intervention can be recommended. In addition, use of a daytime average of 160/95 mm Hg must deny treatment to many patients who would receive it on the basis of the World Health Organisation criteria,⁴ and may deny some of them the benefits in terms of preventing stroke. Furthermore, as a separate issue, we are concerned that the common assumption that patients with "white coat" hypertension are not at risk may be flawed.⁵

We believe that there is a need for prospectively collected data on the clinical outcome of patients managed on the basis of ambulatory rather than clinic pressures and suggest that this is an urgent concern. Such data might be collected by the joint action of academic centres working in this research area. Until such data have been collected, wholesale introduction of this technique in clinical practice may be premature.

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Frequency of citation and outcome of cholesterol lowering trials

EDITOR,—When I answered the critics of my paper¹ I had not read the letter from Gilbert R Thompson,² who thinks that frequent citation of trials reflects their quality, not their outcome. I have grouped the trials according to their quality (table) scoring -1 for unblindedness or use of a drug with frequent and typical side effects (trials 11-17, 19, 23-26, 28, 31, 32, 34 in the original paper); fewer than 500 subjects (trials 11-17, 21, 26); multifactorial approach (trials 28, 31, 32); not using intention to treat data (trial 27); not using randomisation (trials 11, 32); and sponsorship by a drug company (trials 12, 13, 21, 25, 33). I have followed the objection from Durrington and colleagues³ as regards randomisation; I apologise for having misunderstood the methods on that point in some of the papers.

As seen the best trials (groups 0 and -1) were cited four times more often than the others (groups -2 and -3). In the three best groups, however, the trials considered supportive by their directors were cited four to seven times more often than un-

Mean annual citation of trials arranged in four quality groups. Figures in parentheses are numbers of trials

	Quality groups			
	0	-1	-2	-3
All trials	38.8 (5)	48.3 (6)	13.1 (9)	8.8 (4)
"Supportive" trials	59.0 (3)	67.5 (4)	22.5 (4)	7.7 (3)
"Unsupportive" trials	8.5 (2)	10.0 (2)	5.6 (5)	12 (1)

supportive trials. Admittedly, the scoring is crude and arbitrary; nevertheless it is obvious that frequent citation may also reflect irrelevant matters such as a favourable outcome.

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Health care for elderly in Japan

EDITOR,—Yuzo Okamoto's paper on the crisis in the care of elderly people in Japan does not mention one reason why the problems exist and are likely to become worse.¹ Having visited Japan as part of a global survey of primary care, I believe that the basic fault in the Japanese health system is a near total neglect of primary personal care and social care. Since the beginning of this century, and more so since the second world war, the emphasis has been on specialist and hospital services. This has been due to the influence of German medical educational methods before the first world war and American health care philosophies since the second. As a consequence primary care is not recognised as a specialty. There is no special training and no strong professional grouping or political representation.

First contact physicians do exist but are drop outs from hospital specialty training. They set up in the community to provide primary care and endeavour to combine this with their specialist interests. There are 80 000 of them—one per 1500 population—and most work alone. A most unusual custom is that they are allowed to provide clinics as part of their service. These have up to 20 beds, in which they can treat their patients for extra fees: remuneration is by fees for services. These services, however, are not coordinated with community needs and facilities. Home visiting is rare, and primary health teams do not exist. In fact, there is competition to provide primary care between hospital emergency rooms and specialists, to whom Japanese people have free access.

To prevent the crisis to which Okamoto refers a reconstruction of the whole health system is urgently required, in which primary medical and community services are properly planned and funded.

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- 1 Okamoto Y. Health care for the elderly in Japan: medicine and welfare in an aging society facing a crisis in long term care. *BMJ* 1992;305:403-5. (15 August.)

The death penalty

EDITOR,—In his editorial on the death penalty Richard Bonnie drew attention to the paradox faced by some of our medical colleagues, a paradox many of us choose to ignore—due in part, I suspect, to the disturbing questions, the uncomfortable facts, and lack of easy solutions posed by the problem.¹ The problem is, of course, that of medical participation, medical collaboration, or medical acquiescence in punishment (physical, mental, social, legally sanctioned or otherwise) and torture, both of which may at the extremes result in death.

It is time we looked again at the Hippocratic oath of "first do no harm." As stated in the editorial, "doctors hold their medical knowledge in trust for the collective wellbeing of mankind and they must

guard against the exploitation of that knowledge in ways that compromise the supreme aspiration of the profession." Where there is a conflict does harm refer to the long term or short term, to the individual or to the community? The monitoring of the degree of isolation which an individual can withstand means that the individual concerned has at least some safeguards. However, does such monitoring perpetuate a dehumanising punishment; does it impair the development of better or worse forms?

