LETTERS

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DOCTORS AND ISLAMIC STATE

Response of British Islamic Medical Association to articles

The British Islamic Medical Association is shocked by the publication of the two articles by Gardham.[1 2] British Muslim doctors have a proud tradition of humanitarian work in collaboration with many non-governmental organisations in war zones across the world.

What is particularly bizarre is the decision to publish these features to coincide with the 10th anniversary of the tragic 7/7 London bombings.

The association calls for *The BMJ* to redress the balance by celebrating the contribution of Muslim doctors at home and abroad, and it would be pleased to assist in this endeavour.

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1 Gardham D. Time for tighter checks on medical schools? *BMJ* 2015;350:h3511. (30 June.)
2 Gardham D. Islamic State creates jihadi health service. *BMJ* 2015;350:h3487. (30 June.)

Cite this as: *BMJ* 2015;351:h4153

Reinforcing a link between Islam, fear, and violence

Gardham's analysis begins with questions about the teaching and entry standards of medical schools overseas—namely, in Muslim majority nations bearing the brunt of terrorism—and their accreditation by the General Medical Council.[1] On its own this argument may have merit, but Gardham's attempt to link this as a material threat is unfounded and poorly constructed. The insinuation of guilt in the article's headline serves only to ostracise Muslim doctors.

Not only is the solution of tighter checks and profiling students McCarthyist in nature, the article conveniently omits the complex factors that can give rise to radicalisation: alienation, stigmatisation, foreign policy grievances, and deprivation to name a few.[2] Gardham recycles a tired negative stereotype that religious conservatism and practice are vehicles for extremism. Research from the Behaviour Science Unit at MI5 says that a "well established religious identity actually protects against violent radicalisation."[3] Such was the one sided nature of this feature that no effort was made to mention the thousands of devout Muslims tirelessly working in the NHS, contributing to civic society and supporting humanitarian causes.

If sentiments like these continue to be perpetuated and remain unchallenged, they will subtly entrench an association between Islam, fear, and violence. There is already a great deal of animosity towards Muslims: a recent poll suggested more than half of Britons see Muslims as a threat.[4] *The BMJ* needs to do better than giving such contentious views an uncontested platform. I eagerly await the issues where contributions of Muslim doctors will be celebrated without being polarised through the prism of national security.

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Cite this as: *BMJ* 2015;351:h4025

Editor's reply

Thank you to all those who have written in response to the articles by Gardham.[1-8]

The BMJ fully recognises the enormous contribution that British Muslim doctors make to the NHS and to global humanitarian work overseas, and we pay tribute to those who have lost their lives as a consequence. Regulation of medical schools and radicalisation are of great and topical interest. It would be odd if *The BMJ* ignored such matters. However, it was never our intention to cause offence to graduates of the University of Medical Sciences and Technology (UMST) working in the UK and elsewhere, or to other UK Muslim doctors.

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Cite this as: *BMJ* 2015;351:h4177

APA COLLUSION WITH PENTAGON

Blindness to institutional betrayal by the APA

The actions of the American Psychology Association (APA) described in the Hoffman report constitute institutional betrayal, or "wrongdoings perpetrated by an institution upon individuals dependent on that institution."[1 2]

Members of the APA leadership betrayed the human rights of those who are tortured, the profession's ethics, and the society that trusted them.[3]

But institutional betrayal is only half the story. How did the collusion between the APA and the Department of Defense persist for nearly a decade, despite many knowing of its existence.

After the Hoffman report was released, Jean Maria Arrigo, a psychologist the APA tried to discredit for speaking against its interrogation policy, received many emails from colleagues apologising for not believing her.[4]

Such behaviour can be explained by betrayal blindness—an unawareness, not knowing, and forgetting exhibited by people when confronted with betrayal.[5] In the case of the APA, members have a vested interest in believing in the "goodness" of the institution that they depend on for their professional credibility and for furthering their collective interests.

True reparation and lasting change require betrayal blindness to be dealt with at organisational and individual levels. Institutionally, this includes increasing transparency and protecting members when they report abuses of power.[6] For individuals, it means rigorous self examination and awareness of our tendencies towards betrayal blindness so that we are more likely to "see" abuse in the future.

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1 McCarthy M. American Psychology Association colluded with Pentagon and CIA to protect interrogation program, report finds. *BMJ* 2015;351:h3805. (13 July.)

Cite this as: *BMJ* 2015;351:h4172

DIETARY SUPPLEMENTS

Potent and untested drugs sold as "dietary supplements"

A new challenge to public health has recently emerged from potent and untested drugs being sold under the guise of "dietary" supplements.[1-4] Fuelled by growing demand for products promising a better body, enhanced performance, and increased wellbeing, this trend highlights creative marketing strategies used in the illicit supply of drugs.

Nine supplements suspected of containing drugs were analysed as part of an investigation for the television programme *Spotlight* (broadcasted 31 March 2015 by BBC Northern Ireland). The supplements were bought from high street shops and from an e-commerce site (box). Products were

Content of nine dietary supplements bought on the high street and internet

PRODUCT 1 Strip Ts*: Caffeine, 1,3-dimethylamylamine (DMAA), synephrine

PRODUCT 2 Strip Ts*: Caffeine, (DMAA), synephrine

PRODUCT 3 Angel Dust: Caffeine, 1,3-dimethylbutylamine (DMBA)

PRODUCT 4 Ostapure: Ostarine

PRODUCT 5 Hemo Rage: Caffeine, synephrine

PRODUCT 6 SD Extreme: methasterone

PRODUCT 7 Metha-Quad Extreme: Methylstenbolone, methasterone, 13-ethyl-3 methoxy-gona-2,5(10)-dien-17-one

PRODUCT 8 Mutant Noxx Mass Power Blend: Caffeine, DMBA

PRODUCT 9 M1T Hulk XT: Methyl-1-testosterone

*Same product bought from two different shops.

sold as "fat burners" or "pro-hormones," with packaging often blatantly listing chemical names of drugs.

