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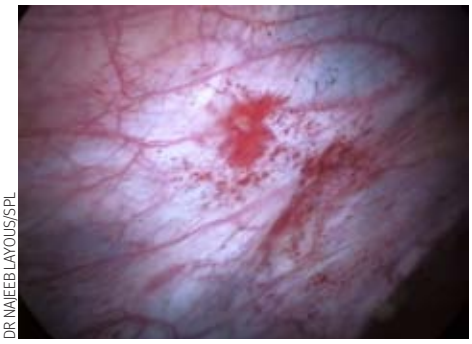
LETTERS

ENDOMETRIOSIS

More on the missed disease



DR NAJEEB LAYOUS/SPL

Engemise and colleagues do not mention dyschezia as a symptom of endometriosis.[1] Excruciating pain in the rectum, worst premenstrually and during menstruation, is indicative of deep endometriosis in the rectovaginal septum and should prompt a general practitioner (GP) to refer to a gynaecologist.[2]

The 7025 women with endometriosis in the survey commissioned by the All Party Parliamentary Group for Endometriosis,[1 3] reported that they had waited three years before first consulting their doctor. Less than half thought that their GP took them seriously when they first presented with symptoms, and 65% were first told that they had another condition.

Diagnosis is delayed partly because the symptoms of endometriosis overlap with normality—for example, dysmenorrhoea requiring simple analgesia or the occasional "ouch" during sexual intercourse is probably normal. Four out of five women with endometriosis have had time off work with pain.[3] If these women were assumed to have endometriosis, the delay in diagnosis would considerably improve.

The combined contraceptive pill is as effective as gonadotrophin releasing hormone agonists for symptom control and useful long term treatment in women who don't want to conceive.[4 5] Treatment with a combined oral contraceptive could be started by the GP with referral if symptoms persisted. An alternative would be a long acting reversible hormonal contraceptive.

Alternative causes of pain could be excluded by GPs—for example, endometrioma by pelvic ultrasonography, chlamydia, irritable bowel syndrome, and constipation. Referral would be appropriate if scanning results were abnormal, pain persisted despite treatment, or the woman was trying to conceive.

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Competing interests: None declared.

1 Engemise S, Gordon C, Konje JC. Endometriosis. *BMJ* 2010;340:c2168. (23 June.)
2 Royal College of Obstetricians and Gynaecologists. Endometriosis, investigation and management (Green-top 24). 2006. www.rcog.org.uk/womens-health/clinical-guidance/investigation-and-management-endometriosis-green-top-24.
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Cite this as: *BMJ* 2010;341:c3727

CHILD INFLUENZA VACCINATION

Panvax febrile reactions not a predictor

Collignon and colleagues assert that febrile reactions seen in pandemic influenza A/H1N1 vaccine (Panvax) clinical trials were an overlooked predictor of the excess febrile reactions seen with CSL's seasonal trivalent influenza vaccine that prompted suspension of its use in children under 5.[1] Yet most febrile reactions reported in the Australian Panvax trial were mild, with severe fever (›39.5°C) in only 2%.[2] Fever was dose related, and the results included children who received 30 µg—four times the dose in Fluvax Junior. In the 15 µg arm, only one child had severe fever after the first dose. In the US trial,[3] which evaluated 7.5 µg and 15 µg doses, rates of moderate and severe fever in under 3s in the 7.5 µg arm were both less than 2%. In children 3 years and older, rates of fever in the 7.5 µg group were similar to those for placebo. Severe fever did not occur.

With 8.7 million doses of Panvax and 370 000 doses of Panvax Junior distributed in Australia, only 16 cases of febrile convulsions were reported to the regulator, a rate similar to previous trivalent vaccines, thus challenging the claim that the reactions seen with the 2010 vaccine should have been anticipated.

In Australia in 2009, pandemic flu led to 877 hospital admissions, 29 admissions to intensive care, and four deaths in children under 5.[4] In light of this considerable morbidity and mortality, also reported in the US,[5] and low rates of febrile reactions after vaccination, asserting that "more harm than good seems likely from vaccinating" seems a miscalculation of risks and benefits.

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Competing interests: TN was chief investigator on the CSL sponsored trial of the pandemic H1N1 vaccine in Australian children. He has received travel assistance from the World Health Organization and CSL to present the data on this and other H5 influenza vaccine studies at WHO scientific meetings.

1 Collignon P, Doshi P, Jefferson T. Ramifications of adverse events in children in Australia. *BMJ* 2010;340:c2994. (9 June.)
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4 Office for Health Protection, Department of Health and Ageing, Government of Australia.
5 Centers for Disease Control and Prevention. Fluview report, 2009-2010 influenza season week 20 ending May 22, 2010. www.cdc.gov/flu/weekly.

