LETTERS

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BREAST SCREENING REVIEW

The new citizens' juries are biased

IMAGE SOURCE/ALAMY

It is now acknowledged that women need better information when deciding about breast screening.[1] This is not a new recommendation.[2]

But is a poorly conceived (illegitimate?) citizens' jury an appropriate method to "consider ways of presenting to eligible women, data on benefits and harms of breast screening arising from the Marmot review"?[3]

On 11 October 2012, I accepted an invitation from King's Health Partners (KHP) to be a witness at a 2.5 day citizens' jury, beginning 19 November 2012, facilitated by the Office for Public Management (OPM).

On receiving my "witness briefing" I was dismayed by its biased and faulty content. I was also appalled that the Advisory Group to Informed Choice about Cancer Screening (ICCS) at KHP appointed to oversee and govern "A new approach to developing information about NHS cancer screening programmes" and some expert witnesses for the Marmot review knew nothing about it. I received intelligence that the promoters (KHP) considered me to be someone with "a very particular negative story" and were concerned that "it would prejudice the jury." These shocking revelations prompted me to resign as a witness, fully explaining my reasons. KHP and OPM asked me to reconsider. I declined, and also declined their request to suggest a replacement witness.

Observers will be restricted—charities allowed, but not medical journalists. The last half day is set aside for presentation of the "new breast cancer screening information leaflet draft for consideration by jury," presented by an official from ICCS.

This is an appalling waste of £35 000 (€43 680; $55 950) of public money. Deliberative democracy is not being enabled or delivered by this biased and controlled event, planned in private, which, judged against the ideal Jefferson Center outline,[3] is not a true citizens' jury.[4]

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Competing interests: None declared.

HT is an independent citizen advocate for quality in research and healthcare.

1 Hawkes N. Breast screening is beneficial, panel concludes, but women need to know about harms. *BMJ* 2012;345:e7330. (30 October.)
2 Thornton H, Edwards A, Baum M. Women need better information about routine mammography. *BMJ* 2003;327:101.
3 Jefferson Center. Citizen juries. http://jefferson-center.org/what-we-do/citizen-juries/.
4 Paul C, Nicholls R, Priest P, McGee R. Making policy decisions about population screening for breast cancer: the rôle of citizens' deliberations. *Health Policy* 2008;85:314-20.

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SAFETY OF ANTITHROMBOSIS STOCKINGS

Antithrombosis stockings must have non-slip soles

A doctor patient died last year after slipping on a hospital floor and sustaining a cerebral bleed. He was wearing antithrombosis stockings but no slippers.[1] Informally, a clinician at a different hospital said that the stockings "can be lethal," and that he always advised patients to wear them from the ankle upwards to avoid slipping.

Persistent inquiries by one of us (EP) have revealed that the obvious solution—making the soles non-slip—is being investigated in at least two hospitals, and that a third and major hospital is considering changing all its antithrombosis stockings to the non-slip variety. In the absence of a central policy, perhaps individual doctors who prescribe these stockings could be encouraged to specify that the stockings should have non-slip soles.

As family and friends of a much loved doctor who might otherwise have been with us today, we urge—on behalf of future patients—that rapid progress is made to abolish the use in hospitals of antithrombosis stockings without non-slip soles.

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Competing interests: None declared.

1 Phillips SM, Gallagher M, Buchan H. Use graduated compression stockings postoperatively to prevent deep vein thrombosis. *BMJ* 2008;336:943.

Cite this as: *BMJ* 2012;345:e7817

PRISON ENVIRONMENT AND HEALTH

Don't use clonazepam for epilepsy to reduce drug misuse

As a group of GPs who work in a women's prison we welcome the series on prison medicine.[1] We want to raise a matter that has profound implications for prison care and for primary care prescribing—the widespread misuse of prescription drugs obtained from GPs and drug services.

Predominant among these is clonazepam—usually prescribed by primary and secondary care for epilepsy. Almost without exception this diagnosis will not have been confirmed by video telemetry because the "fits" we see in prison are clinically not epileptic in nature.

We routinely replace clonazepam with alternative antiepileptic drugs, such as lamotrigine, and have had no clinical problems arising from this policy.

We would welcome a change to clonazepam becoming a hospital prescribed drug only, because there is no merit in having another benzodiazepine available in primary care when dependence on this group of drugs is such a big problem. It could then be restricted to the treatment of intractable epilepsy confirmed by video telemetry.

