catory difficulty as increased dietary fibre may aggravate the constipation that is already present.

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Modern medicine and war

SIR,—We were interested that Dr Tony Delamothe's conference report (19 March, p 852) totally ignored the developments in psychiatry which have emerged from the impact of war in this century.

The most obvious example is that of shell shock, which had a considerable effect on the field of psychological medicine and encouraged several reforms of mental health care during the interwar years. Shell shock brought the neuroses into the mainstream of mental medicine and gave credibility to Freudian theories. Treatments such as "faradisation"—that is, administering painful electric shocks to the larynx to soldiers with hysterical aphonia—soon became discredited as doctors discovered that psychotherapeutic techniques were far more effective. One of the main exponents of these was W H Rivers, who established Freud's theories in the Royal Army Medical Corps through his influential article in the *Lancet* in 1917.¹

The large number of ex-servicemen requiring aftercare for shell shock eventually led to the Mental Treatment Act 1930, which empowered local authorities to set up outpatient psychiatric clinics and allowed the mentally ill to be voluntary patients. This was a first move towards the decriminalisation of mental illness which culminated in the Mental Health Act 1959 and laid the ground for the development of psychiatric community care.

S H Foulkes's experience at Northfield Military Hospital during the second world war led him to develop group analytic psychotherapy, which has become a common form of treatment in psychiatric wards. T F Main introduced the term "therapeutic community" in 1946 arising from his experience at Northfield, and this concept of care was developed at the Cassel Hospital where he later worked. In contrast, Sargant has suggested that the second world war gave an important impetus to the development of physical treatments in psychiatry.²

The Vietnam war led to several studies on post-traumatic stress disorder and increased our knowledge of the psychological consequences of acute stress. The Falklands conflict will probably have similar consequences.³

To consider the impact of modern war on medicine without considering the impact of modern war on psychiatry is rather like proposing a production of Hamlet without the prince.

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Passive smoking and lung cancer: a publication bias?

SIR,—Dr Jan P Vandenbroucke (6 February, p 391) surmises that there may be some publication bias relative to male data on passive smoking because the data published by Wald *et al*¹ do not conform to a "funnel" pattern when measured against the standard error of the natural logarithm of relative risk. Having made some effort to gather unpublished data on passive smoking, I would like to make some comments.

Firstly, there are two minor errors in fig 2. The ordinate is labelled logarithm of relative risk when it is in fact the relative risk itself plotted on a logarithmic scale. Also the open circle at $x=0.4$ and $y=2.25$ should be black since it represents Hirayama's data for men.

Dr Vandenbroucke is correct on two points: there are some unpublished data on men, and male and female data should be treated separately. He is also correct that authors, confronted with weak data for men alongside stronger data for women, are inclined to drop the former in favour of the latter. These weak male data, however, do not necessarily mean low or negative relative risks.

Two studies in which data on women but not on men were published are those by Humble *et al*² and Brownson *et al*.³ Their unpublished data on men are shown in the table.

In analyses I have made on relative risks of lung cancer from passive smoking I have used a minimum of 10 years' exposure or exposure of a spouse for admission of data (World Conference on Smoking and Health, Tokyo, 1987). Therefore, I prefer the 33+ year exposure data of Buffler *et al*⁴ shown in the table to the 0+ year exposure data that Wald *et al*¹ used. Also Wald *et al* used a roundabout method to calculate their 2.45 relative risk for Akiba *et al*,⁵ which is higher than the odds ratio calculated by Akiba *et al* from matched analysis (1.8) or their crude odds ratio (2.1) or "observed" deaths divided by their "expected" deaths of Wald *et al* (1.7). For Akiba *et al* I prefer their matched analysis value of 1.8 and have calculated 95% confidence intervals from their 90% confidence intervals. Also shown in the table are the data from the other studies in men that Vandenbroucke took from Wald *et al*.

If one plots the relative risk data in the table on a logarithmic scale against the standard error of $\ln(RR)$ as calculated by Dr Vandenbroucke one gets a funnel shaped distribution centred on a relative risk of 2.06, which is the value one gets by aggregating the relative risk data using the method of Blot and Fraumeni.⁶ The relative risks from the two unpublished studies are higher than the combined relative risk, not lower as Vandenbroucke expected. Excluding them from the analysis reduces the com-

bined relative risk to 1.86. Using the data on men in Wald *et al* as is (Buffler *et al* and Akiba *et al* unchanged) yields a broader funnel centred on a combined relative risk of 1.5. Adding the two unpublished studies raises this relative risk to 1.7. In either case, on the basis of evidence so far available, there is no indication that publication bias explains or will explain the observed relative risk among men for lung cancer from passive smoking.

