

LETTERS

Letters are selected from rapid responses posted on bmj.com. After editing, all letters are published online (www.bmj.com/archive/sevendays) and about half are published in print
▶ To submit a rapid response go to any article on bmj.com and click “respond to this article”

INSERTS IN *THE BMJ*

Ballot all RCGP members on assisted dying

The recent Care Not Killing insert answers Timothy Harlow and colleagues’ concerns about *The BMJ*’s impartiality on the subject of assisted dying prompted by the Dignity in Dying insert last year.¹

However, the latest insert contains a serious inaccuracy. A “FACT” put forward by Rob George was that the Royal College of General Practitioners (RCGP) opposes assisted dying. This may not be correct.

The RCGP council rightly stated that 77% (234) of members who responded directly to their consultation opposed changing the RCGP’s stance of opposition,² but this was only 0.48% of the membership. The statement was relayed to the media and quoted in parliament as though this small fraction represented the response of the college’s total membership.

Faculties were also consulted but varying methods were used, leading to flawed results (1479 responses). From the RCGP’s own analysis, 40-50% of these members sought a move to neutrality, or a stance of support.

Eight faculties representing 271 members (18% of faculty responses) presented no numerical breakdown of actual responses, stating only “in favour of a move to neutral” or “in favour of remaining opposed.”

Data presented from the consultation have other serious flaws. Seven of 32 faculties (8800 members) did not report results, implying that they did not consult. Three faculties seemed to offer only two choices—wanting the RCGP to oppose or support a change in the law, with no option for neutrality. Twenty eight per cent (416 members) of faculty responses were from the “West Midlands faculty,” which does not exist. The RCGP stated that there was confusion between the Midlands and West Midlands faculties, but the numbers still do not correlate.

I believe the RCGP should now offer a ballot to its 49 000 members, validated by an independent body, to prevent further dissemination of misinformation and provide accurate representation of its members.

Philip Hartropp retired general practitioner, Peterborough PE7 3UZ, UK
phartropp@aol.com

Competing interests: I am a board member of Dignity in Dying and member of Healthcare Professionals for Assisted Dying.

Full response at: www.bmj.com/content/347/bmj.f7149/rr/696081.

- 1 Harlow T, Baker I, Bullock R, Gannon C, George R, Shuler A, et al. *BMJ* is not always impartial about the advertisements it includes. *BMJ* 2013;347:f7149. (4 December).
- 2 Royal College of General Practitioners. Assisted dying consultation analysis. 2014. www.rcgp.org.uk/policy/rcgp-policy-areas/assisted%20dying.aspx.

Cite this as: *BMJ* 2014;348:g3274

● OBSERVATIONS, p 21

MEDICAL TRAINING

Frailty related aspects of care under-recognised in UK teaching

Patients presenting to the NHS are increasingly frail and affected by multiple comorbidities, polypharmacy, cognitive impairment, and physical dependency. Geraint and Fuller recently proposed a model of care for this cohort—recourse to multiple medical specialisms—which is not evidence based.¹ One of the examples used to underline their argument, the Cochrane review of stroke unit care,² is an exemplar of quite the opposite. The studies included in this review described a model of care that used multi-professional assessment across multiple domains to establish management plans that were iterated forward against clearly stated goals.

The stroke unit trialists were conducting comprehensive geriatric assessment, which was also considered by a separate Cochrane review in generic older populations with frailty and shown to have an impact equivalent to, if not surpassing, that of stroke units.³ For almost all the studies included in these analyses the control arm was “usual medical care,” exactly the model of multiple medical specialisms advocated by Fuller and Simpson.

Patients with advanced frailty need specialists in comprehensive geriatric assessment, who can use the expanding evidence base in the care of older people to deliver the most clinically effective care. Trainee doctors recognise this, with more applicants to geriatric medicine than any other speciality for higher medical training in 2014. However, frailty related aspects of care remain under-recognised in UK medical curriculums at all levels,⁴ so non-geriatricians are underprepared for practice that will require them to care for dependent patients with multiple diagnoses.

For the “Shape of Training” review to be effective, it must present an opportunity to tackle the problems of complexity, multimorbidity, and frailty, while being

clear about the role of organ and procedure specialists.⁵ Currently, there is confusion.

