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LETTERS

GLOBAL NON-COMMUNICABLE DISEASE

Where did all the other non-communicable diseases go?

Serious consideration is needed about which non-communicable diseases to discuss at this month's United Nations meeting if people in low income countries are to benefit.[1] The diseases selected are more problematic in high income than in low income countries. Stroke, heart disease, diabetes, and chronic obstructive lung disease primarily affect older adults while low income countries remain largely populated by youth. According to World Health Organization data,[2] upper middle income countries stand to benefit most if comparing the burden of non-communicable diseases that would be addressed in the proposed agenda with the burden that would not be addressed using age adjusted mortality.

The risk factors targeted are also more prevalent in high and upper middle income countries. Tobacco, alcohol, and obesity are to some extent luxuries that are not yet affordable to the poorest people in the world (table). Targeting risk factors where they are less prevalent will be less efficient.

The table raises additional interesting questions that won't be addressed. For example, given that some risk factors for hypertension (such as obesity and physical inactivity) are comparatively low in low income countries, why are hypertension rates fairly similar? Furthermore, the targeted risk factors apply to these conditions in higher income countries. Risk factors for the same conditions are likely to be different in low income countries and won't be considered in this "one size fits all" approach. Substantial evidence suggests that early deprivation and environmental exposures affect adult health,[3] but these will not be explored in the proposed programme.

Invitations for the meeting had not been extended to selected delegates in August.[4] The meeting has reportedly gone "wobbly" partly because countries in Africa don't want to be diverted from today's immediate health burden to address health problems they may have tomorrow. Indeed, the programme's narrow proposed focus may have negative consequences for the people it aims to help.

Gretchen L Birbeck director and professor, Michigan State University, International Neurologic and Psychiatric Epidemiology Program (INPEP), East Lansing, MI 48824, USA **birbeck@msu.edu**

Competing interests: GLB has received research funding from the US National Institute of Health, the Rockefeller Brothers Fund, and the US Centers for Disease Control related to research on non-communicable diseases.

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Cite this as: *BMJ* 2011;343:d5785

CALORIE LABELLING ON HIGH STREET

Serious methodological flaws compromise study findings

Dumanovsky and colleagues investigated the effect of calorie labelling in restaurants.[1] However, their study uses one of the weakest research designs (uncontrolled pre-post study) that would not merit inclusion in a Cochrane Systematic Review of health systems. This un-interpretable paper has received widespread publicity and has been presented as a causal argument against labelling food on restaurant menus in, for example, the *Wall Street Journal*, the *Economist*, and *Time Magazine*. Calorie labelling may have no effect, but this study cannot contribute to the debate owing to serious methodological flaws.

Firstly, the uncontrolled design does not account for various factors that may explain the observed finding of no change, before and after the law. For example, availability and advertising of cheap high calorific foods from 2007 to 2009 could have resulted in an overall increase in calorie consumption in other cities. The fact that there is no difference in calorie consumption in New York City between 2007 and 2009 could be misinterpreted. This is unfortunate as the study could have easily integrated a control group by collecting data during the same time from other cities, preferably bordering New York City with similar population characteristics but no labelling law.

Secondly, the "before" group (a single time point) is not an appropriate group for comparison as some restaurants surveyed in 2007 already had calorie labelled their food. The authors mention that the Subway chain labelled its menu for some foods in 2007. This would contaminate any comparison of the effect of labelling on calorie intake and bias the results towards the null or no effect of the law.

Aakanksha H Pande PhD candidate
apande@fas.harvard.edu
Stephen B Soumerai professor of population medicine, Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute, 133 Brookline Street, Boston, MA 02215, USA

Competing interests: None declared.

1 Dumanovsky T, Huang CY, Nonas CA, Matte TD, Bassett MT, Silver LD. Changes in energy content of lunchtime purchases from fast food restaurants after introduction of calorie labelling: cross sectional customer surveys. *BMJ* 2011;343:d4464. (26 July.)

