to suggest that in the main we officiously keep people alive has never been true. To insinuate that we do not find out the wishes of the patients at appropriate times is equally untrue. To imply that something written six months previously should dictate what we do today is simply foolish. To recommend we take it into account is certainly what we do in the hospice world and, I am sure, in the main, elsewhere.

Most doctors work well with their patients and the patients' relatives at these difficult times, but many of us feel that it is right that we may be asked to account for our actions in a court of law. It seems that they are already having problems in the Netherlands.²

This long debate on euthanasia and advanced directives has stimulated a great deal of rethinking and has brought to light many very useful ways forward for the profession and alerted patients to the need for good communication with their physicians. I hope that many feel, as I do, that we cannot simply legislate these difficulties away. I believe that the public opinion surveys show that the majority support the principle of caring, not legislation.

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Clinical oncology information network

EDITOR,—M C Gulliford suggests that the Royal College of Radiologists has dismissed the use of population based registries for evaluating treatment of cancer.¹ Many registries have incomplete data that have been extracted by clerks from inadequate hospital case notes. In Gulliford *et al*'s study of bladder cancer the rate of discrepancies between cancer registry data and hospital case notes was 17% for the date of first operation, 12% for the date of first radiotherapy and 16% for the radiotherapy dose.² Only 15% of patients receiving chemotherapy were recorded as such in the registry; 28% of the case notes gave no data on pathological tumour stage. There was also confusion regarding the classification of superficial and invasive bladder cancers. Another major confounding factor is that important prognostic factors may not be recorded either in cancer registration data or in cancer treatment centres.

The clinical oncology information network project intends to address these problems by seeking national agreement on the type of data to be collected.³ Equally important is the assignment of precise definitions to data. Körner statistics record the number of "new patients" seen, but there is no agreed definition of a new patient. The Royal College of Radiologists recognises that patients treated in cancer centres are only a subset of the population with cancer as a whole.

Ian Basnett and colleagues urge us to improve our current systems.⁴ The clinical oncology information network project intends that information on patients with cancer will be captured at clinical workstations integrated into the usual working conditions of clinical oncologists and their staff. This should help to improve the accuracy and completeness of data acquired and eliminate transcription errors. Cancer registry data would be produced as a byproduct.

The secretary of state for health owns case records. The Royal College of Radiologists will own the summary data used for national comparative audit. To secure the cooperation of the medical profession, participants in the clinical oncology

information network must be satisfied that the data will be used appropriately. The use of data in computer systems compliant with the network would not be restricted by the Royal College of Radiologists.

Basnett *et al* compared process and outcome in a teaching and a non-teaching district.⁵ The teaching district did more scans and had a significant, 20% better survival rate at five years. The largest difference that might be expected to result from treatment is 10%. The discrepancy probably results from stage migration: if more investigations that detect metastases are carried out patients will be reclassified from a lower to a higher stage. With increasing numbers of tests the prognosis at all stages improves. This will constantly confound comparative audit. The clinical oncology information network will address this by achieving agreement among oncologists on the definition of stages and by analysing groups assigned stages according to the definition even if additional tests are done. Basnett *et al*'s study compared practice in two districts between 1982 and 1986 with consensus guidelines issued in 1986, so any conclusion drawn is probably irrelevant. Recent practice needs to be audited against contemporary guidelines that reflect a professional consensus rather than the recommendations of a consensus conference.

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Overdose of diltiazem

EDITOR,—In response to John Kenny's editorial on the hazards associated with calcium channel blockers in overdose¹ I wish to report my and colleagues' findings with respect to fatal overdose of diltiazem.² Diltiazem is an antianginal drug that has been available in Britain since 1985. Six fatal cases of overdose have been reported.^{2,4} It is difficult to estimate the incidence of overdose of diltiazem as only one poisons centre in Britain (the National Poisons Information Service, London) keeps a database on overdoses of this drug. Between 1983 and 1988, 14 cases of overdose of diltiazem occurred in adults and five cases of accidental ingestion occurred in children. In France, between 1979 and 1988, 83 cases of overdose occurred in adults and 51 accidental poisonings occurred in children.⁵ The true incidence of overdose of diltiazem is probably grossly underestimated.

