLUM SEEKERS

Bad news for everyone

SCOTT BARBOUR/GETTY IMAGES

The Court of Appeal ruling limiting access to NHS services for refused asylum seekers is bad news for everyone.[1] It is bad news for refused asylum seekers as we know from bitter experience that, despite safeguards, they will come to harm.[2] It is bad news for other vulnerable migrants with a poor understanding of or ability to communicate their entitlement to free NHS health care, who will be charged in error.[2] It is bad news for public health as, although many infectious diseases will be exempt from charging, doctors will be unable to diagnose them promptly if communities are not routinely accessing services. It is also bad news for the public purse as treating emergencies is much more costly than preventive medicine.

There is no evidence of significant rates of "health tourism"[3-5] and no justification for charging vulnerable migrants for NHS services while they await removal from the country. Health professionals should press the government to amend the Health Bill, which is currently going through parliament, to restore access to NHS services for vulnerable migrant communities. This is likely to be the fastest way to rectify the damage done by the Court of Appeal ruling.

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Competing interests: None declared.

1 Dyer C. Government must give guidance on care of failed asylum seekers who cannot return home. *BMJ* 2009;338:b1345. (31 March.)
2 Kelley N, Stevenson J. First do no harm: denying healthcare to people whose asylum claims have failed (June 2006). Available from: www.refugeecouncil.org.uk/policy/position/2006/healthcare.htm.
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PRIMARY MEDICAL CARE MARKET

Destabilisation of primary care with equitable access

I welcome the critique by Ellins and colleagues of yet another poorly thought out "reform"—the opening up of the primary medical care market with equitable access.[1]

My practice is one of the lowest funded practices in Derbyshire, and covers an area of high deprivation. Indeed, for the level of deprivation we serve there isn't a lower funded practice in Derbyshire.

For several years we had to "compete" with practices run by the primary care trust that we later discovered were being funded at around £120 a patient, while we received some £90 a patient if we reached all our targets.

But now we have to "compete" with a new "Darzi" health centre which is funded to open 8 am to 8 pm, 7 days a week, with appointments that are 40% longer than the general medical services contract at a cost that is over £160 a patient for any registered patient.

It is also funded to provide a walk-in service, and we now understand that the out of hours centre that was based in the town will close when the walk-in centre is open and patients who ring the out of hours service will be told they can attend the walk-in centre instead. In effect this is driving our patients (but not the infirm and housebound) into the new health centre, where they will no doubt be invited to register.

With high workload and comparatively poor funding we already have found it difficult to recruit and retain partners and nurses. This isn't competition: it's destabilisation.

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Competing interests: JSA is a general practitioner working in an area affected by "equitable access."

1 Ellins J, Ham C, Parker H. Opening up the primary medical care market. *BMJ* 2009;338:b1127. (31 March.)

Cite this as: *BMJ* 2009;338:b1600

HEALTH CHECKS EVERY FIVE YEARS

Ankle brachial pressure index?

We are surprised that the ankle brachial pressure index is not included in the Department of Health's latest screening of vascular risk in those aged 40-74.[1]

The index can be measured in primary care, and a reduced value is a powerful independent predictor of cardiovascular mortality risk.[2 3] Therefore symptom-free patients with a reduced ankle brachial pressure index might benefit from aggressive risk factor modulation and exercise treatment.

The NHS vascular health check is already being rolled out by primary care trusts across the country, so an opportunity to reduce cardiovascular mortality may have been missed.

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Competing interests: None declared.

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2 Leng GC, Fowkes FG, Lee AJ, Dunbar J, Housley E, Ruckley CV. Use of ankle brachial pressure index to predict cardiovascular events and death: a cohort study. *BMJ* 1996;313:1440-4.
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Cite this as: *BMJ* 2009;338:b1599

NEUROGENIC BLADDER DYSFUNCTION

Bladder stimulation for neurogenic bladder

An important alternative to intermittent bladder catheterisation for neurogenic bladder dysfunction is bladder stimulation.[1]

Suprapubic bladder stimulation was evaluated at Queen's Square Hospital, London, in a prospective, but non-randomised, study in 36 patients.[2] The device improved

the symptoms in 25 patients and reduced the post-voiding residual from a mean of 175 (SD 78) ml to 68 (32) ml. There were no complications and most patients complied well. The authors concluded that suprapubic vibration is an effective means of emptying the neurogenic bladder and that the device may be a useful alternative to clean intermittent self catheterisation. The Queen's Square Bladder Stimulator (Malem Medical) was introduced to clinical units and patients in Australia in 1998 on the basis of the trial.

The effect of bladder stimulation can be evaluated in clinical practice using a within patient crossover trial—for example, comparing it with no treatment or intermittent catheterisation, or both, using residual bladder volume to guide management. With careful design, a series of patients studied in a crossover design could make a useful contribution to future reviews on this topic and be available long before any randomised controlled study.

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Competing interests: MSK imports and distributes the Queen's Square Stimulator and other Malem devices in Australia.