Cite this as: *BMJ* 2011;343:d5797

Authors' reply

Pande and Soumerai present an overly simplistic critique, not grounded in the reality of public policy evaluations. We did not conclude, as they suggest, that the intervention was ineffective. The 15% of patrons who reported seeing and using calorie information purchased fewer calories. In 2009 almost 1.3 million New Yorkers reported eating fast food at least once a week, resulting in around 3 million visits weekly (New York City Community Health 2009, unpublished data). This means that many New Yorkers will use this information to purchase fewer calories each week. Furthermore, the total number of calories purchased in several major chains significantly fell in the overall restaurant sample.

Prevalence by income of risk factors targeted in proposed non-communicable disease programme.* Values are mean percentages of population unless stated otherwise

Country GDP (n=193)	Mean annual alcohol consumption (L) (n=188)	Obesity (n=163)	Tobacco use (n=152)	Raised blood glucose (n=101)	Physically inactive (n=122)	Hypertension (n=133)
High	9.2	24.4	20.9	6.3	43.6	41.0
Upper Middle	8.4	25.8	21.9	10.2	42.6	42.3
Lower middle	5.2	20.2	19.1	23.4	34.9	38.0
Low	3.7	5.0	12.4	3.3	18.0	38.0
	P<0.0001	P<0.0001	P=0.0003	P=0.0007	P<0.0001	P=0.006

*Based on World Health Organization data.[1] GDP=gross domestic product.

Further evaluation over time is warranted.

They suggest that this evaluation could be meaningfully pursued only with Cochrane quality randomised trials. However, the restaurant industry, which aggressively opposed the policy through the courts, would not have cooperated with randomisation. Randomised trials have not been feasible for key public health policies such as those that enforced seatbelts, raised tobacco taxes, and removed lead from paint.

Although using other jurisdictions as controls is a reasonable alternative suggestion, it was not feasible in the few months between approval and implementation. The design limitations, which were clearly discussed, reflect typical difficulties confronting policy evaluation, in which timely studies are often the only option, and while imperfect, still furnish critically useful information.

Regarding possible contamination of the baseline, calorie information provided by Subway in 2007 was restricted to a small sticker on the display case covering only a few of its products. It was not equivalent to earlier implementation of comprehensive calorie posting. More importantly, if one company voluntarily provided information at baseline, it was, in fact, the societal condition before the policy change under evaluation, and hence does not invalidate our findings.

Lynn Silver director, Office of Science and Policy, New York City Department of Health and Mental Hygiene, Bureau of Chronic Disease, New York, NY, USA **lsilver@health.nyc.gov**
Mary T Bassett director, African Health Initiative, Doris Duke Charitable Foundation, New York, NY, USA

Competing interests: None declared.

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CYCLING IN URBAN ENVIRONMENTS

Benefits of public bicycle schemes must be evaluated carefully

Rojas-Rueda and colleagues' paper compares the health benefits of Bicing (Barcelona's public bicycle share scheme) with possible risks associated with increased cycling.[1] Public bicycle share schemes seem to be one of the most effective methods of increasing the number of bicycle trips across a population, providing additional transport options, and improving awareness of the possibilities that bicycles offer urban transport systems.

However, the authors' flawed assumptions about the proportion of Bicing users who substituted a motor vehicle journey invalidate their results. Their assumption that 90-100% of Bicing users would otherwise have made the trip by car greatly overstates the actual rate of trip substitution. The available data show that only 9.6% of Bicing trips substitute for a car journey.[2] Moreover, 6.3% of such trips were previously private bicycle journeys, which neutralises any benefit to public health. More than a quarter of Bicing trips are taken by people who would previously have walked,[3] and given the evidence that walking has twice the health benefit of bicycle riding (on a per km basis),[4] Rojas-Rueda and colleagues' results probably overstate the health benefits of the scheme.

