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LETTERS

RULES OF CONSCIENCE

BMJ's poor portrayal of issues

The headline on the cover of the *BMJ*'s 16 May issue, "Interrogating detainees: why psychologists participate and doctors don't," is, at best, an example of poor communication. It violates Grice's maxims of good communication: avoid obscurity of expression, make your contribution one that is true, and be sufficiently informative. At worst, it has a feel of tabloid journalism, designed to get readers' interests at the cost of accuracy. It is incorrect and misleading to state in a British journal that "psychologists" participate in the interrogation of detainees, when only a comparatively small number of American psychologists—for example, military psychologists—have been prepared to participate in interrogation. Psychologists who are members of the British Psychological Society adhere to a strict code of ethics and conduct, which is in line with the guidelines issued by the United Nations.

The editor's portrayal of the morality and ethics of doctors and psychologists (at least in the United States) seems overly simplistic and biased in its presentation, designed more to grab attention than to communicate clearly about important issues.[1] She takes no account of the strong debate about issues such as interrogation in the US psychology profession and in other countries such as the United Kingdom.

Although Pope and Gutheil examine ethics policies, their implicit assumption that the "age of the profession" could compromise ethical attitudes is untenable.[2] History is full of examples where the practice and ethics of doctors—for example, psychiatrists—have been compromised by the social and political context—for example, in the former Soviet Union.

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1 Godlee F. Rules of conscience. *BMJ* 2009;338:b1972. (14 May.)
2 Pope KS, Gutheil TG. Contrasting ethical policies of physicians and psychologists concerning interrogation of detainees. *BMJ* 2009;38:b1653. (30 April.)

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Betray ethics, betray trust

The harm caused by the interrogation methods described by Pope and Gutheil goes far beyond the considerable damage, sometimes fatal, of methods commonly understood to be torture.[1] When psychologists or doctors design and help to inflict such methods, they engage in three betrayals. They betray the trust and human rights of those who are tortured. They betray fundamental professional ethics.[2] And they betray the trust society places in such professionals.[3]

The harm caused by acts that are physically, sexually, or psychologically damaging—for example, child abuse—is greater when a trusted figure is involved.[4] The Orwellian transformation of trusted professionals into those who use their training and skills to design and help inflict methods whose reality is masked by euphemisms such as "harsh" or "extreme" can interfere with the ability to reason realistically.[5]

The trauma that occurs when professionals betray individuals, fundamental ethics, and society affects us all.

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1 Pope KS, Gutheil TG. Contrasting ethical policies of physicians and psychologists concerning interrogation of detainees. *BMJ* 2009;38:b1653. (30 April.)
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TREATING FAILED ASYLUM SEEKERS

Access to primary care

Newdick's editorial on failed asylum seekers' legal entitlements to free NHS health care requires comment.[1]

Firstly, nobody is excluded by law from free NHS primary health care because of their residency or immigration status. General practitioners retain a discretion to register failed asylum seekers to the same extent that they have a discretion to register any patient—and registration does not require that "difficult and sensitive questions" are asked or immigration documents or passports checked. It is also unlawful for practices to act in a discriminatory way when registering asylum seekers and refused asylum seekers. As the BMA warns, general practitioners must take into consideration contract regulations as well as the ban on discrimination in the Human Rights Act 1998. Health professionals must also be careful not to breach section 20 of the Race Relations Act 1976 by discriminating against asylum seekers by refusing to provide them with healthcare services.[2]

Secondly, doctors in primary and secondary care have a duty to provide all necessary investigations and treatment in an emergency, or that are urgent or immediately necessary, regardless of any steps being taken to recover payment. Indeed, even investigations and treatment deemed non-urgent should be provided irrespective of payment if the patient cannot return home in a medically acceptable time.[3]

Lastly, the denial of free secondary NHS health care violates binding international health law ratified by four in every five countries worldwide, including the United Kingdom.[4]

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Stick to our ethical principles

The NHS Act 2006 has worrying implications for the treatment of failed asylum seekers in England, although it does not apply to Scotland.[1] The legal process for claiming asylum is notoriously difficult, and those at most need of protection may be least able to navigate it, resulting in failed asylum status.

