

Routinely asking women about domestic violence

Seeking the causes of disease, not routine inquiry, is good practice

EDITOR—We fail to detect partner abuse because we do not ask.^{1,2} Inability to accurately diagnose partner abuse prevents screening criteria being met. Taket et al propose routine inquiry to improve detection. However, one of these authors showed how difficult asking about partner abuse is.³ Exhortation to ask routinely will not overcome professional reluctance.

More research about acceptability to women,³ and what happens after disclosure, is needed before routine inquiry is instigated. Old fashioned diagnostic inquiry may suffice, provided diagnostic skills are improved by training to spot post-traumatic stress disorder. Physical signs fade long before the psychological scars of partner abuse.¹ Post-traumatic stress disorder is present in 35% of those who have experienced partner abuse, is often comorbid with depression, and is indicative of experiencing the severe end of the domestic violence spectrum.^{1,4}

Symptoms include panic attacks, flashbacks, nightmares, hypervigilance, and poor sleep. Among clinical indicators of intimate or partner abuse (thick files, multiple injuries, drunkenness, depression, and post-traumatic stress disorder¹) only post-traumatic stress disorder specifically identifies and acknowledges the type of trauma experienced during the diagnostic process. The causative role of that trauma in patients' subsequent distress becomes clear. A non-blaming attitude is engendered towards patients whose traumatic experiences may leave them feeling shame and self-blame, as well as severe anxiety. The abused faces complex decisions about what to do next.

Seeking the causes of disease is consistent with good diagnostic medical practice, whereas routinely asking people about trauma feels inappropriate and will not be done.

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Competing interests: None declared.

- 1 Campbell JC. Health consequences of intimate partner violence. *Lancet* 2002;359:1331-6.
- 2 Richardson J, Feder G, Eldridge S, Chung WS, Coid J, Moorey S. Women who experience domestic violence and women survivors of childhood sexual abuse: a survey of health professionals' attitudes and clinical practice. *Br J Gen Pract* 2001;51:468-70.
- 3 Taket A, Nurse J, Smith K, Watson J, Shakespeare J, Lavis V et al. Routinely asking women about domestic violence in health settings. *BMJ* 2003;327:673-6. (20 September.)
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Inquiry may be acceptable in different healthcare environments and to different women

EDITOR—Taket et al debated the value of routinely asking about domestic violence.¹ Although no one would disagree that domestic violence is a major health problem and that health care offers opportunities to identify a largely hidden problem, the statement that routine inquiry in healthcare is acceptable to women is far from proved.

Work from primary care studies, including the authors' own work, has shown that sizeable proportions of women, ranging from 51% to 15%, object to routine inquiry about domestic violence.^{2,3}

The adverse consequences of routine inquiry to a woman who found it unacceptable should not be underestimated. A dysfunctional consultation could result, and the healthcare professional would become extremely reluctant to conduct future inquiries.

Interestingly, similar work from the prenatal setting indicates a much higher rate of acceptability.¹ The reasons for this are not clear, but may be related to age, the increased feelings of responsibility that pregnant women feel, or the status of the healthcare professional. More work is needed to identify in which healthcare environments routine inquiry is acceptable and the characteristics of women who find routine inquiry unacceptable.

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Ill considered professional interference in personal relationships will prove damaging

EDITOR—The notion that, because some social problem has effects on health, this justifies medical intervention aiming to tackle it has acquired a growing influence on medical practice. The result is that medicine is stretched beyond its sphere of competence as social problems are redefined in medical terms.

Surveys conducted by promoters of the concept of partner abuse are said to reveal that up to a half of all women are victims.¹ Such contentious statistics are used to support the proposal that general practitioners should subject their female patients to routine inquiry to identify whether they are currently being abused.²

General practitioners are said to be in a unique position to identify partner abuse because of our privileged access to intimate aspects of our patients' lives. But making such intrusive and impertinent inquiries when women consult us is an abuse of the doctor-patient relationship. Although activists claim that interrogating women about their experience of abuse can empower them, such interventions enhance professional power.

When we as doctors identify the hidden cases of partner abuse, we are supposed to encourage them to access support services. Whether many women will benefit from professional support is doubtful, but ill considered professional interference in intimate personal relationships will inevitably prove damaging.