Elliot Fishman PhD scholar, Centre for Accident Research and Road Safety, Queensland University of Technology, QLD 4059, Australia **e.fishman@qut.edu.au**

Competing interests: None declared.

1 Rojas-Rueda D, de Nazelle A, Tainio M, Nieuwenhuijsen MJ. The health risks and benefits of cycling in urban environments compared with car use: health impact assessment study. *BMJ* 2011;343:d4521. (4 August.)
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Cite this as: *BMJ* 2011;343:d5771

More needs to be done

Rojas-Rueda and colleagues wrongly assume that most users of Barcelona's public bicycle share scheme switched from car driving, invalidating many of their claims.[1]

What surprises me most are the relatively similar mortality rates quoted in this study for cyclists and car drivers. In Britain in 2009, the death rates per billion miles travelled were 34 for cyclist versus 2.8 for car drivers—a 12-fold difference.[2]

William P Soutter gynaecologist, Imperial College Healthcare NHS Trust, London W12 0HS, UK
patsoutter@btopenworld.com

Competing interests: None declared.

1 Rojas-Rueda D, de Nazelle A, Tainio M, Nieuwenhuijsen MJ. The health risks and benefits of cycling in urban environments compared with car use: health impact assessment study. *BMJ* 2011;343:d4521. (4 August.)
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Cite this as: *BMJ* 2011;343:d5773

CESAR RANGEL/AFP/GETTY IMAGES

Authors' reply

We started with the assumption that 90% of Bicing users previously made the same trip by car and conducted further (sensitivity) analyses using other scenarios of mode shift (assuming that 9.6% of Bicing users came from cars, 55.1% from public transport, and 26.1% from walking) (see web appendix to paper). They made little difference to the results (10.46 *v* 12.46 deaths avoided for the main driver of the analyses—physical activity), so did not change the main message of the paper. Our analyses also found that walking may have greater benefits than cycling, and we reported an increase of 0.61 deaths a year in those who previously walked for 2 km on a regular basis and shifted to Bicing for the same amount of travel.

Traffic deaths (per billion km travelled)

Reference	Bike	Car	Ratio	Description
Bicing Barcelona	4.54	3.72	1.2	Urban area
De Hartog[2]	8.2	1.9	4.3	All Netherlands
UK[1]	20.8	2.64	7.8	All UK

We found that the difference in traffic incidents between cyclists and car drivers was less than reported in the UK,[1] possibly because we did the calculation of risk for an urban area and not the whole country (resulting in fewer miles travelled and fewer deaths). Cycling mortality reported in Barcelona (and used in this study) was low (five deaths in the past nine years) resulting in a low comparative risk between cycling and driving. When we conducted sensitivity analyses using the higher traffic mortality rates reported by De Hartog,[2] this had little effect on our final results (table).

David Rojas-Rueda predoctoral researcher
Audrey de Nazelle researcher
Mark J Nieuwenhuijsen research professor, Centre for Research in Environmental Epidemiology, 08003 Barcelona, Spain

Competing interests: None declared.

1 Department for Transport. Reported road casualties Great Britain 2009. 2010. www2.dft.gov.uk/adobepdf/162469/221412/221549/227755/rrcgb2009.pdf.
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Cite this as: *BMJ* 2011;342:d5774

NICE ON DISINVESTMENT

NICE recommendations for disinvestment

Garner and Littlejohns summarise the difficulties faced by the National Institute for Health and Clinical Excellence (NICE) in identifying low value NHS activities.[1] NICE's work has evolved from new appraisals of specific technologies towards initiatives that include hundreds of do not do recommendations drawn predominantly from existing clinical guidelines.[2] Evidence that these

initiatives are effective is mixed and limited.[3] NICE should reconsider its shift away from technology appraisal of existing interventions. Advantages of technology appraisals include:

