Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

The health of Gulf War veterans

Professor Lee and colleagues (October 2002 *JRSM*)¹ presented their findings in 1000 Gulf War veterans who came to their programme for medical advice, and combined the data with those from two previous surveys, each of 1000 veterans, by Coker *et al.*² and their own group³. I question the methodology and statistical models adopted by Lee *et al.* in their two papers^{1,3}.

First, why did they not adhere to the reviewing criteria adopted in the first paper by Coker? Introduction of the term 'wellness' serves to confuse. There is no differentiation between individuals who were well when they attended and those who considered that they were unwell. Second, would it not have been better to adhere to Chapter 18 diagnosis (International Statistical Classification of Diseases) throughout the series, with appropriate comment? To change the criteria between papers prevents comparison of like with like. Third, whilst chronic fatigue syndrome (CFS) is included in the initial paper—87 diagnosed with the syndrome—it has been abandoned by Lee *et al.*, despite the predominance of relevant symptoms. 'Multiple unexplained physical symptoms' and somatic disorders are included, which have no accepted criteria.

The major concern is the inclusion of 1057 individuals who were well by any definition and attended for reassurance, information, etc. This fundamentally distorts the statistics: overall, the percentages should be taken not from 3000 but from the 1943 individuals who attended because they felt ill. If the Chapter 21 individuals are extracted from Table 2, this leaves 837 ill in the first 1000, 494 in the second 1000 and 612 in the third 1000. Affective symptoms are then, respectively, 59% (from 50%), 98% (from 49%) and 62% (from 38%); fatigue 50% (from 42%), 91% (from 45%) and 42% (from 26%). This is reflected throughout. Table 3 then becomes uninterpretable. Table 5 should be based on 1943 individuals and is effectively distorted by 50%—thus, post-traumatic stress disorder (PTSD) becomes 19% (from 12%), depression 9% (from 6%) and so on.

Even if we allow for the self-selection in the veterans seen by Lee *et al.* there is a major discrepancy regarding PTSD between this cohort and the series reported a few weeks later by Wessely's group in the *BMJ*⁴. In Lee's paper the prevalence is said to be 12% but should be 19%, as I have shown; in Wessely's paper it is no more than 3%. Could the explanation be that Lee *et al.* dropped CFS from the reviewing criteria used by Coker *et al.*? Should many of their PTSD diagnoses have been CFS?

Because of these aberrations, the two papers by Lee *et al.* contribute little to the understanding of illnesses affecting Gulf War veterans.

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- 4 Ismail K, Kent K, Brugha T, *et al.* The mental health of UK Gulf War veterans: phase 2 of a two phase cohort study. *BMJ* 2002;**325**:576–81

Authors' reply

As is made clear in our paper, the intent was to review the diagnoses of all 3000 who attended and to make some assessment of wellbeing, as detailed by Lee *et al.*¹. Those attending the Gulf Veterans' Medical Assessment Programme (GVMAP) are referred by their medical attendants on the basis that they have health concerns relating to their service in the Gulf. It is therefore appropriate to include all 3000 referred, as the population in which the prevalence of diseases found is expressed rather than restricting the population denominator to just those found to be ill. When one discusses the prevalence of disease in a population, one usually includes the whole population as the denominator rather than just the unwell portion. This addresses Wilson-Ing's concern that we have fundamentally distorted the statistics.

Wilson-Ing further suggests that we have changed diagnostic criteria because of the reduction of Chapter 18 diagnoses. The first point to make is that the bridging 100 exercise in our first paper¹ was designed to compare the diagnostic criteria between that paper and that of Coker *et al.*². Secondly, it is hardly surprising that the diagnostic pattern is different, given both the time that has elapsed and the considerable research effort that has gone into Gulf veterans' illnesses without finding any convincing evidence of unique Gulf-related illness. To suggest that the diagnosis of chronic fatigue syndrome (CFS) has been abandoned by us is disingenuous, since Wilson-Ing is not in a position to make clinical diagnoses on our series. We, who have seen the patients, are satisfied that the symptoms presented do not amount to chronic fatigue syndrome^{3,4}. We have certainly not included medically unexplained physical

symptoms or somatic disorders in our diagnoses, but have discussed these aspects in the discussion section of the paper. We would suggest that the references therein provide the background and criteria for our discussion.

