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Placebos used not to be used in studies

EDITOR,—I qualified in medicine before the second world war, when clinical trials were not the common events that they later became in hospital practice. In the prewar and early postwar years we used to ask patients to give us signed permission to add or substitute new drugs in their treatment without informing them; there was no placebo.¹

In the early days of corticosterone treatment for rheumatic disorders in 1949 and 1950 expectations were so high that, in trials of substances reported to have been effective before cortisone became available, dramatic clinical reactions were often seen after the first injections of what later proved to be inactive agents. These reactions, however, rapidly disappeared after the next two or three injections. In one such trial films taken of a patient after the first injection were almost as dramatic as the original film that Hench *et al* showed in New York in 1949 of patients receiving large doses of cortisone (seventh international congress on rheumatic diseases). In a later controlled trial of cortisone versus aspirin carried out by the Empire Rheumatism Council, however, no such dramatic results were seen.² The Empire Rheumatism Council carried out a multicentre controlled trial of gold in 77 patients with rheumatoid arthritis, who received 50 mg sodium aurothiomalate weekly by intramuscular injection to a total of 1 g over five months.³ There was a significant improvement by all criteria except radiological criteria in these patients from month 3 to month 18 (one year after completion of the course), but in 82 control patients, who received 0.5 µg of the same substance weekly to a total of 0.01 mg, the improvement was not significant. A homoeopathic influence was suspected by some.

The most satisfactory assessment of the clinical benefits of a new treatment probably occurs when the patient is unaware that a trial is in progress and no placebo is necessary. Because such trials are as much to assess unwanted as to assess desired effects, however, patients today have to be fully aware of all possibilities in agreeing to such trials and placebo control is necessary.

F DUDLEY HART
Honorary consultant physician

Chelsea and Westminster Hospital,
London SW10 9NH

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Deciding which selective serotonin reuptake inhibitor to prescribe

EDITOR,—Recent articles have debated the relative costs of selective serotonin reuptake inhibitors for depression in relation to their tolerability and efficacy.^{1,2} I M Anderson and B M Tomenson raise the point that cost-benefit analyses should include real life prescribing situations rather than the atypical situations found in short clinical trials.¹

Intense media publicity and debate have been

given to fluoxetine, with many sensational stories and claims being made. Particular prominence has been given to stories of suicide, aggression, and personality changes in patients taking the drug, despite the paucity of supporting evidence.³ This has led, understandably, to great concern in many patients taking the drug. I have begun to spend a large proportion of consultations with patients for whom I have prescribed fluoxetine discussing these news items and repeating the true facts about the drug.

In a retrospective audit of my practice over the past 18 months I found that six of 11 patients prescribed fluoxetine had raised concerns related to the media coverage. Two of the six stopped taking the drug, and three of the others admitted to reduced compliance, directly because of the adverse publicity. In comparison, only one patient out of eight prescribed one of the other selective serotonin reuptake inhibitors mentioned the media coverage, and compliance remained unchanged.

Several differences between selective serotonin reuptake inhibitors could influence the choice of drug on clinical grounds.⁴ In the absence of specific indications, however, I am now more likely to prescribe an inhibitor other than fluoxetine. This permits more productive use of consultation time and means that an unfortunate cause of poor compliance does not arise. While fluoxetine may be the cheapest selective serotonin reuptake inhibitor in terms of direct costs,⁵ the added costs of additional consultation time and longer duration of illness because of non-compliance may well nullify this advantage.

ANTHONY J CLEARE
Lecturer in liaison psychiatry

Department of Psychological Medicine,
Institute of Psychiatry,
London SE5 8AZ

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Treating mentally disordered prisoners

Mental Health Act Commission should visit prisons

EDITOR,—“The numbers of untreated psychotic men in prison will grow,” state H Needham-Bennett and I Cumming.¹ In the late 1950s the doors of local mental hospitals were unlocked and Broadmoor Hospital became so overcrowded that it was difficult to run a therapeutic regime. The private hospitals, starting with St Andrew's in Northampton, then expanded and absorbed many patients who needed some security. The private hospitals were followed by the regional secure units, which in their turn absorbed many patients who were difficult to place.

Today Broadmoor Hospital is full and at times can accept only emergency cases, private hospitals have a waiting list, and regional secure units are struggling (in some weeks Fromeside Clinic receives one or two requests for admissions from other parts of Britain, usually London). So, as in the past, prison health care centres fill up with psychotic patients. These patients cannot be treated because it is unlawful to treat them, nor can they be moved to hospitals as there are often no empty beds with appropriate security. While this may not be the scenario in some parts of England,

it evidently is in the prison described by the authors.

If the situation worsens, as the article implies it will, is the next step to allow the Mental Health Act to function in prison hospitals? And, if so, will this be just for short term emergency treatment or for longer term treatment? The implications are profound, and some people would fear that re-designed and reserved areas of prisons could become revolving door asylums with patients with chronic psychosis and personality disorders manipulating their way into prison by the time honoured method of throwing a brick through a police station's window.