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Management of urinary tract infections in children

Priorities need to be set

EDITOR—Coulthard et al show how they succeeded in increasing compliance among general practitioners with the 1991 guidelines of the Royal College of Physicians on the management of urinary tract infections in children.^{1,2} Their study particularly emphasised the imaging investigations. An overwhelming number of children (610) underwent scanning with dimercaptosuccinic acid, which yielded only 15 with renal scars (the extent and potential clinical significance of which are not described).

Another measure of success was the finding that 90% or more of the study children under 4 years old were given antibiotic prophylaxis. No study has shown that children benefit from this practice.

An opportunity was missed to devote precious resources to achieve these outcome measures (which have not been shown to improve the wellbeing of these children) above those such as identifying and managing well established risk factors for urinary tract infections (such as constipation and bladder instability) and achieving the prompt recognition and treatment of urinary tract infections. Prompt recognition and treatment are undisputed factors in limiting or even preventing potential renal scarring, which the study group did not achieve.

The imaging guidelines in the royal college's recommendations should move away from their blanket approach so that their yield of important abnormalities is increased.

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- 2 Royal College of Physicians Research Unit Working Group. Guidelines for the management of acute urinary tract infection in childhood. *J R Coll Physicians Lond* 1991;25:36-42.

No evidence exists

EDITOR—Renal disease is serious, but it is peculiarly difficult to find direct evidence that it can be prevented by the systematic approach to possible urinary tract infection in young children advocated by Coulthard et al.¹

Clinical Evidence identifies no relevant randomised controlled trials² and one systematic review of descriptive studies that itself found no evidence of benefit.³ The claim by Coulthard et al that Sweden's aggressive approach has reduced end stage renal failure is a bold conclusion to draw from small numbers in the epidemiological survey they cite.⁴

Another paper they offer as evidence of serious sequelae of urinary tract infection in

children implies that such infections may not be the problem.⁵

Serious renal disease is comparatively rare,⁴ whereas urinary tract infection in childhood is common. Even if effective, the number needed to screen to prevent one adverse outcome is likely to be huge. Arguments for an aggressive approach are largely theoretical: theory is crucial but has generally proved a dismal basis for screening programmes.

General practitioners are often the first port of call for children who might have urinary tract infections. Many would enthusiastically adopt the proposed approach if the balance of evidence, or even of common sense, weighed in its favour, but this does not yet seem to be clearly so. Investigation has costs: worry and inconvenience for families, exposure to radiation, funding, and time no longer available for more evidence based activities—but then again, it might work. I will be keeping my eyes open for the much needed prospective trial with adequate follow up and meaningful outcome measures.

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Authors' reply

EDITOR—Jadresic is concerned that our nurse led study of general practice management of children with urine infection resulted in many children undergoing imaging but few kidney scars being found. Sandell also advocates investigating fewer children, as he believes serious disease is rare.

Their conclusions are misleading, however, because they ignore the many children whose scarring related hypertension or renal failure does not present until adult life. Some 20 adults receive transplants annually in England's north east, and many more develop hypertension resulting from scarring that started in infancy.¹ The question remains, can scarring be prevented, rather than just imaged once it has happened?

We agree with Jadresic that the priority in managing children with urinary tract infections is for prompt recognition and treatment which may allow prevention of scarring. We have shown that in about three quarters of infants (who are at greatest risk of scarring) urinary tract infection is not normally diagnosed but that our study intervention improved this. Our study practices

also identified 12 infants with vesicoureteric reflux and infection before they developed scarring.

Sandell argues for basing all practice on evidence, but often no ideal data exist, so clinical plans need to be formulated from the best available evidence plus theoretical speculation. Until early diagnosis is consistently achieved there is no point in constructing randomised controlled intervention trials. Our model can produce a reliable diagnosis rate that will allow questions to be addressed, such as the value of particular imaging strategies and antibiotic prophylaxis. That is the next stage.

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- 1 Vernon SJ, Coulthard MG, Lambert HJ, Keir MJ, Matthews JNS. New renal scarring in children who at age 3 and 4 years had had normal scans with dimercaptosuccinic acid: follow up study. *BMJ* 1997;315:905-908.

Paying for bmj.com



BMJ is the property of the world

EDITOR—When I read the *BMJ* in Mexico I have access to scientific literature of high quality that is fundamental for my clinical and teaching work. Thus when I read that in January 2004 the *BMJ* will be accessible only on payment, I feel that I am losing one of my most important sources of knowledge.¹

Many doctors in the developing world do not have access to the electronic versions of medical journals (*JAMA*, the *Lancet*, the *New England Journal of Medicine*, *Bone*, *Diabetes Care*, etc). Now with this decision of the BMJ Publishing Group the *BMJ* is lost to us, and I think this is not just.

