patient's relatives it should not howl too loudly when non-medical staff inadvertently do the same.

PHILIP BARLOW
Consultant neurosurgeon

Institute of Neurological Sciences,
Southern General Hospital NHS Trust,
Glasgow G51 4TF

- 1 Beales D. Draft bill aims at improving confidentiality. *BMJ* 1994;309:360. (6 August.)
- 2 Gillon R. Confidentiality. *Philosophical medical ethics*. Chichester: John Wiley, 1986:106-12.
- 3 General Medical Council. *Professional conduct and discipline: fitness to practise*. London: GMC, 1992:26-7.
- 4 Brazier M. *Medicine, patients and the law*. Harmondsworth: Penguin, 1987:67.
- 5 Scottish Law Commission. *Mentally disabled adults: legal arrangements for managing their welfare and finances*. Edinburgh: SLC, 1991:102. (Discussion paper No 94.)

Circumcision and uncircumcision

EDITOR,—In his review of a book on "uncircumcising" Roger S Kirby is doubtful whether circumcision desensitises the glans to sexual stimuli,¹ even though many men complain that this is the case, including some who have been circumcised as adults. I am not aware of any published objective studies comparing the sensitivity of the glans in circumcised and uncircumcised men. Furthermore, although there is obvious macroscopic change in the appearance of the glans after circumcision, no published studies of the histological changes associated with this have been carried out, so far as I know. Although the profession has been performing circumcision for a century, we have never looked into its anatomical or physiological consequences. It is unwise to ignore what patients are telling us.

The fact that this book has been written should alert us to the possibility that circumcision may be more harmful than we have supposed. The knowledge that some men perceive that the function and feeling of their penis have been impaired by this operation, usually carried out in childhood without their consent and often with little or no medical indication, should concern us and stimulate further research into penile function and sensory perception. If we have no objective information about the effects of circumcision after 100 years it is hardly surprising that the profession is ignorant about the effects of uncircumcision after 10. Until this subject is properly investigated we cannot dismiss what these men report as a placebo effect and should keep an open mind.

JOHN WARREN
Consultant physician

Princess Alexandra Hospital,
Harlow, Essex CM20 1QX

- 1 Kirby RS. The joy of uncircumcising! Restore your birthright and maximize sexual pleasure [book review]. *BMJ* 1994;309: 679. (10 September.)

Importance of awareness of religious customs

EDITOR,—Further to A R Gatrads' article on Muslim customs surrounding death,¹ it is important that all health care workers are constantly aware of all religious customs.

A 72 year old man was sent to an accident and emergency department by his nursing home as the nurses were concerned that he had not eaten or drunk for the previous five days. He spoke no English and had no relatives or next of kin. He had lived in the home for two years, and the history was obtained from the nurses there.

On examination there were no abnormal findings. Investigations including biochemistry,

haematology, chest radiography, analysis of a midstream urine specimen, and blood culture gave negative results.

The hospital staff realised that he was hungry and gave him food, which he ate with relish. It became apparent that the nurses in the home had failed to appreciate that their patient was adhering to the requirements of Ramadan. Meals at the home were served only after sunrise and before sunset, and during the month of Ramadan Muslims must fast during daylight hours. For following his religious beliefs he had been subjected to numerous investigations and an uncomfortable night in hospital. Thus not only medical staff but also staff in institutions need to be aware of religious beliefs. Carers in institutions are often the only source of information.

ELIZABETH AITKEN
Registrar

Department of Geriatrics,
Lewisham Hospital,
London SE13 6LH

- 1 Gatrads AR. Muslim customs surrounding death, bereavement, postmortem examinations, and organ transplants. *BMJ* 1994; 309:521-3. (20-27 August.)

Help for sick doctors

Confidential help is available

EDITOR,—Liam J Donaldson and Claudia Court drew attention to the important matter of sick doctors.^{1,2} They both referred to the unsympathetic attitudes of colleagues and employers when the sickness is alcohol or drug misuse.

Doctors who have an alcohol problem often live in fear of drawing attention to themselves, this fear being shared by their spouses and families. They usually do not know how and where to seek fully confidential medical help that can be trusted and regarded as safe. They fear employers and colleagues, often without cause, and they commonly most fear the General Medical Council, again probably without cause. Because of these factors the sickness may continue unaddressed, to the detriment of all concerned. This situation should not and need not arise. There is a well established way of approaching these understandable fears of discovery.