We would also welcome a more general debate on the diagnosis of pseudoseizures in the prison population and management with psychological techniques rather than drugs. A discussion of other prescription drugs such as mirtazepine, gabapentin, and tramadol, which are much more commonly used for this relatively young population than seems warranted, would also be useful.

We are aware that this has implications for the wider prescribing of potentially addictive drugs in primary care—from analgesics to psychotropic drugs.

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Competing interests: None declared.

1 Ginn S. Prison environment and health. *BMJ* 2012;345:e5921. (17 September.)

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AWARENESS ABOUT ANTIBIOTICS

European Antibiotic Awareness Day and access to antibiotics

The fifth annual European Antibiotic Awareness Day (EAAD) was on 18 November 2012.[1] It aimed to promote knowledge about appropriate use of antibiotics and reduce the emergence of drug resistance and other "collateral damage" as a result of antibiotic exposure.[2] Prudent antibiotic use is emphasised within the recent Department of Health antibiotic stewardship strategy.[3]

Antibiotics differ from other classes of drug, in that administration to an individual can affect the wider population. Patients must have ready access to the treatments they need, but unfortunately some recent initiatives to facilitate this have included applications for over-the-counter and online prescription of antibiotics for infections such as cystitis. The British Society for Antimicrobial Chemotherapy (BSAC) thinks that these measures are counterproductive and will be damaging in the longer term. BSAC believes that these measures are, at very least, against the spirit of antibiotic stewardship and should be strongly discouraged.[4]

Easy access to antibiotics could increase exposure to these precious drugs as well as antibiotic resistance. This would limit their period of effective use. Although data on the uptake of online prescriptions are awaited, we fear that—rather than replacing current prescribing practice—such usage will add to it. It is possible that some people could be given inappropriate treatment, because no medical history is available at the time of prescription. There will also be a separation between treatment and the GP record. Surveillance of antibiotic consumption will be hampered.

Antibiotics are a dwindling resource, threatened by the worldwide spread of resistance and the failure to develop and market new agents.[5] Timely access to appropriate treatment for infections is important, but increasing access to antibiotics in an uncontrolled manner is not the way to achieve this.

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Competing interests: None declared.

1 Department of Health. Resources to support the 2012 European Antibiotic Awareness day in England. www.dh.gov.uk/health/2012/10/eaad-resources/.
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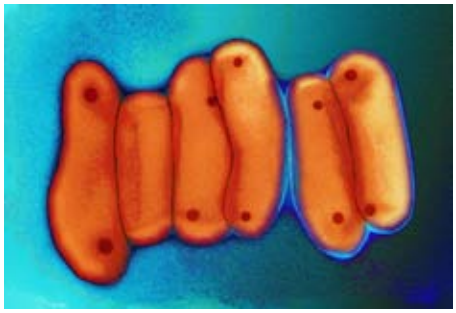
Cite this as: *BMJ* 2012;345:e7819

DIAGNOSIS OF TUBERCULOSIS

Time to debate rapid molecular testing for tuberculosis?

The diagnosis of tuberculosis is challenging.[1] The sensitivity of microscopy and smear positivity in diagnosing respiratory tuberculosis is only 57-81%.[2] The World Health Organization's action plan to combat multidrug resistant (MDR) tuberculosis includes the use of rapid molecular diagnostic tests for MDR tuberculosis in all appropriate patients by the end of 2013.[3] Current National Institute for Health and Clinical Excellence (NICE) guidance recommends carrying out such tests only on smear positive patients in whom a rapid diagnosis would alter care, before a large contact tracing initiative, or in those at risk of having MDR tuberculosis.[1]

Since April 2011, we have used the Xpert MTB/Rif test as a front line rapid molecular test for diagnosing *Mycobacterium tuberculosis* and rifampicin resistance. We tested all respiratory samples that requested testing for *Mycobacterium* spp and non-respiratory samples in which there was a high index of clinical suspicion. Over the first 13 months we processed 725 samples and detected 17 cases of tuberculosis, later confirmed on culture. Of these, four were negative on microscopy and were not considered at high risk of MDR tuberculosis, so would not have fitted the NICE guidelines for rapid molecular testing. Two of these smear negative cases were detected on non-respiratory samples—an abscess and lymph node aspirate. The positive test results in these cases allowed earlier instigation of treatment and infection control procedures. These tests were fast and reliable, with no false positives or negatives during the initial 13 months.