Furthermore, if the Mental Health Act is to be used in prisons the Mental Health Act Commission would need to be involved. While allowing for the circumstances, it would insist on at least reasonable physical standards for those prisoners being treated under the Mental Health Act.

It is time for the Mental Health Act Commission to have a remit to visit the local prison when it inspects a hospital. After all, it is of little value writing satisfactory reports on a hospital when a number of its psychotic patients are being detained untreated in the local prison's health care centre. Should the commission start to visit prison health care centres it might identify a lack of intensive care units and medium stay beds as an important factor contributing to the steadily worsening situation.

R W K REEVES
Consultant forensic psychiatrist

Fromeside Clinic,
Stapleton,
Bristol BS16 1ED

- 1 Needham-Bennett H, Cumming I. Waiting for a disaster to happen. *BMJ* 1995;311:516-7. (19 August.)

Solution to treating prisoners in hospital is financial

EDITOR,—The situation that N Needham-Bennett and I Cumming describe in a prison health care centre¹ is all too familiar,² despite successive initiatives to improve provision for mentally disordered prisoners.^{3,4} We take issue, however, with the authors' proposal that the Mental Health Act 1983 should be revised to allow compulsory psychiatric treatment in prisons.

In March 1992 the Department of Health and the Home Office invited proposals from the four Thames regional health authorities to provide a better service for mentally disordered male prisoners remanded into custody. Our successful proposal combined a medical and nursing prison based assessment service and a 14 bedded locked ward exclusively for the inpatient care of mentally ill men who would otherwise have been remanded into custody. In its first year the service saw 150 referrals and admitted 62 patients, who had been charged with offences ranging from murder to shoplifting. A full description of the service is in preparation, as is a report of an independent audit of the impact of the service on the remand population at Wormwood Scrubs prison. More than half of those seen were referred within two weeks of their remand into custody. More than two thirds of those referred were assessed within five days of referral. Of those for whom admission was recommended, one fifth were admitted within five days and more than half within two weeks of assessment.

The independent evaluation has confirmed the success of our service. We are currently funded entirely through regional health budgets, without any contribution from the Home Office. A major determinant of our costs has been the delay in concluding cases dealt with at crown courts: the mean length of admission for cases dealt with at magistrates' courts is 42 days and at crown court 95 days. We are therefore constrained in the clinical management of patients by external judicial processes over which we have no control and which

substantially increase the cost per admission. In addition, we are responsible for transporting and escorting our patients for court appearances; this cost would otherwise be met by the Home Office. Should local purchasers be responsible for these costs in future?

We are convinced that the proper place for mentally disordered prisoners requiring hospital treatment is hospital. We have shown that the problems described by Needham-Bennett and Cumming are not insoluble; the solution is not legislative but financial. The delays inherent in the resolution of serious cases inflate our costs. We have expressed our concerns to the Home Office but have received only an acknowledgement. In the absence of any acceptance of joint responsibility by the Department of Health and the Home Office for funding services for mentally disordered remand prisoners, we believe that the current situation is a disaster that is already happening.

KEVIN MURRAY
Consultant forensic psychiatrist

MARTIN LOCK
Clinical research fellow

Bentham Unit,
West London Healthcare NHS Trust,
Southall,
Middlesex UB1 3EU

AKINTUNDE AKINKUMNI
Senior registrar

Camlet Lodge Regional Secure Unit,
Chase Farm Hospital,
Enfield,
Middlesex EN2 8JL

TIM WEAVER
Research fellow

ADRIAN RENTON
Senior lecturer in public health medicine

Department of Epidemiology and Public Health,
Imperial College of Science, Technology, and Medicine,
St Mary's Hospital Medical School,
London W2 1PG

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Transverse myelitis unlikely to be due to measles, mumps, and rubella vaccine

EDITOR,—K A Joyce and J E Rees report on a 20 year old man who developed subacute transverse myelitis two to three weeks after immunisation with measles, mumps, and rubella vaccine.¹ Five days after vaccination he developed a feverish exanthematous disease, which fluctuated for two weeks and preceded the onset of the neurological symptoms. Postvaccination transverse myelitis was diagnosed when a significant rise in titres of rubella antibodies was observed. The authors suggest that antibody status should be checked before vaccination.

The course of events is incompatible with rubella related to the vaccine. Rubella-like disease related to vaccination develops nine days after vaccination at the earliest and does not last as long as two weeks. An increase in rubella IgM antibodies is possible after vaccination. Measurement of the titres cannot differentiate between wild virus and the attenuated vaccine strain. As the incubation period of wild rubella is 14-21 days² the patient may have had natural rubella.

Postvaccination transverse myelitis is diagnosed by exclusion, and serological tests should include tests for viruses such as echovirus and herpes simplex virus as well as coxsackievirus groups A

and B—particularly because the patient had a transient rash over his upper body.

