liberties are being infringed, both by their being placed on a register and by their being subjected to the close surveillance that this entails. Costs judicial review will follow,¹⁴ the beneficial outcome of which may be that a legal framework for supervision is derived ultimately from case law. In the meantime, others who seek the aid of mental health services may find themselves disadvantaged by the shift of resources necessary to service the registers.

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¹ Harrison G, Barter P. Supervision registers for mentally ill people. BMJ 1994;309:551-2. (3 September.)

Most patients in Bow and Poplar would be on the register

EDITOR,—Robert Pugh and colleagues report a census of psychiatric inpatients to calculate the possible number of registration registers on psychiatric services.¹ Using operational criteria, they found that a high number (179 of 234 inpatients) fulfilled the Department of Health's criteria for inclusion on the register, and they conclude that the register would have considerable resource implications for community teams. The register is “intended first and foremost for patients being cared for outside hospital.”¹

The Bow and Poplar local mental health team provides a multidisciplinary service to an inner city population of 60,000 in a socially deprived area of London. On 23 June we had a caseload of 229 patients. Keyworkers were asked to answer a questionnaire for each patient, covering six criteria for inclusion on the supervision register as specified by the Department of Health (table). The questionnaire was completed for 209 (91.3%) patients.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current risk of suicide or serious self harm</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Current history of sexual abuse</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Current risk of serious harm to others</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Incarceration or detention</td>
<td>43</td>
<td>16</td>
</tr>
<tr>
<td>If untreated, risk of serious self harm</td>
<td>22</td>
<td>83</td>
</tr>
<tr>
<td>If untreated, risk of serious harm to others</td>
<td>38</td>
<td>12</td>
</tr>
</tbody>
</table>

*Data available for only 209 patients.

Number of patients fulfilling each criterion for inclusion on supervision register (n = 229)*

In our practice, 65 patients met at least one of the six criteria; 24 fulfilled one or more of the first three criteria, representing current risk. These data are based on the subjective opinion of the keyworker (a community psychiatric nurse, nurse behavioural therapist, or team psychiatrist). The decision to place a patient on the register would be made by the consultant psychiatrist. The keyworker, however, is often the professional with most knowledge of the patient and, having responsibility for his or her aftercare, would be “under the spotlight with the consultant psychiatrist.”

The high number of patients fulfilling the criteria for inclusion on the register in this community sample is consistent with Pugh and colleagues' findings for inpatients. The main reason for the potentially high numbers of supervision registers would be the potential risk resulting from failure to comply with drug treatment.

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Medical ethics

Justice has a wider scope

EDITOR,—I am concerned that Raanan Gillon's article on the role of medical ethics is dangerous because it be in danger of oversimplifying a complex subject beyond reason—in particular in respect of the idea of justice.¹ Whereas the first three principles may be thought of as relatively straightforward concepts affecting a clinician's personal moral behaviour in relation to the care of individual patients, justice is of much wider scope: it is capable of interpretation in formal, ethical-political, individual, and sociopolitical terms, each of which has its own range and scope of application and finds a specific role in relation to health care ethics.

The question of the social and political definitions is particularly fraught in these times of the ready identification of justice with economic values, and in a more sophisticated analysis of how they may approach allocative questions. In answering their questions I am concerned that we do not start by saying that justice was defined by Aristotle as the equal treatment of equals, and the unequal treatment of unequals; in fact, in Heller's view he was saying, in criticising The Republic, just the opposite.² He did not believe that people could be equal in any way, and his idea of distributive justice was that it should follow the existing political and economic structure of society. Unfortunately, many people take Gillon's view, and in most cases they have already decided to treat people in accordance with their own definition of whether they are already equal or unequal. This runs counter to Gillon's point that we should not seek to impose our views on others.

Thus, though I agree that the principles of autonomy, beneficence, and non-maleficence can and should be usefully discussed together as guides in medical practice, I believe firmly that justice is a concept of an entirely different order and should be treated separately. Perhaps what is really needed is a deeper understanding of each of these important concepts, when ethical questions are exercising the minds of us all.

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The four principles may clash

EDITOR,—Raanan Gillon describes the four principles of medical ethics and gives a commentary on their scope for their health care workers. In several places he hints at the likelihood of a clash in the application of these principles, and it might have been helpful if he had worked through an example.

For instance, I agree that to practise beneficence and non-maleficence we need empirical information about the probabilities of the various harms and benefits that may result from proposed health care interventions. The gold standard for appropriately estimating the cost versus benefits of any new intervention is the randomised controlled trial, yet patients participating in randomised controlled trials are to some extent objects rather than subjects and therefore, according to Kant's definition, have lost their right to self determination. Here we observe a classic clash of categorical imperatives.