I would like to read in your pages that the *BMJ* “is one of the high quality journals that proudly continues the tradition of the free dissemination of science.”

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- 1 Delamothe T, Smith R. Paying for bmj.com *BMJ* 2003;327:241-2. (2 August.)

Move is understandable but sad end to a decade

EDITOR—The *BMJ* is worth its weight in gold. It is sad to see the end of freely exchanged knowledge via the internet and to see that some will have privileged access over others.¹ I hope that this is not a return to the days when medical journals were closed to all but the few. Even in the 21st century some editors would prefer to keep their journals closed to those outside their discipline. One way of achieving this is to make it subscription only on proof of membership, which excludes the sort of debate opened up by the *BMJ*.

Worryingly, the editors at the *BMJ* seem unaware that poverty in the United Kingdom, as well as specified “lower and middle income countries,”¹ means that many people cannot access the paper *BMJ*. It is only kept in large city libraries. Such people certainly do not have access to computers and only some libraries give free access to the internet as yet. Lay readers need the information provided by the *BMJ*. They are not waiting at the portals in any prurient way but use the journal for research and information that is not accessible through other means. There are thousands who have no access to further education or specialist journals.

So the ideal of free access to knowledge and information on an equal basis through the internet falls by the wayside. Although understandable, this move is a sad way to end a decade.

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¹ Delamothe T, Smith R. Paying for bmj.com *BMJ* 2003;327:241-2. (2 August.)

Nothing is for free

EDITOR—I am delighted that over the past six years (when the internet became accessible in my town) I have had the pleasure of reading the *BMJ* online. The printed version is extremely expensive for me (my monthly salary is around 200 euros). But fortunately I can still enjoy the *BMJ* for free even after 2005 as I live in Russia.¹

But I can see that it is an expensive gift. Even I could pay something—for example, 5-10 euros a year. Anyway, thank you for an excellent information source and educational tool.

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¹ Delamothe T, Smith R. Paying for bmj.com *BMJ* 2003;327:241-2. (2 August.)

Move is a sensible surprise

EDITOR—Ironically, I saw Delamothe and Smith's announcement about paying for access to bmj.com when double checking the URL of the *BMJ* while writing a sentence in my MA dissertation: “Some journals, such as the *British Medical Journal*, are currently available free online to the general public.”¹

This sentence, however, refers to access for health professionals in developing countries. I therefore congratulate and admire the decision to keep free access for lower and middle income countries while collecting from those more able to pay.

My only concern is that the BMJ Publishing Group may not be charging enough to sustain its services, cover the administrative costs of collecting subscription fees, and still be able to support services such as INASP-Health (International Network for the Availability of Scientific Publications).

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¹ Delamothe T, Smith R. Paying for bmj.com *BMJ* 2003;327:241-2. (2 August.)

Researchers will submit their articles elsewhere

EDITOR—The move to charge for access to bmj.com is sad.¹ While I was not naive enough to believe that the *BMJ* would stay free forever, I had hoped that it would at least set a trend by keeping its open access policy and adopting an author pays model.

As a researcher I would be more than happy to spend money from my research grants to pay a fee for having an article processed by the *BMJ*. In closing the door and making the *BMJ* once again a subscription journal, the *BMJ* loses much of its appeal as the place for researchers to submit their high quality papers. At least for non-Britons, the high (international) visibility of articles published in the *BMJ* may have been the main motivation for submitting something there.

Researchers are interested in global impact, not in impact on BMA members alone. The *BMJ*—dubbed the “Better Medical Journal” by Richard Smith—becomes the “British Medical Journal” once more.

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Is this measure scientific literature's half open sesame?

EDITOR—Over the past decade the *BMJ* has shown its commitment to widening access by providing universally free online content and reduced subscriptions for people in resource limited settings. Given its support for open access, it is regrettable that, in the face of falling paper sales, the journal should opt to squeeze subscriptions for the few years it has left instead of fully adopting the more progressive open access model.^{1,2}

Under the open access model, each article is paid for only once, subsequently becoming freely available to everyone (with internet access). This point is not being lost on funders. In the United States, the Public Access to Scientific Information Act seeks to place all scientific research substantially funded by government in the public domain.³ Currently, the US government spends \$45bn annually on scientific research, the results of which are largely unavailable to taxpayers. The privatisation of scientific information by publishers undermines the accountability of funders and the scientific community to the intended beneficiaries of such research—the public.

