If certain measures (care of the cervical spine, intubation and ventilation, setting up an intravenous line, splinting fractured limbs) are performed at the scene of the accident and the critically injured patient is transferred to the appropriate hospital by the appropriate means within the "golden hour" morbidity and mortality can be reduced. Other interventions (such as fluid resuscitation and applying military antishock trousers) that entail a philosophy of "stabilise then mobilise" are less beneficial than those entailing a philosophy of "scoop and run," especially in urban areas. This may not be true, however, if the transfer to hospital takes longer than 20 minutes.

The Royal College of Surgeons of Edinburgh holds courses for the diploma in immediate care, and there are British textbooks and other courses specifically on this subject. The Royal Army Medical Corps runs a battlefield army trauma life support course based on the principles of advanced trauma life support. It caters for the field management of casualties without the sophistication of hospital care and thus meets the criteria of the immediate care module suggested by Mowat.

It is not only, however, the immediate care of patients with trauma that needs to be addressed but also the continuum of care (from the scene of the accident to rehabilitation) and accident prevention. Successful care is care that returns an injured patient to society quickly.

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Behçet's disease

SIR,—B Wechsler and J C Piette have mysteriously omitted to mention chlorambucil as a treatment in Behçet's disease.¹ This alkylating agent may have a useful role in preventing recurrent episodes of uveitis and encephalopathy in the disease.^{2,3}

Recurrent ocular symptoms may progress to loss of useful vision within 10 years in a considerable proportion of people.⁴ Death and permanent deficit after Behçet's disease affecting the central nervous system have been well documented.^{5,6} As corticosteroids may not ultimately prevent blindness or death,⁷ chlorambucil should be considered in appropriate patients despite its small risk of oncogenicity.

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Diagnosing pulmonary embolism

SIR,—We welcome N W Morrell and W A Seed's pragmatic approach to the difficult problem of reliably diagnosing pulmonary emboli.¹ Ventilation-perfusion scans are often requested

and relied on to confirm or exclude pulmonary embolus. Misgivings about the reliability of the test led us to audit the scans obtained in our hospital and assess the consistency of reporting among radiologists.

During 1991, 608 lung scans were obtained, of which we located 567. Altogether 162 (29%) were reported as being "high probability" scans and 330 (58%) as "low probability" scans, which is a much lower proportion than that in the studies quoted by Morrell and Seed.^{2,3} In our study only 15% of the patients would have required a further procedure to determine whether they had pulmonary emboli by Morrell and Seed's criteria.

When five consultant radiologists who regularly report isotope lung scans were presented with 10 scans, clinical information, and chest x ray films—simulating the normal reporting conditions—inconsistent results were produced. In each case the majority opinion was assumed to be correct. On this assumption, the original scan had been misreported in four of the 10 cases in a way that would have altered the diagnosis and subsequent management. The original report had been of low probability in three cases; one scan initially reported as high probability was reported by the consultants as low probability. If these results are representative, up to 40% of reports may be misleading.

A practical strategy for dealing with scans that fall between low and high probability scans is useful, but we need to be sure that the initial categorisation is correct more than 60% of the time.

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Free For All: "Cancer positive"

SIR,—Jeffrey Tobias is entitled to his opinion of our programme, but he should not mislead readers over facts.¹

Firstly, he seems to suggest, incorrectly, that patients treated at the Bristol centre who were included in the study reported in the *Lancet* were not having orthodox treatment.

Secondly, he says that these patients "still seemed to do worse in the long run." This was never stated, even by the researchers: Bristol patients were observed for an average of only six months.

Thirdly, with regard to overall survival, the press release put out by the Imperial Cancer Research Fund and the Cancer Research Campaign in September 1990 quite properly stated, "it is still too soon to compare overall survival." Even if the study was continuing this would still be true: some patients were entered into the study less than five years ago.

Fourthly, the woman who said that some doctors would "throw you out of the room" at the mention of the Bristol centre also said of other doctors: "They'll be, oh, great, especially the younger ones. . . . They're very keen and ask you all about it." Tobias seems anxious to polarise the discussion. We would like the two sides to come together, and we believe that orthodox and complementary medicine can and should gel, as they already do in many NHS hospitals.

Fifthly, it was not Penny Brohn who said that "the charities' publicity machine made sure it was made public" but ourselves, in our commentary.

The Bristol Cancer Help Centre had no hand in making the programme.

Sixthly, the report did not analyse the effect of treatments on offer at Bristol; indeed, the researchers made no use of the questionnaires which would have documented compliance.

Finally, the "sensational story" was not "gobbled up" by the tabloid papers any more than by the quality press. The *BMJ* gave it 39 column inches in September 1990, the *Times* 20, and the *Sun* only three.

