

mon midwifery practice. This multicentre randomised controlled trial did not support the effectiveness of this intervention. Given the study design involving seven different units, these results would probably be applicable to other populations. Therefore, in the absence of evidence of a beneficial effect, we would suggest that this advice should be discontinued, at least as a way of changing the fetal position.

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## Clinicians' roles in management of arsenicosis in Bangladesh: interview study

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The British Geological Survey in 2001 estimated that 46% of all shallow tube wells in Bangladesh contained arsenic at concentrations exceeding the World Health Organization's guideline concentration of 0.01 mg/litre. An estimated 28-35 million people were thought to be exposed to arsenic in their drinking water at concentrations exceeding even Bangladesh's arsenic standard of 0.05 mg/litre.<sup>1</sup> Many thousands of cases of chronic arsenic poisoning have now been identified, but the real magnitude of the health impact is still undefined.

In the 10 years since the problem of arsenic contamination of tube wells, on which a large proportion of the population depend for their drinking water, was identified the development of a coherent national strategy to manage this problem has been disappointingly slow.<sup>2</sup> Doctors have a vital role both in the diagnosis and management of arsenicosis and in the mitigation of this major public health threat<sup>3</sup> through educating their patients about options open to them to avoid the health effects of chronic poisoning. We explored the current and the desirable participation by doctors in the national arsenic mitigation effort.

### Methods and results

In early 2002 one of us (RM) interviewed 20 doctors working in three hospitals in Dhaka that are well known for their interest and involvement in the arsenic problem and 22 doctors of comparable seniority from two other large hospitals in the city. The selection of the sample was purposive in that, with the help of administrative staff of the three "arsenic" hospitals, we identified a group of clinicians in departments of medicine, surgery, and dermatology, who were known to be actively involved in care of patients affected by arsenic. From the two other hospitals we identified

from staff lists a randomly selected group of clinicians, of comparable seniority to those in the first group, who worked in a range of clinical specialties.

Interviews were also conducted with 17 senior managers from government, non-governmental, and international agencies that participate in the national arsenic mitigation programme in Bangladesh. Candidate agencies were identified for us by responsible government ministries, and respondents to the interview were identified by the chief administrator of each agency.

The table shows responses to key items in the interviews, including separate tabulation of the responses from the two groups of clinicians. Hospital doctors working outside the specialist arsenic units reported an inadequate understanding of the diagnosis and pathophysiology of arsenic poisoning, have not received training in this field, and are not involved in the national arsenic mitigation process. They are also apparently not diagnosing arsenic poisoning, whether or not the affected patients are presenting to them with the multisystem complications that chronic exposure to arsenic produces. Their hospitals provide services to patients from areas that are known to be contaminated.

Several representatives of the arsenic mitigation agencies confirmed that progress in development of an effective national mitigation programme is slow and that an understanding of the public health nature of the problem is widely lacking. They also expressed the view that doctors could have several important roles in dealing with the problem.

### Comment

Doctors working in two Dhaka hospitals that receive patients from contaminated areas were inadequately informed to recognise and manage arsenicosis.

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## Perceptions of clinicians and representatives from arsenic mitigation agencies about the role of doctors in the management of the arsenic problem in Bangladesh

	Group 1*	Group 2†
<b>Hospital based clinicians (n=42)</b>		
Frequency of seeing patients with arsenicosis:		
Daily	16	0
One or more cases in a month	4	0
One or more cases in past six months	0	3
Unsure of having seen any arsenicosis patients	0	19
Self reported ability to identify symptoms and signs of arsenicosis:		
Adequate	17	4
Inadequate	3	18
Self reported understanding of pathophysiology of arsenicosis:		
Adequate	9	1
Incomplete	4	9
Do not know	7	12
Received training or guidelines on managing arsenicosis:		
Yes	8	1
No	12	21
Understanding of the nature of the problem:		
A public health issue	17	11
Not sure of the nature of the problem	3	11
Involvement in any government arsenic mitigation policy and activity:		
Yes	3	0
No	17	22
<b>Representatives from arsenic mitigation agency (n=17)</b>		
Role of respondent's agency in the arsenic mitigation programme:		
Patient identification, management, and training of doctors		5
Tube well testing for arsenic, supply of alternative water supply, increasing awareness of arsenic:		3
Arsenic and other health related research		2
All the above		4
General focus on health and health system		1
Patient identification and applied geology		1
Organising public health professionals		1
Effectiveness of government action on the arsenic problem:		
Not effective		7
No comment		10
Perceived problems in mitigation efforts:		
Lack of understanding about the public health nature of the problem		7
Lack of proper coordination and poor management		2
Lack of training manpower		2
No emphasis on research activities		1
Centralisation of power and poor governance		1
Misuse of fund on transport and travelling abroad		1
Lack of transparency		1
All above		2
Views on desirable role of doctors in mitigation programmes:		
(1) Best practice criteria for clinical management and epidemiology		3
(2) Mass awareness and more training to health workers		1
(3) Knowledge about public health nature and new research		1
(4) Health hazards of alternative technology		1
(5) Invention and validation of alternative technology		1
(6) Responses 1-4		5
(7) Responses 1-5		5