The *BMJ* as a leading medical journal can do much more to open the door to scientific information: by influencing competitors, funders, institutions, and individuals, and by working with independent researchers and those in under-resourced settings towards a more equitable form of publication. For the moment, this door remains ajar.

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¹ Delamothe T, Smith R. Paying for bmj.com *BMJ* 2003;327:241-2. (2 August.)

² Delamothe T, Godlee F, Smith R. Scientific literature's open sesame? *BMJ* 2003;326:945-6.

³ McLellan F. US bill says government funded work must be open access. The bill also wants to break up and redraw the rules on scientific publishing. *Lancet* 2003;362:52.

Let the journal be innovative in maintaining information flows and linkages

EDITOR—Responses to the move of paying for bmj.com have focused on cost and value.^{1,2} I, however, regret this move for its effect on the usability of the medical web.

The closer we get to a seamless flow of information, and the connections and transitions between items of information, the better. But much of the medical web is isolated in little bubbles with an access

barrier to be negotiated, and much is not indexed by the search engines.

The journals hosted on the Highwire servers are already in a bubble for search engines for realistic reasons, but it is a pity that the *BMJ's* content is about to retreat deeper into the foam we all struggle through.

Authentication and the need for collecting money impair the function characteristic of the web—linkage between items of information—thereby reducing the usability and usage of the system as a whole. However, the move proposed seems to be the emerging consensus in newspaper publishing.

If we have to have a charging system to maintain profits, so be it. But can the journal that was innovative in open medical web publishing ensure that it is innovative in maintaining the flow and connections despite its payments, please?

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Competing interests: AM worked for a while for a company trying to improve access through the foam.

- 1 Delamothe T, Smith R. Paying for *bmj.com* *BMJ* 2003;327:241-2. (2 August.)
2 Electronic responses. Paying for *bmj.com* *bmj.com* 2003. Bmj.bmjournals.com/cgi/eletters/327/7409/241 (accessed 21 Nov 2003).

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Summary of responses

EDITOR—By 21 November 77 readers had responded to Delamothe and Smith's editorial.^{1 2}

Most of them were sanguine about the decision to charge a reasonable fee (£10-20 (\$17-34; €14-28)) for access to *bmj.com*, although the question was raised whether subscribers to the paper journal actually subsidised web users worldwide. Some expressed their thanks for having had free access for so many years and wondered why other journals had not followed suit. The idea that charging was a way to keep the *BMJ* independent and maintain the breadth and width of subject matter was welcomed.

Several readers from outside the United Kingdom used the website in preference to the paper journal for reasons of cost, although telephone charges across the world vary, as well as the difficulties with telecom infrastructure in some countries.

Nearly all correspondents recommended that different categories of fee should be introduced for different users, not only countries. Correspondents who had reached retirement age were especially anxious that this should be taken into consideration.

The idea that web readers should provide access credentials was viewed with criticism, implying dishonesty on the part of web readers. Several expressed the hope that the access fee might result in a reduced amount of pharmaceutical advertising in the journal. In practical terms, the consensus seemed to be that six months' blocked access after publication, rather than a year, was long enough.

One reader thought that rapid responses and access to Medline should remain free. Others thought that specialists might be made to pay, whereas the public should have free access—a question of influence, whose potential loss worried several correspondents. Worryingly, £20 might not be enough to maintain the quality. Sponsorship was one possible alternative.

Among the negative reactions were warnings that subscription budgets might not stretch to including this additional new fee and thus lose the *BMJ* readers. Also brought into the equation was the fact that the *BMJ* is a general journal that is of great interest to specialists, who might not read it if they had to pay.

Paying for *bmj.com* is giving up a vision, wrote one of the later correspondents, and another declared that it was an own goal of greed. Free access helps to make medicine more democratic and accountable. And if access to information is the cornerstone of the health business then perhaps the *BMJ* Publishing Group should reconsider its position.

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Competing interests: None declared.

- 1 Delamothe T, Smith R. Paying for *bmj.com* *BMJ* 2003;327:241-2. (2 August.)
2 Electronic responses. Paying for *bmj.com* *bmj.com* 2003. Bmj.bmjournals.com/cgi/eletters/327/7409/241 (accessed 21 Nov 2003).