DR LINDA STANNARD, UCT/SPL

Abubakar and colleagues call for research on the cost effectiveness of routinely using molecular tests to diagnose active tuberculosis and drug resistance.[1] However, given the published data on these tests, our favourable experience, WHO's endorsement of these tests, and ongoing changes in migration in the UK (with its likely effect on the incidence of tuberculosis), the time is ripe for debate on the usefulness of these tests in improving the diagnosis of tuberculosis and MDR tuberculosis.[4 5]

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Competing interests: None declared.

1 Abubakar I, Griffiths C, Ormerod P; on behalf of the Guideline Development Group. Diagnosis of active and latent tuberculosis: summary of NICE guidance. *BMJ* 2012;345:e6828. (17 October.)
2 National Collaborating Centre for Chronic Conditions. Tuberculosis: clinical diagnosis and management of tuberculosis, and measures for its prevention and control. 2006. www.nice.org.uk/nicemedia/live/12193/51951/51951.pdf.
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SALIVARY GLAND SWELLINGS

Ultrasound guided core biopsy is diagnostic tool of choice

Mehanna and colleagues' section on obtaining a tissue diagnosis in salivary gland swellings merits further comment.[1]

Fine needle aspiration cytology (FNAC) has traditionally been the biopsy technique of choice in the parotid glands. It is quick, safe, and can be highly accurate, although it requires optimised conditions to perform well. In clinical practice such conditions are rarely available, and FNAC is mostly done free handed in the outpatient setting. This is reflected in the significant heterogeneity in performance demonstrated in a recent meta-analysis.[2] In addition, FNAC provides only a cellular aspirate so is inherently limited in the diagnosis of parotid cancer, with relatively poor sensitivity and a high false negative rate.[2 3] It is also limited in the diagnosis of lymphoid proliferation (differentiation of reactive node from lymphoma), and in these cases usually acts as an indicator of the need for excision. Because of these limitations,

ultrasound guided core biopsy (USCB) has been evaluated in the parotid glands.[4]

USCB, performed under local anaesthetic, is quick, safe, and pain free. The core of tissue allows immunohistochemical analysis, with typing and grading of tumours and diagnosis of lymphoid hyperplasia. Ultrasound guidance ensures that intraparotid vessels and facial nerves are avoided. Tumour seeding is not reported with small bore needles (18G, 1.2 mm). The technique has no serious reported complications and has shown high diagnostic accuracy in several series. A meta-analysis has confirmed that USCB is more accurate than FNAC, that results are less heterogeneous, and that non-diagnostic rates are lower.[5] With increasing acceptance and availability, USCB will probably largely replace FNAC as the biopsy diagnostic tool of choice, as it has done in breast biopsy practice.

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Competing interests: None declared.

1 Mehanna H, McQueen A, Robinson M, Paleri V. Salivary gland swellings. *BMJ* 2012;345:e6794. (23 October.)
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MYALGIA WHILE TAKING STATINS

Try once weekly rosuvastatin…

I was surprised that the 10 minute consultation on myalgia while taking statins did not mention once weekly rosuvastatin.[1] We have prescribed this successfully for patients who were previously intolerant to statins. This approach has been used for many years.[2]

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Competing interests: None declared.

1 Lasker SS, Chowdhury TA. Myalgia while taking statins. *BMJ* 2012;345:e5348. (14 August.)
2 Backes JM, Moriarty PM, Ruisinger JF, Gibson CA. Effects of once weekly rosuvastatin among patients with a prior statin intolerance. *Am J Cardiol* 2007;100:554-5.

Cite this as: *BMJ* 2012;345s:e7457

… or no treatment

Lasker and Chowdhury described many drug related alternatives for this patient intolerant of simvastatin but omitted one obvious option.[1] According to their data on numbers needed to treat, even this high risk patient had only a one in 33 chance of benefiting from simvastatin. If these figures were presented to the patient he might opt for no treatment at all, given the statistical likelihood that he would not benefit. Often, no treatment is the best treatment.

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Competing interests: None declared.

