endorsed or distrusted. They seem, however, to be unaware of the extensive literature about the limitations of this test. The test for homogeneity advocated by Perry and Persaud would have failed to detect significant variability among the results of trials carried out before the fourth international study of infarct survival ($P=0.15$) in the magnesium meta-analysis despite the striking asymmetry in the funnel plot.

Two factors are involved in generating this apparent discrepancy. Firstly, the test of homogeneity is notorious for its lack of statistical power, and an important degree of heterogeneity cannot therefore be excluded on the grounds of a non-significant result of the test.⁵ Secondly, the funnel plot examines a specific feature of variability in meta-analyses of randomised controlled trials—namely, that the spread of the results should be symmetrical around the combined effect estimate and become less as the sample size increases. In other words, the plot should resemble an inverted funnel. The biases leading to asymmetrical funnel plots such as the selective publication of small studies with positive results and non-publication of small studies with negative results (publication bias), may decrease variability among studies. Clearly, the application of any test for homogeneity is futile in this situation.

In conclusion, contrary to Perry and Persaud's assertion, the simple visual examination of a funnel plot, although subjective, is often more useful than the statistical manoeuvre entailed in testing for homogeneity. It is unfortunate that funnel plots are not more widely used and that too much faith is placed in the results of tests for homogeneity. The development of numerical measures embracing the information contained in funnel plots, together with a statistical test for symmetry, may help to address this issue in future.

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- 1 Perry A, Persaud R. Misleading meta-analysis. *BMJ* 1995;310:1604. (17 June.)
- 2 Egger M, Davey Smith G. Misleading meta-analysis. *BMJ* 1995;310:752-4. (25 March.)
- 3 ISIS-4 Collaborative Group. ISIS-4: a randomised factorial trial assessing early oral captopril, oral mononitrate, and intravenous magnesium sulphate in 58050 patients with suspected acute myocardial infarction. *Lancet* 1995;345:669-85.
- 4 Yusuf S, Koon T, Woods K. Intravenous magnesium in acute myocardial infarction. An effective, safe, simple, and inexpensive intervention. *Circulation* 1993;87:2043-6.
- 5 Egger M, Davey Smith G. Magnesium and myocardial infarction. *Lancet* 1994;343:1285.

NHS computer network will breach venereal disease regulations

EDITOR,—Ross Anderson raises the serious concern of potential breaches of confidentiality because the proposed NHS network has insufficient safeguards to protect patient information.¹ Aggregated databases containing the records of tens of millions of patients will be a great temptation for dishonest NHS employees, who could access the network to find sensitive medical health records to sell. It would be a dream come true for the blackmailer. Breaches of confidentiality of the kind envisaged in the editorial have the potential to cause much harm to the individual patient.

I have grave concerns about the network and its proposed extension of access to the wider NHS. The changes, if implemented, will be a serious

breach of the NHS (Venereal Diseases) 1974 Regulations. Service provision in genitourinary medicine is based on confidentiality, and this has encouraged patients to seek medical advice. It is not enough to concede that databases on patients with AIDS should not be connected to the network. Because of absolute statutory confidentiality, genitourinary physicians have been able to reassure patients of confidentiality of service and encourage patients and their consorts to attend clinics. There are moral, legal, and ethical arguments in maintaining patients' confidentiality within general medicine and genitourinary medicine and HIV and AIDS in particular. Patient confidentiality, if compromised, will considerably damage confidence in the NHS, destroy the trust that is crucial for a successful clinical relationship, and have a serious impact in the control and prevention of sexually transmitted diseases and HIV infection.

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- 1 Anderson R. NHS-wide networking and patient confidentiality. *BMJ* 1995;311:5-6. (1 July.)

Definitions in palliative care

EDITOR,—The recent correspondence about palliative care services for cardiology fails to differentiate between the three distinct yet interacting aspects of palliative care.

