coagulant treatment may have differed in some (perhaps complex) way. The protective effect of hospital 6 did not relate to any single factor. While thromboembolic prophylaxis is no panacea, our results suggest that it is associated with reduced deaths from pulmonary embolism. Complacent reliance on anticoagulant treatment—or, for that matter, any drug or procedure—should be avoided.

Hospital 6, which among other things routinely used pharmacological anticoagulant prophylaxis (although 14% of this hospital's patients did not receive it), had a much lower 90 day mortality. No single variable (including prophylaxis) explained this, and our audit generated rather than tested hypotheses. We trust that hypotheses generated by the correspondents will be put to the test so that mortality can be reduced and patients' care improved. Clearly, something can be learnt from the package of care at hospital 6. Readers should focus on why differences in mortality occurred among centres and not be distracted by the issue of thromboembolic prophylaxis, a disputed subject that our study was not designed to address. We agree that more detailed and larger scale studies of both prophylaxis and outcome after hip fracture are needed.

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Cost effective strategies for reducing coronary risk in primary care

EDITOR,—The implication of K Field and colleagues' paper seems to be that the cost of screening in cardiovascular prevention is high in primary care, particularly when the screening is not targeted at high risk patients.¹ I agree with this but disagree with the model used in the paper to assess the cost effectiveness of reducing coronary risk. I think that the message to purchasers that we should use lipid lowering treatment only in patients with cholesterol concentrations above 9.5 mmol/l is dangerous. This is reminiscent of the nonsensical recommendation made by the Scottish Home and Health Department some years ago for a cut off of 10 mmol/l.

It is naive to estimate benefits simply on the basis of total cholesterol concentration, particularly when examining a population of women. Up to a quarter of women aged 35 or more have a high density lipoprotein cholesterol concentration, but many of these women have a low attributable cardiovascular risk on the basis of their non-high density lipoprotein cholesterol concentrations. This explains why the cost effectiveness was less evident in women in Field and colleagues' paper and may have tended to skew the data.

We should be moving away from simple reliance on absolute numerical values of cholesterol. We should assess people's absolute risk on the basis of other metabolic measurements, such as glucose, triglyceride, and high density lipoprotein cholesterol concentrations, as well as information on blood pressure, smoking, family history, and established cardiovascular disease. I await the misguided moves of commissioners of health care with trepidation.

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1 Field K, Thorogood M, Silasy C, Normand C, O'Neill C, Muir J. Strategies for reducing coronary risk factors in primary care: which is most cost effective? *BMJ* 1995;310:1109-12. (29 April.)

Scots first with drug advice team

EDITOR,—A recent news story claims that the West Midlands region primary care drug and therapeutics committee is the first in Britain,¹ but Ayrshire and Arran primary care drug and therapeutics committee has been in operation since November 1993.

The committee's main remit is to promote good prescribing practice by general medical practitioners. To this end it has produced a primary care drug formulary. It regularly prepares and issues information on drugs and prescribing for general practitioners and community pharmacists. It also prepares assessments on new products so that they can be reviewed and recommendations made regarding their inclusion in the formulary. It reviews drugs covered by the health board's guidelines for the responsibility for prescribing between hospitals and general practitioners, and it liaises with the trust drug and therapeutics committees.

The members comprise four general practitioners, nominated by the general practice subcommittee; two community pharmacists, nominated by the area pharmaceutical committee; the medical prescribing adviser; the primary care drug information pharmacist (since her appointment in 1994); and the pharmacist facilitator (who acts as secretary). The meeting is chaired by the chief administrative pharmaceutical officer. Ayrshire and Arran is, as far as I am aware, the only health board that has a primary care drug information pharmacist employed exclusively to provide information for professionals working in primary care.

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1 Carnall D. West Midlands GPs get new advice team. *BMJ* 1995;310:1284. (20 May.)

Use of sunbeds increases risk of intraocular malignant melanoma

EDITOR,—The risk of skin cancer associated with use of sunbeds that emit ultraviolet radiation has been highlighted recently.^{1,2} The public should also be aware that use of sunbeds has been linked to intraocular malignant melanoma.

Three case-control studies have examined the relation between the use of sunlamps and risk of intraocular melanoma. One study found that people with the disease were more likely to report use of a sunlamp (relative risk 1.4 (95% confidence interval 0.9 to 2.2)).³ The second study found an association with exposure to ultraviolet or black lights (relative risk 3.7 (1.6 to 8.7)).⁴ The final study found that the risk was increased for those who occasionally used sunlamps compared with those who never used them (relative risk 3.4 (1.1 to 10.3)).⁵ In these studies, exposure to sunlamps had one of the strongest effects on risk of intraocular melanoma.

Collectively, these studies suggest that use of a sunlamp may be associated with a twofold to fourfold increase in the risk of developing intraocular melanoma.

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1 Shuttleworth A. Sunbeds and the pursuit of the year round tan. *BMJ* 1993;307:1508-9.
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3 Tucker MA, Shields JA, Hartge P, Augsburger J, Hoover RN, Fraumeni JF. Sunlight exposure as risk factor for intraocular malignant melanoma. *N Engl J Med* 1985;313:789-92.

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Israel refuses amnesty for dying physician

EDITOR,—The oldest man in the Israeli prison system is a doctor who once had a worldwide reputation for his work on congenital malformations and was head of the department of preventive medicine at Tel Aviv University Medical School. He is Professor Abraham Marcus Klingberg, who is now 77 years old and ill and yet continues to serve out an 18 year sentence. The Association of Israeli-Palestinian Physicians for Human Rights has been lobbying Israeli public officials for his release on humanitarian grounds for the past two years, and we would welcome the support of the international human rights community for our efforts.

In January 1983 Professor Klingberg was secretly arrested by the Israeli security services on charges of transmitting classified information to the Soviet Union, and a trial was held in camera. For almost 10 years he was held in prison under a false name to prevent publicity, and the security services spread rumours that he had gone mad and was being held in a mental asylum somewhere in Europe. His wife, who died in 1990, was ordered to stay silent, and his daughter was prevented from seeing him for five years.

In 1994 Professor Shlomo Shibolet was allowed to conduct a medical examination on Professor Klingberg on two occasions and documented a considerable deterioration in his health between April and December. He noted an increasing frequency of episodes of angina and of transient ischaemic attacks as well as neurological abnormalities and that Professor Klingberg said that he no longer wishes to struggle on and would prefer to die. Professor Shibolet concluded that Professor Klingberg was likely to die in the near future.

In June Professor Klingberg appealed to the district court for early release from prison on humanitarian grounds. The proceedings were again held in camera, and Israeli officials argued that he continued to constitute a security threat and could not be released. The appeal was rejected by the court on these grounds. The Association of Israeli-Palestinian Physicians for Human Rights calls on the Israeli judiciary to grant an amnesty for an old man, a distinguished doctor and scientist, so that he can spend his remaining days with his daughter.

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Retraction of letter

Academic integrity

We recently published the following letter: Bird J. Academic integrity. *BMJ* 1995;310:1068-9. It has now come to our attention that this letter is fraudulent.

The letter was written on notepaper from St Mary's Hospital, London, which was subsequently found to be out of date, and was signed by "Dr J Bird, consultant physician." St Mary's has never heard of Dr J Bird, and his name is not listed in the *Medical Directory* or medical register. We think that this is sufficient evidence for us to retract the letter.