1 Buckley B, Grant AM. What is the most effective management of neurogenic bladder dysfunction? *BMJ* 2009;338:b659. (12 March.)
2 Dasgupta P, Haslam C, Goodwin R, Fowler CJ. The "Queen Square bladder stimulator:" a device for assisting emptying of the neurogenic bladder. *Br J Urol* 1997;80: 234-7.

Cite this as: *BMJ* 2009;338:b1603

COMPETING INTERESTS ET AL

Stealth advertising and academic stalking

In a rapid response Leo and Lacasse critiqued a study published in *JAMA* for not mentioning that a psychosocial intervention was as effective as an antidepressant for post-stroke depression and for failing to record relevant conflicts of interest.[1] *JAMA*'s editors have since contacted Leo and his superiors.[2] This dispute highlights the fact some studies in respected journals amount to stealth advertising,[3] and when legitimate scientific critics point this out, they may be the recipients of academic stalking.[4]

Stealth advertising and academic stalking mean that many patient volunteers generate research data that are never made accessible to the public. For example, the Turner et al analysis of antidepressant trials found that 3449 depressed patients participated in studies that were never published.[5] Another 1843 patients participated in studies in which the data were published as positive in conflict with the Food and Drug Administration's assessment that they were negative studies. Someone should ask those patient volunteers if that's acceptable to them.

It is time for institutional review boards around the world, on behalf of the human subjects they are committed to protect, to demand internet accessible raw data from all approved scientific studies. This will allow consumers and the professionals who treat them to decide for themselves how to balance safety and effectiveness when choosing treatment options. Patient volunteers deserve nothing less for their sacrifices.

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Competing interests: Full details are given in the rapid response (www.bmj.com/cgi/eletters/338/feb05_1/b463#211256)

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5 Turner EH, Matthews AM, Linardatos E, Tell RA, Rosenthal R. Selective publication of antidepressant trials and its influence on apparent efficacy. *N Engl J Med* 2008;358:252-60.

Cite this as: *BMJ* 2009;338:b1612

JAMA's rule needs time limit

JAMA's policy in relation to those who may raise concerns about selective disclosures or misleading information in a published article is not altogether unreasonable if it had a time limit for the period of requested silence during a fair investigation of concerns.[1] The real question for journal editors should be how long is reasonable: five weeks, five months, 15 months?

The *BMJ*'s standard seems to be something less than five months, given that it published Leo's concerns. If the desirable investigation period is agreed to be less than five months, what should it be so as to account for matters such as complexity or ease of contact with authors? Medical journal editors should work together to come up with a universal policy that is fair to both a journal and the person raising any concern about a journal's potentially misleading or incorrect content.

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Competing interests: None declared.

1 Tanne JH. JAMA's new rule on whistleblowers' silence during investigations creates controversy. *BMJ* 2009;338:b1352. (31 March.)

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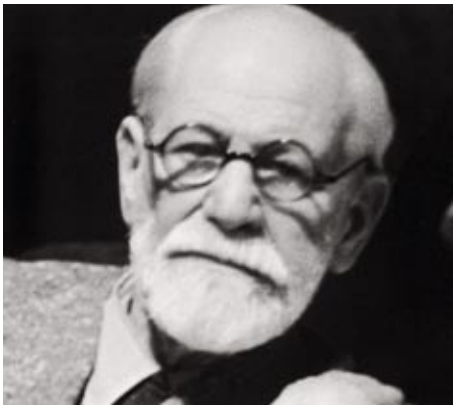

STUDIES ON HYSTERIA

The dark side of Freud's legacy

Lucas's review of Breuer and Freud's *Studies on Hysteria* does not mention its most damaging legacy—namely, the widespread belief that all symptoms that elude diagnosis are psychosomatic in origin.[1] This assumption has caused untold frustration and distress to patients who, on top of having illnesses that elude medical diagnosis, have to face being misdiagnosed as having psychological illness despite their protestations to the contrary.[2]

Freud based his theories on his claims that his patients' symptoms were psychosomatic and that they resolved fully after his talking cures. With the benefit of modern medical knowledge, Freud's patients can be seen to have been relating histories that point clearly towards physical illnesses that weren't known or diagnosable at the time. Anna O's history, for example, indicates tuberculous meningitis, and, despite Freud's claims, she had severe symptoms long after her supposed cure.[3]

We have enough medical knowledge to diagnose, retrospectively, the physical illnesses of Freud's patients, but we don't know how many more physical conditions may be as yet unknown to the medical profession. How many of the unexplained symptoms that we currently assume to be psychological will become explicable in physical terms once medical knowledge has advanced another few decades or centuries? All too often, the medical profession ignores one of the most important lessons to be learnt from Freud's story—that, if we are unable to explain a patient's symptoms, the reason may not be that the symptoms are psychosomatic but simply that our knowledge is imperfect.

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Competing interests: None declared.

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Cite this as: *BMJ* 2009;338:b1606