The *palliative approach* is relevant to all patients with incurable conditions. It emphasises the importance of considering psychosocial and spiritual aspects as well as the purely physical. It includes consideration of family and domestic carers. Most specialties and all general practitioners look after patients with life threatening disease; attention to the patients' concerns and fears can guide management and ensure appropriate interventions. A palliative approach should be a core skill of every clinician, who may seek expert specialist help to ensure the best possible quality of life for the patient.

Palliative interventions aim to improve the control of symptoms—for example, palliative surgery, radiotherapy, or chemotherapy. They are usually carried out and monitored by specialists in the relevant discipline.

Specialist palliative care is delivered by clinicians who have specialist accredited training. Specialist palliative care teams are multidisciplinary and relate to both general and hospital practice, being available to provide advice and support that bridges the divide between home and hospital and to provide hospice care.³ They cooperate with others rather than take over from them. Specialist palliative care has a duty to carry out research and, through effective education, to disseminate widely the lessons learnt. It must be available to support those giving care with a palliative approach.

The importance of recognising these definitions is twofold. Firstly, in many areas confusion exists about the conditions that are the legitimate province of palliative care. Recognition of the difference between the general palliative approach and specialist palliative care can reduce this difficulty. If the cardiology example is pursued, general practitioners and hospital doctors treat patients with end stage ischaemic heart disease with a palliative approach; angioplasty in this context is a palliative intervention done by specialists. A palliative medicine physician may become involved by advising on opioids and sedation for intractable dyspnoea and chest pain and helping with psychosocial distress, including family

support. Secondly, because purchasers are uncertain how to contract for palliative care, distinction between the three categories may encourage logical decisions.

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- 1 Gannon C. Palliative care in terminal cardiac failure. *BMJ* 1995;310:1410-1. (27 May.)
- 2 Beattie JM, Murray RG, Brittle J, Catanheira T. Palliative care in terminal cardiac failure. *BMJ* 1995;310:1411. (27 May.)
- 3 Department of Health and Welsh Office. *A policy framework for commissioning cancer services. Report of the expert advisory group on cancer to the chief medical officers of England and Wales.* London: DoH, 1995.

Emergency delays

EDITOR,—Commenting on Luisa Dillner's news item¹ on a report by the Clinical Standards Advisory Group on urgent and emergency admissions to hospital,² Christine H Dearden states that accident and emergency staff should be given admitting rights for patients seen as emergencies in the accident and emergency department.³ I chaired the group that prepared the report, and we concluded, "Assessment of need for admission by a house officer of [emergency] patients referred through the accident and emergency department has been described as inappropriate since the need for admission has already been assessed by a more senior doctor in the accident and emergency department." In our recommendations we proposed that handover arrangements should be agreed so that patients may be admitted without repeated examination by junior trainees from other departments.

There is no doubt that the practice of not trusting the accident and emergency department is widespread and causes distress. As Dearden writes, "this has no benefit to either the hospital or the patient."

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- 1 Dillner L. Emergency delays need urgent attention. *BMJ* 1995;310:283. (4 February.)
- 2 Clinical Standards Advisory Group. *Urgent and emergency admissions to hospital.* London: HMSO, 1995.
- 3 Dearden CH. Emergency delays. *BMJ* 1995;310:1199. (6 May.)

Hepatitis C and haemophilia

EDITOR,—In her editorial on hepatitis C and haemophilia Christine A Lee states that recombinant factor VIII "cannot transmit bloodborne viruses."¹ Although this belief is widely held, it is not correct. All biological substances can harbour infectious agents, and consequently all biopharmaceutical products carry some risk of infection, however small. Recombinant factor VIII is prepared from mammalian cell lines containing viral DNA²; in addition, substances of bovine, murine, and human origin may be used at several stages in the manufacturing process.³ Even when technology that inactivates viruses is used, each of these substances has at least a theoretical risk of transmitting infectious agents.

Haemophilic patients were infected with hepatitis C before effective technologies to inactivate viruses had been developed and at a time when the risk and severity of viral infections from coagulation factor concentrates were not fully appreciated.⁴ The degree of safety of plasma derived concentrates in which viruses have been inactivated is now reasonably well established through extensive and detailed follow up of their

widespread clinical use.⁵ In the case of recombinant factor VIII, however, the equivalent clinical measurements of safety have still to be carried out as this new product, which may advance care in haemophilia, seeks to become established.