Cite this as: *BMJ* 2010;341:c3714

SHARING SUMMARY CARE RECORDS

Time for a rethink

The summary care record was based on an unverified need. In their systematic review Greenhalgh and colleagues reveal the errors in this approach.[1] The next review should be to research what could be saved by using what is already out there and working. It must be completely objective, rather than being used to justify current policy.

What has not yet been examined are the alternatives to extracting patient data into a single database. The most accurate and complete patient records are general practice records. The move to enterprise systems and storage by all clinical system suppliers makes records potentially available at all times. Most patients (70%) could currently access their records if the practices switched this functionality on. This would make their medical history, allergies, alerts, and treatment viewable out of hours and in an emergency. Spend a fraction of the money

encouraging all suppliers to develop this further, and on the clinical engagement needed for practices to adopt this functionality, rather than on the summary care record.

This also removes the concern about the state having access to patient records since records would remain under the control of those entering the data. System suppliers would look after storage, and patients give consent before viewing.

Secondary care results and discharge summaries are stored in general practice records. Patients with kidney disease needing instant results, for example, could access a portal web page pulling in both secondary and primary care data. The data are not extracted and stored, merely viewed; that viewing is recorded, and then switched off.

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Competing interests: None declared.

1 Greenhalgh T, Stramer K, Bratan T, Byrne E, Russell J, Potts HWW. Adoption and non-adoption of a shared electronic summary record in England: a mixed-method case study. *BMJ* 2010;340:c3111. (16 June.)

Cite this as: *BMJ* 2010;341:c3707

LOCUM ISSUES

The price of saving money

As a locum consultant in ENT surgery, I found the issue of 3 July insulting.[1] Sensationalist editorials entitled "Time to face up to the locums scandal" and a cover title of "Misfits: The trouble with locums" will not inspire confidence in the patients I see daily. Instead it will give them the impression that they are receiving second class care.

The high profile locum disasters are no different from the plethora of non-locum disasters. Shipman and most recent scandals such as Bristol were not caused by locums.

Most locums, including me, do not aspire to be locums for life and are in this temporary position for various reasons. Locums are crucial to the NHS. It is no exaggeration to say that if all locums resigned tomorrow the NHS would collapse.

If having locums in medicine compromises safety, we must look abroad, where most countries do not have a locum system because they have more doctors. Saving money has a price.

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1 Godlee F. Time to face up to the locums scandal. *BMJ* 2010;340:c3519. (30 June.)

Cite this as: *BMJ* 2010;341:c3875

The elephant in out of hours primary care

Cosford and Thomas identify factors possibly contributing to the death of David Gray at the hands of Daniel Ubani,[1] but they ignore the elephant in the living room—namely, payment rates for general practitioners (GPs) who volunteer to work for out of hours providers.

Since primary care trusts took over responsibility for commissioning out of hours care, out of hours providers have come under increasing pressure to cut costs. This has resulted in pay rates being cut, or at least not increased in line with inflation. Staffing levels on some shifts have been cut too. In short, GPs who volunteer to work for out of hours providers are, on the whole, doing more work for less pay. This has led many GPs to cease working for their local out of hours providers. Others, myself included, are hanging on in there, but volunteering for fewer shifts than previously. This has forced out of hours providers to depend more heavily on agency doctors to fill unstaffed shifts. Some of these doctors are unfamiliar with local healthcare arrangements and, I suspect, the computer systems that they are required to use.

Politicians and NHS administrators talk sanctimoniously about delivering value for money to the taxpayer. They need to be reminded that sometimes value for money comes at a price that can be measured in human life.

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Competing interests: TJC works on an ad hoc basis for South East Health, an out of hours provider.

1 Cosford PA, Thomas JM. Safer out of hours primary care. *BMJ* 2010;340:c3194. (22 June.)

Cite this as: *BMJ* 2010;341:c3881

Time to tackle the system

The issue of 3 July discussed the problems with locums,[1 2] but the question remains, Why is the locum system still alive?

Locums used to be a way to advance your career, but since Calman they should have become obsolete. With the current fixed rotations, it should be easier to calculate the number of staff to fill a rota. The addendum to Isles's paper showed that costs are ludicrous: "Scotland spent £47m on locum doctors in 2008-9, 4.3% of overall medical staffing expenditure. About £27m of the spend was on agency locums."[2] Why aren't these posts filled with proper trainees, which is probably cheaper? The hidden costs of the locum system are having a professor of medicine find staff.[2]

Who applies for locum posts? Without being unjust to all the good locums, applicants are usually foreign doctors wanting to make extra money and local doctors who cannot get training positions. Neither necessarily provides good quality cover.