\*Clinicians from Dhaka Community Hospital, Dhaka Medical College Hospital, and the Post Graduate Medical University Hospital, selected because of their known active involvement in care of arsenicosis.

†Clinicians from Sir Salimullah Medical College/Mitford Hospital and Shahid Suhrawardy General Hospital, selected randomly from staff lists to provide a group of doctors of comparable seniority to doctors in group 1.

Remedial action is necessary if this lack of professional capacity is common. If it is the problem could be addressed by brief training courses on arsenic and public health for all medical practitioners in Bangladesh. Millions of Bangladeshis may be at risk of life threatening complications of chronic arsenic ingestion.

Contributors and guarantor: This work forms the substance of an M Phil thesis submitted by RM to the Australian National University for examination on 14 November 2002 and recently

accepted for the degree. RMD, GR, and BC were joint supervisors of the research. All four authors participated in study design, interpretation of results, and drafting of the paper. RM conducted the interviews and prepared the main draft of the table and paper.

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Competing interests: None declared.

Ethical approval: The work was not submitted to ethics review on the basis that this was a simple, voluntary survey, in which participants understood that they could decline to participate in a study whose purpose was fully explained by the interviewer.

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### Corrections and clarifications

*British cancer death rates fell by 12% between 1972 and 2002*

Cancer Research UK has alerted us to an error in the data for female incidence of cancers that it supplied for the graph in this news article by Zosia Kmietowicz (7 February, p 303): the male and female curves for incidence are both correct, but the female curve should appear for the same period as the male curve (1975 to 2000). All rates for incidence and mortality shown on the graph are for Great Britain.

*The eVALuate study: two parallel randomised trials, one comparing laparoscopic with abdominal hysterectomy, the other comparing laparoscopic with vaginal hysterectomy*  
The authors of this paper by Ray Garry and colleagues appeared in the wrong order (17 January, pp 129-33). Although the authors submitted the correct order, this was somehow scrambled by us during the editorial process—unfortunately our attempts to unearth how this happened have failed. The authors should have been listed in the following order: Ray Garry, Jayne Fountain, Su Mason, Jeremy Hawe, Vicky Napp, Jason Abbott, Richard Clayton, Graham Phillips, Mark Whittaker, Richard Lilford, Stephen Bridgman, Julia Brown. We apologise to the authors for this mistake.

*Measuring the health of nations: analysis of mortality amenable to health care*

The authors of this paper, Ellen Nolte and Martin McKee, have alerted us to an error in their data processing, which affects figures 1 and 2 in their paper (*BMJ* 2003;327:1129-32). Deaths from colon cancer had been mistakenly excluded for Denmark, Finland, Germany, Norway, and Sweden. In figure 1 the standardised death rates for “amenable mortality” for these countries are 81.43, 71.81, 74.42, 66.50, and 58.46 respectively. In figure 2 the respective values for “amenable mortality plus ischaemic heart disease” are 109.29, 114.99, 106.17, 97.09, and 87.50 respectively. In recalculating the data for those countries, the authors also discovered a minor miscalculation for the UK values (which should be 87.46 in figure 1 and 129.98 in figure 2). The revised values slightly affect the rankings (although not the United Kingdom), but the authors state that the revisions do not at all affect the overall conclusion of their paper.