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- 1 Lee CA. Hepatitis C and haemophilia. *BMJ* 1975;310:1619-20. (24 June.)
- 2 Kaufman RJ, Wasley LC, Davies MV, Wise RJ, Israel DI, Dornier AJ. Effect of von Willebrand factor coexpression on the synthesis and secretion of factor VIII in Chinese hamster ovary cells. *Mol Cell Biol* 1989;9:1233-42.
- 3 Adamson R. Design and operation of a recombinant mammalian cell manufacturing process for rFVIII. *Ann Hematol* 1994; 68(suppl III):S9-14, S25-8.
- 4 Hay CRM, Preston FE, Triger DR, Underwood JCE. Progressive liver disease in haemophilia: an understated problem? *Lancet* 1985;i:1495-8.
- 5 Mannucci PM. Viral safety of plasma-derived and recombinant products used in the management of haemophilia A and B. *Haemophilia* 1995;1(suppl 1):14-20.

Professional performance bill

EDITOR,—H Jacobs and P J Tomlin misunderstand the effect of a particular section of the medical (professional performance) bill currently going through parliament.¹ They interpret clause 1.9 as meaning that “any doctor referred to the council and whom the council intends to investigate and bring before its disciplinary committee should temporarily lose his or her registration.” That is not correct. The position, as now, is that no doctor’s registration will be suspended under the new legislation, except by direction of a committee, after due process, which includes giving the doctor the opportunity to appear before the committee and be legally represented.

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- 1 Jacobs H, Tomlin PJ. Professional performance bill. *BMJ* 1995;311:631. (2 September.)

Private prescribing of controlled drugs

EDITOR,—I am slightly surprised by Elizabeth Parameshwar’s letter.¹ I learnt about the patient on whom she reports when the patient’s partner came to see me in general practice. He was concerned about both his partner and himself and their increasing drug use. He could not continue to pay for their private prescriptions without either resorting to crime or selling some of the drugs he had been prescribed.

While his partner was a patient in the psychiatric wing he stated that the drug dependency unit had not offered any help in terms of her drug use. This seemed to be because she used more methadone than the staff in the unit would prescribe under their prescribing policy. They would not consider giving her a prescription for injectable methadone even in the short term as a bridge to her using oral methadone, and they would not offer any help with her other addictions to benzodiazepines and amphetamines.

This woman had to return to her private prescriber because she had no alternative. I presume that the private prescriber then gave her what she asked for, probably being unaware of her recent psychotic breakdown.

This woman is not a patient of mine, but her

partner and her child (who is under the threat of being taken into care) are. I believed strongly that they were a couple with a difficult drug problem and should be managed in the specialist services, and hence I referred them back to the drug dependency unit. Until now they have not received the help they desperately need.

Although I agree that private prescribing of controlled drugs needs close scrutiny, this needs to go hand in hand with a rethink of the prescribing policies of some drug dependency units.

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- 1 Parameshwar E. Private prescribing of controlled drugs needs closer scrutiny. *BMJ* 1995;310:1407. (27 May.)

Careers advice for medical undergraduates

EDITOR,—Simon Wilson and Ashley Reece understate the problems of careers advice in the opening sentence of their letter; “the provision of careers advice to medical undergraduates seems an obvious necessity.”¹ Perhaps this is obvious, but in practice careers advice is not given. Seventy per cent of a cohort who qualified in medicine in 1986, studied by Allen, stated that they had had no formal careers advice at medical school.² Many career decisions are taken at medical school, and these are often based on unpleasant encounters with senior doctors or negative experience in certain specialties, and this impression gained by Allen in her previous studies³ was still the case among those who qualified in 1986.

The best careers advice comes during one to one sessions with a skilled careers adviser, but, clearly, this is time consuming. For postgraduate trainees the network of clinical tutors and designated educational supervisors can provide this. In addition, the departments of most postgraduate deans have associate deans with a special interest in female graduates, who provide careers advice for women.