(1) Newsworthiness, which aids dissemination
(2) Focus on the most important decisions
(3) Freedom from doubts about the ability of clinical guidelines to incorporate cost effectiveness considerations.[4]

The lack of candidates for total disinvestment need not be a barrier.[1] NICE appraisals of innovations often do not recommend total investment for all subgroups. A disinvestment analogy could see recommendations for research into existing interventions in clinical subgroups where cost effectiveness is doubtful and evidence lacking. The worry that highlighting potentially inappropriately used interventions might prejudice views isn't a strong reason for not doing so.[1] The appraisal will synthesise the evidence and we can adjust our opinions in light of it. The greater danger would be in not challenging prejudices.

Perhaps the greatest challenge is identifying potential candidates for partial disinvestment. A starting point might be procedures with high geographical variation in use. One cause of variation is differences among clinicians in diagnostic thresholds or beliefs in the value of the intervention, rather than differences in clinical need.[5] Many interventions are both costly and invasive. Therefore, the onus should be on clinicians with high intervention rates to demonstrate (by participating in research) that their approach results in better patient outcomes at an acceptable cost, rather than on primary care trusts to demonstrate otherwise.

William Hollingworth reader in health economics
William.Hollingworth@bristol.ac.uk
Charlotte Chamberlain public health registrar, University of Bristol, School of Social and Community Medicine, Bristol BS8 2PS, UK

Competing interests: WH receives funding from the National Institute for Health Research's service delivery and organisation programme for a project entitled: "Using clinical practice variations as a method for commissioners and clinicians to identify and prioritise opportunities for disinvestment in health care."

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Cite this as: *BMJ* 2011;343:d5772

MMR VACCINATION AND EGG ALLERGY

Refer children with a previous serious reaction to an expert

The Practice article by Rolfe and Sheikh may help to reduce the numbers of egg allergic children referred to hospital to have their measles, mumps, and rubella (MMR) vaccine.[1] Unfortunately, they state that "Children who have had previous serious reactions to any vaccine should be vaccinated under hospital supervision" without any further clarification. How would they define a serious reaction? For example, if this included a convulsion after the third set of primary immunisations there would be little point in immunising in hospital against MMR because any convulsion is likely to occur 5-10 days after the vaccine. It may have been better to suggest that after a serious reaction to a vaccine, a child should be referred for expert advice about further vaccinations. This would be primarily for advice, which would usually recommendgoing ahead with further vaccinations.

David A C Elliman consultant paediatrician, Whittington Health, London N19 5NF, UK
ellimd@gosh.nhs.uk
Helen E Bedford senior lecturer in children's health, UCL Institute of Child Health, London, UK

Competing interests: None declared.

1 Rolfe A, Sheikh A. Measles, mumps, and rubella vaccination in a child with suspected egg allergy. *BMJ* 2011;343:d4536. (3 August.)

Cite this as: *BMJ* 2011;343:d5779

Is safe and feasible

Rolfe and Sheikh cite recent guidelines recommending that all egg allergic children should receive the measles, mumps, and rubella vaccine.[1 2] These guidelines also recommend that an allergy specialist should guide the provision of other egg containing vaccines (including flu and yellow fever), for which the risk-benefit is less clear.[2]

Several life threatening travel related diseases are preventable by vaccines containing egg antigen, but limited data on the safety of their administration to egg allergic individuals are available to inform risk-benefit analysis.[3 4]

From 2000 to 2010 we immunised 14 people with suspected egg allergy aged 18-43 years, using a clinical protocol based on risk assessment (clinical presentation and radioallergosorbent test (RAST) for egg white specific IgE) and supervised immunisation depending on risk (possibly including prophylactic intravenous cannulation with or without 20% intradermal test doses).

