though screening is demonstrably cost effective.⁴ Foremost among the unresolved questions is the ability of physicians to treat bone disease once it is detected. The number of knowledgeable physicians is increasing, but not enough for them to manage the 100-fold increase in caseload that could result from population screening. Today less than 5% of patients with fracture undergo densitometry, and less than one third of the potential patients with indications (for example, those taking corticosteroids or with malabsorption or hyperparathyroidism) are symptomatic. Barlow and colleagues note that critics confuse clinical densitometry in patients showing symptoms or indications with screening.¹ Physicians must become educated about bone disease so that they can manage effectively the increased caseload that will result from justified use of densitometry, and they must not be misled by disingenuous arguments against screening.

RICHARD B MAZESS*
President

Lunar Corporation,
313 W Beltline Highway,
Madison,
WI 53713,
USA

*Lunar Corporation manufactures equipment for bone densitometry.

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Women need to be fully informed about risks of hormone replacement therapy

EDITOR,—As women doctors, we were surprised by A J Isaacs and colleagues' suggestion that women doctors are in favour of using hormone replacement therapy themselves and that this predicts wider use by the general population.¹ Their statistics hardly support this assertion: of 1514 doctors written to, only 344 confirmed that they currently took such treatment. Women doctors, in common with other women, are subjected to considerable pressure to use hormone replacement therapy, and the risk of serious side effects may be overlooked.

A 50% increase in the risk of breast cancer is associated with current use of hormone replacement therapy for more than five years.² Given the already high and rising incidence of this disease in Western populations, this is more frightening to most women than heart disease or osteoporosis, for which hormone replacement therapy is claimed to be beneficial. (The possibility that postmenopausal women taking hormone replacement therapy who develop breast cancer have a better prognosis than those not taking hormone replacement therapy should not be an argument for mass treatment.)

Suicide has been found to occur in more women taking hormone replacement therapy than expected; not all of these women had a psychiatric history.³ The mood swings of women taking hormone replacement therapy have been analysed⁴ but may still not be recognised as side effects of a mood altering and possibly addictive drug. This can have implications not only for the women themselves but for those people associated with them, including their families and work colleagues.

The possible cardiovascular benefits of hormone replacement therapy, which have been frequently quoted, have been questioned.⁵ Safer

ways of decreasing the risk of both heart disease and osteoporosis involve changes in lifestyle, including taking more exercise and having a healthier diet. These should be vigorously advocated, as should stopping smoking.

The menopause is a normal physiological state, not a disease. Drug treatment should not be given to the general population. Women wishing to make informed choices about hormone replacement therapy, balancing the possible benefits against the dangers and side effects, remain confused by much contradictory information. Those who are concerned about the risks should contact a new organisation, DASH (Doctors Against Abuse from Steroid Sex Hormones), for an alternative approach to the widespread promotion of hormone replacement therapy. The secretary is Dr E Grant, 20 Coombe Ridings, Kingston upon Thames, Surrey KT2 7JU.

ELIZABETH H PRICE
Consultant medical microbiologist
Great Ormond Street Hospital for Children NHS Trust,
London WC1N 3JH

HELEN KAYE LITTLE
Consultant radiologist
Bronglais Hospital,
Aberystwyth,
Dyfed SY23 1ER

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Education for educating surgeons

Training for trainers does exist in Britain

EDITOR,—Christopher Bulstrode and Gareth Holsgrove rightly point out the need for those people who are responsible for the day to day education and training of young doctors to be sufficiently well versed in educational techniques to undertake their tasks effectively.¹ However, their assertion that "no such training for trainers currently exists in Britain" disregards:

- The long tradition of mandatory educational training for trainers in general practice—for instance, there are about 150 accredited and reaccredited trainers in general practice in Devon and Cornwall
- Several regional initiatives in "educating the educators"—for example, the south and west scheme for consultants organised through the postgraduate deans
- The distance learning approach to medical education—including an MSc—taken by Dundee University, which has seen over 50 hospital doctors complete courses
- The MSc and diploma in medical education from the University of Wales College of Medicine. This course, established in 1987, is constructed on a modular basis and requires a commitment of 19 days a year for two years. Eighty three students, 53 of whom are British doctors, have completed or are completing this course.

Clinical staff who have taken opportunities for in depth education of this sort are able to be the source of a cascade of education to a wide range of clinical colleagues in their locality and are a cost effective means of promoting good educational experience for doctors in training.

GIFFORD BATSTONE
Director
Medical Development Programme,
King's Fund Development Centre,
London W1M 0AN

- 1 Bulstrode C, Holsgrove G. Education for educating surgeons. *BMJ* 1996;312:326-7. (10 February.)

Surgeons' knowledge base needs to be increased

EDITOR,—We share Christopher Bulstrode and Gareth Holsgrove's concerns about and approach towards the education of surgeons¹ but would suggest that in addition to addressing surgeons' attitudes and behaviour we should increase their knowledge base. This would mean incorporating disciplines such as clinical epidemiology into training programmes. We adopted this approach in our recently established MSc in clinical orthopaedics at the University of Teesside and introduced didactic and small group teaching of clinical epidemiology and biostatistics. Students gain further experience while completing their compulsory research based dissertation.