A recent publication by the NHS Executive, *Making Your Career in Medicine*, is a useful guide and is to be circulated to all second year medical undergraduates in the autumn; it is available free from the Women’s Unit, 80-94 Newington Causeway, London SE1 6EF. The publication’s initial section gives short accounts of the careers of 15 successful doctors, all of whom have found success by unconventional routes. The second section is of practical guidance in making decisions about a career. There is also a section giving information about where to go for further advice. This guide should be strongly recommended to undergraduate and postgraduate doctors in training.

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- 1 Wilson S, Reece A. Careers advice for medical undergraduates. *BMJ* 1995;311:194. (15 July.)
- 2 Allen I. *Doctors and their careers. A new generation.* London: Policies Studies Institute, 1994.
- 3 Allen I. *Doctors and their careers.* London: Policies Studies Institute, 1988.

Israeli Medical Association shirks “political aspects” of torture

EDITOR,—There is a body of evidence, collated by both domestic¹ and international human rights organisations,² of the longstanding use of torture in Israel as an instrument of state policy that cannot be ignored. This material also documents the

questionable role of doctors in army units and detention centres as well as the persistent silence of the Israeli medical establishment. Only in 1993, following publicity about the existence of a medical “fitness for interrogation” form (in effect fitness for torture), was the Israeli Medical Association prompted to intervene. They disavowed the use of this form by doctors, but they did not denounce torture per se nor the everyday presence of the same doctors in and around rooms where this was practised.

Torture in Israel continues, and indeed interrogators have been given official sanction to increase the coercive power of this work. Thus I recently wrote to the Israeli Medical Association to point out that they had returned to a position of silence and to urge them to take a stand. Dr Y Blachar, chairman of the centre committee, replied that the association responds when irregular behaviour by an individual member is brought to its attention, but “we are most careful not to get involved in the political aspects of the issue.” This is an ethically untenable stance. The core problem is not isolated malpractice (and who would report this to the Israeli Medical Association anyway, given that the testimony of victims is discounted?) but the routine role of doctors in what Human Rights Watch calls a bureaucratised system that has processed thousands of Palestinian detainees. As the representative body, the Israeli Medical Association cannot evade a responsibility to offer ethical leadership to those examining detainees before or after interrogation and who are likely to be in collusion with torture. The association has a duty to ensure that the two international antitorture codes for doctors, the World Medical Association’s Declaration of Tokyo and the United Nations’ Principles of Medical Ethics, are adhered to by their members.

Further, the Israeli Medical Association cannot maintain that it has no position on the highly deleterious effects on physical and mental health that flow from the use of torture in Israel, as elsewhere.

It has been noted that medical associations in countries where torture is used systematically are often remarkably passive on this issue.³ This may be a survival strategy in states like Iraq or Syria, which do not hesitate to strike at doctors interested in justice for their patients, but this does not apply in Israel. The Israeli Medical Association’s stance seems to threaten its standing in the international medical fraternity and representative institutions, as was the case with South Africa, for instance. I invite others to add their voices to this request for the association to rethink its position and to respond through the *BMJ*.

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- 1 Gordon N, Marton R, eds. *Torture, human rights, medical ethics and the case of Israel.* New Jersey: Zed Books/Association of Israeli-Palestinian Physicians for Human Rights, 1995.
- 2 Human Rights Watch/Middle East. *Torture and ill-treatment. Israel’s interrogation of Palestinians from the Occupied Territories.* New York: Human Rights Watch, 1994.
- 3 British Medical Association. *Medicine betrayed. The participation of doctors in human rights abuses.* London: Zed Books, 1992.

Correction

Rethinking consultants

A typesetter’s error and an editorial error occurred in this letter by K E F Hobbs (5 August, pp 392-3). The second paragraph should have referred to the inadequacy of consultant numbers [not members], and the eighth paragraph should have read: “The future of research and development in medicine is of vital importance to its viability, and there is still a cohort of trainees . . . that would wish [not would not wish] to climb this ladder of academic clinical practice.”