The conventional argument in dealing with this paradox is that patients can retain their autonomy by volunteering for these trials and giving full informed consent. Yet how often is this consent fully informed, and what about the danger, when consent is being sought, of alarming patients by giving them unsolicited and frightening information, which in its turn breaks one of the moral principles of beneficence and non-maleficence? (M Baum, Francis Fraser lecture, British Postgraduate Medical Federation academic assembly, 1994.)

Another problem arises when increasing numbers of patients exercise their right to self determination by refusing to participate in the randomised controlled trial while at the same time demanding the best treatments based on the outcomes in volunteers in previous generations of trials. Do such patients have the right to autonomy while denying their responsibility to the very society that presumably confers these rights?³ For too long people such as myself at the cutting edge of research on cancer have been subjected to the ill informed attacks of self appointed ethicists and “consumers' advocates.” Gillon puts it eloquently when he states, “such disagreement about justice results from us all disagreeing with us by bad faith or incomparable moral standards. In principle it is open to resolution within our shared moral commitment.” Please help me to resolve this ethical dilemma.

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Sacks J. Putting duties to rights. Times 1994 May 31

Author's reply

EDITOR,—Does Paul J Heath's moral stance really allow him to believe that doctors do not need to convince themselves with or in the light of facts in their medical practice? If not, as I assume, then he agrees that justice is a relevant part of medical ethics. Of course justice is a complex and vigorously debated moral issue, as I tried to indicate—but the problem is not one of getting away from the need for it. As Aristotle, I think that I gave a reasonable and fairly standard interpretation, but exegesis too is inherently contestable.

In response to M Baum, I do not have a general answer to how to resolve conflicts between the principles, though I believe that as a profession we should do so collectively and within the norms of our society provided that it too is committed to these fundamental moral principles. With regard to clinical research and Kantian ethical propriety, however, no such conflict need arise. It is morally acceptable to treat people as means to an end provided that they understand and agree—that is, provided that they are also respected as ends in themselves. Such respect does not require full information in relation to consent, which is just as well since full information is unattainable. What is required is adequate information, and adequate respect for people's circumstances.

Yes, it is undoubtedly true that sometimes people, having been given adequate information, do refuse to participate in clinical trials even though they themselves may have benefited from clinical trials on previous patients. Nonetheless, for my own part I would reject any attempt to coerce them into such participation. The participation of patients in clinical trials is admirable but...
not morally obligatory. Even if it were, it is not our job as doctors to keep our patients up to the moral mark.

A non-coercive, non-judgmental policy reflects and shows our proper primary moral commitment as doctors to the interests of our current patients. But I believe that it is also the policy that best promotes the advancement of medical science. Overall we are likely to recruit far fewer research subjects by moral arm twisting than if we ask our patients merely by pointing out the great benefits of their participation in clinical trials but gracefully accepting any refusals.

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Circumcision and uncircumcision

EDITORS,—I wish to respond to Roger S Kirby's review of my book.1 Kirby expresses doubt that the reception of sexual stimuli is affected by circumcision.

Circumcision. While the current effort to research that question directly is still in preliminary stages, Ritter has discussed at length the various ways in which circumcision interferes with the sexual function of the penis—including the consequences to the glans itself.2

Kirby makes no distinction between surgical and non-surgical restoration procedures when he warns " ... one should worry about the effects to the sexual function of the glans."3 While surgical restoration entails all the usual surgical risks, such risks are not encountered with non-surgical methods. I am in contact with hundreds (if not thousands) of men who are restoring their foreskin by a variety of non-surgical methods. I know of no case of injury beyond minor abrasions when tape has been removed too vigorously.

Finally, as a psychologist, I am aware of the placebo effect, which Kirby suspects may be the cause of the reported gains in the sensual sensitivity of the glans. I now know dozens of men who have had a re-covered glans for several years. If their enhanced sexual sensations are simply a placebo effect the consequences of this particular placebo are long term and stable.

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1 Kirby RS. The joy of uncircumcising! Restore your birthright and maximize sexual pleasure [book review]. BMJ 1994;309: 979. (10 September.)

Assisted suicide for depression

EDITORS,—It is important to learn the appropriate lesson from Alan D Ogilvie and S G Potts's editorial concerning Dr Boudewijn Chabot's assistance in the suicide of a depressed patient.4 Euthanasia can be compared to psychosurgery, since it is an inherently destructive medical intervention that is always regrettable and, while occasionally warranted, is potentially open to abuse. As with psychosurgery, restrictive legislation should be part of the caution to ensure sufficient consultation to provide adequate safeguards.5

The disquiet raised by the Chabot case is not over the fact that the patient's suffering was psychological rather than physical (all suffering is psychological); it is because it was not clearly established that the suffering could not be relieved. There was presumably no great urgency for Dr Chabot to act as his patient was not critically ill. If he had been required to refer his patient to a tribunal for a formal second opinion before he intervened the treatment options would have been thoroughly reviewed. A tribunal would be most unlikely to recommend euthanasia (or assisted suicide) before a trial of drug treatment, and probably electroconvulsive therapy, had been shown not to produce any change in the patient's wish to die.

