

NURSE DELIVERED ENDOSCOPY

Authors' response

We wish to clarify some points raised by Norton and colleagues in their editorial accompanying our papers.¹⁻³

The subtitle, stating that nurse endoscopy “is as clinically effective as that delivered by doctors, but may cost more,” is inaccurate. We found doctors more cost effective because their outcomes were slightly better, even though they cost slightly more than nurses.

In the papers we summarised the main outcome measures of the trial, but more detail is given in the full report, where we describe other measures including polyp detection rates.⁴ The procedure duration seems long because it was timed from one extubation to the next, to reflect any activities undertaken by endoscopists between patients.

The editorial's discussion of the threshold chosen for cost per QALY is open to misinterpretation. A threshold of £5000 does reveal a 60% probability of doctors being cost-effective, but as this threshold increases so the probability of doctors being cost effective increases. At a threshold of £15 000 (at which the National Institute for Health and Clinical Excellence (NICE) is unlikely to reject a technology), the probability of doctors being cost effective is over 80%. Nevertheless, we reiterate the uncertainty in these findings, and still advocate caution in interpreting the results.

Finally, we did not state that “shortages of doctors are no longer relevant,” but noted that policy concerns have shifted from doctor shortages to potential surpluses. We agree that bowel cancer screening will necessitate an increase in the endoscopy workforce, and we hope that this trial informs the policy debate.

John Williams professor of health services research, Centre for Health Information, Research and Evaluation, School of Medicine, Swansea University, Swansea SA2 8PP
j.g.williams@swansea.ac.uk

Gerry Richardson senior research fellow, Centre for Health Economics and Hull York Medical School (HYMS), University of York, York

Karen Bloor senior research fellow, Department of Health Sciences, University of York

Competing interests: None declared.

- 1 Norton C, Grieve A, Vance M. Nurse delivered endoscopy. *BMJ* 2009;338:a3049. (10 February.)
- 2 Williams J, Russell I, Durai D, Cheung WY, Farrin A, Bloor K, et al. Effectiveness of nurse delivered endoscopy: findings from randomised multi-institution nurse endoscopy trial (MINuET). *BMJ* 2009;338:b231. (10 February.)
- 3 Richardson G, Bloor K, Williams J, Russell I, Durai D, Cheung WY, et al. Cost effectiveness of nurse delivered endoscopy: findings from randomised multi-institution nurse endoscopy trial (MINuET). *BMJ* 2008;337:b270. (10 February.)
- 4 Williams J, Russell I, Durai D, Cheung WY, Farrin A, Bloor K, et al. Executive summary. What are the clinical outcome and cost-effectiveness of endoscopy undertaken by nurses when compared with doctors? A multi-institution nurse endoscopy trial (MINuET). Health Technology Assessment 2006;10:No 40. www.hta.ac.uk/execsumm/summ1040.htm

Cite this as: *BMJ* 2009;338:b1082

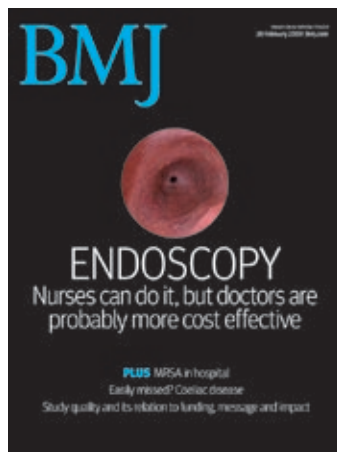
Opportunity costs of endoscopy

Norton and colleagues refer to the opportunity costs of endoscopic procedures performed by doctors and consider whether their time could be more effectively spent elsewhere.¹

Of course, you might ask the same question about whether valuable clinical nurses are best used as endoscopists. Acquiring the manual skills to perform these procedures is quite straightforward. Indeed, the recent pilot study by the UK Department of Health confirmed that administrators, healthcare assistants, phlebotomists, and clinical physiologists can all be successfully trained to become endoscopy “practitioners.”²

The opportunity costs of these workers may be even lower than those of nurses.

For a well defined, large volume screening test such as flexible sigmoidoscopy in symptomless patients this may be a reasonable, perhaps even cost effective, approach. However, evaluating patients with gastrointestinal disorders requires more than practical dexterity. It relies on a physician's ability to interpret symptoms and signs and understand the natural history of disease. As Sir Christopher Booth warned more than 20 years ago, once gastroenterologists stop seeing the patient as a whole, we too risk becoming “technicians.”³



Richard J Aspinall consultant physician, Department of Gastroenterology and Hepatology, University Hospital of Wales, Cardiff CF14 4XN

richard.aspinall@cardiffandvale.wales.nhs.uk

Competing interests: RJA performs endoscopies.

- 1 Norton C, Grieve A, Vance M. Nurse delivered endoscopy. *BMJ* 2009;338:a3049. (10 February.)
- 2 Gardiner AB. Results of the United Kingdom's first pilot study for nonmedical endoscopy practitioners. *Colorectal Dis* 2009;11:208-14.
- 3 Booth CC. What has technology done to gastroenterology? *Gut* 1985;26:1088-94.