So, is the continuing presence of the locum system a sign of a failing medical staffing policy? Does it hide problems with trainees stepping out of training schemes, or the inadequacy of the NHS in dealing with the European Working Time Directive? Or is it there because it has always been there?

It is time for the colleges and General Medical Council to rethink their staffing strategies, and to challenge the locum system itself, not locum doctors.

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Competing interests: None declared.

1 Dickson N. Responsibilities of individual doctors. *BMJ* 2010;340:c3385. (29 June.)
2 Isles C. How I tried to hire a locum. *BMJ* 2010;340:c1412. (29 June.)

Cite this as: *BMJ* 2010;341:c3876

New scheme for staff shortages

Rather than use locums,[1] hospital trusts could establish "trust posts" and use the Medical Training Initiative (MTI) scheme to fill them.[2] The savings on locum costs would more than fund the salaries of the additional doctors.

The MTI scheme was established in 2009 to provide well qualified enthusiastic overseas doctors to work and train for two years in the UK. They must have at least three years' postgraduate experience, high scores in the International English Language Testing System (IELTS), and a further qualification such as the MRCP. Applicants are interviewed overseas by UK consultants using standard formats looking particularly for good communication skills and clinical competencies.

The selection process should ensure that the trust receives doctors of high quality. Quality for the graduate must also be assured by incorporating training and assessment into the job description. These are not official posts of the Postgraduate Medical Education and Training Board (PMETB), but they must embrace the same training principles and the training component should be approved by the college and postgraduate dean.

A leap of faith is needed to move away from the locum culture. Trusts must accept that locums are expensive, of indeterminate quality, and in short supply and that junior posts are always unfilled. The MTI scheme is an alternative way to deal with perennial vacancies with a degree of continuity not currently enjoyed by trusts, most of whose junior doctors rotate every four months. Overseas links can also be established: we in the UK have much to learn from overseas doctors, who bring their own skills, experience, and work ethos.

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1 Isles C. How I tried to hire a locum. *BMJ* 2010;340:c1412. (29 June.)
2 Trewby P. The Medical Training Initiative scheme. 21 Apr 2010. http://careers.bmj.com/careers/advice/view-article.html?id=20000927.

Cite this as: *BMJ* 2010;341:c3880

English as she is spoke

I was a specialist registrar (SpR) in medical microbiology. My consultant and I were discussing a complicated case of an elderly man admitted to the surgery ward. I had earlier asked the surgery SpR to hold off antibiotics and instead monitor the patient. My consultant thought otherwise and wanted antibiotics started. "I would speak to him," he said as he finished the conversation. I assumed that my consultant had decided to speak to the surgery SpR himself to start antibiotic treatment and so I did nothing. I later realised that "I would" had meant "You should".

I was born and brought up in India and came to the UK several years after my primary medical qualification. English as spoken in India is an entirely different language in many ways. Native languages (India has 18 official languages and hundreds of dialects) are often translated into English in the mind of the speaker before words are uttered, and will and would, shall and should, can and could, and may and might are often used interchangeably during conversations. Context and gestures are therefore extremely important.

Even trivial misunderstanding can lead to serious consequences. Anyone educated in a non-English speaking country should undergo language checks.[1] In my case described above, the error was spotted in time and no harm was done.

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Competing interests: None declared.

1 Hawkes N. BMA meeting: BMA chairman demands better language checks for foreign doctors. *BMJ* 2010;340:c3496. (30 June.)

Cite this as: *BMJ* 2010;341:c3882

DIABETES AND RAMADAN

Fasts after bariatric surgery

The requirement to observe a total fast (all forms of nourishment including liquids) during daylight hours in the month of Ramadan poses a great challenge in the management of people who have undergone bariatric surgery.[1] Bariatric surgery is increasingly performed for the correction of morbid obesity, particularly in people with comorbid conditions such as diabetes.[2] Most bariatric procedures limit the amount of food or drink consumed in one sitting, so patients are advised to sip fluids frequently throughout the day. A total fast during long summer days would put these patients at risk of dehydration. Long fasts could lead to the desire to eat larger amounts more quickly on breaking the fast. This could cause vomiting, compounding dehydration and poor nutritional intake. Foods commonly eaten at the sunset meal, such as sweets and deep fried pastries, would also put some patients at risk of dumping syndrome or steatorrhoea. The small stomach volume might make it difficult to fit in nutritional supplements and drugs around meal times.