It is regrettable that neither Donaldson nor Court mentioned the British Doctors and Dentists Group, the one peer group that can and does help doctors totally confidentially and without involving outsiders. It has existed for over 20 years and is composed of a large number of formerly addicted colleagues who have been helped to recovery and thence to normal lifestyle, including being able to work professionally in happy and permanent sobriety. Help and guidance are given freely to colleagues by colleagues who are themselves former sufferers and are now free of compulsive addiction to alcohol or drugs. The group does not involve anybody outside the medical and dental professions or anybody within the professions who has not been a sufferer. In gratitude for the help that they have received group members are only too willing to share their experiences and knowledge with any newcomer who chooses to seek out the group. The success rate is high and recovery is usual.

The Doctors and Dentists Group is available to any colleague nationwide who seeks it; it fulfils one of the recommendations in the Holland report,² in that it provides every worried doctor or his or her partner or spouse with access to a confidential telephone number over which private discussion can take place.

A telephone number for any of 12 geographical areas within the United Kingdom can be obtained by using in the first instance a private number. No surnames or addresses are asked for, and calls will be taken by a doctor who has made a happy and

successful recovery and identifies himself only as "James." Call him if you think you might need help on 021 353 6817. You will receive reassurance and understanding and will be given a contact number where help can be obtained in your part of the country.

- 1 Donaldson LJ. Sick doctors. *BMJ* 1994;309:557-8. (3 September.)
- 2 Court C. British study highlights stigma of sick doctors. *BMJ* 1994;309:561-2. (3 September.)

Occupational health departments can help and be trusted

EDITOR,—On the basis of my experiences in practising occupational medicine within the NHS I agree with Liam J Donaldson's assertion that many doctors perceive occupational health departments as irrelevant to them and as having too close a relationship with management.¹ This perception stems from a basic lack of understanding about the practise of occupational medicine and occupational health and also about the workings of a modern NHS occupational health department.

Most doctors come into contact with occupational health departments only when they start a new job or when they are called for vaccinations. This is despite the fact that most departments now provide a comprehensive range of services to other members of staff. Doctors' lack of contact with occupational health departments is probably because until recently they did not fully understand their management responsibilities within a multidisciplinary organisation and were oblivious to the fact that health and safety legislation applied to them.

The lack of trust in occupational health departments may stem from the origins of such departments as nurse sick bays and it may also reflect the lack of clinical status which afflicts departments without consultant occupational physicians. That information is leaked to management, however, is totally erroneous: occupational health departments go to great lengths to protect clinical confidentiality. Perhaps this fear is based on practices elsewhere in hospitals? Occupational physicians are skilled in assessing and managing ill health in the workplace. It is sad that doctors do not feel able to consult them more often.

JOHN HARRISON
Senior lecturer in occupational medicine

Department of Environmental and
Occupational Medicine,
Medical School,
University of Newcastle upon Tyne,
Newcastle upon Tyne NE2 4HH

- 1 Donaldson LJ. Sick doctors. *BMJ* 1994;309:557-8. (3 September.)

Value of Kleihauer test

EDITOR,—Jennifer K M Duguid and Imelda Bromilow question the reliability of the Kleihauer test,¹ while Elizabeth A Letsky and Mahes de Silva suggest that a higher dose of anti-D immunoglobulin would eliminate use of the test.² We report a case showing the danger of this proposal.

A woman who was group O RhD negative delivered a baby who was group O RhD positive in 1989 and was given the standard dose of 500 IU of anti-D immunoglobulin. In her second pregnancy in 1992 screening for antibodies yielded negative results at 16 and 32 weeks; at 35 weeks intrauterine death occurred without warning. Postmortem examination attributed death to transplacental haemorrhage secondary to placental infarction. She was given 500 IU of anti-D immunoglobulin. Kleihauer testing showed over 45 fetal cells per low power field, and an additional 6000 IU of anti-D

immunoglobulin was given. At 48 hours there were still over 50 cells per low power field, which necessitated a further 5000 IU; she thus received 11 500 IU in total. The count was 10 cells per low power field at 96 hours and <2 at 120 hours. Titres of anti-D antibodies fell to 0.1 IU/ml at five months.