Cite this as: *BMJ* 2009;338:b1071

COELIAC DISEASE

Don't forget increased risk of fetal growth restriction

The article on how easily coeliac disease is missed did not highlight the association between undiagnosed coeliac disease and an increased risk of fetal growth restriction.¹ Fetal growth restriction is a major pregnancy complication responsible for a 5-20 fold increase in perinatal mortality and for considerable perinatal morbidity. In addition, it may have lifelong consequences, ranging from neurodevelopmental delay to an increased risk of developing hypertension, heart disease, and diabetes later in life.²

There is a growing body of evidence supporting the association between undiagnosed coeliac disease and fetal growth restriction, odds ratios varying between 1.3 and 6.^{3,4} Treatment of maternal coeliac disease reduces the risk of fetal growth restriction to that of the general population.⁵ Two further studies recently carried out in our unit, one in a high risk Irish population and the other a large Danish population based study, confirm this association and highlight the benefits of treatment of coeliac disease with a gluten free diet. In contrast, other interventions to reduce the incidence of fetal growth restriction have met with disappointing results.

Fergus P McCarthy clinical research fellow

Fergus.mccarthy@ucc.ie

Ali S Khashan postdoctoral researcher

Louise Kenny senior lecturer,

Anu Research Centre, Cork University Maternity Hospital,

University College Cork, Wiltan, Cork, Republic of Ireland

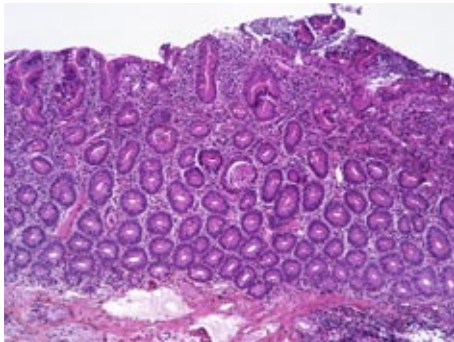
Eamonn Quigley professor of medicine and human physiology, Alimentary Pharmabiotic Centre, Department of Medicine, University College Cork

Fergus Shanahan professor and chair, Department of Medicine, University College Cork

Competing interests: None declared.

- 1 Jones R, Sleat S. Coeliac disease. *BMJ* 2009;338:a3058. (19 February.)
- 2 Simeoni U, Zetterstrom R. Long-term circulatory and renal consequences of intrauterine growth restriction. *Acta Paediatr* 2005;94:819-24.
- 3 Ciacci C, Cirillo M, Auremma G, Di Dato G, Sabbatini F, Mazzacca G. Coeliac disease and pregnancy outcome. *Am J Gastroenterol* 1996;91:718-22.
- 4 Salvatore S, Finazzi S, Radaelli G, Lotzniker M, Zuccotti GV. Prevalence of undiagnosed coeliac disease in the parents of preterm and/or small for gestational age infants. *Am J Gastroenterol* 2007;102:168-73.
- 5 Ludvigsson JF, Montgomery SM, Ekblom A. Coeliac disease and risk of adverse fetal outcome: a population-based cohort study. *Gastroenterology* 2005;129:454-63.

Cite this as: *BMJ* 2009;338:b1069



ISW/SPL

Non-invasive diagnosis needed

My personal story of self diagnosed gluten intolerance is similar to that of Jocelyn Anne Silvester—if you omit the barium investigations and substitute cholecystectomy (probably unnecessary).¹ I had a positive family history of presentation in the mid-forties and a negative endomysial antibody test, and after several deliberate and inadvertent gluten challenges I decided not to proceed with a biopsy as I did not want to suffer needlessly for a test which would adhere to the guidelines but not alter my management. I, too, would have needed to take time off work if I had resumed a gluten diet. Fortunately, I had a specialist who supported me in this decision.

As a general practitioner, I am identifying more cases than previously, and more patients are presenting with self diagnosis. However, I feel a hypocrite when I reiterate the current recommendation—to remain on a normal diet until biopsy—knowing that this often entails weeks of unnecessary suffering and that I did not follow this recommendation myself.

Is it not time for more consideration to be given to non-invasive methods of prompt diagnosis?

Pat Hoddinott senior clinical research fellow and general practitioner, Public Health Nutrition Research Group, University of Aberdeen, Aberdeen AB25 2ZP p.hoddinott@abdn.ac.uk
Competing interests: PH has self diagnosed gluten intolerance.
 1 Silvester JA, Rashid M. Coeliac disease and a gluten-free diet. *BMJ* 2009;338:b380. (19 February.)

Cite this as: *BMJ* 2009;338:b1070

MEASURING UP THE NHS

The story of outperforming expectations continues

The quality and outcomes framework (QOF) showed that before 2004 general practitioners were poor at recording “quality markers,” even those based on good clinical evidence, and the change in contract inevitably pushed practices (not necessarily individual general practitioners) into measuring the markers with money attached. Surprise, surprise—at least to the employers and the Treasury—entrepreneurial, innovative, and “thinking” general practitioners rapidly outperformed expectations¹ and have since been penalised financially for so doing and damaging the relationships in practice teams.