LOUISE BATALLA DURAN/AL AMY

Research in this area is virtually non-existent. On the basis of clinical experience we recommend that patients avoid total fasts in the first 12-18 months after bariatric surgery; after this, the risk of postprandial vomiting is reduced and otherwise healthy patients may observe religious fasts if fluids are taken throughout the day (for example, fasting during Lent). In addition, advise patients to base meals on complex carbohydrates and high quality proteins, and advise those who have had malabsorptive procedures such as gastric bypass to continue taking nutrient supplements.

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Competing interests: None declared.

1 Hui E, Bravis V, Hassanein M, Hanif W, Malik R, Chowdhury TA, et al. Management of people with diabetes wanting to fast during Ramadan. *BMJ* 2010;340:c3053. (23 June.)
2 Leff DR, Heath D. Surgery for obesity in adulthood. *BMJ* 2009;339:b3402.

Cite this as: *BMJ* 2010;341:c3706

HOW TO THINK LIKE AN ETHICIST

Think like a cop

In promising method in the "madness" of bioethics, Sokol offers "structure" as the preferred course of treatment. Did John steal the stethoscope? Think . . . thief. Did Tracy kill a child when she failed to intubate? Think . . . negligence.[1]

To think like an ethicist, in other words, think like a cop. Better, think like a lawyer. The only question is whether you are a lawyer for the defence (the hospital) or the prosecution.

In his examples, and his evocation of structural thinking without any thought of ethical values, we see the problem of the bioethics Sokol proposes. It has nothing to do with right and wrong, with what should be done to whom and when, only with the structural analysis of a situation irrespective of content.

This substitution of analytic structure for ethical content has a long history that predates bioethics. It is, for example, the subject of Foucault's famous "Discipline and punish," the way matters of justice and morality have given way to questions of procedure.[2]

What is remarkable, and sad, is that this does indeed encompass much of the bioethics of the past two decades, and Sokol's allegiance to structure rather than ethical debate over what is right is these days perhaps as good as bioethics gets.

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Competing interests: None declared.

1 Sokol DK. How to think like an ethicist. *BMJ* 2010;340:c3256. (23 June.)
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Cite this as: *BMJ* 2010;341:c3702

CIRCUMCISION

Parity for the sexes?

Bewley and colleagues' arguments against female genital mutilation[1] are irresistible, so why are they not applied to the male equivalent, circumcision?

Their arguments against medical involvement in even "nicking" the female genitalia are compelling on logical grounds, but there is still the important issue of the public's and

parental/patient preferences. The arguments hold, without any exception that I can see, for the male equivalent: circumcision. For a detailed account of male circumcision in its many varieties, including some that can be described only as brutal, in relation to the female equivalent, see the recent article by Johnson calling for a consistent approach to tackling "harmful cultural practices."[2]

I have been impressed by how strongly the public feels that male circumcision on religious grounds should be offered by doctors,[3] and such views have prevailed in Scotland, where circumcision is available in the NHS.

If the services are available for cultural reasons for males, surely similar requests, for equally strongly held views, deserve some consideration in relation to females. Alternatively, let us apply the same stringent arguments to both sexes. The debate is currently incomplete, for whether decisions are to be made solely on clinical grounds, or to include public and patient preferences, males and females are not being treated equally. It is hard to argue that public and patient preferences have no place, whatsoever, in publicly funded services, and such an argument contravenes NHS policy.

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Competing interests: None declared.

1 Bewley S, Creighton S, Momoh C. Female genital mutilation. *BMJ* 2010;340:c2728. (2 June.)
2 Johnson M. Male genital mutilation: Beyond the tolerable? *Ethnicities* 2010;10:181-207.
3 Bhopal R, Madhok R, Hameed A. Religious circumcision on the NHS: opinions of Pakistani people in Middlesbrough, England. *J Epidemiol Community Health* 1998;52:758-9.

Cite this as: *BMJ* 2010;341:c3888

STRANGULATION BY BLIND CORDS

Safety kit is here in Australia

Consumer Affairs Victoria, in Australia, reports that at least 15 young children in Australia have been strangled by Venetian blind cords since the early 1990s.[1] It offers a free curtain and blind cord safety kit through its website.[2] The problem and the kit, which tensions the blind cord close to the window frame so that it does not hang loose, reducing the risk of strangulation, are described in a video.[2]

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Competing interests: None declared.

1 Masand M. Accidental strangulation with a Venetian blind cord—a near miss. *BMJ* 2010;340:c3458. (29 June.)
2 Consumer Affairs Victoria. Are your curtains and blinds safe? www.consumer.vic.gov.au.