Paul V Knight president
paul.knight@ggc.scot.nhs.uk
David Oliver president elect
Zoe Wyrko director of workforce
Adam L Gordon honorary secretary
Gill Turner vice president for clinical quality, British Geriatrics Society, London EC1M 4DN, UK
Competing interests: None declared.

Full response at: www.bmj.com/content/348/bmj.g2865/rr/696978.

- 1 Fuller G, Simpson IA. “Modernising Medical Careers” to “Shape of Training”—how soon we forget. *BMJ* 2014;348:g2865. (30 April).
- 2 Stroke Unit Trialists’ Collaboration. Organised inpatient (stroke unit) care for stroke. *Cochrane Database Syst Rev* 2013;9:CD000197.
- 3 Ellis G, Whitehead Martin A, O’Neill D, Langhorne P, Robinson D. Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database Syst Rev* 2011;7:CD006211.
- 4 Gordon AL, Blundell A, Dhesi JK, Forrester-Paton C, Forrester-Paton J, Mitchell HK, et al. UK medical teaching about ageing is improving but there is still work to be done: the Second National Survey of Undergraduate Teaching in Ageing and Geriatric Medicine. *Age Ageing* 2014;43:293-7.
- 5 Greenaway D. Securing the future of excellent patient care. 2013. www.shapeoftraining.co.uk.

Cite this as: *BMJ* 2014;348:g3325

SEX, HEALTH, AND ATHLETES

Coercion based on stereotypes is unfair



JOHN GILES/PA

As director of the only legal agency in the US focused on serving children and youth with differences of sex development or intersex conditions, I can say that the international sports authorities’ response to concerns about women athletes with high endogenous androgen levels hurts more women than just the athletes involved.¹ Many young women with differences of sex development have approached me, fearful that they may not be welcome or allowed to participate in sports. Fortunately, many college and high school athletic associations have more accommodating policies in place. Such policies have not led to an epidemic of “unfairness” in college sports.

Indeed, it is not clear how a naturally occurring difference in androgen levels is any more unfair than any of the other naturally occurring physical gifts that most international athletes possess. What does seem unfair is to single out certain athletes on the basis of stereotyped ideals about sex and coerce some of them into permanent and perhaps unwanted medical interventions.

Anne Tamar-Mattis attorney, Advocates for Informed Choice, POB 676, Cotati, CA 94931, USA
director@aiclegal.org

Competing interests: None declared.

1 Jordan-Young RM, Sönksen PH, Karkazis K. Sex, health, and athletes. *BMJ* 2014;348:g2926. (28 April.)

Cite this as: *BMJ* 2014;348:g3447

Sex testing in sport can ruin lives

Congratulations on your stand, which I support.¹ As a former doctor to international teams, I realised that sex testing had the potential to be unscientific, inhumane, and a sign of sex bias owing to the attitudes of mostly male committees in the international sports hierarchy.

Taboos pointedly not discussed were laughed off—for example, genetically abnormal men and the lack or rarity of performance based evidence (let alone proof) of an advantage or disadvantage related to genetic variation. Problems arising between sex test variations and drugs or doping, including the legitimate clinical use of (incidentally) performance enhancing drugs, remain unresolved. For years the moral judgments were crafted by the drug testing industry's current interests and limitations.

Surely the moral question is the implicit denial of the individual's right to privacy and personal integrity. I have seen women and men undoubtedly "grown" and performance enhanced by anabolic steroids. However, the hysteria over the woman you discuss seems to have resulted in her life being all but ruined by official intrusion, without any concern for ethical behaviour. Has "sport" really come to this?

Sadly, yes. It has.

Peter Sperryn editor, *British Journal of Sports Medicine*, UK sperryn@doctors.org.uk

Competing interests: None declared.

1 Jordan-Young RM, Sönksen PH, Karkazis K. Sex, health, and athletes. *BMJ* 2014;348:g2926. (28 April.)

Cite this as: *BMJ* 2014;348:g3468

RESEARCH PRESS RELEASES

Post all press releases online, with named authors

McCartney argues that press releases from academic journals can be misleading and suggests that guidelines, similar to CONSORT, would improve standards.¹ This is a laudable

aim, but with so much variation in the type and content of research articles it would be extremely complex to design, implement, and police.