We as doctors should be advocating for improvements in the asylum process if we wish to reduce illness and health service use in asylum seekers and reap associated economic benefits. Above all, we should remember to stick to our ethical principles, even in the face of authority, to provide care in the best interest of our patients.

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OPEN GOVERNMENT?

Timely access to information

The Freedom of Information Act 2000 is an important health policy research tool that ought to be put to greater use.[1] I have used it extensively to investigate stroke policy.

I asked the House of Commons in March 2008 whether, and, if so, when, the National Audit Office provided the Committee of Public Accounts with a full copy of the Oxford University Consulting review of the November 2005 stroke report.[2] The request was refused, absolute exemption under section 34 (parliamentary privilege) being applied with a speaker's certificate supplied as conclusive proof.

Hiding behind parliamentary privilege in this case seemed not to be in the interests of the public. If MPs had been kept in the dark about the full content of the critical Oxford report can the public have trust and confidence in MP recommendations about stroke services and priority of funding and developments?[3] This is important as details of the national stroke strategy impact assessment can be used to show that a greater percentage of the overall estimated £502 million net benefit of the strategy comes from early supported discharge and community rehabilitation than from acute imaging and thrombolysis.[4]

The public and health policy researchers have a right to access information in a timely manner. Currently just £5.5 million is spent on the information commissioner's work with the Freedom of Information Act, comparing unfavourably with the sums spent by MPs on their own expenses. MPs should increase the information commissioner's funding as a matter of priority.

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CLOSTRIDIUM DIFFICILE

Community *Clostridium difficile*

We reviewed clinical and microbiology data on patients with positive results for *C difficile* toxin in this NHS trust from May 2007 to April 2008.[1]

General practitioners' practice in requesting tests for *C difficile* toxin varied widely. Overall, 24 patients with diarrhoea had positive test results, 12 patients presenting to their general practitioner and 12 to the accident and emergency department. All except one had a history of either admission in the previous six months or exposure to antibiotics in the previous four weeks. Five of the 12 patients presenting to accident and emergency had visited a general practitioner in the previous seven days without *C difficile* infection having been suspected. Death was attributable to *C difficile* in three patients.

C difficile infection with onset in the community is increasingly recognised.[2] Admission and antibiotic treatment are major risk factors.[3] General practitioners should test patients with diarrhoea and recent admission or antibiotic exposure for *C difficile* toxin. Currently used tests are not very sensitive.[4] General practitioners should treat patients with risk factors empirically if the diarrhoea is severe.

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TRAMPOLINE INJURIES

How to avoid injury

The onset of spring is guaranteed to see family trampolines being dusted off and children attending hospital with trampoline related injuries.[1] We analysed 50 cases presenting to the accident and emergency department at this hospital over six weeks in comparison with the safety guidelines of the Royal Society for the Prevention of Accidents (RoSPA) (table).[2]

Factors associated with trampoline injuries

Factor	Prevalence of injury, Ninewells study (n=50)	RoSPA guidance[2]
Multiple users	80%	74% of injuries associated with multiple users
Lack of adult supervision	46%	Adult "spotter" reduces risk of injury
Lack of safety net	64%	Safety net reduces chance of child falling to ground
Site of injury	54% legs, 32% arms, 14% head, neck, face, chest	Injuries seen in all parts of the body, including neck, arms, legs, face, and head

The table shows that the most important factor associated with trampoline injury is having many users on a trampoline at one time. RoSPA reports that the lightest person is five times more likely to be injured. We have found that the severity of the injury also increases with the mismatch between child and adult weights. For example, a child of 20 kg can experience a force equivalent to a 3.5 m fall when bouncing with an adult of 80 kg (S Menelaws et al, spring scientific conference of the College of Emergency Medicine, April 2009).

Adult supervision is crucial in preventing trampoline injuries. The most influential role of a supervising adult is to ensure safety guidelines are followed, exuberance is controlled, and help is provided with setting up and dismounting from the trampoline. We note that children have been hurt while being supervised or bouncing with adults who have been drinking at a summer garden party, for example. Adults, please note that lager, wine, and trampolines do not mix.

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Competing interests: None declared.

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