As Kenny pointed out, routine drug screening for calcium channel blockers does not take place. As many of the complications of calcium channel blockers are cardiovascular in nature, cases of overdose could be missed and their clinical features assumed to be due to existing cardiovascular disease. We reviewed cases of overdose of diltiazem and attempted to correlate clinical sequelae with drug concentrations.² The therapeutic range of concentrations was 100-200 µg/l. At concentrations of 1000-1500 µg/l conduction abnormalities greater than first degree heart block and hypotension occurred. All patients with concentrations > 1500 µg/l required a temporary pacemaker, and all patients with concentrations > 6100 µg/l died.

If drug assays were routinely available not only could the diagnosis be made but serious side effects could be anticipated. Caution must be used, however, when drugs are taken in combination (one patient took diltiazem together with a β blocker and died, despite intensive resuscitation, with a diltiazem concentration of 1500 µg/l²). Similar caution should be used when the patient is elderly, has severe coronary artery disease, or has any other disease that can lower the "mortality threshold." A literature review showed that the mean time for recovery in uncomplicated cases was 36 hours, allowing the withdrawal of supportive treatment.

Similar toxicological reviews for the other calcium antagonists would be useful to determine the drug concentrations at which complications are likely to occur. As the use and the risk of misuse of calcium channel blockers increase there will be an increasing need to assay these drugs in acute cases.

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Mental health law

EDITOR,—Responding to my paper on mental health law,¹ the National Schizophrenia Fellowship writes² that it supports supervised discharge orders.³ The form that such orders might take, however, has now been called into question by the recommendation by the Clunis inquiry that, within the order, "if the responsible medical officer considers that the patient has failed to comply with the plan, or that the patient's mental health is deteriorating, the patient may be recalled to hospital."⁴ The Department of Health's original version of the order would allow only for urgent case review with a view to re-sectioning under the Mental Health Act if the patient was deemed detainable. Hence, in terms of coercion of the patient the Clunis inquiry's recommendation goes further than both the department's proposal and the community supervision order recommended by the Royal College of Psychiatrists⁵ by constructing what amounts to conditional discharge. If enacted in relation to patients who are not offenders such an order might be open to challenge in the European Court of Human Rights.

Officers of the Royal College of Psychiatrists point to apparent inaccuracies in my statements about examination in mental health law of candidates for the MRCPsych.² I did not intend to suggest that the subject was not examined at all. I wrote, "the college does not formally examine in mental health law." Hence, although very general legal questions can potentially be set in the written examination, the college does not currently think that specific legal provisions can be examined. I believe that this has given rise to the belief among candidates that the subject is not examined at all—shown by reported "patchy knowledge."² Otherwise, more specific examination rests on both a chance meeting between an oral examiner and candidate from the same legal jurisdiction and the wish of the examiner to examine the subject. I am sorry that I did not qualify the statement more clearly. The officers' assertion that "there is no dispute between the college and Irish candidates" is correct, and I regret it if the reverse could have been an interpretation of my words. I believe that the college did stop written examination of specific

mental health law because of a complaint by Irish candidates, but clearly the continuation of this policy may well relate to perceived difficulties concerning candidates from other jurisdictions.

Legal provisions are a crucial part of the armamentarium of clinical psychiatry, and it is necessary to overcome practical examination difficulties through examining in alternative jurisdictions. There should be an emphasis on the interface between clinical psychiatry and law, based on the demonstration of adequate knowledge of not only the Mental Health Act 1983 but also common law, including topics beyond civil detention (I am a member of a joint working party of the BMA and Law Society that is writing a book to inform all doctors about a variety of civil legal incapacities). I applaud the college's exploration with the Department of Health of ways of providing training in mental health law both for trainee psychiatrists and as part of continuing professional development for consultants.

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Locums should have log books

EDITOR,—Clare Dyer's article on a consultant who was found guilty of serious professional misconduct after failing to investigate complaints that a locum, Dr Behrooz Irani, was endangering patients contains a factual error. In February 1993 (that is, six months after the incident at Castle Hill Hospital) Dr Irani was not working in Hull but was employed as a locum consultant anaesthetist at St Lawrence Hospital, Chepstow. The incident in which Dr Irani left the operating theatre to make a telephone call led to an operating department assistant noticing that the patient in whose charge he was left was receiving a hypoxic gas mixture and was beginning to show signs of oxygen desaturation. Fortunately we were using a computerised anaesthetic record system, which captures all physiological and machine data, and we were able to confront Dr Irani with this incontrovertible evidence of his incompetence. Dr Irani was immediately dismissed from his post and was reported to the General Medical Council.