At our first workshop on evidence based orthopaedic surgery in Middlesbrough last November, all students found such teaching useful for their practice and research projects. They also wanted more, and accordingly we are now exploring the possibility of ward rounds and journal clubs with the involvement of educators and clinical epidemiologists. A copy of the proceedings of the workshop is available on request.

We have two concerns. Firstly, because our MSc course has attracted only visiting doctors, local career trainees are not benefitting, although we are targeting them through the regional training programme. Secondly, there are limited opportunities for the trainees to practise what they have learnt because their seniors may not have received such training and may find their questioning challenging. It is in this latter respect that the initiatives described by Bulstrode and Holsgrove will be useful.

We would be pleased to hear from others embarked on similar programmes to share experiences and collaborate with them to promote evidence based orthopaedic surgery.

RAJAN MADHOK
Coordinator, evidence based orthopaedic surgery programme
South of Tyne Health Commission,
South Shields NE33 3BN

JOHN STOTHARD
MSc course director
Middlesbrough General Hospital,
Middlesbrough TS5 5AZ

- 1 Bulstrode C, Holsgrove G. Education for educating surgeons. *BMJ* 1996;312:326-7. (10 February.)

College has found strong demand for training programmes

EDITOR,—As Chris Bulstrode and Gareth Holsgrove emphasise, consultant surgeons need to be educated in the principles and methods of teaching while undertaking clinical work.¹ Indeed, it is important that they are educated in these principles and methods so that they can apply them to any educational opportunity and thereby maximise the efficiency of their teaching.

At the Royal College of Surgeons of England we have been running a "training the trainers" programme since May 1994 and have found that there is a strong demand for our courses. The two day course was initially designed for consultants who teach on various courses on practical skills, including minimal access and basic surgical skills. We soon found, however, that we were receiving requests from many other surgeons, whose main concern was teaching juniors in the workplace. We therefore vary the emphasis of our courses to take account of the needs of the particular participants who are attending. Over 200 surgeons have now taken part in these courses, and we expect that number to have more than doubled by the end of this year: 35 courses are planned, and they are fully subscribed until September.

The training the trainers project is a major development within the Raven department of

education at the college, and we are looking to extend the range of courses offered at the existing, foundation, level as well as developing more in depth education modules on topics such as assessment and evaluation. In terms of our own evaluation, we are working with the regional postgraduate dean in Wessex to evaluate the training the trainers courses, which have attracted over 100 surgeons from the Wessex area. Feedback received at the end of the two day course has been positive, and we are hoping to follow this up with a survey of how participants are applying what they have learnt to their own clinical situation.

Any initiative with the same broad aims of developing an understanding of how adults learn in terms of knowledge, skills, and attitudes as applied to medicine is certainly to be welcomed.

RODNEY PEYTON
"Training the trainers" tutor

Royal College of Surgeons of England,
London WC2A 3PN

1 Bulstrode CJK, Holsgrove G. Education for educating surgeons. *BMJ* 1996;312:326-7. (10 February.)

Compliance therapy in psychotic patients

Authors were wrong to compare treatment with no treatment

EDITOR,—I read Roisin Kemp and colleagues' paper on compliance therapy in psychotic patients with some anxiety.¹ The sessions of structured compliance therapy contained elements that all psychiatrists use to some extent, in a "freehand" manner. For example, I cannot imagine a psychiatrist not discussing side effects, particularly if the patient expresses concern. Again, all of us try to give patients insight into the need to continue with drug treatment even when they feel well.

I was therefore concerned by the authors' statement that in the control group "the same therapists listened to the patients' concerns but declined to discuss treatment." I am most unhappy about seriously ill patients being deprived of an important element of their management, and I am surprised that the ethics committee accepted such a protocol. I thought that the time when a treatment was compared with no treatment was long past.

Surely the appropriate course of action would have been to compare the structured treatment with the intuitive approach practised by most psychiatrists. This would have given more meaningful results than the artificial comparison used.

G O DUBOURG
Consultant emeritus

11 Fairlawns,
Mansfield,
Nottinghamshire NG18 3EP

1 Kemp R, Hayward P, Applewhaithe G, Everitt B, David A. Compliance therapy in psychotic patients: randomised controlled trial. *BMJ* 1996;312:345-9. (10 February.)

Many ethical questions arise from study

EDITOR,—I applaud Roisin Kemp and colleagues' efforts to devise and test a means of improving psychotic patients' compliance with antipsychotic drugs.¹ I was disappointed, however, that the authors did not address several important issues more fully.

Did the control group receive routine clinical care in addition to the control intervention? If not and they had no opportunity to discuss their treatment with a doctor then several further questions arise. Firstly, was it ethical to offer a treatment short of what many would regard as good practice? The authors themselves refer to "the potentially devastating consequences of relapse," yet did they withhold from their control

group treatment that they had reasonable grounds to believe might help prevent relapse? Secondly, is it acceptable to offer a treatment short of what the NHS patient's charter states a patient has a "right" to expect—that is, to "have any proposed treatment, including any risks involved in that treatment and any alternatives, clearly explained to you before you decide whether to agree to it"?² Thirdly, how were side effects and response to treatment monitored by the treating psychiatrist?

