Letters

The *BMJ* interview: Sir Liam Donaldson

The health services and the dream

Editor—The audience for the *BMJ* interview of Sir Liam Donaldson on doctors' careers, patient safety, the GMC, and whether we should have an independent NHS should perhaps have moderated their expectations.[1] The main participant was an esteemed spokesperson for a huge state bureaucracy—the personal advancement of whose employees depends on compliance towards their masters, while range of thought and articulation of unwelcome facts are considered less essential.

How much more interesting the interview might have been if the media had had the intrepidity and nous to ask Donaldson: "How have the health services managed to conjure an inverse relation between doctors' salaries and doctors' morale—is this a trick of a mature democracy or a circumstance unique to the British health services?"

"Also you mention 'primary victims' and 'patient safety': were there not lessons even 20 years ago (for example, the Cleveland affair) which, if heeded, might well have built in the 'potential avoidability' (your term) of later disasters, including professorial blunders? Today, why is there still no mechanism to uncover, and therefore deter, recurrence of even some daily, rudimentary, single medical errors nationwide—important enough on their own, but scandalous when medically ignored and enabling repetition. You talk of medical 'regulation' which is not accountability (any more than is 'education' or 'training'). Was it not exactly this lack of clinical accountability that emboldened known serial medical miscreants until the press, patients, or police brought them to account?"

Media events do not permit dull programming. Just one of these questions might have taken the whole interview to address properly—unthinkable in the sharp, glossy world of presentation. But it would have elevated the programme to a quite different level.

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1 The *BMJ* interview: Sir Liam Donaldson. http://bmj.bmjjournals.com/cgi/content/full/333/7573/DC1 (accessed 26 Oct 2006).

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Avoiding the painful truth and scapegoats

Editor—I write with reference to the *BMJ* interview with the chief medical officer, Sir Liam Donaldson.[1] I do not support his proposal that the standard of proof should be the civil standard when adjudicating about a doctor's performance.[2]

The individual doctor is the natural target when things go wrong and someone is needed to carry the blame, but this is scapegoating. When this occurs other, more abstract, institutional factors are missed.

When facing illness, disability, pain, blighted lives, and death many patients, families, and professionals invest medicine and doctors with a supernatural power to overcome illness. But these fantasies cannot be sustained when reality reveals the truth that doctors are limited and that some are more limited than others; the disappointment that follows can create a wish for revenge.

The revalidation agenda is politically expedient. The reality of rationing cannot be denied. However, the political debate we have avoids acknowledging the reality of the fragility of human health, limited public resources, and the limited power of medicine to "make things right."

Instead the government and the chief medical officer have encouraged fantasy thinking by promising ever better care, and ever higher standards, more nurses, more doctors, more operations, etc. The consequence is that someone or something has to carry the badness, and this seems to be the "underperforming doctor." The revalidation debate risks colluding with this manic response and makes the scapegoating of individual doctors more likely.

As doctors we should lead the way in pointing out the painful truths of human existence, sickness and death, the limitations of medicine, and acknowledge explicitly the limitations of funding that occur in any health system. The criminal threshold should be retained for actions that threaten the livelihood of the doctor under investigation. If this threshold were to be lowered to the civil level then, on the balance of probabilities, many doctors may find their lives wrecked as they become scapegoats of a system in denial.

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1 The *BMJ* interview: Sir Liam Donaldson. http://bmj.bmjjournals.com/cgi/content/full/333/7573/DC1 (accessed 26 Oct 2006).
2 *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*. London: Department of Health, 2006.

Health in the Middle East

HIV prevention is hindered in the United Arab Emirates

Editor—The national policy for HIV/AIDS of the United Arab Emirates (UAE) lacks implementation strategies (www.moh.gov.ae/moh_site/prev_med/anbk/s19.htm). There is a political reluctance to identify high risk groups and debate AIDS.[1] Instead, authorities rely on mandatory HIV testing. HIV positive nationals are barred from government employment, educational institutions, and drawing on the marriage fund, contravening the regulations of the International Labour Organization, of which the UAE is a member.

Legal and political restraints prevent non-governmental organisations from working with risk groups. Young people's sexual concerns are ignored since they are considered sexually inactive. Men, unwilling to wait for sanctioned sex, have sex with other men in Kuwait, Oman, Qatar, and Yemen.[1] Homosexual sex is punishable by death or subject to forced hormone treatments, making harm reduction absent. Child protection organisation ECPAT identifies the UAE as the most cited destination for sex trafficking (www.ecpat.org.uk/).

HIV infection in intravenous drug users is high: 73% of prisoners are HIV positive in Bahrain[1] and 66% in one Iranian city.[2] Similar trends are likely in the UAE.