In the absence of crime it is the doctor who decides whether a person is mentally ill, mentally handicapped, in need of treatment, etc. In the event of crime the ultimate decisionmaker in any contested case as to whether a person is competent to be executed is the judge, not the doctor. I feel that Bonnie is drawing a fine line when he seems to differ from the working party that claimed that determining competence for execution is necessarily equivalent to medical permission. It certainly is a major step in determining whether the ultimate punishment of the death penalty will be applied. As for treatment of the incompetent prisoner or patient, surely he or she should be dealt with as are other incompetent patients. A prisoner remains a person with rights.

"The dignity of the condemned should not be subordinated to the dignity of the medical profession." Nor should the dignity of the medical profession be used to legitimise or maintain dehumanising practices, some of which are in current use; practices which many of us ignore. It is time for all in the medical profession and in the media in general to acknowledge how medicine and medics are used in punishment and torture practices and perhaps to campaign actively to abolish the word "punishment" and refocus on the word "rehabilitation." Unless and until we reclaim and redeclare "first do no harm" we will as a profession—be it by default, neglect, or reluctance to enter into and maintain the needed debate until alternatives are found—continue to acquiesce to the practice of "minimise the harm."

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- 1 Bonnie RJ. The death penalty. *BMJ* 1992;305:381-2. (15 August.)

EDITOR,—Richard J Bonnie, a professor of law, contends that doctors should participate in capital cases—those in which a guilty verdict may result in the defendant being judicially executed.¹ A doctor's evidence may promote a guilty verdict, for instance, by excluding a mental disorder or from the presentation of forensic medical evidence.

But if a doctor's professional testimony contributes to a guilty verdict for which the sentence is execution then, in effect, that doctor's professional expertise has become one of the tools used to kill someone. It is difficult to see any real distinction between that and the circumstance Bonnie rightly condemns, where a doctor is "serving as an agent of the state's punitive apparatus" if he decides whether or not a person is fit for a punishment or directs how a punishment should be administered. The inconsistency of the professor's position is that in the former instance he exhorts doctors to influence verdicts which happen to carry the death penalty and in the latter he condemns medical influence facilitating the predictable consequences of the same guilty verdict. The niceties of the distinction are likely to be lost on the person being executed.

A recent infamous case illustrates the point. Judith Ward was found guilty of carrying out IRA bombings, in part, as a result of the psychiatric report. The widespread disapprobrium heaped on the psychiatrist's head was excited not so much by Miss Ward being found guilty of a crime she did

not commit, bad though this may be, but because she spent 18 years in prison. She suffered from the sentence, not the verdict. Doctors cannot disclaim the consequences of their professional contributions.

In many countries a majority of the population supports capital punishment and a doctor's beliefs are a matter of personal conscience. It must, however, be a matter of public concern if medicine is contributing, even if at some distance, to injuring someone's health so lethally that the victim ceases to exist. There is an unbridgeable gap between that and what the ancients had in mind when, in composing the Hippocratic Oath, they wrote "Whatsoever house I enter, there will I go for the benefit of the sick."

The bottom line must surely be that doctors should not use their professional skills to influence judicial proceedings towards a guilty verdict when sentences might be expected to harm a defendant's health. Whether purists would say that includes prison sentences in this country's current penal system is another story.

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Preparing for a foreign fellow

EDITOR,—Having trained in very different health service, professional, legal, and social welfare systems (NG trained in India and AC in South Africa), we would like to highlight areas in addition to those outlined by Lindsay J Smith and Catherine Marraffa¹ where the need for information is essential to the successful integration of doctors coming from Third World countries.

Although the NHS may be well known in most parts of the world, few of us arrive with a working knowledge of its actual structure and hierarchy. The general practitioner as the gatekeeper for access to specialist care is by no means a universal model, and the relative absence of "walk in" outpatient clinics surprises many—as does the amount of communication and correspondence required between the primary and secondary care staff.

Intraprofessional hierarchies and job titles vary widely, and working in a multidisciplinary environment can prove difficult for the uninitiated. Statutory responsibilities, particularly under the mental health legislation, are likely to be totally unfamiliar. The problem, however, is wider than this, and the entire medicolegal framework may appear alien to the newly arrived doctor. Given the dilemmas faced even by those conversant with the system,² this should not be unexpected.