In his comments about PTSD, Wilson-Ing is falling into the trap of not comparing like with like. Since PTSD is associated with exposure to trauma, it is likely that we would see more of it, since we were reporting upon the diagnoses of a group of military veterans who had health concerns as a result of their service in a conflict, than Ismail would find in a study examining the mental health of a sample of the whole Gulf veteran population which includes those with no health concerns⁵. The analogy is to claim that there is a higher prevalence of lung cancer among patients attending a chest clinic than amongst the general population. The suggestion that the alleged excess of PTSD may be misdiagnosed CFS rather misses the point, explicitly stated in our paper, that the suggested diagnoses of PTSD were confirmed by consultant psychiatrists.

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Asperger's syndrome

The article by Professor James (January 2003 *JRSM*¹) was of considerable interest to me, though as a surgeon I cannot claim expert knowledge of mental processes. Asperger's syndrome appears to be a higher form of autism with full possession of intellectual faculties, as possibly exemplified by his examples of Newton, Einstein and Cavendish, but with an inability to form social and emotional bonds. I used to be a member of Mensa but left after realizing that 90% of the members were incapable of maintaining their end of a conversation and had difficulty in expressing any personal

warmth; the only emotion I ever encountered was naked aggression.

Doctors like to wrap an insoluble problem in a syndrome because it gives them the satisfaction of pigeon-holing a patient and restores their authority, enabling them to say 'You have X syndrome but there is no treatment' rather than confess they are completely at a loss. This satisfies patients as well, who are more than likely to wear their label as a badge of pride. I think that Asperger was only describing a variant of normal. If it is an abnormal state, there must be thousands of cases in this country, myself included.

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REFERENCE

- 1 James I. Singular scientists. *J R Soc Med* 2003;**96**:36–9

Outpatient clinic: where is the delay?

Mr Patel and his colleagues (December 2002 *JRSM*¹) discuss the pattern of work in a urology outpatient clinic. It is disturbing that so little time (4.8 minutes) is actually spent with the patient during consultations, and more so that this has decreased so much in the recent past. A notable observation is that 27% of patients did not keep their appointments. If they had, the workload would have been even greater. If the missing patients had arrived and had required on average the same amount of time with the consultant, then the clinic would have been 51 minutes longer—or, if the clinic could not be extended, the time spent with each patient would come down to only 3.5 minutes. This strengthens the arguments of the authors regarding improving efficiencies and investment in staff and training.

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How objective are systematic reviews?

Dr Linde and Dr Willich (January 2003 *JRSM*¹) have done a great service to the medical community by showing us how systematic reviews (SRs) can differ confusingly regarding a range of methodological aspects. As they point out, SRs are designed to avoid biases and make conclusions as objective as possible. Given the diversity of the SRs analysed, I was impressed with the level of agreement many of them reached in their conclusions. Table 1 summarizes five subject areas where our own SRs were cited. The concordance of the conclusions is stunning.

Table 1 Conclusions of systematic review

Subject area	First author (year) [Ref]*	Verbatim conclusion†
Homeopathic arnica	Lüdke (1991) [48] Ernst (1998) [47]	'... efficacy ... must be interpreted with utmost care'‡ [Efficacy is] 'not supported by rigorous clinical trials'
Garlic for hypercholesterolaemia	Lawrence (2000) [35] Stevinson (2000) [34]	'Garlic ... [has a] small positive effect on lipids' 'Garlic is superior to placebo ... , however, the size of the effect is small'
Peppermint for irritable bowel syndrome	Jailwala (2000) [41] Pittler (1998) [40]	'Peppermint oil ... requires further investigation' '... peppermint oil ... has so far not been established beyond reasonable doubt'
Acupuncture for tinnitus	Dobie (1999) [25] Park (2000) [26]	'No treatment can yet be considered well established' 'Acupuncture ... has not been demonstrated to be efficacious'
Ginkgo for intermittent claudication	Moher (2000) [27] Pittler (2000) [28]	'...Ginkgo ... [is] slightly more effective than placebo' 'Ginkgo is superior to placebo'