It seems to need restating that, in the words of Sir Walter Bodmer himself, "women going to Bristol had more severe disease than control women." He was good enough to apologise on camera for the distress caused, saying: "I am very sorry that a mistake was made." A further important point is that the Bristol women were younger than the controls, and evidence shows that breast tumours tend to grow faster in younger women.²

What scientific conclusions, if any, may be drawn from such a study is, in our view, a matter for an independent inquiry. We agree that a review committee should have pointed out major flaws. The problem was that no review committee did so.

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- 1 Tobias J. Publish and be damned. *BMJ* 1992;304:991. (11 April.)
- 2 Cheung CWD, Johnson AE. Carcinoma of the breast: measurement and the management of treatment. *Br J Radiol* 1991;64: 121-32.

Improving postgraduate training in ophthalmology

SIR,—J H Sheldrick and colleagues sought to obtain information on undergraduate and postgraduate ophthalmic training by analysing diagnostic accord between general practitioners and an ophthalmologist.¹ Their finding of agreement in nearly 60% of cases suggests that training in ophthalmology must be reasonably good. Though they acknowledge that this was a self selected group of general practitioners working under abnormal conditions, I think that they have seriously underestimated the effect that this has on any conclusions that may be drawn from their study.

The quality and nature of referrals from primary care to ophthalmic casualty and outpatient departments are valid reflections of the adequacy of training. The aims of training should be to instruct in the management of simple eye conditions (such as blepharitis) and to provide awareness of more serious problems (usually visual) requiring referral. In a recent audit of 102 referrals to the clinic at St Paul's Eye Hospital I found that in 34% of cases the urgency of the outpatient appointment could not be assessed because inadequate information had been provided. In only 55% were symptoms described, and in only 23% was the duration of symptoms mentioned. It is more important for a referral letter to include the history and results of simple examination (including visual acuity) than for it to include a suggested diagnosis.

Standard referral forms have been advocated.² Issuing general practitioners with such forms, with examples, could be an important step in postgraduate training. Improving the quality and promptness of the hospital's reply to the general practitioner is another potential opportunity for education. Bringing the ophthalmologist into the general practitioner's surgery, as proposed by some fundholders,³ may be the ideal solution but is probably feasible on only a small scale.

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- 1 Sheldrick JH, Vernon SA, Wilson A. Study of diagnostic accord between general practitioners and an ophthalmologist. *BMJ* 1992;304:1096-8. (25 April.)
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Ethics and multicentre research projects

SIR,—We strongly support Peter Moodie's suggestion that there should be a "national committee to give conditional approval" to multicentre trials.¹ We have concerns about the role of local research ethics committees in these trials, which have been expressed by others.^{2,3} Recent guidance from the Department of Health, which merely advised "that committees should arrive at a voluntary arrangement under which one [local research ethics committee] is nominated to consider the issue on behalf of them all" simply dodges all the difficulties and will do nothing to help the organisers of large projects to get prompt, authoritative advice on ethics.⁴

Major research projects must have ethical review by independent professionals who are expert in many disciplines, including statistics, pharmacology, epidemiology, toxicology, and sociology, as well as having a practical understanding of ethical issues. Our district's local research ethics committee simply does not possess all this skill, though it does have knowledge of local circumstances. We suspect that this may be true in other districts.

In the past two years our committee has considered 114 research projects, of which no less than 70% have been multicentre drug trials. In considering these projects we have been repeating the work of many other such committees. Each local research ethics committee has its own application form, so researchers have to redraft their applications to suit the styles of different districts. This is an expensive waste of effort whose main effect is to deter research.

Surely there should be, as Moodie suggests, an authoritative expert committee that could comment on multicentre research projects. These comments would be available to both local research ethics committees and researchers. This would both ensure high standards and smoothe the process of ethical approval.

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- 1 Moodie P. The role of local research ethics committees. *BMJ* 1992;304:1129-30. (2 May.)
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Conference on ethical review of clinical research

SIR,—In his editorial Peter Moodie discusses Rabbi Julia Neuberger's report *Ethics and Health Care: the Role of Research Ethics Committees in the United Kingdom* and refers to the need for improved training of members of ethics committees.¹

A training conference for members of ethics committees is being organised jointly by the Association of Independent Clinical Research Contractors and the Centre for Philosophy and Health Care, University of Wales. A wide range of speakers has been invited from the NHS, academic

research, and the pharmaceutical industry. Entitled "Ethical review of clinical research," the conference is being held at Robinson College, Cambridge, from Monday 21 September to Tuesday 22 September with registration on Sunday 20 September. We have had a good response so far from members of NHS research ethics committees, and further information may be obtained from me at Simbec Research, Merthyr Tydfil, Mid Glamorgan CF48 4DR (telephone 0443 690977).