1 Lasker SS, Chowdhury TA. Myalgia while taking statins. *BMJ* 2012;345:e5348. (14 August.)

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PRACTICE, p 48

IMPRISONMENT OF CYRIL KARABUS

Consider the risks of working in the UAE carefully

Your editorial about Professor Karabus's imprisonment in Dubai highlights the risks facing clinicians who work in the United Arab Emirates (UAE).[1]

This case is just one of many examples of highly respected and skilled doctors and nurses being persecuted over the years in the UAE for allegedly causing a patient's death or harm before the incident has been properly investigated. I worked in the UAE from 1998 to 2002 as an emergency physician in a tertiary academic hospital. During this time several doctors were deported or fled the country overnight in fear of deportation, imprisonment, confiscation of their passports, or having to pay "blood money" to patients' families.

While working in the UAE this risk, created by an extreme blame culture coupled with poor public understanding of Western medicine, was ever present. Risks extended beyond the working environment. Being involved in a road traffic accident in which someone died could land you in serious trouble. An elder in our church spent months in shackles after being involved in a car accident in which a woman died. I was once arrested for not getting out of the fast lane of the motorway quickly enough and offending a highly connected man in his luxury car. I was arrested, my passport confiscated, and I was forced by a police officer to apologise.

Tax-free salaries, free luxury accommodation, paid schooling, and plane tickets continue to make the UAE an attractive career prospect. The crime rate is low (no surprises there) and the lifestyle is enviable. The UAE provided all of this for me and my young family and we were lucky to return after four years, enriched financially, socially, and culturally. Before deciding to work there, however, I advise you to consider the risks carefully.

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Competing interests: None declared.

1 Nathanson V. The imprisonment of Cyril Karabus is deplorable. *BMJ* 2012;345:e6815. (9 October.)

Cite this as: *BMJ* 2012;345:e7528

NEWS, p 5

BAD MEDICINE: MEDICAL NUTRITION

The new vicious circle of malnutrition and nutraceuticals

I agree with Spence that nutritious local foods are better than medicated foods.[1]

In developing countries such as Nepal a high proportion of children and women continue to have protein-energy malnutrition and micronutrient deficiencies. Obesity and related chronic conditions are increasing, probably because of the growing number of "junk" foods that are aggressively marketed, often with questionable claims about their nutrient content.

Programmatic responses by governments and donors focus mainly on reducing prevalence statistics through targeted interventions that fix the symptoms of undernutrition but not the social inequalities that cause them. For more than a decade Nepal's Ministry of Health has been supplementing foods with vitamin A, iodine, iron, folic acid, and other micronutrients as recommended by international organisations that fund such activities.

Children with "wasting" currently receive ready to use therapeutic foods. Similarly, multiple micronutrient powders are distributed to children in a bid to control anaemia. Organisations that provide money for these interventions fund studies that report a reduction in the occurrence of "wasting" and anaemia.

The use of locally produced foods that are known to be rich in nutrients is not being actively promoted.[2] Consequently, people with malnutrition have to rely on ready made foods provided by international aid. Without a conscientious effort to prevent and manage malnutrition through optimal use of nutritious local foods, international efforts may, unintentionally, produce sustained dependence.

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Competing interests: None declared.

1 Spence D. Bad medicine: medical nutrition. *BMJ* 2012;344:e451.
2 Department of Food technology and Quality Control. Food composition table for Nepal. Ministry of Agriculture Development, 2012.

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FUTURE OF WHO

Match global needs with donor objectives to reverse WHO crisis

Since its creation in 1948, the World Health Organization has been involved in a variety of successful global health initiatives. Legge identifies the "substantial shortfall in the funds available for basic administrative functions" that is now limiting WHO's effectiveness.[1] He stresses that the three decade freeze on "assessed contributions" has left WHO beholden to voluntary donors and recommends persuading member states to "untie" their donations to increase WHO's autonomy.

We believe that this proposal will not improve WHO's advocacy or budgetary position. The article underemphasises the political pressures that affect WHO's decision making and action, framing WHO as an "independent" health organisation. The solution of untying funding restrictions from conditionalities is impractical and may cause WHO to lose funding sources. It is perhaps idealistic to suggest that an organisation dependent on donors should not consider its donors' requests and objectives. This is especially true in today's climate of "healthconomic crisis,"[2] in which governments and institutions are reluctant to fund transnational organisations.