From the above discussion it can be seen that the combined relative risk is quite different for the two sexes: a 100% increase for men (or 70% by adding the two new studies to the analysis of Wald *et al*) versus only a 35% increase for women (according to Wald *et al*) or 40% using a more selective and updated analysis.⁴

In conclusion, it is unlikely that publication bias—that is, the suppression of work with high standard errors by authors or reviewers—has any substantial effect on the relative risks that have been calculated from published reports for passive smoking for either men or women. If any investigators have data on passive smoking, however, particularly for men, that have not been published or that they have not been able to get published I would be interested in receiving them for a possible subsequent report.

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The Biopsy cut procedure for renal biopsies

SIR,—The report by Dr Jennifer Donald and others (27 February, p 606) of the use of the Biopsy gun (Henleys Medical Supplies, London) in AIDS patients has encouraged us to report our experience with the gun for biopsies of both native and transplant kidneys. Lindgren described the equipment and has reported on its use for biopsy of a wide range of organs, including the kidney, combined usually with ultrasonic imaging.¹

This new spring trigger device shoots a modified Tru-Cut needle with both the cannula and obturator in a high speed simulation of a manual

Passive smoking relative risk for lung cancer versus standard error of $\ln(RR)$ in men

Authors	Exposed to smoke		Not exposed		Relative risk	95% Confidence interval	Standard error of $\ln(RR)$ as calculated by Vandenbroucke
	Lung cancer	No lung cancer	Lung cancer	No lung cancer			
Unpublished data							
Humble <i>et al</i> ²	5	37	3	93	4.2	1.0 to 16.8	0.72
Brownson <i>et al</i> ³	3	10	1	9	2.7	0.2 to 31	1.29
Relative risks changed from Wald <i>et al</i> ¹							
Buffler <i>et al</i> ⁴	2*	8*	6*	34*	1.6	0.30 to 8.05	0.84
Akiba <i>et al</i> ⁵	3	9	16	101	1.8	0.44 to 7.46	0.73
As reported by Wald <i>et al</i> ¹							
Correa <i>et al</i>	2	26	6	154	2.29	0.30 to 17.33	1.03
Kabat and Wynder	5	5	7	7	1.00	0.20 to 5.06	0.82
Lee <i>et al</i>	8	14	7	16	1.30	0.37 to 4.54	0.64
Gillis <i>et al</i>	4	306	2	515	3.25	0.60 to 17.65	0.86
Hirayama	7	1003	57	19222	2.25	1.04 to 4.86	0.40
Combined relative risk					2.06	1.31 to 3.22	0.23

*Private communication.

biopsy. The main advantage is the speed and accuracy of needle operation when the specimen is taken.

Although both the machine and manual needles are of similar gauge and notch size—14 gauge and 200 mm respectively—generally a larger piece of tissue is obtained with the automated system. For example, one core was taken from the same kidney with each technique: the diameters were 1.15 and 1.00 mm for the automated and manual systems respectively. Using the device with a smaller gauge needle, serial multiple specimens can be taken in the transplanted kidney, making this an alternative to fine needle aspiration for the investigation of suspected rejection. The use of the gun in transplanted kidneys is well reported.²

The gun can be used singlehandedly, allowing ultrasonic imaging to be carried out by one operator. The only disadvantage is that it is a more expensive technique as the modified needle for the gun costs more. The gun can be sterilised for use in the operating room, but the needles are not reusable.

This is a major improvement on manual percutaneous renal biopsy, and the technique should be more widely known.

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Health of long term benzodiazepine users

SIR,—In France, as in Britain, benzodiazepines are the most commonly prescribed psychotropic drugs, accounting for a third of all those prescribed.

In January 1984 we carried out a study in which all patients admitted to an internal medicine unit were asked about benzodiazepine use during the previous year.¹ Alcohol, tobacco, and concurrent drug consumption and past illnesses and operations were also recorded. There were 129 patients, and 49 were identified as benzodiazepine users; the remaining 80 had not used benzodiazepines in 1983. Twenty four of the users were long term users (daily intake of at least one benzodiazepine for over four months) and 25 intermittent users (less than four months' use). Seventeen of the long term users had taken the drugs for over a year.

Users and non-users did not differ in sex ratio, and tobacco and alcohol consumption was similar in non-users, long term users, and intermittent users. The long term users were predominantly elderly. The users had had substantially more

medical conditions and surgical procedures than the non-users, and there was a strong association between use of benzodiazepines and concurrent drug use (table). Cardiovascular and musculoskeletal disorders were the most common diseases in the users. Among the long term users the drugs had been prescribed for insomnia (6) or anxiety (6), or both (12). Generalists had more often prescribed them than psychiatrists, though psychiatric morbidity had been found in 11 patients. Seven patients had a diagnosis of depression.