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- 1 Moodie P. The role of local research ethics committees. *BMJ* 1992;304:1129-30. (2 May.)

Ethics of embryo manipulation

SIR,—I agree with Mary Warnock that the mildly handicapped are "not properly entitled to speak" on behalf of children and parents afflicted by the "disastrous" diseases for which prenatal and pre-implantation screening and selection services are being developed.¹ Certain statements that Warnock makes, however, raise the important question of "who is?" This is highlighted, for example, by the statements that intervention of a preventive nature is aimed at abolishing "a few disastrous diseases which have a fatal outcome or cause an intolerable burden to the sufferer" and that while many of the mildly handicapped "lead tolerable and indeed enjoyable lives" the same is "simply not true" of patients with these disastrous diseases.

From my own experience, both as a doctor and as a patient seriously affected by such a disastrous disease, I would point out that the issue of the tolerability and potential of lives such as mine is not at all simple. As in other areas of major adversity, while the burden of many such diseases currently screened for may seem intolerable to some patients, others afflicted with the same burden may continue to enjoy the experience of life (with the exception perhaps of a few diseases such as anencephaly) despite the severe difficulties and early death. The aim of preventing an intolerable burden to the sufferer is, of course, a noble one, but unless it is possible to prevent the disease without also preventing the patient, who might in reality find life a great deal more than tolerable, such screening is not something that some sufferers, myself included, wish for.

This is, of course, a personal view, and I fully accept that in a difficult area of imponderables and inevitable uncertainty others with different values, perspectives, beliefs, and goals may logically make different choices. It is surely important, however, given the moral and ethical uncertainty and disagreements that exist, for all concerned with these issues to accept that there is much that cannot be stated to be simply untrue or true. I believe that no individual, patient, organisation, or committee can be truly qualified to make absolute statements on the quality of our lives or be properly entitled to do so.

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- 1 Warnock M. Ethical challenges in embryo manipulation. *BMJ* 1992;304:1045-9. (18 April.)

Legislation, morals, and ethics

SIR,—In *A Man For All Seasons* Sir Thomas More warns his future son in law of the dangers of a society with no law, but he still recognises the

inadequacy of the law. Pragmatically we need legislation for the function of society, and formulation by consensus is optimal. But I was troubled by the views expressed by Dame Mary Warnock in her Green College lecture.¹ She said: "Research using human embryos (subject to time limitations) and in vitro fertilisation are permitted by law; the rights and wrongs of that need no longer be a subject of public debate." She also said: "The moral question having been settled one way, the law has now clarified the issue."

These statements suggest an elevation of pragmatic legislation beyond any status it can really be accorded. I agree that legislation must be formulated for the moral dilemmas confronting our society, but that legislation should be recognised for what it is—a clumsy but necessary instrument in the area of morals and ethics and no more.

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- 1 Warnock M. Ethical challenges in embryo manipulation. *BMJ* 1992;304:1045-9. (18 April.)

Fellowships for doctors from Czechoslovakia

SIR,—For the past 40 years the medical profession in Czechoslovakia has been prevented from having normal contacts with colleagues in the United Kingdom and other Western countries. Doctors have had difficulties in obtaining medical books and journals in English and attending conferences abroad. Often they have used outdated methods of investigation and treatment, and there has been a shortage of modern equipment, drugs, and materials. Since the recent political changes senior doctors from Czechoslovakia urgently need to develop contacts with their colleagues in Western countries and to update their medical knowledge. In the present economic situation, however, they cannot finance visits abroad.

The Catching Up Trust was set up in April 1990 to provide fellowships for doctors from Czechoslovakia to enable them to visit hospitals and medical institutions in the United Kingdom. The trust fund is financed by donations from individual people, industry, and commerce. The fellowships are offered to senior doctors from medical schools to help them to re-establish links with doctors in the United Kingdom and to learn about recent developments in their specialty, current trends in research, and advances in medical education. It is hoped, too, that the scheme will facilitate opportunities for junior specialists in Czechoslovakia to participate in postgraduate programmes for overseas doctors in the United Kingdom.

The trust works in cooperation with the scientific advisory committee at the Ministry of Health in Prague and the deans of the medical schools, who select candidates for the fellowships. The trust coordinates the fellows' placement in the United Kingdom and monitors their progress. British doctors and British academic institutions have shown a tremendous amount of good will; the first four fellows, who are visiting British hospitals now, appreciate the warm welcome given to them.

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Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.