Letters to the Editor

Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk]. Letters should be no longer than 300 words and preference will be given to letters responding to articles published in the *JRSM*. Our aim is to publish letters quickly. Not all correspondence will be acknowledged.

Doctors and manslaughter—response from the Crown Prosecution Service

In an article published in the *JRSM*, Volume 99, Ferner and McDowell adopted a literature review of doctors charged with manslaughter since 1795. From a reading of their article it is possible to determine that they arrived at the following conclusions. First, that there had been a significant increase in the prosecution of doctors for gross negligence manslaughter since 1990; second, that the majority of these doctors should not have been prosecuted; third, that the Crown Prosecution Service (CPS) has failed to abide by its own prosecution Code; and fourth, that we have charged doctors as ‘an emotionally satisfying way to exact retribution . . .’

We question the methodology, analysis and conclusions reached by the authors. They relied for the most part on newspaper reports, a notoriously unreliable source, for an accurate account of the allegations. In every case all the evidence is considered by experienced doctors before any prosecution is commenced.

We apply the criminal law on gross negligence manslaughter as we are required to do, yet Ferner and McDowell criticise us for not using the criteria of ‘mistakes, slips (or lapses) and violations’, tests that are unknown to the criminal law.

Ferner and McDowell have failed to understand the CPS ‘realistic prospect of conviction’ test and have applied a simplistic numerical test against all the cases they could identify. The test is whether *in this particular case* there is a realistic prospect of conviction, not whether half of all defendants are convicted.

The suggestion that, by charging doctors with manslaughter, the CPS is somehow seeking some emotional satisfaction in retribution is self-evidently bizarre and entirely unsupported by any evidence.

Competing interests Stephen O’Doherty is Deputy Director of the Special Crime Division of the CPS.

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Authors’ reply

Mr O’Doherty glosses over our most obvious finding: more and more doctors are being prosecuted for gross negligence

manslaughter. The Crown Prosecution Service (CPS) cannot confirm or refute this, because they do not keep relevant statistics. We hope this will change.

Mr O’Doherty criticizes us for using the published evidence to classify the aetiology of acts that have led to manslaughter charges. We recognized the difficulties with this approach in our article. We maintain that a doctor who makes a slip of the sort that is inevitable in human actions should not be judged criminally negligent, whatever dire consequences there are for the patient. This is consistent with the legal test that the CPS must of course apply, that the error was so bad that *no reasonable doctor* of the same level of experience, in the same situation, would have made that error.

The Code of the CPS requires that, for a case to be brought, the jury should be more likely than not to convict.¹ The outcome of any individual case is binary: ‘convicted’ or ‘acquitted.’ Laws of statistics apply even to lawyers. If the probability of conviction were exactly 0.5, then there would be just a 5% chance of the observed 14 convictions in 39 cases brought since the CPS and their colleagues in Northern Ireland were set up.² The CPS can take no comfort from the fact that nearly a quarter of recent cases were abandoned before trial or dismissed by the judge.

We impute no emotional motives to the CPS in our article. We do contrast society’s desire for retributive justice with the desire to reduce deaths from errors. This is crucial. Society has to choose whether to exact retribution, or to minimize harm. All those involved need to realize that the two goals are inconsistent.

Competing interests R E Ferner has received fees for writing medicolegal reports. S E McDowell has no competing interests.

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REFERENCES

- 1 Anonymous. The Code for Crown Prosecutors. London: Crown Prosecution Service, 2004
- 2 Lowry, R. Vassarstats. Exact binomial probabilities. Available at <http://faculty.vassar.edu/lowry/binomialX.html> (accessed 8 October 2006)

Good doctors: safer patients—the Chief Medical Officer's prescription for regulating doctors

'Medical professionalism signifies a set of values, behaviours and relationships that underpins the trust the public has in doctors.' was the definition offered in the Report of the Working Party of the Royal College of Physicians. Trust in doctors remains high, higher than in politicians or civil servants.¹

The practice of medicine, centring on the unique doctor–patient relationship, cannot be conducted on the same lines as a business enterprise, such as an airline, with regulation by an elected Board of Directors, as advocated by Sir Donald Irvine² and Sir Liam Donaldson.³ Professionalism is the basis of medicine's contract with society,⁴ to whom it should be responsible, individually and a whole. As has been reported in the national press,⁵ the General Medical Council (GMC) has already moved to proposing independent regulation through balanced composition of its regulatory council, with no one group having an inbuilt majority. This inevitable and necessary change will be uncomfortable for some doctors. It is, however, far preferable to Sir Liam's and Sir Donald's proposals, which would diminish doctors, create mistrust, and not be in the best interests of patients. This threat to medical professionalism must be resisted at all costs, as the supportive comments of many of the signatories to our petition (<http://www.gopetition.com/online/9679.html>) indicate.

Competing interests None declared.

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REFERENCES

- 1 Hayward B, Mortimer E, Brunwin T, for The Committee on Standards in Public Life. *Survey of Public Attitudes Towards Conduct in Public Life*. London: BMRB Social Research, 2004
- 2 Irvine D. Good doctors: safer patients—the Chief Medical Officer's prescription for regulating doctors. *J Roy Soc Med* 2006;**99**:430–1
- 3 Cole A. England to consider shake-up of medical regulation. *BMJ* 2006;**333**:163
- 4 Medical Professionalism Project. Medical professionalism in the new millennium: a physicians' charter. *Lancet* 2002;**359**:520–2
- 5 Timmins N. Doctors' disciplinary body seeks new regime. *Financial Times* 2006

Open access, medical research, and the internet economy of scale

Few would gainsay Walport and Kiley's¹ optimistic forecast regarding academic publishing, given the Wellcome Trust's move to require its sponsored research be made freely

accessible via PubMed Central or its equivalent within six months of publication. With the issue of 'who will pay' thus having been largely addressed, the question of 'how much is owed' should be explored next.