Our data agree with those of Dr E K Rodrigo and others (27 February, p 603), although the prevalence of long term use was lower in their study (2.2%) and in that of Dr Kevin Morgan and others (p 601) (11.2%) than in ours (18.6%). This difference might be due to the fact that we studied inpatients, who have a higher rate of chronic diseases than outpatients. Nevertheless, like Dr Rodrigo and others, we found a strong association between benzodiazepine use and concurrent psychotropic and non-psychotropic drug use, and in both studies cardiovascular and rheumatological diseases were the most commonly associated illnesses. Our long term users had had more surgical procedures, however, and this was the only difference between our long term and our intermittent users.

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A better deal for senior house officers

SIR,—As vocational training scheme course organisers we wholeheartedly agree with the leading article by Stella Lowry (27 February, p 590). Since the inception of the Derby scheme in 1973 a half day release course has operated for all trainees in hospital posts and in general practice for about 30 weeks each year, and there have always been problems of trainees in some hospital posts being released to attend these meetings. We do not expect 100% attendance but would suggest that 60-70% should be possible. In practice, however, some senior house officers manage only 10-20% of sessions. When we question why this is so we are told that service commitment or staff shortages have prevented their attendance. This problem has not lessened with the large increase in hospital staffing or with personal approaches to the consultants concerned, despite them all agreeing

in principle to allow their senior house officers to attend. If we press the argument home on educational grounds we are often met with the answer that the post can always be withdrawn from the scheme.

To introduce educational aims and set sessions for all senior house officers is of paramount importance but will come about only through the colleges asking to see the educational plans that consultants have constructed for their senior house officers on visits to reapprove posts for training purposes, asking the doctors concerned whether tutorial time is made available, and, more importantly, encouraging consultants to attend courses on learning and teaching.

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Medical researchers in general practice

SIR,—Dr Richard Smith's excellent article *Medical researchers training and training* (26 March, p 920) has prompted me to write about the position of general practice research.

About 40% of all doctors in Britain are general practitioners and nearly all the people of Britain have a family doctor. About 96% of consultations are dealt with completely by the general practitioner, and only 4% are referred for a specialist's opinion. A very wide range of clinical medicine is seen by the general practitioner, giving considerable opportunity for research. The academic standards of new entrants to general practice are higher than ever. More high flyers are coming into general practice out of choice, and there is now no shortage of doctors who would be potentially good research workers.

The best way of learning research skills is to do research with the advice and help of experienced colleagues. General practice is now represented in every medical school in the country, in 16 with professorial departments, where research can be carried out in professional surroundings, with the facilities of a library, computing, and statistics. Research is carried out by the academic staff as well as research fellows and often funded by outside bodies. The Royal College of General Practitioners is at present offering research fellowships to allow a general practitioner to carry out research in this way. Most research, however, is carried out in the doctor's own practice, where he would also have a full clinical commitment. It is reasonable that a good study should be supported financially so that, in addition to paying the running expenses of a study, money should be made available to buy some of the doctors' time, so that partners are not penalised for the necessary absences of their researching partner.

One of the best ways of learning research methods in general practice, without being attached to an academic department, is to write an MD thesis. It is difficult to accept this challenge and at the same time have a clinical commitment but it can be done provided the doctor has the will and determination to do it.

In two studies of MD theses from British medical schools in 1958-72 an average of just over 3% were from general practice.^{1,2} The reasons given by the general practitioners for writing a thesis seemed to be more to do with the challenge to their intellectual ability than for any personal gain; 86% of the doctors in the two studies had carried on doing research afterwards.

Good thinkers, especially if they are determined and dedicated, are rare, and they should be en-

Characteristics of the three groups of patients

	Total (n=129)	Long term users (n=24) (1)	Intermittent users (n=25) (2)	Non-users (n=80) (3)	p Value	
					1 + 2 v 3	1 v 3
Cardiovascular and rheumatological diseases:						
Present	89	19	20	50	<0.05	NS
Absent	40	5	5	30		
Past operations:						
<2	93	14	11	68	<0.001	<0.005
≥2	36	10	14	12		
Associated drugs:						
<3	98	12	18	68	<0.001	<0.001
≥3	31	12	7	12		
Other psychotropic drugs:						
Yes	21	9	5	7	<0.005	<0.001
No	108	15	20	73		