The fantasy of a slippery slope is born not of reason but of a dismissive contempt for the moral sensibilities of the majority of the population—that is, for common sense. It is unfortunate that the House of Lords select committee did not avail itself of the recent opportunity to place the law on a more rational and coherent footing. As Smith noted, however, "the tide seems to be running for euthanasia." The slippery slope is submerging, and Lord Walton's sandcastle will not prevail for long.

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Payment proposed for blood donations in Germany

EDITORS,—During a recent meeting of the International Society of Blood Transfusion in Amsterdam, F von Auer, of the Federal Ministry of Health in Germany, issued a formal statement, which indicated that health authorities, in an attempt to address the challenge of self sufficiency in blood and blood products, planned to introduce a system of payment for all blood donors and that the reimbursement would be DM 50 (£20) per donation. This would be a serious breach of the European Union directive 89/381. Of more immediate concern, however, is that it could represent the beginning of a movement in Europe leading unecessarily to a drain on Germany's already and unneccessary diminution in the safety of blood and blood components.

I hope that colleagues in Germany will advise their ministers of the gravity of this retrograde development for it not only will have an impact on the safety of blood in Germany but may, long term, add appreciable restrictions to the movement of blood and blood components throughout Europe. It will also almost certainly lead to a disruption of the Euroblood programme—whereby some European blood transfusion services support deficiencies of supply in the United States—for the Federal Drug Agency is unlikely to permit the movement of blood and blood components from paid blood donors into the United States in return.

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Rebuilding health services in Rwanda

EDITORS,—African Rights' report of the massacres in Rwanda makes sombre reading.1 The fact that doctors and other health workers were involved in the genocide, either willingly or after they and their families had been threatened with immediate death, is well documented. One of the effects of this is only now becoming clear: a whole layer of primary health care workers has all but disappeared. The more senior they were the more likely they were to have been implicated in the massacres (or killed for refusing to take part).

Many health workers who were not involved are unable to return from Zaire, where the Hutu militias are openly active and still use appalling brutality to intimidate their "own" people to prevent them returning to Rwanda. The destruction and looting of health facilities have been almost universal but are far easier to remedy than the loss of this extensive and selective loss of key health workers.

Save the Children Fund is working closely with the new government to help rebuild primary health care services in the prefecture of Ruhengeri. Here, two thirds of all health centre staff are missing, being either dead or in the camps in Zaire. The fact that the remaining staff are predominately from the most junior grades has major implications for this reconstruction of services. The staff must be encouraged and their training needs sensitively assessed. In the short to medium term, new supplies of equipment and drugs, for example, must match the staff's training and abilities. In a population as traumatised as this, where virtually everyone is shocked and grieving, any such assessment must be performed delicately.

The community's confidence in health workers has been greatly shaken. Village meetings, the rebuilding of health centre committees, and community diagnosis are proving useful in rebuilding trust. The future is uncertain; despite threats from the militias and ousted officials to invade from Zaire the new government in Rwanda has made a clear statement that it needs support. So do health workers at village level.

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2 Differt L. Human rights group condemns UN in Rwanda. BMJ 1994;309:845. (5 October.)

Influence of patients' expectations on disease

EDITORS,—Michael Loudon continues the debate about the contribution of psychological factors to the development of the chronic fatigue syndrome and the influence of patients' expectations on the progression of illness.1

I developed glandular fever over a year ago. For three months earlier this year I had considerable but variable difficulty in getting out of bed in the morning, muscle 'woodeness' all over, and wobbly legs in association with a still positive Paul Bunnell test. Normal activities have not been a problem for some time now, but I am still struggling to resume sporting activities at something like my previous level.

Why do we seek to make general statements? It is so easy to illustrate the futility of trying to generalise. For example, the teenage son of one of my colleagues on the nursing staff at our hospice died of hepatitis arising from the early stages of glandular fever, despite his transfer to a liver unit. By contrast, I had a normal appetite from the beginning of my illness and no abdrolinal tenderness. If this lad died of hepatitis and I had no hepatitis at all, does anyone suggest that he did not have any helpful attitude to his illness, while I did? I think not. Why? Because when we understand and can measure we accept that there is a range of organically based illness.

Surely the reason why there is scepticism about whether the chronic fatigue syndrome has an organic basis is because of the implications for long term absenteeism from work as well as the cost to the country in benefits. These are hardly consider-