their residual risk of having a child with cystic fibrosis. Couples in which one partner has no identifiable mutation and the other partner is not tested have a risk of 1 in 16 100 (1/25×1/161×1/4); they represent 96.6% of the couples. Couples in which one partner but not the other has an identifiable mutation have a risk of 1 in 644 (1/1×1/161×1/4); they represent 3.3% of the couples. Couples in which both partners are carriers have a risk of 1 in 4; they represent 0.1% of the population.

As the male partner is usually tested only if the woman carries a mutation, the above calculation does not take into account all the couples in which the man is a carrier but his female partner is not. Such couples should also represent 3.3% of all the couples. Therefore, in the above calculation, 96.6% of the couples are given a low risk of 1 in 16 100 whereas the correct proportion should be 93.3%, because another 3.3% of the couples (those in whom only the man has the mutation) have a risk of 1 in 644.

One of the main objectives of screening for carriers of cystic fibrosis is to allow individuals to make better reproductive decisions. This is true for carriers but also for non-carriers. I think that both partners should be tested independently to make sure that accurate counselling is given to all couples, even if it may sometimes be difficult to explain our limitations. Furthermore, there may be a risk of stigmatisation because a larger number of women than men are being identified as carriers.

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Patients who have had fractures of the distal forearm do not lose bone as expected

EDITOR,—Women's lifetime risk of experiencing a fracture of the distal forearm is 15%.¹ Such fractures are associated with considerable pain and morbidity. They are also associated with an increased risk of vertebral fracture,² although these anatomical sites have different bone compositions, with the forearm being composed predominantly of cortical bone whereas the spine is composed predominantly of trabecular bone.

In response to the work by N F A Peel and colleagues³ we have prospectively examined rates of bone loss at the lumbar spine over five years in 1003 women (age range 45-64) who had been recruited from a general population cohort.⁴ Data on prevalent fractures of the distal forearm during the 10 years before the baseline were collected from subjects, and incident fractures were recorded during the study. Bone mineral density at the lumbar spine (L1-4) was measured with dual energy x ray absorptiometry (Hologic QDR-1000) at the baseline and at 12, 24, 36, 48, and 60 months. Short term reproducibility (the coefficient of variation) calculated with repeat measures in normal volunteers was 0.8%. Annual percentage rates of change in bone mineral density at the lumbar spine in individual subjects were calculated by linear regression analysis.

Data were available on 32 women who had sustained a fracture of the distal forearm and on 664 controls who had not. Table 1 shows characteristics of the cases and controls. Bone mineral density at the lumbar spine was reduced in the women with a fracture, and this relation was unaltered by adjustment for age. The rate of change in bone mineral density at the lumbar spine was significantly different from zero in the controls ($P < 0.001$) but not in the patients with a fracture ($P = 0.15$) and was significantly greater in the controls than in the patients with a fracture. The results were not affected by adjustment for age, weight, height, menopausal status, and use of hormone replacement therapy.

Our data confirm Peel and colleagues' findings that patients with a fracture of the distal forearm did not lose bone as expected. The data support the hypothesis that the low spinal bone mineral density of these women may be a consequence of either reduced peak bone mineral density or a period of accelerated bone loss before the menopause. This rapid loss could also affect the microarchitecture of bone and may explain the increase in forearm fractures seen at the time of the menopause. Large prospective studies in younger premenopausal and perimenopausal women will be required to clarify these findings.

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Table 1—Baseline characteristics of patients with forearm fracture and controls without fracture. Figures are means (SD) unless otherwise stated

Variable	Patients with fracture (n = 32)	Controls (n = 664)	P value
Age (years)	57.8 (5.1)	52.4 (5.7)	<0.001
Height (cm)	160.1 (6.0)	161.8 (6.1)	0.12
Weight (kg)	67.7 (12.3)	66.5 (12.0)	0.59
No (%) postmenopausal	26 (90)	392 (62)	0.002
No (%) using hormone replacement therapy	7 (22)	150 (23)	0.93
Bone mineral density of lumbar spine (g/cm ²):			
Unadjusted	0.835 (0.149)	0.991 (0.160)	<0.001
Adjusted*	0.889 (0.150)	0.988 (0.148)	<0.001
Rate of change in spinal bone mineral density (%/year):			
Unadjusted	0.62 (2.4)	-0.39 (1.7)	0.02
Adjusted†	0.38 (1.7)	-0.36 (1.7)	0.03

*Adjusted for age. †Adjusted for age, weight, height, use of hormone replacement therapy, and menopausal status.