Behringwerke has distributed about 8.8 million doses of monovalent rubella vaccine and measles, mumps, and rubella vaccine in the German market since 1980. No case of suspected transverse myelitis has become known to us. On the assumption that the yearly incidence of transverse myelitis in Germany is similar to that in Minnesota (approximately 7.4/100 000 people),³ postvaccination transverse myelitis after rubella vaccination is unlikely. Furthermore, the three other published cases of myelitis to which Joyce and Rees refer occurred after the administration of vaccines other than those currently used. There is insufficient evidence to indicate a causal relation between the currently used human diploid cell rubella vaccines and neuropathy.⁴

In conclusion, Joyce and Rees do not provide sufficient evidence to show that this case of transverse myelitis was caused by measles, mumps, and rubella vaccine. The need to check the patient's antibody status before vaccination cannot be deduced from this case report.

REINHARD FESCHAREK
Head of pharmacovigilance

HERMANN DASS
Assistant director

Behringwerke AG,
Drug Surveillance Department,
PO Box 11 40,
35001 Marburg,
Germany

- 1 Joyce KA, Rees JE. Transverse myelitis after measles, mumps, and rubella vaccine. *BMJ* 1995;311:422. (12 August.)
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General practitioners' depression

EDITOR,—The Personal View giving a general practitioner's account of her depression and her reflections on her work is honest and courageous.¹ I found it helpful and encouraging. I am a 37 year old full time female general practitioner who is married with two small children. While I view my job as secure and have no immediate plan to move, I find it depressing to think that I may be in the same place for 30 years. Five years is as much as I can cope with. For a while I felt guilty about this abandonment of the accepted norm for general practice—but no longer. The NHS is changing so rapidly that we must all embrace the possibility of career changes, as the new registrars in general practice seem to be doing.

HESTER DUNLOP
General practitioner

Fieldhead Surgery,
Golcar,
Huddersfield HD7 4QQ

- 1 I should have been more selfish. *BMJ* 1995;311:957. (7 October.)

Notification of tuberculosis is compatible with venereal diseases regulations

EDITOR,—The Department of Health shares Alexander S Pym and colleagues' concern that undernotification of cases of tuberculosis, particularly in association with HIV infection, could have important public health consequences.¹ Undernotification causes difficulties for con-

sultants in communicable disease control when they carry out their responsibilities for local monitoring and control of tuberculosis and may result in contacts of infectious patients not being screened for the disease.

Concern about confidentiality has been given as one reason for failure to notify patients with HIV infection who have tuberculosis. Some clinicians are thought to be under a misapprehension that the NHS Venereal Diseases (1974) Regulations take legal precedence over the legislation on notification. This is not the case, nor is notification incompatible with the regulations, since the purpose is to identify and prevent further cases. The HIV status of the patient does not need to be stated on the notification form.

In response to concerns about possible under-notification of tuberculosis, last April I wrote to all consultants in genitourinary medicine, consultant physicians, and consultant paediatricians to remind them of their statutory duty to notify known or suspected cases of tuberculosis under the provisions of the Public Health (Control of Disease) Act 1984.

J S METTERS
Deputy chief medical officer

Department of Health,
London SW1A 2NS

- 1 Pym AS, Churchill DR, Coker RJ, Gleissberg V. Reasons for increased incidence of tuberculosis. *BMJ* 1995;311:570. (26 August.)

Problem based learning at medical school

Some people think it's thrilling . . .

EDITOR,—Having survived a traditional medical education in Britain, I have spent the past 14 months working at McMaster University, during which time I tutored a problem based learning group. I am glad to learn from John Bligh's editorial on problem based learning that the attitude of some universities to undergraduate medical study has changed greatly.¹ Continued learning should be an integral part of a professional career. Medical students in a traditional programme fill folders with lecture notes giving the currently accepted "facts," but this method of learning is unavailable after graduation. Doctors must develop a new learning strategy if learning is to continue in their postgraduate years, but, often, they stick to the strategies that they used as medical students.

Problem based learning allows students to develop a learning strategy that is effective throughout their professional life, but it is not practised in a vacuum. As in professional life, previous knowledge is not ignored but used by the tutorial group to formulate group and individual learning objectives. Once these have been agreed by the group the individual students are free to address those objectives in ways that are relevant to them. They may use books, computerised literature searches, or journals or spend time in a clinic talking to patients and family; many will also talk to relevant staff. This new knowledge is then brought back to the group.

Students recognise that their educational development is best served by cooperation within the group and by a free exchange of ideas and uncertainties. Removing formal examinations from the undergraduate course so that students see their peers as colleagues rather than competitors encourages this. A dual track system exists as examinations throughout the undergraduate course are usually considered important by proponents of the traditional approach. With the traditional approach students are tempted to spend more time on the part of the course that leads to examinations and to compete against each other rather than strive toward understanding.