Eleven of these people underwent RAST (4/11 were positive) and 12 were prophylactically cannulated. Three received an intradermal test dose. Of these, one RAST positive individual had an immediate urticarial reaction to the test dose, precluding full dose administration. Another RAST positive individual developed a minor local reaction that did not prohibit full dose administration. Of the 14 egg allergic patients, 10 (including 2/4 with positive RAST) received egg containing vaccines without major adverse events; four received vaccines that did not contain egg.

Overall, the frequency of serious allergic reactions was low in this cohort with suspected egg allergy referred for specialist guided immunisation. Under appropriately supervised and monitored conditions, people with egg allergy may be vaccinated without excessive risks, so egg allergy is not necessarily a barrier to receiving egg containing vaccines.

Christopher J A Duncan research fellow
chrisduncan@doctors.net.uk
Andrew D McCallum specialty registrar in infectious diseases
Rona MacDonald specialty registrar in genitourinary medicine
Michael E Jones consultant physician, Regional Infectious Diseases Unit, Western General Hospital, Edinburgh EH4 2XU, UK

Competing interests: None declared.

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Cite this as: *BMJ* 2011;343:d5780

Authors' reply

With respect to the point raised by Elliman and Bedford, the word constraints of the article prevented any detailed discussion about the types of vaccine related reactions that may warrant a specialist assessment or vaccination under specialist supervision. In any case, because of the array of possible adverse reactions to various vaccinations it would be impractical and ill advised to try to provide an exhaustive list. Rather, given that GPs and their teams have considerable experience with vaccinating infants, we suggest that any reactions that cause clinicians undue concern should be discussed with a specialist colleague before administration of further vaccinations. We agree that in most cases it will ultimately prove safe to proceed with further vaccinations.

Aziz Sheikh professor of primary care research and development **aziz.sheikh@ed.ac.uk**
Alexandra Rolfe clinical research fellow, University of Edinburgh, Edinburgh EH8 9DX, UK

Competing interests: None declared.

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WE SHOULDN'T FEAR SOCIAL MEDIA

A few fears felt using Facebook

Facebook and Twitter are part of most trainee doctors' social lives.[1] The General Medical Council has recently issued guidelines on their use because of concerns about violations of confidentiality and professional boundaries. If it had not been for two Facebook experiences I may not have paid them much attention.

The first incident relates to professional boundaries. I noticed that a patient I regularly saw knew some unusually personal facts about me. It eventually transpired that the patient was accessing my Facebook photograph albums, in particular my profile pictures, which were not secure. My patient's curiosity resulted in the discovery of details about my family and roughly where I lived. The problem is easily solved: all those with accounts need only double check their security settings and carefully consider what they put on their profile picture.

Facebook can also create a false sense of security. After a particularly difficult shift I posted that I had had an "eventful night." This in itself does not breach confidentiality, but the post generated many comments from colleagues, each one adding a bit of detail. Considered together, the comments gave quite an accurate description of the shift, so the post was deleted.

These incidents won't prevent me from using Facebook, but they reminded me that you can never quite take off the doctor's badge.

Clare H Fenton trainee psychiatrist, York YO30 4XT, UK
clarefenwick@yahoo.com

Competing interests: None declared.

1 McCartney M. We shouldn't fear social media. *BMJ* 2011;343:d4864. (3 August.)

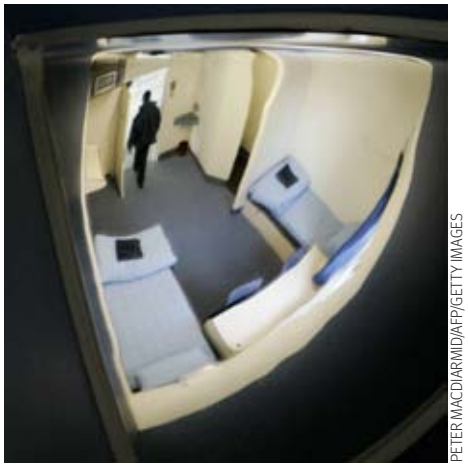
Cite this as: *BMJ* 2011;343:d5619

DEATHS AT UK IMMIGRATION CENTRES

Immigration centre healthcare should be transferred to Department of Health

The three recent deaths at UK immigration detention centres will be investigated by the Prisons and Probation Ombudsman, who will need to consider the organisation of healthcare in these centres to try to learn from them and prevent more deaths.[1] Deaths to which clinical errors have contributed—which these probably are—usually have roots in the systems that the person relied on for care.[2]