Dietary fat intake and risk of stroke

Association may differ with subtypes of ischaemic stroke

EDITOR—He et al report no association between dietary fat intake and risk of stroke in men but did not analyse their data with reference to the different subtypes of ischaemic stroke.¹ The association between serum cholesterol concentrations and the various subtypes of ischaemic stroke may differ.

Sacco et al reported that the protective effect of high density lipoprotein cholesterol is more pronounced in preventing ischaemic stroke due to atherosclerosis compared with lacunar infarction, cryptogenic infarction, and cardioembolic stroke.² It may be interesting to ascertain if any of the different subtypes of ischaemic stroke are associated with dietary fat intake.

The proportion of subjects prescribed cholesterol lowering drugs is not stated by He et al. The result of the heart protection study showed a relation between cholesterol reduction with simvastatin and stroke prevention.³ Those with a high fat dietary intake might be more likely to be prescribed statins, and this may account, in part, for their reported lack of association between dietary fat intake and risk of stroke.

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2 Sacco RL, Benson RT, Kargman DE, Boden-Albala B, Tuck C, et al. High-density lipoprotein cholesterol and ischaemic stroke in the elderly: the Northern Manhattan Stroke Study. *JAMA* 2001;285:2729-36.
3 Heart Protection Study Collaborative Group. MRC/BHF heart protection study of cholesterol lowering with simvastatin in 20,536 high risk individuals: a randomised placebo-controlled trial. *Lancet* 2002;360:7-22.

Allegations about dietary fat are unfounded

EDITOR—The finding of He et al that intake of total fat, cholesterol, or specific types of fat are not associated with stroke does not surprise those who have followed the scientific literature about the diet-heart idea from the very beginning.¹ What surprises me is their statement that there is strong evidence that type of dietary fat predicts risk of coronary heart disease.

Except for *trans* fat there is no such evidence at all. In a review² of the relevant ecological, dynamic population, cross sectional, case-control, and cohort studies almost all of them were inconclusive or, most often, contradictory, and in two meta-analyses of the dietary trials³⁻⁴ the number of deaths in treatment and control groups were identical.

There is no support either from the study used as evidence by He et al because the weak association found between intake of saturated fat and coronary heart disease in that study disappeared after adjustment for other risk factors.⁵

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3 Hooper L, Summerbell CD, Higgins JPT, Thompson RL, Capps NE, Davey Smith G, et al. Dietary fat intake and prevention of cardiovascular disease: systematic review. *BMJ* 2001;322:757-63.
4 Ravnskov U. Diet-heart disease hypothesis is wishful thinking. *BMJ* 2002;324:238.
5 Hu FB, Stampfer MJ, Manson JE, Rimm E, Colditz GA, Rosner BA, et al. Dietary fat intake and the risk of coronary heart disease in women. *N Engl J Med* 1997;337:1491-9.

Authors' reply

EDITOR—We agree with Epstein that the association between serum cholesterol concentration and the various subtypes of ischaemic stroke may differ. Unfortunately, we do not have enough data to allow us further to study the subtypes of ischaemic stroke in this cohort.

Any possible association between dietary fat and stroke could be attenuated if participants with high dietary fat intake were taking cholesterol lowering drugs. However, error from this source is likely to be modest because our results were virtually unchanged after exclusion of 4474 (10.23%) participants who reported history of hypercholesterolemia at baseline (data not shown).

Ravnskov questioned our statement that the types of fat were more important than

total fat in predicting risk of coronary heart disease. Findings from early studies on dietary fat and coronary heart disease were inconsistent, in part, because of the inadequate dietary assessment, incomplete adjustment for total energy intake, and failure to account for other components of diet. On the basis of metabolic studies, epidemiological observations, and randomised trials, the quality of fat rather than the amount of total fat is clearly important in determining risk of coronary heart disease.^{1 2}

Hu et al, which we cited, found that after adjustment for other risk factors, replacement of 5% of energy from saturated fat with the same amount of polyunsaturated fat was associated with a 50% lower risk of coronary heart disease.³ A protective effect of polyunsaturated fat is also supported by the results of randomised clinical trials.⁴

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- Hu FB, Manson JE, Willett WC. Types of dietary fat and risk of coronary heart disease: a critical review. *J Am Coll Nutr* 2001;20:5-19.
- Ascherio A. Epidemiologic studies on dietary fats and coronary heart disease. *Am J Med* 2002;113(suppl 9B):s9-12.
- Hu FB, Stamper MJ, Manson JE, Rimm E, Colditz GA, Rosner BA, et al. Dietary fat intake and the risk of coronary heart disease in women. *N Engl J Med* 1997;337:1491-9.
- Sacks FM, Katan M. Randomized clinical trials on the effects of dietary fat and carbohydrate on plasma lipoproteins and cardiovascular disease. *Am J Med* 2002;113(suppl 9B):s13-24.