The royal colleges' overseas doctors training schemes now provide a focal point for the entry of many foreign graduates, and the Royal College of Psychiatrists has taken the initiative by addressing most of these issues in its recently introduced induction courses. None the less, there remain many entrants outside such formal schemes. We believe that those proposing to host such visitors should, in addition to Smith and Marraffa's "shopping list," also note the potential difficulties we have mentioned above.

This is not to say that visitors should not make their own preparations—Dan Veale provides an excellent example.³ In particular, psychological readiness to enter a new medical system at a position often lower in the pecking order than that occupied in the home country will go a long way towards improving peer relations and job satisfaction.⁴ Although working in a foreign country, living in an alien culture, and frequently using a language other than one's mother tongue will inevitably be a challenge, it is not necessarily

difficult to make an overseas sojourn one of life's most rewarding experiences.

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Pain during mammography

EDITOR,—I am astonished at the tone of D R Rutter and colleagues' paper on discomfort and pain during mammography.¹ They suggest that the pain reported by 6% of women undergoing mammography can be excused given that it had largely disappeared within 5-10 minutes; this is unacceptable as a reason for not acknowledging that for some women the experience is sufficiently unpleasant that they choose never to return, and tell their friends. I am sure that if male doctors had to undergo the same squeeze technique on their testicles because it detected testicular cancer early they would tell their friends and vote with their feet in the same way. Why not acknowledge that for a third of women the procedure can be anything from uncomfortable to exquisitely painful depending on the degree of premenstrual breast tenderness as well as the other reported contributing factors? The issue of adequate pain relief for the examination must be addressed, otherwise more and more women will forgo it.

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Euro exams

EDITOR,—Other monospecialist sections of the European Union of Medical Specialists have watched with interest the urologists' lead in setting pan-European examinations.¹ I look forward to seeing the results of these examinations and am interested to read that 10% of eligible urologists have applied to sit the examination so far. The cardiologists have taken a different view and have favoured a system akin to that already in operation in the United Kingdom—that is, approval of training posts and "accreditation" once a trainee has spent the requisite number of years in post.

There is general agreement that some form of accreditation is necessary for specialists in Europe. But I, and others, doubt whether an examination is applicable to all medical specialties. The variation in methods of assessment, however, is a healthy sign since we will be able to learn from each other's mistakes.

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- 1 Euro exams. *BMJ* 1992;305:13. (4 July.)

EDITOR,—The urologists and anaesthetists are not alone in seeking to bring some standardisation of training in different European countries.¹ The European Society of Medical Oncology, comprising some 1500 members from 35 European countries,

is particularly concerned to ensure the highest possible standards of training for cancer physicians throughout Europe.

In 1989 we instigated a certification process for medical oncology on the basis of a review of the applicant's curriculum vitae and passing a multiple choice examination. The examination has been set annually since 1989 and despite being available only in the English language has proved popular. Already over 400 oncologists have been certified.

Great Britain is most fortunate in having the college structure to monitor training and the guidelines from the Joint Committee on Higher Medical Training of the Royal College of Physicians are being used to assist colleagues in other European countries to devise appropriate training programmes.

Medical oncology is recognised as a discrete subspecialty of internal medicine in only a small proportion of European countries, and consequently many non-specialists find themselves involved in treating cancer. The narrow therapeutic index of systemic therapies for cancer makes this situation highly undesirable on both health and economic grounds. The European Society of Medical Oncology is seeking recognition for medical oncology throughout the European Community and encouraging the development and monitoring of training programmes.

Clearly, examination is only one method of assessing standards of competence, but it is hoped that the initiative taken by the society will contribute to lessening professional discrepancies between oncologists in the European countries and improve the level of oncological training throughout Europe.

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Americans and SI units

EDITOR,—Magne Nylenna and Richard Smith make too much of our decision to use both conventional and SI units, in that order. Certainly, it stretches things quite a bit to see it as "akin to the WHO deciding that trying to eradicate polio is just too tiring." The purpose of our decision was simply to permit our American readers to understand the data we publish—not an unreasonable goal for a journal. It was a pragmatic decision, not an ideological one.

We appreciate that we are an international journal, and we greatly value our growing readership outside the United States. For this reason, we are using SI units in addition to conventional units and sending to our subscribers abroad a conversion booklet at no charge.

Whether we (and Nylenna and Smith) like it or not, American physicians (who constitute most of our readership) and the institutions in which they practice do not use SI units, and we have learnt that our journal cannot force them to do so. All we seemed to be accomplishing in using only SI units was to limit communication—a quixotic and, we believe, arrogant position for us to take. The contention of Nylenna and Smith that we have some overriding responsibility to continue to do so strikes us as overdrawn by at least several scruples.

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