When medical emergencies occur in immigration detention centres, particularly out of hours, detainees must gain access to care by attracting the attention of a custody officer. If responses are dilatory, detainees cannot go to a hospital or call an



PETER MACDIARMID/AFP/GETTY IMAGES

ambulance. Resulting delays have been evident in previous deaths in such centres.[3]

Uniquely, healthcare in immigration detention centres is commissioned by the UK Border Agency, which lacks the appropriate staff, competence, and culture. Since prison healthcare was transferred from the Home Office to the Department of Health standards have greatly improved, although further progress is needed. Transfer of healthcare in immigration detention centres to the Department of Health was recommended by the chief inspector of prisons in 2006,[4] and has still not occurred. Accountability is further diffused by outsourcing: the UK Border Agency contracts the running of the majority of centres to private companies, which often subcontract.

The 25 000 immigration detainees held each year are not "serving time for a crime" but are imprisoned, sometimes for years,[5] for the administrative convenience of the UK Border Agency. Immigration detention centres are supposed to be short term holding facilities to enforce speedy and lawful involuntary return of people whose claims for leave to remain in the UK have been found to be without legal merit. These centres are currently incapable of providing adequate longer term healthcare.

Frank W Arnold doctor, Reading RG6 1QB, UK
arnold_frank@hotmail.com

Competing interests: FWA has examined and advised over 700 immigration detainees at their or their legal representative's request, and is sometimes paid for medicolegal reports resulting therefrom. He helped to found the Medical Justice Network and gave evidence to the Prisons Inspectorate report.[4]

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Cite this as: *BMJ* 2011;343:d5776

DOCTORS AND TORTURE IN ISRAEL

Why the secrecy?

A two year delay in response means that the World Medical Association (WMA) and probably the BMA are failing in their duties.[1 2] It is incumbent on any national medical association to draw to the attention of the WMA any involvement of its doctors in torture.

The deliberations of the International Committee of the BMA are "secret," and despite being a member of the BMA for nearly 50 years I am not allowed to know what it does or fails to do. This is despite repeated requests.

I have asked to know exactly what action the BMA has taken with the WMA on the involvement of Israeli Medical Association doctors in torture and what response there has been from the WMA. I have failed to extract this information from the BMA. I am told the Freedom of Information Act cannot force its disclosure.

This secrecy is a disgrace and I have to assume there are things the BMA wishes to hide.

Please will the BMA tell us the full truth about its actions (and inactions) and its responses regarding the above? Why are the activities of the international committee secret from BMA members? They should be a matter of pride.

Christopher J Burns-Cox physician, Bristol, UK
chris.burns-cox@virgin.net

Competing interests: None declared.

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Cite this as: *BMJ* 2011;343:d5792

BMA's reply

In March 2010 the BMA wrote formally to the World Medical Association (WMA), requesting that the WMA call upon the Israeli Medical Association (IMA) to undertake a rigorous, independent, and transparent investigation into allegations against the IMA of medical complicity in torture, as set out by both Physicians for Human Rights (Israel) and the Public Committee Against Torture in Israel.

I have had email correspondence with Burns-Cox on this matter and he has also had contact with the secretariat to the BMA international committee. In December 2009, I met with Burns-Cox at BMA House to discuss, at length, his concerns.

Vivienne Nathanson director of professional activities, BMA, London WC1H 9JP, UK vnathanson@bma.org.uk

Competing interests: None declared.

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