

the association's statement is simple: "The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose." No degree of political convenience must be allowed to tamper with this simple but precise definition, and every democratic citizen in the world—not only those who are doctors—should reject any legalistic attempt to justify torture.

The American Medical Association made a long awaited policy statement this month. It said, "Physicians must not conduct, directly participate in, or monitor an interrogation with an intent to intervene, because this undermines the physician's role as healer."⁶ The American Psychiatric Association, too, has just reiterated its position that psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture of any person and that no psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees.⁷ The American Psychiatric Association also says that "psychiatrists who become aware that torture has occurred, is occurring, or has been planned must report it promptly to a person or persons in a position to take corrective action."

Intellectuals and academics must also take a stand. They need to discuss and debate the "philosophy of torture" (if such a concept exists) and to show its inherent incompatibility with the idea, albeit imperfect, of democracy. The use of euphemisms such as "harsh interrogatory" to describe torture should also be academically discredited, since it contributes to public mystification.⁸

There is also an urgent need to make clear to all health workers that participation in torture or abuse of prisoners is against the ethical core of healthcare professions. National and international medical codes and covenants on participation in torture or abuse of prisoners are a good starting point, but they are not enough. Health students should be educated explicitly on active engagement with human rights, going beyond simply considering health to be a human right

and ensuring abstention from participating in any behaviour which demeans human rights.

Annas and Grodin's proposal 10 years ago for an international court to judge the behaviour of physicians and other health workers and to keep records on complicity in human rights violations merits further discussion.⁹ In their words, "the world's physicians and lawyers should work together to develop and support worldwide mechanisms to articulate and enforce standards of medical ethics and human rights, including the establishment of an international organization dedicated to this cause, and a permanent tribunal with the authority to punish human rights abuses." An international medical tribunal could initially act by making public statements denouncing doctors who have committed documented violations of human rights, but could also use its influence to urge national medical associations to revoke such doctors' licence to practise. It would be a demanding task, but it would be worth the international effort to do it.

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The diagnosis and treatment of carpal tunnel syndrome

Surgery—whether open or closed—works, but only if the diagnosis is right

Research p 1473

The randomised controlled trial of Atroshi and colleagues (p 1473) in this week's *BMJ* shows that there are no substantive differences in the outcome of carpal tunnel syndrome treated with either a conventional open decompression of the median nerve or an endoscopic approach.¹ Their findings confirm those of earlier studies which also found no fundamental difference in outcome that could be

attributed to the technique of surgical release of the carpal tunnel.²⁻⁴

Given that the result of surgical treatment for carpal tunnel syndrome is not universally successful, however, what other factors might have an important impact on the outcome? One key determinant is probably the accuracy of the diagnosis.^{5 6} When the diagnosis is wrong treatment will fail no matter what it

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comprises while, as Atroshi and colleagues have shown, an accurate diagnosis is associated with success after adequate decompression by any means.

Standardised diagnostic criteria are lacking for many, if not most, medical conditions. The term “gold standard” is often used to imply that there is a definitive diagnostic criterion for a given condition, but gold standards exist only by consensus. Despite the fundamental role played by diagnosis in determining treatment and prognosis, little attention has been paid to the effect variations in diagnostic criteria may have on treatment outcomes.

Indeed, much evidence on treatment outcomes is flawed because diagnostic criteria are rarely explicitly described in intervention studies. Inconsistencies in diagnostic practices for common medical conditions may lead to differing patterns of resource use, including the use of diagnostic tests and variations in estimates of disease prevalence, treatment, and outcomes.⁷

Carpal tunnel syndrome is commonly diagnosed by a broad range of medical and surgical specialists as well as by primary care doctors working in a wide variety of practice settings. The best diagnostic criteria for the syndrome have not been established, and there is considerable disagreement as to the relative importance of various clinical findings.⁸ To a certain extent, the absence of consensus on the best diagnostic criteria for the syndrome is related to a general reliance on the results of electrodiagnostic testing as a diagnostic gold standard.

Unfortunately, the electrophysiological criteria for making a diagnosis of carpal tunnel syndrome may vary substantially between laboratories. In addition, like all laboratory tests, electrodiagnostic tests may yield both false positives and negatives. The results of electrodiagnostic tests are best interpreted in the context of clinical findings. Electrophysiological data alone cannot be taken as reliable evidence of the diagnosis of carpal tunnel syndrome, although they may be helpful in cases where there is uncertainty after a careful clinical evaluation. Under these circumstances the outcome of electrodiagnostic testing should be seen as raising or lowering the probability of the syndrome first established on clinical grounds.

The problems surrounding the evaluation and treatment of carpal tunnel syndrome, including the

impact on outcomes such as workers' compensation, is a good example of the challenges facing clinical researchers in a variety of subjects. Until there is consensus on the diagnostic criteria for the disease in question, there will always be a risk of comparing apples with oranges.

For carpal tunnel syndrome, these diagnostic variations have been at least partially responsible for wide variations in the observed prevalence of the condition in different workplace settings. This has led to possibly erroneous conclusions regarding the aetiological role of certain types of work in the development of the condition, with enormous implications for insurers, patients, and employers. There are well established strategies for developing and measuring this type of consensus, such as the Delphi technique.⁹ While this approach to standardising diagnostic criteria for common medical conditions may prove to be arduous, the benefits are clear and potentially far reaching.

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Rational prescribing for children

In an evidence based desert, safe and appropriate treatment is difficult and too easily exploited

Many drugs used to treat children are unlicensed or off label.¹ Three recent news stories highlight how children, like adults, are at risk from overprescribing and inappropriate prescribing. A systematic review conducted by the National Institute for Health and Clinical Excellence has shown fluoxetine (with or without cognitive behavioural therapy) to be the only selective serotonin reuptake inhibitor that is more effective than placebo in teenage patients with depression.² Furthermore, the US Food and Drug Administration and the Medicines Healthcare Products

Regulatory Agency have shown that most randomised controlled trials have reported higher rates of “possibly suicide-related event” and “suicide attempt event” among adolescents and children taking selective serotonin reuptake inhibitors than in those taking placebo.³ The systematic review on fluoxetine included children as young as 7 years old and found no conclusive evidence of increased suicidal behaviour or ideation in studies lasting seven to 12 weeks.² It may be surprising or even confusing for the public, nevertheless, to find that the European Medicines Agency recently

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