In the meantime, two easily implemented changes would ensure accountability and transparency, and help improve standards. Firstly, all press releases in all academic journals should be made publicly available online, alongside the academic journal article they relate to, so that everyone can see whether the press release contained misrepresentations or exaggerations. Secondly, all academic journal press releases should give named authors, including at least one author from the academic paper itself, who take full responsibility for the contents.

In many cases—especially for research relevant to patients' choices or policy matters—the bulk of an academic paper's research impact comes from press coverage. This means that the press release is often as important as the paper itself. Press releases should therefore be accessible and treated as seriously as the academic papers themselves.

Ben M Goldacre research fellow in epidemiology, London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK ben.goldacre@lshtm.ac.uk
Competing interests: I receive income from writing and speaking about problems in science and science reporting.

1 McCartney M. Research press releases need better policing. *BMJ* 2014;348:g2868. (28 April.)

Cite this as: *BMJ* 2014;348:g3448

Responsible reporting of research in the media

Press officers have a tough job writing press releases that please the authors of a paper, catch the eye of a journalist, and responsibly report the science all at once. Responsibility lies with both the scientists and press officers involved, including press officers at journals—the journal press release for the seven-a-day story mentioned by McCartney didn't spell out that it was just an association.¹

But a good press release alone cannot guarantee good news coverage, and responsible reporting should look for the broader scientific importance of a study—a job the Science Media Centre helps with by providing journalists with third party expert comments.²

The idea of guidelines is a good one and will require everyone concerned to be involved. Efforts along similar lines have been made before.³

The good news is there is ever more scrutiny of how research misinformation makes it into the news, something that can occur at any stage from study authors, through journals and press offices, and on to news desks. Robust research

on the subject should provide pointers for the best way forward.

Robin Bisson science information officer, Science Media Centre, London NW1 2BE, UK
smc@sciencemediacentre.org

Competing interests: None declared.

- 1 McCartney M. Research press releases need better policing. *BMJ* 2014;348:g2868. (28 April.)
- 2 Science Media Centre. Expert reaction to new study into fruit and veg consumption and mortality. 2014. www.sciencemediacentre.org/expert-reaction-to-new-study-into-fruit-and-veg-consumption-and-mortality/.
- 3 Stempa. Stempa guide to being a press officer. http://stempa.org.uk/stempa-guide-to-being-a-press-officer/.

Cite this as: *BMJ* 2014;348:g3449

ROUTINE REFERRAL LETTERS

Problems with sharing clinical data in routine referral letters

Adams's article raises two important problems.¹ Firstly, in general terms, the requirement for clinicians from all fields to offer patients copies of letters written about them to other health professionals was stated in the NHS Plan in 2000, to be implemented in April 2004.² The experience of Adam's patients shows that 10 years later this is still a major problem for many doctors, and to the detriment of many patients.

If doctors copied letters—referral letters from primary care to hospital or vice versa—to patients it would avoid uncertainty about what was or was not said and what information is consigned to the history books. Most paediatricians have embraced this and a minority write directly to parents with copies—with parents' permission—to other relevant people.³ It has many advantages in terms of involving the patient/parent in their health and treatment. Additionally, parents can correct misinformation that gets repeated in successive letters.

Secondly, specific to a person's HIV status, patients and parents are quite right to be concerned about who will find out. Doctors might be bound by patient confidentiality with possibly severe consequences for breaching that, but other members of the multidisciplinary team, clerical staff and so on, do not seem to be held to the same account. Many years ago in my home town a child was almost forced out of school by the lynch mob mentality of other parents who had found out that the child was hepatitis B positive. If a child was known to be HIV positive this would lead to even greater hysteria.

Charles Essex consultant neurodevelopmental paediatrician, Leamington Spa CV32 4RB, UK
charles.essex@virgin.net

Competing interests: None declared.

- 1 Adams K. Routine referral letters share clinical data without patients' consent. *BMJ* 2014;348:g2419 (4 April)
- 2 Department of Health. The NHS plan: a plan for investment a plan for reform. Department of Health; 2000.
- 3 Essex C. Copying letters to patients is coming to a clinic near you. *BMJ* 2003;326:1330-1.

Cite this as: *BMJ* 2014;348:g3223