We propose three actions to reverse this crisis:

1 WHO must independently establish global health priorities, based on global needs, before engagement with voluntary donors
2 Member states and donors must be transparent; motivations and interests should be declared, as proposed in 2000 by the WHO Committee of Experts on the Tobacco Industry.[3] As far as is practicable, the priorities of the member states and donors must be clear from the beginning
3 The first two recommendations should be considered together to allow funding to be secured. Priority matching may not be seamless, so all global health priorities may not be met.

As argued elsewhere,[2 4] global public health has changed radically in recent decades, with transnational companies and market imperatives playing an increasingly important (and sometimes deleterious) role in formulating policy. However, WHO's response should not be to reassert absolute power by insisting on the unconditionality of aid. Rather, it must work to foster an atmosphere of transparency, allowing differences of opinion to be clearly articulated and resolved with time.

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Competing interests: None declared.

1 Legge D. Future of WHO hangs in the balance. *BMJ* 2012;345:e6877. (25 October.)
2 Williams C, Maruthappu M. "Healthconomic crises": public health and neoliberal economic crises. *Am J Public Health* [forthcoming].
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4 Maruthappu M, Williams C. The biomarket. *Glob Public Health* [forthcoming].

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WHISTLEBLOWING BARRIERS IN THE NHS

Inquiries into homicides by psychiatric patients

Patrick probably uses the term whistleblowing in a wider sense than just disclosures under the Public Interest Disclosure Act 1998.[1] She means having an open culture in the NHS about performance management.

I was a whistleblower in this wider sense when I produced a critique of my trust's inquiry into the care of a patient who had committed homicide.[2 3] Such inquiries can become destructive when deflecting blame becomes an over-riding factor at the expense of professional consequences for staff.[4] There were injustices for staff in the trust action plan but the chair of the trust told me that it could not be changed. I therefore made it clear that I would go to the Strategic Health Authority (SHA), which had a responsibility to commission an independent report according to Department of Health guidance.

I eventually received a reply to my critique, to which I responded. Just before this, I was formally investigated about another matter and was told that I would face a disciplinary panel, but this never happened after I involved the National Clinical Assessment Service.

An independent SHA report was eventually produced,[5] which I welcomed. I can't say that the timing of the disciplinary matter was definitely related to my raising concerns about the trust report, but it did make it harder for me to follow through on my concerns.

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Competing interests: None declared.

1 Patrick K. Barriers to whistleblowing in the NHS. *BMJ* 2012;345:e6840. (9 October.)
2 Double D. Barriers to expressing concern in the NHS. 2012. http://dbdouble.blogspot.co.uk/2012/10/barriers-to-expressing-concern-in-nhs.html.
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4 King M and 59 other signatories. Community psychiatry inquiries must be fair, open and transparent [letter]. *Times* 2006 Dec 4.
5 NHS East of England. Looking through the reeds. 2008.

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FORTY YEARS OF MURDER

Prostitutes I have had

JUDITH ARONSON/NPG

I read the autobiography of Professor Simpson (above) before entering medical school at a time when I considered trying to follow in his footsteps.[1] My copy, handed down from my father, a GP, sits in my study next to Browne and Tullet's biography of Spilsbury, which belonged to my grandfather, also a GP.

Just browsing through my copy now, I notice that I had highlighted some passages, probably soon after starting medical school:

- Contrasting himself with Spilsbury: "It is in teaching, training pupils, writing, the media and in lecture travelling that lasting repute lies"
- "I think there is hardly any subject on which doctors are generally agreed"
- Haigh (the acid bath murderer) "was doubly wrong. First, because the Crown has to prove murder, not produce a dead body…Secondly, every trace…had not gone, as I was able to prove"
- "'Now, I've had a number of prostitutes over the years," to get the attention of medical students when lecturing to them
- "It applies to us all: we need well informed opposition, proper testing of our views and an occasional grilling in court to ensure real fair-mindedness"
- Describing a colleague: "He died…an unhappy man, I felt, who had never sought, as we all have to do, the respect and goodwill of his own colleagues"
- "Coincidences are far more common in life than fiction"
- "We shall all die after our last meal (but it doesn't necessarily follow that it killed us)."

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Competing interests: TY knew some of Keith Simpson's grandchildren when he was younger.

1 Haynes H. Forty years of murder. *BMJ* 2012;345:e6737. (8 October.)

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