Nearly 80% of infections in the Middle East and North Africa are heterosexually transmitted.[3] In Saudi Arabia, women are infected by their husbands' engagement in extramarital sex.[4] The same trend for Emirati women is suggested (El-Khatib, personal communication, May 2005). Evidence

is inconclusive, but premarital sex seems to be increasing. The teaching of sexual health in schools is limited and censors edit textbooks. HIV/AIDS is covered as part of the science curriculum.[5]

The UAE's gross domestic product during 2000-25 could be reduced by 25.6% as a result of not investing in prevention, for example.[1] The international community can help avert an epidemic by encouraging the UAE to tackle HIV immediately.

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Making healthcare systems more responsive to women in Pakistan

Editor—Health seeking behaviour depends largely on the attributes of a healthcare system and not merely on people's choices or circumstances.[1] Lack of proper nutrition for girls, early marriages, and multiparity have been some of the determinants of the unrelenting ill health of women in Pakistan.[2] Insufficient primary care services, antenatal care, and intrapartum care, particularly in the public sector, are the reality.[3]

This situation has contributed to frightening indicators of maternal and child morbidity and mortality in the country.[4] Qualitative research was conducted with women of the district of Ghizar in northern Pakistan, a remote terrain where healthcare provision in the public and private sectors is even worse. High fertility rates, large family sizes, low literacy rates, and mediocre income per head are demographic features. Iron deficiency anaemia is the most widespread nutritional problem among women and has severe consequences for their reproductive health.

Local women largely rely on traditional practices for prenatal and postnatal health. The head of the family or any other adult man always decides about consulting a healthcare provider. Rarely are women allowed to go alone for a consultation, even in emergencies. Seldom would a woman have money to spend on her own health. A median delay of three days before a consultation is common among women.

The private sector is mostly preferred for seeking health care. The public sector often has a limited range of services, a dearth of female staff, poor quality of medicines, and staff with an insensitive attitude.

Women's health seeking behaviour is complex and must be appreciated to formulate healthy public policies as opposed to mere delivery of healthcare services.[5]

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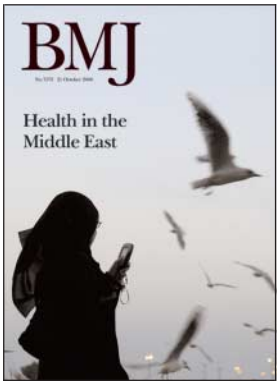
Psychological implications of Iraqi invasion

Editor—In a rapid response to Dyer's news item, Rana highlights the risks of psychological damage on the Iraqi population stemming from their exposure to an apparent vast increase in violent death.[1 2] Previous studies have shown that 8% of men and 20% of women who are directly exposed to life threatening violence go on to develop post-traumatic stress disorder in the following weeks. This becomes a chronic disorder lasting years in up to 30% of these people.[3] With over 500 000 violent deaths there will no doubt have been many more people exposed to grave violence. It therefore seems likely that the nation of Iraq may suffer a double blow, firstly by losing a sizeable proportion of its population—and the study shows that 15-45 year olds are most commonly affected—and secondly by the serious consequences of people with post-traumatic stress disorder. This may also be compounded by cultural barriers that prevent people from seeking psychological help.



The mainstay of the coalition's medical effort has been directed at assisting with basic medical help and treating injured civilians in Iraqi or coalition hospitals. The medical literature provides ample examples of rebuilding psychiatric facilities in a post-war era, most notably the experiences of doctors in former Yugoslavia.[4] We must learn the lessons of history and expedite the psychiatric help for Iraqi civilians.[4]

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No strong link between depleted uranium and cancer

Editor—In the editorial on lessons in tackling chronic disease in the Middle East Nishtar mentions the increased incidence of cancer from exposure to depleted uranium.[1] This is often a controversial and emotive subject. The reference cited in the editorial[1] is a cohort study that did not find an excess risk of cancer associated with exposure to depleted uranium and included adjustments for confounding lifestyle factors such as alcohol and smoking.[2] The majority evidence and expert opinion on the lack of a clear association between depleted uranium and cancer are quite consistent, although a possible case for lung cancer has been suggested.[3] Another editorial on the public health effects of depleted uranium[4] and the two part report of the Royal Society Working Group both consistently uphold this view.[3]

The highest levels of exposure are on the battlefield and probably incur an added risk of lung cancer death of 1 in 1000, particularly for inhaled particles.[3] Soldiers who survive inside a vehicle hit by a shell containing depleted uranium may double their lifetime risk.[3] The added risk of leukaemias or other cancers caused by radiation from depleted uranium is less than five in a million for all possible levels of exposure.[3] A recent population based retrospective study reiterates the lack of association between depleted uranium and leukaemia and testicular cancer.[5] Longer term follow-up data are awaited, but the current argument is not in favour of a strong link.