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Definition of authorship may be changed

Peer reviewers should be identified at end of each published paper

EDITOR,—A recent meeting of academics, editors, peer reviewers, and such at the University of Nottingham concluded, not before time, that the definition of authorship in medical research should be changed.¹ Dr Drummond Rennie, deputy editor of *JAMA*, is reported to have said that "authorship" should be scrapped and authors replaced with "contributors" and "guarantors": the "film credit" approach.¹ That is right as far as it goes; it just does not go far enough. Rennie omitted from his credits the peer reviewer ("peer" is defined as an equal, a fellow, an antagonist²). This omission is ironic since reviewers formed a substantial part of Rennie's audience.

Nowadays, peer review is an integral, responsible, educative, and constructive part of medical research. It looks at the science and the originality. If these are found to be acceptable then peer review can illuminate the message. Take a simple example: say the contributors have omitted a useful reference (most of us, if we are honest, do the definitive literature search after the study instead of the other way round). Peer review should pick that up and, at its very best, should also improve content, style, layout, and readability. Peer reviewers perform these essential and thankless tasks for a pittance; they deserve better than a yearly pat on the back. (We can say this without blushing because no one has yet asked us to review anything more than our pension plans.)

If we take the cynical view, inclusion of peer reviewers in the "credits" would confirm that peer review has happened, would spread the blame, and would concentrate the mind of the reviewer, who would be as entitled as contributors and guarantors to reply to correspondence. If necessary he or she could also meet allegations of fraud, gift authorship, ghost authorship, or "jobs for the boys" (work accepted for publication not on the basis of merit but on the basis of friendship).

Peer reviewers of papers that are not accepted for publication should probably retain the privilege of anonymity (the medical researcher can always submit the study to another journal). Peer reviewers of accepted papers should not be anonymous.

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Clinicians who enter patients into randomised controlled trials should be acknowledged

EDITOR,—It is generally accepted that multicentre randomised controlled trials are important for the adequate assessment of health technologies¹ and

benefit individual patients.²⁻⁴ They need to be large enough to allow sufficient statistical power to answer the research questions posed. It is also known that only a small proportion of eligible patients are entered into such trials (for example, only 3-5% of patients with cancer in Britain are included in clinical trials⁵). Among the many reasons for this lack of accrual is a belief that multicentre trials do not officially recognise the considerable time and effort required by clinicians to identify suitable patients, obtain informed consent, and complete the necessary forms.

Incentives to recruit patients into trials are required. We suggest that clinicians' vital contribution to randomised controlled trials should be acknowledged separately at the end of published papers. In large multicentre trials it is often not practical or desirable for all collaborating clinicians to be mentioned as authors of papers. Thus many people's efforts in recruiting patients to trials go unrewarded: they do not have publications to their name, and their research is denied the recognition that, since the publication of the Culyer report,⁵ is now necessary to gain funding. Benefits could be gained if it became standard practice for all published papers to incorporate a list of clinicians who enrolled more than a (trial specific) number of patients into the trial. Not only would this acknowledge the important work of these clinicians in the trial but it would also provide evidence of their participation in research for academic assessment and for their curriculum vitae and provide kudos for the clinicians and their department.

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Childhood bereavement

Bereavement is painful but does not necessarily make children ill

EDITOR,—Dora Black suggests that bereaved children and their families should routinely be offered counselling to prevent depression and other mental health problems in the future.¹ Although psychiatric morbidity is increased in bereaved children, however, most of them do not develop important depressive conditions.² Indeed, the association with child psychiatric disorder is not as strong as when the child has lost a parent through divorce or separation.³ Bereavement is painful but does not necessarily make children ill. Most bereaved children rely on family and personal resources to deal with their loss and do not require professional help.