Ostarine, found in product 4, is a selective androgen receptor modulator that is being tested as a medicine, but has not been authorised for marketing. The stimulant [1],3-dimethylamylamine (DMAA) was found in products 1 and 2, and 1,3-dimethylbutylamine (DMBA) was found in products 3 and 8. DMAA was recently identified in "dietary supplements" and has been associated with adverse events, including acute myocardial infarction, strokes, and deaths.[4] Since regulators removed DMAA from the market, an analogue DMBA has appeared as a replacement.[3] Products 6, 7, and 9 contained anabolic steroids, some of which have been associated with hepatoxicity.[2] Although advertised as legal pro-hormones they are controlled drugs in the UK.

These findings illustrate market developments, which now include dietary supplements containing medicines, "legal highs," and controlled drugs. Many experienced users are aware of this marketing strategy. However, young and inexperienced people may be unknowingly exposing themselves to potent drugs. Clinicians should ask patients about the use of supplements and report suspected adverse events to medicine agencies.

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1 Evans-Brown M, Kimergård A, McVeigh J, et al. Is the breast cancer drug tamoxifen being sold as a bodybuilding dietary supplement? *BMJ* 2014;348:g1476.

Cite this as: *BMJ* 2015;351:h4181

THE HARDEST WORD

Cultivating candour about our mistakes

Oliver raises the important point that those responsible for organising healthcare must also be candid about their mistakes if they expect clinicians to do the same.[1] We believe that another key ingredient in cultivating candour is to organise safe spaces for junior doctors to share their experiences of making mistakes.

To this end, we have organised an annual session entitled "So things can go wrong," in which foundation year doctors share medical errors that they have made with final year medical students. The focus is not on how to avoid the error in future but on what happens once a mistake is made. Foundation year doctors share the patient's and family's response, the clinical governance process, and their own emotional journey after making the mistake. We have also piloted sessions in which foundation year doctors share their stories with other doctors at their level. The atmosphere here is different: there is a heightened vulnerability when admitting mistakes to your peers compared with speaking to a group of students.

Sessions like these allow junior doctors and medical students to see that they are not the only ones who make mistakes, to reflect on what happens when a mistake is made, and to discuss how best to deal with the consequences. Most importantly, they help cultivate a culture in which talking about our mistakes is not shameful and becomes the norm—exactly the type of culture we need to live out the duty of candour.

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1 Oliver D. The hardest word: managers and leaders should say sorry too. *BMJ* 2015;351:h3644. (3 July.)

Cite this as: *BMJ* 2015;351:h4121

Cultivating candour needs organisational leadership

Oliver and Hibbs and colleagues (previous letter) highlight that duty of candour is our collective responsibility—from junior doctors to organising chiefs.[1 2]

Organisational leadership and culture play a vital role in cultivating organisational trust,[3] empowering culture that facilitates learning (rather than blame),[4] and nurturing compassion in staff.[5] If we as healthcare professionals can see the "person in the patient," the duty of candour would be as a natural as saying "sorry" is part of being compassionate.[6]

Chief executives play a crucial role in creating the organisational trust and engaging environment needed for duty of candour culture to flourish. They must ensure that this is embedded within the organisation's culture, particularly at the frontline.[7] In Leeds, our chief executive Julian Hartley has created and systematically embedded the organisational values known as "the Leeds way"[8]—"patient centred, collaborative, fair, accountable, and empowered"—using the crowd sourcing tool known as the "way-finder."[9] In 2014, he publicly apologised after an inquiry into paediatric cardiac surgery in Leeds—where care were found to be unacceptable for 16 families—an inspiring way to lead by example.

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Cite this as: *BMJ* 2015;351:h4123

THE NHS GOES DIGITAL

Severe lack of investment in electronic infrastructure

A renewed push to create a fully digital NHS is welcome.[1] My experience as a junior doctor over the past year was an eye opener.

There is a severe and chronic lack of investment in the electronic infrastructure. Computers are often 10-15 years old, crash constantly, and take excessive amounts of time for systems to load. It is frustrating and an inefficient use of time—I often use my personal phone to check the *BNF* for prescribing and *UpToDate* for the latest clinical knowledge while waiting for things to load. The difference is massive. And you can't leave to do other tasks because colleagues are lining up to use the computer.

A multitude of electronic systems exist—one for ordering tests, one for viewing the results, one for viewing images, one for writing discharge letters, and so on. This is unnecessary and inefficient, with so much time being wasted waiting for the different systems to load.

The designers and maintainers of the digital NHS seem not to understand the needs of the end user. For a modern organisation to function efficiently, it needs reliable and relevant hardware (computers, tablets, etc), ubiquitous wi-fi access, and streamlined electronic systems. Junior doctors starting in August will be surprised at how fragmented and backward the current system is.

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1 Armstrong S. Finally, the NHS goes digital. Or does it? *BMJ* 2015;351:h3726. (13 July.)

Cite this as: *BMJ* 2015;351:h4170