The couple wanted to start another pregnancy but were counselled against this. At six months no anti-D antibodies were detectable and cautious approval was given. Conception occurred within a month. Antibody titres were nil throughout the pregnancy. A baby who was group O RhD positive was born at 38 weeks. Kleihauer testing showed 10 cells per low power field; only 1000 IU of anti-D immunoglobulin was required.

Transplacental haemorrhage remains one of the important causes of Rh isoimmunisation; if it is severe the rate of fetal loss can be 40%.³ The D antigen is a potent immunogen, but formation of antibodies is not invariable after stimulation of D negative people with D positive cells. Formation of antibodies commonly occurs in 60% of women during immunisation programmes. This figure is dose related, and larger infusions of 200 ml red cells may induce the formation of antibodies in over 90%.

When a whole unit of RhD positive blood was given to volunteers, suppression occurred when 100 IU of anti-D immunoglobulin was given for each millilitre of red cells.⁴ Similarly, when RhD negative women have received transfusions of Rh positive blood inadvertently, sensitisation has been prevented provided sufficient immunoglobulin is given.

Without the information from the Kleihauer test this patient might not have had a successful third pregnancy. The test may need better quality control, but it remains the only way of detecting massive transplacental haemorrhage for which even a standard postpartum dose of 1500 IU of immunoglobulin would be inadequate.

R P BALFOUR

Consultant obstetrician and gynaecologist

Princess of Wales Hospital,
Bridgend,
Mid Glamorgan CF31 1RQ

F G WILLIAMS

Consultant in transfusion medicine

J A F NAPIER

Medical director

National Blood Transfusion Service (Wales),
Rhydylafar,
Cardiff

1 Duguid JKM, Bromilow I. Value of Kleihauer testing after administration of anti-D immunoglobulin. *BMJ* 1994;309:240. (23 July.)

2 Letsky EA, de Silva M. Preventing Rh immunisation. *BMJ* 1994;309:213-4. (23 July.)

3 Sebring ES, Polesky HF. Feto-maternal haemorrhage: incidence, risk factors, time of occurrence and clinical effects. *Journal of Transfusion* 1990;30:344-57.

4 Millison PL, Engelfriet CP, Contreras M. *Blood transfusion in clinical medicine*. 9th ed. Oxford: Blackwell Scientific, 1993.

Government clarifies long term NHS care

EDITOR,—John Warden's report on the clarification of responsibilities for long term health care suggests that the government has come full circle.¹ However, the draft guidance contains the serious proviso that the individual authorities (health and social services) throughout the country reach their own agreements about "local criteria for eligibility"—that is, who needs health authority care (free at the point of issue) and who needs social service residential (historically always means tested) or domiciliary care. In the past the Department of Health has issued guidelines, which in my experience have been widely accepted and have emphasised the importance of considering domiciliary care when practical. These guidelines were spelt out in 1965 in the memorandum for local

authorities and hospital authorities that accompanied circulars 14/57 and HM(57)86,² and they are still broadly correct in defining responsibility.

The delegation for deciding criteria for responsibility locally is another example of the abandonment of the concept of a national health service, as the criteria will almost certainly vary from area to area. It will also result in endless committee meetings, with much waste of professional time and public money, to decide clinical boundaries. Any disagreements in the local areas will largely be due to lack of financial resources, resulting from the government spending so little of its gross national product on the health service compared with governments of other developed countries. Why is it impossible to continue to use the previous classification of responsibility nationally, with give and take with regard to local and individual needs.

Perhaps the stumbling block is that the Department of Health is trying to hive off the financial responsibility for long term nursing care while paying lip service to it. The government gave evidence to the House of Commons' social services committee in 1991 which states: "Health Authorities have a responsibility under the NHS Act 1977 to provide nursing care for those who cannot or do not wish to pay for it."³

J ANDREWS

Honorary consultant geriatrician,
West Middlesex Hospital

Shepperton,
Middlesex TW17 8NG

1 Warden J. Government clarifies long term NHS care. *BMJ* 1994;309:498. (20-27 August.)

2 Ministry of Health. *Care of the elderly in hospitals and residential homes*. London: Ministry of Health, 1965. (Memorandum for local authorities and health authorities in conjunction with circular 14/57 and HM(57)86.)