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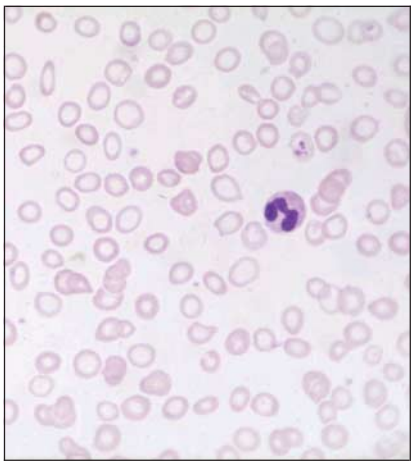
Investigating iron status in microcytic anaemia



PATHOLOGY IMAGE COLLECTION/ST BARTS

General practitioners could test for ferritin, etc, before referral

EDITOR—Some points in the article on investigating iron status in microcytic anaemia by Galloway and Smellie have an impact on endoscopy services and two week waiting list referrals from general practitioners for investigation of anaemia.[1] While most referred patients have at least a full blood count and haemoglobin indices done at time of referral, ferritin has rarely been measured. A simple coeliac disease screen and testing for haemoglobinopathies in the appropriate ethnic groups would also pick up a considerable number of patients who can then avoid unnecessary endoscopy, especially colonoscopy, and the associated risks.

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Positive diagnosis of anaemia of chronic disease

EDITOR—The case of renal carcinoma presenting as mild microcytic anaemia described by Galloway and Smellie is not rare.[1] As well as a normal serum ferritin, such patients have a characteristic pattern of low serum iron and low serum transferrin, whereas iron deficient patients have low serum iron and high transferrin—provided the patient is not taking iron at the time of the test.

When anaemia of chronic disease is diagnosed, the hunt for a cause proceeds entirely differently from iron deficiency: chest x ray and abdominal ultrasonography rather than investigation of the gastrointestinal tract. Occult malignancy is high on the list. (Other causes such as rheumatoid are usually obvious.) Too many such patients linger on endoscopy and barium enema waiting lists. I highlight this important diagnosis in my first lecture to first year students.

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Zincprotoporphyrin and soluble transferrin receptor have a role

EDITOR—More "sophisticated" tests can be included in Galloway and Smellie's proposed guidelines on iron status in microcytic anaemia.[1] Ferritin seems a weak compromise compared with the yield from diagnostic algorithms using soluble transferrin receptors or zincprotoporphyrin.[2 3]

High zincprotoporphyrin concentrations detect not only real iron deficiency but also derangements in intracellular iron metabolism caused by chronic inflammatory diseases, myelodysplasia, or lead poisoning.[3] Falsely high results occur only in the rare congenital erythropoietic porphyria and protoporphyria.

Ferguson et al reported the potential use of soluble transferrin receptors to distinguish anaemia of chronic disease from that of iron deficiency.[4] The clinical validity of concentrations of soluble transferrin receptors was compared with that of bone marrow aspiration in 129 patients.[5] Concentrations of soluble transferrin receptors performed well in detecting iron deficiency anaemia (area under the curve 0.98), the calculated index of the ratio of soluble transferrin receptors to $\log_{10}$ ferritin providing an outstanding parameter (area under the curve 1.00).[5]

Incorporating the zincprotoporphyrin or the soluble transferrin receptors/ferritin index, or both, in the investigation of iron deficiency anaemia may be the way ahead for secondary and primary care.[2] It can save time, bypassing trials of iron treatment, and provides the necessary justification for more expensive (renal tract ultrasonography) and invasive tests (endoscopy of the upper and lower gastrointestinal tract).

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Causes and management of iron deficient anaemia

EDITOR—Galloway and Smellie's review of investigating iron status in microcytic anaemia did not cover several key points.[1]

Common causes of iron deficiency include tropical disease, such as schistosomiasis, amoebiasis, and hookworm. The estimated prevalence of hookworm is one billion people.[2] This has to be borne in mind as a potential source of iron deficiency in travellers or immigrants from an endemic area.

Serum ferritin and other molecular markers of iron status are acute phase reactants. They should be used with caution and not in isolation.[3] Patients in whom a microcytic anaemia is incidentally or unexpectedly discovered should have a blood film examination. This would show poikilocytes, occasional target cells. In cases of malabsorption it can show a dimorphic blood picture, which may not be recorded by blood counters.

A haematology opinion should be sought in patients whose cause of anaemia is unclear. A good example is a patient with seropositive rheumatoid arthritis using both disease modifying agents and non-steroidal agents. This history renders serum measurements unintelligible. A bone marrow biopsy confirms the diagnosis.

Once the anaemia has been confirmed as iron deficient, the obvious treatment is iron replacement, providing there is no underlying cause. Oral iron replacement is the traditional mode of treatment,[4] but it is associated with gastrointestinal disturbance.[5] Elderly people are most susceptible to these complications, so compliance is poor.[5] The response to iron supplementation needs to be monitored, and if there is no adequate response then other forms of iron supplementation should be considered under specialist supervision.

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