Non-commercial randomised clinical trials need money for meetings and travel expenses

EDITOR—Chalmers et al highlight from their survey of non-commercial randomised trials the challenges faced by researchers seeking funding for trials addressing issues that are not of interest to industry.¹

For any large multicentre clinical trial to reach its target accrual, the clinical research community must be committed to the trial at the earliest stages of its development. Current financing of peer reviewed trials by the Department of Health and the Medical Research Council begins only once a full proposal is approved. However, costs are incurred in the process of developing a full proposal, particularly by national meetings to discuss and develop the detailed protocol and the administrative support for revisions of the text.

Although much of the communication between clinicians can be done by email, meetings of clinicians face to face are needed to debate the research question and practicalities for a clinical trial. In a trial supported by industry these meeting expenses are usually reimbursed. This is not the case for non-commercial trials, in which study leave budgets for cancer professionals are

often inadequate and discourage wide participation.

A more level playing field is needed. A way forward may be the creation of NHS research and development and Medical Research Council budgets (perhaps £1000-£2000) for meeting and travel expenses for shortlisted proposals to facilitate the development of full proposals. This might encourage and accelerate the conduct of non-commercial trials of interest to clinicians and patients.

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Competing interests: IHK has received research funding from the Department of Health (research and development).

- Chalmers I, Rounding C, Lock K. Descriptive survey of non-commercial randomised trials in the United Kingdom 1980-2002. *BMJ* 2003;327:1017-9. (1 November.)

Illiteracy is not just a historical phenomenon

EDITOR—West suggests that doctors' reluctance to copy letters to patients is an anachronism stemming from the fact that patients were often illiterate in the 18th and 19th centuries.¹

Glasgow Royal Infirmary is a large teaching hospital, whose local catchment population is one of the most deprived in the United Kingdom. One of us with colleagues surveyed 127 consecutive, unselected patients with rheumatoid arthritis attending a rheumatology clinic and found that 3% could not read and 15% (1 in 6) were functionally illiterate.² We have no reason to believe that these patients were in any way unrepresentative. Copying letters to these patients is not an effective way of empowering them.

Email and internet sites, although popular with a minority,³ will not serve the needs of patients with low levels of literacy. In our cohort illiteracy was associated with significantly more hospital visits, but overall function was similar, with implications for resources and funding.

We wholeheartedly believe in fully sharing information with our patients, but whereas audiotapes and videotapes may be useful, they assume access to appropriate equipment and again have implications for funding.

For some, the best option is likely to be adequate time with an appropriate health-care professional—a resource unfortunately in short supply.

Perhaps Glasgow is different from York, but we suspect illiteracy is more widespread than many doctors appreciate, even in the 21st century.

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Patients need comfort and control in beds and chairs

EDITOR—Bliss's plea for elderly people to be freed from the tyranny of having to sit in chairs is laudable.¹ She also highlights the dangers of forced sitting in chairs, which is based on a widespread misconception that if we as health professionals get patients out of bed into a chair we are making progress.

Transferring from bed to chair is beneficial only if it enables patients to stand up and walk. Unfortunately most designs of chairs in hospitals and care homes have horizontal seats, which allow patients to slip forwards into a slumped position. Also the arms do not protrude forwards sufficiently to enable the person sitting to bring the centre of gravity forwards over the feet and rise unaided.

Most hospital beds are equally unsatisfactory. All beds should have a head down slope to encourage venous drainage in the legs and prevent the patient from slipping forwards when sitting in bed.

So far as the patient is concerned, most hospital beds have not changed since Florence Nightingale. The patient still has no control. In one respect we have regressed because self help bed poles and handles have been discarded. Why? Presumably because they are not aesthetic.

All hospital beds should incorporate patient operated electrical control of back rests and bed height. Patient autonomy is being increasingly accepted, so why are health professionals depriving their patients of control of their freedom and comfort in bed?

Of course we will be told that ideal chairs and beds for all would be too expensive. But how would that cost compare with the savings in nursing time and injured nurses' backs?

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