3 House of Commons Social Services Committee. *Fourth report, the financing of private residential and nursing home fees*. Vol 2. London: HMSO, 1991:92. (HC421/II.)

Floating eye clinic

EDITOR,—Giles Tremlett's news item on a Russian eye hospital ship operating in the area of Gibraltar¹ suggests that ophthalmology is in danger of confusing two issues that should be kept apart. The first issue concerns the legality of a foreign registered floating eye hospital operating in British-Spanish territorial waters, presumably without any attempt having been made to obtain a licence for the doctors on board from the relevant professional body: in the case of Gibraltar this is presumably the General Medical Council in London. I would be interested to learn what international legal opinion had to say about this. Secondly, the methods used to treat patients on board have been attacked.

Professor Svyatoslav Fyodorov, who set up the clinic, has made numerous innovative contributions to ophthalmology. He was one of the founder members of the International Intraocular Implant Club, which I set up; the inaugural meeting took place at the Royal Society of Medicine in July 1966 under the presidency of Harold Ridley. I could muster only 17 colleagues, including Professor Fyodorov, from around the world who believed that lens implantation after cataract extraction had a future. In those days Professor Fyodorov did not speak any English, but he still came to the meeting from Archangel. Two years later—and by then fluent in English—he read papers at the implant club's next meeting in Budapest.

Professor Fyodorov has a worldwide reputation for rescuing Sato's work on radial keratotomy from oblivion and putting it on a sound scientific and surgical footing. Where would refractive surgery be today without Professor Fyodorov's input? I am not saying that all the procedures carried out on the hospital ship are beneficial and cost effective, but so far as we know they are not harmful. Money

talks, and if 20 000 patients contribute \$24m a year the Floks Eye Clinic must be doing something right.

I have one practical suggestion. British nationals who own second homes in Spain have to pay local tax on any rents they generate, in addition to paying Britain tax. Why not invite the Floks Eye Clinic to pay tax on its earnings to Gibraltar or Spain or else move on?

D P CHOYCE

Past president,

International Intraocular Implant Club

London W1M 7DG

1 Tremlett G. Ophthalmologists protest at floating eye clinic. *BMJ* 1994;309:359. (6 August.)

Acronymophilia

Abbreviations and acronyms are different

EDITOR,—Tsong O Cheng uses the word acronym incorrectly in the editorial entitled acronymophilia.¹ An acronym is a pronounceable word formed from the initial letters of other words. Thus MONICA, RADAR, and LASER are acronyms whereas BMJ, MRFIT, DPPS, NHEFS, HHS, KFC, and CHS are abbreviations and not acronyms. All acronyms are abbreviations but not vice versa. An uglier but more correct title would have been abbreviationophilia.

JAMES WAFULA

Consultant radiologist

Brook General Hospital,
London SE18 4LW

1 Cheng TO. Acronymophilia. *BMJ* 1994;309:683-4. (17 September.)

Acronymophilia knows no bounds

EDITOR,—The examples of acronyms cited by Tsong O Cheng come mainly from cardiology,¹ but all other specialties seem to be affected. Cheng seems to be under the misapprehension that he is alone in his views as the editorial's reference list of 10 SAPs (single author papers) demonstrates the NOAH (no other authors here) syndrome. This is a subtype of the COW (cite one writer) syndrome and an extreme version of the TRAUMA (the references are usually mine alone) syndrome. Are these new syndromes, or have they been described before, possibly under ABA (another bloody acronym)?

S J KRIKLER

Senior orthopaedic registrar

Royal Hospital,
Wolverhampton WV2 1BT

1 Cheng TO. Acronymophilia. *BMJ* 1994;309:683-4. (17 September.)

Terms for which acronyms stand may change

EDITOR,—One point that Tsong O Cheng did not mention in his editorial on acronyms is that the words that some of the letters in GISSI, CONSENSUS, and GUSTO stand for changed between the first and second trials: in GISSI the second S changed from Streptochinasi to Sopravvivenza; in CONSENSUS the N changed from Northern to New; and in GUSTO the U changed from Utilization to Use, the S from Streptokinase to Strategies, and the T from tPA to To.

PETER NICOL

Consultant physician

Department of Internal Medicine,
University Hospital,
S-751 85 Uppsala,
Sweden

1 Cheng TO. Acronymophilia. *BMJ* 1994;309:683-4. (17 September.)