There can be substantial problems in setting up successful primary preventive programmes for bereaved children,⁴ not the least of which is the problem of funding. It is difficult to justify diverting scarce resources from the treatment of children with established mental disorders to provide counselling for children at risk. Such a strategy would have to be supported by

compelling evidence from randomised trials that counselling of bereaved children is an effective way of preventing mental illness, but no such evidence exists.¹

Furthermore, counselling after bereavement, however well intentioned, may be harmful to some children. We know surprisingly little about the process of bereavement among young people. It cannot be assumed that concepts borrowed from research with bereaved adults, such as the idea that bereavement consists of a series of "psychological tasks" that must be completed, apply to children. Yet such concepts are often advocated by those working in the field⁵ and form the basis of treatments such as forced mourning. Until we know more about the efficacy of preventive interventions for bereaved children, psychological treatments should be reserved for those children and families who are clearly having problems.

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People with learning disabilities also need help in bereavement

EDITOR,—Dora Black advocates early intervention for bereaved children.¹ We should also provide intervention for people with learning disabilities. There is often a mistaken belief that such people need to be protected from the knowledge of death either because they do not understand the concepts or because they will cause difficulties for others.

Harper and Wadsworth have reported their preliminary findings that people with learning disabilities display grief responses similar to those of other adults and that the experience of grief does not depend on intelligence.² Responses to grief might, however, be prolonged, and a range of other behaviours might also be exhibited. I have found that many people with learning disabilities are not told when a parent dies and continue to be excluded from participation in rituals surrounding the death. They may also suffer the trauma of being removed from their home, sometimes immediately after the parent has died and often without a single object to remind them of the dead person.³

Great advances in knowledge are being made about the possibilities of psychotherapy for people with learning disabilities.⁴ There needs to be greater awareness that in this group the response to grief may present as altered behaviour. Primary prevention might include preparation by means of group work and sensitive planning by services. After a bereavement the person needs to be given unambiguous information and encouraged to participate in the rituals surrounding death. Carers and support workers should be given specific training, and appropriately adapted counselling—for example, based on non-verbal techniques such as art therapy—should be made available. Liaison with established agencies (whose staff may lack skills in dealing with this

group) would be helpful. Early detection and treatment of psychiatric disorder are essential. Further research is needed to evaluate the usefulness of other interventions—for example, an extended role for case managers. Above all, compassion and understanding are necessary for bereaved people with learning disabilities.

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Asylum seekers who claim to have been tortured should have right to independent medical examination

EDITOR,—I have recently helped to prepare a medical report on a young Nigerian who claims that he was tortured during detention in Nigeria. No charges were ever brought against him despite months of detention under appalling circumstances. His crime was apparently that of belonging to and working for the Campaign for Democracy. He was held in detention in Britain for a year (presumably at enormous expense to taxpayers) while his claim and appeal were considered. During that time he was interviewed by an immigration official who noted that his story was almost certainly false because he avoided eye contact throughout the interview. His appeal against deportation was rejected. Those who have worked in Africa will know that "looking away" is a sign of courtesy and respect in many cultures and is nothing to do with honesty. A medical examination requested by friends of the victim showed that the scars on his body supported his story. On the basis of this his case was reviewed and he is to be allowed to stay in Britain.

Claims of torture are notoriously difficult to check because, for obvious reasons, reports by witnesses are hard to come by and cannot be checked. An independent medical report, as used by the courts in cases in which claims are being made for personal injury, offers an opportunity to check the story told by the victim and should be used in disputed cases.

The Asylum and Immigration Act, which was recently rushed through parliament under dubious democratic procedures, was apparently designed to reduce the flood of applicants for asylum but seems to offer nothing to distinguish genuine applicants from economic migrants. Those applicants claiming to be victims of torture should have been given the right to a full independent medical report.

We have a duty to offer help to those people who have the courage to speak their minds in countries where this is a crime punished by torture and imprisonment without trial. Under the new regulations many political refugees whose applications are genuine will stand no chance of a fair hearing.

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