Cite this as: *BMJ* 2010;341:c3868

Open letter to Professor Peter Rubin, chair of the GMC

You must know that the inclusion of Mrs Penny Mellor on the General Medical Council Expert Group on Child Protection,[1] which has been set up in the wake of David Southall's successful appeal, is an affront to paediatricians and other professionals involved in child protection work.

On 9 May 2010 we wrote to you and Mr Dickson congratulating you on setting up an expert panel to review what is expected of doctors involved in child protection. We had stated: "We have long argued that child protection is an area of medicine made uniquely difficult because the parents of children [or their appointed advocates, that is, those who complain about doctors to the GMC] cannot be assumed always to be acting in the best interests of their child. It is difficult for lay [fitness to practise] panel members, or medical panel members who do not have personal experience of child protection work, to understand this professional environment."

We are astonished that you consider Mrs Mellor an appropriate person to contribute to this group, given that she has:

- Made false allegations against numerous paediatricians, other doctors, and nurses about their involvement in child protection cases, even to the extent of accusing doctors of sexual abuse of children and paedophilia and comparing one paediatrician to Josef Mengele
- Reported such professionals to their employers, regulatory bodies, politicians, and in the media, in some cases wrecking their professional lives
- With others, led a misguided and hostile media campaign against internationally acclaimed paediatricians who were central to the recognition and diagnosis of fabricated and induced illness (FII, previously known as Munchausen's syndrome by proxy), which contributed to your fitness to practise panels' decisions to order the names of Professor Sir Roy Meadow and Professor David Southall OBE to be erased from the medical register in 2004 and 2007 respectively. After much damage to child protection work, these decisions were found to be erroneous: Professor Meadow was reinstated to the medical register by the High Court and Professor Southall by the Court of Appeal
- Created an environment in which doctors are now turning their back on child protection work for fear of being targeted in the above way
- Been convicted herself of "conspiring to abduct a child," Judge Whitburn concluding: "... you have been a self-appointed advocate for those, amongst others, whose children are taken into care on the basis of what was known as Munchausens Syndrome By Proxy, now known as Fictitious Illness Syndrome (sic). Your view was that this was a misdiagnosis, designed to cover up medical negligence. Impervious to debate, convinced you are right, you have traduced, complained about and harried dedicated professional people working in this difficult area. I do not punish you for that, let me make it clear, however tiresome and eccentric your views are, the toleration afforded to you who expressed them, by those who hear them, is part of the price we gladly pay for living in a liberal democracy.

"... What is unforgivable is the way in which you manipulated for your own ... purposes, the genuine distress of the [XXXX] family ... I have no doubt ... that you were the architect, the Svengali of the whole plan. As the Court of Appeal Criminal Division pointed out ... those who act as you and they did commit a serious offence, especially where what is done is to thwart the orders of the Court in respect of a child or proceedings taken in respect of a child, by removing the child from the jurisdiction of the Court and assisting the continuing absence of that child from the jurisdiction.

"... What you are being punished for is orchestrating an abduction of a child, in part at least for your own propaganda purposes; an abduction which lasted over a month ... The very least sentence I can pass upon you, Penelope Mellor, is two years' imprisonment." [Her sentence was later reduced on appeal to 18 months' imprisonment.]"

"But not least, we cannot understand how you can appoint Mrs Mellor to the expert group when she herself has been engaged by parents whose complaints you are currently hearing in a fitness to practise panel in relation to David Southall. We believe that the GMC and its fitness to practise panels have already been unduly influenced by the campaign Mrs Mellor has been a major contributor to. Now she may again exert undue influence and make false representations within your expert group.

We have no objection to the inclusion of critics in the expert group, but by including Mrs Mellor and giving her credence, we consider that the GMC denigrates the work of doctors involved in child protection.

John M Bridson retired paediatrician, and chair
Martin Samuels paediatrician, and member
Nigel Speight paediatrician, and member
Catherine Williams retired academic lawyer, and member, PACA (Professionals Against Child Abuse), www.paca.org.uk

Competing interests: The authors are members of PACA (Professionals Against Child Abuse), www.paca.org.uk. PACA was set up to support professionals, to share information, and to try to provide a more positive view of safeguarding in the media and as a result enable children and families to receive better care.

1 Dyer C. Child abuse experts "astonished" that convicted doctors' critic is in guidance group. *BMJ* 2010;341:c3788. (14 July.)

Cite this as: *BMJ* 2010;341:c3884

See also FEATURE, p 178