For many years, established publishing houses have observed diminished costs per unit in response to greater production volume. But electronic publishing charges at present levels may be seen as excessive, unless special factors can be put forth to justify why US\$3000 is required to publish a scholarly manuscript on the internet.¹

That the value of open access is recognized by charitable foundations is to be commended. But whether a philanthropic entity pays is not the issue. Steep surcharges in web-based publishing serve to drive away submissions from independent researchers who are not funded, not wealthy, or just not lucky enough to get a discretionary waiver. We agree that publication costs are legitimate research costs, but how high will such fees need to rise before the internet publishing community is asked for a receipt? To preserve the public trust, it may be time to audit the toll booth on the information highway.

Competing interests Dr Sills is Editor-in-Chief of the *Journal of Experimental & Clinical Assisted Reproduction* (JECAR), published by BioMed Central.

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- 1 Walport M, Kiley R. Open access, UK PubMed Central and the Wellcome Trust. *J R Soc Med* 2006;**99**:4389

Wet-nursing and rickets

Layinka Swinburne (*JRSM* August 2006¹) provides fascinating documentation that rickets was well-established in London by the early 17th century. However, the widespread prevalence of rickets is commonly ascribed to the industrial revolution of the 19th century, with increased pollution and closely crowded urban dwellings reducing the exposure of children to sunshine.² The origin of rickets before the industrial revolution may relate to the widespread practice of wet-nursing alluded to in the article. Infants from wealthier parishes were sent out of London to wet-nurses in country parishes.³ Nursed children of wealthy parents apparently had the greatest risk of rickets. The wet-nurse engaged in continuous breast feeding, even nursing several children simultaneously. Nursed children were included in the country family of the wet-nurse and not necessarily deprived of sunshine.

As the duration of lactation increases, the concentration of calcium in breast milk declines.⁴ Consequently, the calcium intake of very young infants who were wet-nursed was probably considerably less than required for adequate bone mineralization. Although calcium in breast milk is more bioavailable than that of cow's milk, the concentration of calcium in breast milk is only about one quarter the concentration of calcium in cow's milk. As Swinburne points out, non-dairy weaning paps would further aggravate marginal calcium intake. The appearance of nutritional rickets in the 17th century probably resulted primarily from restricted calcium intake rather than from vitamin D deficiency, coinciding with the increased adoption of wet-nursing.

Nutritional rickets exists along a spectrum ranging from isolated vitamin D deficiency to isolated calcium deficiency.⁵ Nutritional rickets may most often result from relative calcium and vitamin D deficiencies interacting with genetic and environmental factors. Although calcium deficiency as a cause of rickets has been relatively recently described, it may have been the primary cause of nutritional rickets prior to the industrial revolution.

Competing interests None declared.

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REFERENCES

- 1 Swinburne LM. Rickets and the Fairfax family receipt books. *J R Soc Med* 2006;**99**:391–5
- 2 Shaw NJ. Vitamin D deficiency rickets. In: Hochberg Z, ed. *Vitamin D and rickets*. Basel: Karger, 2003:93–104
- 3 Fildes V. The English wet-nurse and her role in infant care 1538–1800. *Med Hist* 1988;**32**:142–73
- 4 Thacher TD, Pettifor JM, Fischer PR, Okolo SN, Prentice A. Case-control study of breast milk calcium in mothers of children with and without nutritional rickets. *Acta Paediatr* 2006;**95**:826–32
- 5 Pettifor JM. Privational rickets: a modern perspective. *J R Soc Med* 1994;**87**:723–5

Gustave Dore's Ogre

I read with interest the article by Aronson and Ramachandran,¹ who suggest that the ogre in the illustration by Gustave Dore for Charles Perrault's fairy tale Tom Thumb has exophthalmos (Figure 1).

I think their suggestion is unlikely. Dore's obese, bloated gargantuan would surely be more likely to suffer with non-insulin dependent diabetes mellitus, hypertension and metabolic syndrome than ophthalmopathy. Dore's illustration of the violent, drunk and overweight bully was no

Figure 1

doubt intended as a caricature and parody of male behaviour consistent with Perrault's presumed wish to use this tale in part as an allegory for domestic violence. Another illustration of the same ogre appears not to show exophthalmos (Figure 2).

Furthermore, the authors in their opening sentences list the extensive bibliography for which Dore provided

Figure 2

Figure 3

illustrations. Surprisingly, they omit to mention the story of Blue Beard (Barbe Bleue), which Dore also illustrated for Perrault. Blue Beard too was an extremely unpleasant character who murdered his seven wives and kept their dead bodies in a secret room in his castle. As is easily seen from Dore's illustration, Blue Beard's eyes look very similar to the ogre's (Figure 3).

I suspect that this was simply Dore's visual metaphor for the popular notion of the madness of staring eyes.

Competing interests None declared.

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REFERENCE

- 1 Aronson JK, Ramachandran M. The Diagnosis of Art: exophthalmos – Gustave Dore's ogre. *J R Soc Med* 2006;**99**:421