and for their mothers collected the information shown in the table and other data such as place of birth, number of other children in the household, and parental social class and smoking. Finally, we are aware that the accuracy of breast feeding recall may represent a problem after so many years, but why should we suspect a differential recall between the two study groups?

We agree that our results must be treated with caution until other evidence supports them. Among our study groups the mothers of low socioeconomic status were more likely to have breast fed their infants. Thus, it is possible that infants who were breast fed longer were also exposed early in life to some viruses, but after our data were stratified by social class, the association between breast feeding and multiple sclerosis did not change. An intriguing point is that the fatty acid composition of human milk may be influenced by maternal diet,⁴ and diet may vary in mothers of differing socioeconomic status and from different countries.

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Implications of supervision registers in psychiatry

See editorial by Harrison on p 551

EDITOR,—Recent incidents have led to concern that discharged psychiatric patients may pose a risk to themselves or others.^{1,2} The Clunis inquiry recommended the establishment of a special supervision group to monitor those patients presenting most risk.³ Patients were deemed to need close supervision if they fulfilled two of the following criteria: they had been detained several times under the Mental Health Act, had a history of violence or persistent offending, had failed to respond to treatment from general psychiatric services, or were homeless. Last December the secretary of state for health announced the introduction of supervision registers. The categories for inclusion on the register are significant risks of severe violence, severe self neglect, and suicide.

On 16 June this year we undertook a census of all inpatients aged under 65 who were drawn from an inner city population of 232 000, recording the extent to which they met the two sets of criteria. Severity of violence was graded from 1 to 3 on the basis of established criteria, with grade 1 indicating assault leading to no detectable injury and grade 3 indicating assault causing major injury.⁴ Operational criteria were defined to grade the risk of

suicide and offending. Treatment was defined as having failed when an admission occurred despite full outpatient compliance, and severe self neglect was defined as an inability to maintain even basic self care at that time. The table shows the numbers of patients fulfilling each criterion. If grade 1 violence, risk of suicide, and offending are excluded 179 of the 234 patients met the Department of Health's criteria for inclusion on supervision registers and 132 met the criteria recommended by the Clunis report; 115 met both sets of criteria.

Numbers of psychiatric patients who met criteria for inclusion on supervision registers

Criterion	No
Violence:	
Grade 1	42
Grade 2	49
Grade 3	23
Suicide:	
Grade 1	37
Grades 2+3	51
Self neglect	118
Offending:	
Grade 1	30
Grade 2	27
Detained under Mental Health Act more than once	148
Failure of treatment	79
Homeless	65

This study relates solely to inpatients and takes no account of outpatient morbidity. Clearly, however, substantial numbers of patients will be included on the registers. Use of the criteria recommended in the Clunis report would reduce the number of patients on the registers at the expense of those at risk of suicide. Servicing the needs of patients on the registers will have considerable resource implications for community teams and inevitably alter their current case mix.

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Complementary therapy used by patients with cancer

EDITOR,—S M Downer and colleagues attempt to shed light on complementary therapies for cancer.¹ I find it puzzling, however, that they conclude that "benefits such as hope and optimism are reported by the patients." This implies that these benefits are conveyed by the treatments in question. While this notion may be correct, it is not based on the results reported in the paper.

The two groups in the survey differ in several characteristics. In their discussion the authors concede that some of the differences are due to self selection: patients treated by complementary therapies had chosen (and paid for) these treatments, and thus their attitudes can be expected to differ. If this is so, why are benefits such as hope and optimism attributed to the intervention and not to the selection? If this logic was applied consequently, would the authors not also have to state that the significantly increased levels of anxiety in users of complementary therapy were due to the use of these remedies? The notion has as

little support from the findings of the survey as the other.

The study's design (questionnaire/interview) does not permit the inference of cause and effect relations. In my view, trials that would allow just that are needed.

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Coronary heart disease in France

EDITOR,—Tony Smith asks why the French have such a low incidence of coronary heart disease and, by implication, why the Scots have such a high incidence.¹ I believe that a partial explanation is the way in which the evidence is gathered. In England and Wales the coroner's system ensures that fairly accurate causes of death are given in doubtful cases. No such system, to my knowledge, exists in France or elsewhere in mainland Europe. In Switzerland a death may be certified as due to a "natural internal event" (I know this because I translated all the documentation for Avon's coroner on a Bristol woman who had died in Switzerland). Such a cause of death is not acceptable in Britain.

In Scotland, which does not have a coroner's system, many doctors are forced to guess the cause of death; most, surely, must opt for some form of heart attack, thereby overestimating this type of condition. France may have the equivalent of the Swiss natural internal event, underestimate the true incidence of coronary heart disease and perhaps partly explain the discrepancy between the two countries.

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- 1 Smith T. French mysteries. *BMJ* 1994;309:277. (23 July.)

BMA criticises delay in implementing Calman report

EDITOR,—There is undoubtedly considerable uncertainty over what is happening with the implementation of the Calman report. The BMA's annual representative meeting commented on delays and looked for someone to blame.¹ It is important to identify where the delays have arisen.

The Working Group on Specialist Medical Training was set up in September 1992. The report was completed by February 1993 but not released until almost three months later, in May. Eight weeks of consultation followed—that is, until the beginning of July. It was not until five months later that the government agreed to implement the report: this was announced by Dr Brian Mawhinney when he spoke to the Harveian Society in December. The timetable for implementation is that the colleges and their faculties should have had their specialist training programmes prepared by July this year; recommendations on general professional training should be prepared by the end of this year; and these changes should be implemented by the end of next year.

The Joint Committee on Higher Surgical Training has completed its preparation of the training programmes in each specialty and reported this to the senate of the royal surgical colleges of Britain and Ireland on 19 July; the outline arrangements will now be forwarded to the Department of