How was consent for participation in the study obtained from the 25 patients detained under the Mental Health Act? It is interesting that no patient withdrew consent during the early part of the trial, a time when one might expect improvement in mental state to lead to a change of heart.

Both the active and control treatments were delivered by the same investigators. Being motivated to find a difference in outcome between the two treatments would have made it difficult to maintain an unbiased approach.

RICHARD GRAY
Registrar in psychiatry

Winford House Hospital,
Exeter EX2 5AF

1 Kemp R, Hayward P, Applewhaithe G, Everitt B, David A. Compliance therapy in psychotic patients: randomised controlled trial. *BMJ* 1996;312:345-9. (10 February.)

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Authors' reply

EDITOR,—We must clarify an important issue regarding our trial: the patients in the control group also had the opportunity to discuss drug treatment with the teams treating them. Our intervention supplemented standard care, which, of course, respects patients' rights to be informed about their drug regimens and treatment, with considerable input from staff. The study was approved by the hospital's research ethics committee, which saw no reason why patients detained under the Mental Health Act should be denied the opportunity to participate in therapeutic research with their consent.

Gray expresses concern about potential bias with respect to the fidelity of treatment. Both the intervention and control treatments were largely administered by the same person to control for non-specific factors relating to the therapist. Continuing supervision ensured adherence to the protocol, with attention being paid to ensuring consistency of input within the intervention and control groups. Anecdotally, patients who received non-specific counselling expressed a readiness to take the opportunity afforded them to discuss general concerns, while they were advised to discuss issues related to their drug treatment with their doctors.

ROISIN KEMP
Research psychiatrist
ANTHONY DAVID
Reader

Department of Psychological Medicine,
King's College Hospital and the Institute of Psychiatry,
London SE5 9RS

PETER HAYWARD
Clinical psychologist

Department of Psychology,
Maudsley Hospital,
London SE5 8AZ

Disease in children with HIV infection in Abidjan

Authors should have emphasised lack of tuberculosis in HIV positive children

EDITOR,—Sebastian B Lucas and colleagues report an impressive series of paediatric necropsies from Abidjan, documenting the range of dis-

ease in African children infected with HIV.¹ The sampling method was to carry out a necropsy on all HIV positive children in the mortuary during the study period and "randomly selected children" who were HIV negative. How random sampling was done is not discussed. The authors state that most children who die in the hospital and the community (the city) pass through the mortuary where the study was carried out; in the 10 month study 408 children were admitted to the mortuary. In a city such as Abidjan do only 40 paediatric (12 years or younger) deaths occur a month? Or are there hidden biases in this population that have not been appreciated?

One of the main outcome measures was cause of death. There is, however, no indication of how this was determined, particularly for children with multiple infectious processes or severe malnutrition (41% of all cases); little clinical information was available to help. I worry that the method of ascribing the cause of death was more subjective than objective, and this is also a problem in the adult necropsy study carried out at the same time.² How was pyogenic pneumonia identified as the cause of death in 86% (49/57) of paediatric cases but only 17% (19/110) of adult cases?

Much of the paper compares the necropsy results in seropositive and seronegative children. I am surprised that one of the principal conclusions is that there is a greater overlap in children than in adults when the adult necropsy data can be interpreted in precisely the opposite way, and when this contradicts clinical findings in Nairobi.³ A much more pertinent and robust observation is the lack of tuberculosis in children infected with HIV. Surprisingly, the authors seem reluctant to emphasise the practical importance of this despite the increasing tendency in many paediatric services in Africa to call any atypical chest problem tuberculosis, particularly if underlying HIV infection is suspected. Nor is this a trivial issue: the use of antituberculous drugs in the paediatric wards in Blantyre, Malawi, has risen nearly 10-fold over the past five years (R Broadhead, personal communication) despite any objective data that tuberculosis was the main aetiological problem.

Finally, it is surprising to see a reference to a paper published in 1991 (the first cited) qualifying the authors' initial statement about numbers of infected children in 1993: something must be wrong.

CHARLES GILKS
Senior lecturer

Liverpool School of Tropical Medicine,
Liverpool L3 5QA

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Authors' reply

EDITOR,—Some of the points raised by Charles Gilks were omitted because of lack of space. During the eight month study all children found in the mortuary at 0730, six days a week, were tested for HIV infection. The HIV negative children were selected for necropsy by lot. Over 408 children in hospital and the community died; cadavers are not taken to the mortuary in a larger proportion of paediatric than adult deaths.¹ The adult necropsy study showed that causes of death in patients with HIV infection were similar in those dying in and outside hospital,² as was the case with the children (data not shown).

For accurate ascertainment of the cause of death combined clinical, laboratory, and necropsy data are ideal but rarely attainable. Necropsy data are