*Reference numbers according to article by Linde and Willich

†From abstracts of published article (where applicable)

‡My translation

There are exceptions, of course. The prime example is acupuncture for back pain, where we have published a 'positive'² and others a largely 'negative' SR³. The difference is, however, readily explicable: we pooled the data from all trials where this was possible² while van Tulder *et al.*² basically relied on a vote count. If studies tend to be small and produce non-significant positive trends, pooling will generate a positive overall result, while vote-counts will yield a negative one.

And then there is homeopathy, which is perhaps the most controversial subject of all. Linde *et al.* have published their landmark SR concluding that 'clinical effects of homeopathy are not completely due to placebo'⁴. Two years later they cast considerable doubt on this by reanalysing the data and concluding that 'there was clear evidence that studies with better methodological quality tended to yield less positive results'⁵. I have recently reviewed all eleven SRs of homeopathy published since Lind's meta-analysis⁴. This collective evidence led me to conclude that 'the best clinical evidence for homeopathy available to date does not warrant positive recommendations for its use in clinical practice'⁶.

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Capacity and consent

Dr Jackson and Dr Warner (December 2002 *JRSM*¹) make an assessment of the knowledge of capacity and consent issues across different medical specialties. I am not surprised by the deficits they identify with the results as attendance to many seminars looking at capacity and consent. More worrying is my personal experience as a psychiatric trainee. When on call, both as a senior house officer and as a specialist registrar, I have received requests from non-psychiatric colleagues to implement the Mental Health Act in order to carry out medical or surgical treatment in patients who either refused or clearly were not able to consent to it. Even in teaching sessions for a mixed-specialty group this issue is not clearly discussed. I would like to see education in the use and limitations of the Mental Health Act along with the training regarding issues of capacity and consent.

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Noise exposure in motorcyclists

As an ear, nose and throat surgeon and a motorcyclist I have both a professional and a personal interest in the matter discussed by Mr McCombe (January 2003 *JRSM*¹). For some while now I have used custom-made ear plugs supplied by Elacin which were, I believe, originally developed in collaboration with the Dutch motorcycle police. These are comfortable for long periods, have effectively abolished the temporary threshold shift and tinnitus which used to be inevitable consequences of a long journey and seem not to impair the appreciation of ambient traffic sounds which is essential for personal survival. I am sure that helmet manufacturers should be persuaded or obliged to include some measure of the 'noisiness' of their helmets in the specification they submit for their kite marking and other safety standards.

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The philosophy of science

Dr Harper's paper (January 2003 *JRSM*¹) refers to the philosophy of science. It is disappointing to see no mention of a giant of 20th century philosophy, Sir Karl Popper. The philosophy of science was an area in which he made

groundbreaking observations. Harper dwells on Kuhn who, worthy though he may be, compares with Popper as a foothill does to Mount Everest. Although he was best known as a philosopher of science, Popper's ideas give insights which advance way beyond the confines of science and this also puts him on a different plane. The philosophy of science without Popper is like Hamlet without the Prince.

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Michelangelo and medicine

John Seamer (December 2002 *JRSM*¹) believes that the statue of David is left-handed as the sling is over the left shoulder. However, the pose of the statue is almost contemplative, as if he was studying Goliath, and does not suggest an imminent attack, in which case the position of the sling is immaterial and the larger size of the right hand should indicate right-handedness.

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