A worrying aspect of this affair is that Dr Irani was able to obtain a post as a locum consultant anaesthetist in Chepstow, having received three good references (two from a previous employer and one from a consultant in Hull) after the events at Castle Hill Hospital in August 1992. I believe that Dr Irani's medical registration should have been suspended pending an inquiry into the incident at Castle Hill Hospital. If he had been required to carry a log book detailing his previous employment and, more particularly, the names of supervising consultant staff we might have been aware of his previous problems before interviewing him for the post in Chepstow.

Locum staff of any grade should be under the supervision of a named senior member of consultant staff in their specialty at the hospitals in which they work. This could be the college clinical tutor or the chairperson of the anaesthetic division. If the names of these supervising doctors were entered into a log book carried by the locum along with the dates of their employment it would be

relatively easy for potential employers to trace the locum's activities and previous posts. It has been suggested that such a system would be cumbersome and expensive, but incidents such as that at Castle Hill Hospital are far from isolated and the costs in human misery alone are enormous.

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Mortality associated with elective caesarean section

EDITOR,—In their analysis of direct maternal deaths reported in the confidential inquiry for 1982-4¹ Lawrence Mascarenhas and colleagues ascribed to vaginal delivery not only the 26 deaths in undelivered women but also the 28 deaths after abortion and ectopic pregnancy.² The number of deaths in women delivered vaginally was 40, which gives a direct case fatality rate of 0.02/1000 maternities, compared with that for elective caesarean section of 0.09/1000. The direct mortality associated with elective caesarean section was thus 4.5 times that associated with vaginal delivery in 1982-4.

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Schizophrenia among residents of hostels for homeless people

EDITOR,—John Geddes and colleagues' study of the prevalence of schizophrenia among residents of hostels for homeless people in 1966 and 1992 is flawed in design, analysis, and interpretation.¹ The authors acknowledge many of these faults in their discussion, but their unwarranted conclusions, specific (even if true) to the situation in Edinburgh, are likely to be misinterpreted by the wider policymaking community. Their findings may well be misrepresented as showing that the problem of severe mental illness among single homeless people is diminishing.

The main design fault derives from the 1992 sampling frame. Only people resident in 1992 in hostels regarded as comparable to those used for the 1966 survey should have been included. The sample in 1992 contained only 72 people (36%) from such comparable hostels. The authors should have presented the characteristics, including the number diagnosed as having schizophrenia, for these 72 people. Though they attempted an adjustment of their 1992 sample, no amount of post hoc adjustment of data can compensate for an underpowered and biased sampling strategy.²

We agree with the authors that homelessness is not an inevitable consequence of the policy of community care for mentally ill people, and their interpretation of their results along these lines, if we set aside the question of validity, is acceptable. What is remarkable, however, is that large scale, systematic, and nationally representative research on the possible links between homelessness and the move in Britain towards smaller psychiatric units based in district general hospitals, involving the phasing out of "new long stay" inpatient care, has not been carried out.³ Until such research is done

the findings of numerous cross sectional surveys of single homeless people, including that by Geddes and colleagues, will continue to pose but not answer important questions.⁴

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Smoking and psoriasis

EDITOR,—Hywel C Williams reviews some of the published work on the link between smoking and psoriasis,¹ but without adequate controls it is not possible to say that smoking could be responsible for up to a quarter of cases of the disease. Most studies have examined smoking in isolation and have failed to consider other confounding variables, particularly alcohol consumption. The only two studies that have taken both factors into account have shown discrepant conclusions: one found smoking to be a greater risk factor than drinking² whereas the other concluded that alcohol alone was a risk factor for the development of psoriasis.³

In our study smoking was shown not to be an independent risk factor for psoriasis. In contrast, there was a strong association with alcohol consumption: 28% of patients with psoriasis drank to excess.⁴ The adjusted risk factor for alcohol in psoriasis was 8.01 (95% confidence interval 3.62 to 17.7). Although the association between heavy drinking and the development of psoriasis is more pronounced in men, it is also relevant in women: 21% of female patients with psoriasis in our survey misused alcohol.

Alcohol thus seems to be more important than smoking in influencing the outcome of psoriasis. Williams emphasises that smoking has little effect on the course of the disease.¹ In contrast, continued drinking is associated with therapeutic failure and abstinence with remission.⁵ We are now investigating the possible mechanisms by which alcohol might influence psoriasis. We would reiterate the importance of taking a comprehensive smoking and alcohol history from all patients with psoriasis, both to assess possible aetiological factors and to predict diagnosis.

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