Now Lord Darzi’s dash to quality in primary care shows up in the requirement in Darzi practice tender documents to invent 12 quality indicators above and beyond QOF, including proposed national or local QOF changes for 2009-10, as a demonstration of clinical leadership and commitment to improved quality outcomes for patients. This within a capped bid price for a 12 hour daily service available to registered and unregistered patients on request, which repeats the disruption to continuity of care found in secondary care, destroying the key foundation stone of the long term doctor-patient relationship on which the QOF “successes” were based.

This feels like anti-professionalism on an institutional scale: being asked to achieve more with less in an environment hostile to personal long term care of individual patients.

Or is it just me?

Ron Carter vocation general practitioner, MKDoC, Milton Keynes MK6 5NG
doctorrncarter@hotmail.com
Competing interests: RC is a general practitioner.

- 1 Hawkes N. Measuring up the NHS. *BMJ* 2009;338:b703. (25 February.)

Cite this as: *BMJ* 2009;338:b1068

ALEXANDER TECHNIQUE TRIAL

A trial subject’s perspective

I was a subject in the ATEAM trial (randomised controlled trial of Alexander technique lessons, exercise, and massage).¹ My tardy response is because I was told that subjects would be informed of the study results. To date this has not happened: I found the paper only when a friend mentioned it to me.

In table 5, which gives the one year results, SF-36 “quality of life mental” shows no effect. This seems to have been overlooked. It is desirable to reduce days of back pain, but until this is zero there is the constant reminder of the

underlying problem. Is it not this continual worry of exacerbation that is wearing, reduces activity, and leads to the low mental state?

The authors say that they used primary outcome measures that have been well validated. Were the subjects used in the validation specifically asked what outcome they would value most after treatment? I would think not. Certainly the subjects in the ATEAM trial were not asked. It is surprising that the authors do not distinguish between what they want to measure and what patients might want them to measure. Why do they think that patients would value an “improvement” on their scales? The validation or otherwise of the wrong measure is irrelevant.

As a patient, for me, the take home message for this study is that none of the treatments cures back pain, therefore, they are not worth bothering with.

Peter Lewis retired medical informatician, Bath BA2 2BB
palewis_bath@hotmail.com

Competing interests: None declared.

- 1 Little P, Lewith G, Webley F, Evans M, Beattie A, Middleton K, et al. Randomised controlled trial of Alexander technique lessons, exercise, and massage (ATEAM) for chronic and recurrent back pain. *BMJ* 2008;337:a884. (19 August.)

Cite this as: *BMJ* 2009;338:b1059

CHOOSE AND BOOK RIDES AGAIN

Orthopaedic attendance also worse with choose and book

We report a similar decline in patient attendance with choose and book to that described by Modayil and colleagues.¹

Choose and book went fully online for elective orthopaedic referrals to our hospital in October 2006. In 2005 there were 3144 elective referrals to orthopaedic outpatients, of which 170 did not attend (5.41%). In 2008 the number of elective referrals rose to 3961, but the number of non-attendances was 349 (8.81%). The increase in non-attendance rates between 2005 and 2008 was significant ($\chi^2=29.49$ (Yates corrected); $P<0.0001$) and equates to a 39% rise in non-attendance rates after the start of choose and book. It inevitably reduces the cost efficiency and productivity of the department.

Despite the *raison d'être* of choose and book, patients complain of a lack of choice about appointment date, appointment time, and hospital availability.² General practitioners bemoan the system’s inflexibility and the inability to refer specific problems to suitable sub-specialists.^{3,4} Hospital doctors lament the change to patient prioritisation with its negative effects on workload and patient care.⁵ In orthopaedics, referral to, and triage by, extended scope physiotherapists adds an extra layer to the process of obtaining

specialist review, resulting in unnecessary delays in treatment, frustration among general practitioners and their patients, and a significant increase in non-attendance rates.

Thomas B Beckingsale third year SpR, orthopaedic surgery
tombeckingsale@doctors.net.uk
Ian W Wallace consultant orthopaedic surgeon, James Cook
University Hospital, Middlesbrough TS4 3BW

Competing interests: None declared.

- 1 Modayil PC, Hornigold R, Glore RJ, Bowdler DA. Patients' attendance at clinics is worse with choose and book. *BMJ* 2009;338:b396. (2 February.)
- 2 Green J, McDowall Z, Potts H. Does choose and book fail to deliver the expected choice to patients? A survey of patients' experience of outpatient appointment booking. *BMC Medical Informatics and Decision Making* 2008;8:36.
- 3 Midgley AK. "Choose and book" does not solve any problems. *BMJ* 2005;331:294.
- 4 Pothier D, Awad Z, Tierney P. "Choose and book" in ENT: the GP perspective. *J Laryngol Otol* 2006;120:222-5.
- 5 Pothier DD, Repanos C, Awad Z. Analysing GP referral priorities: the unforeseen effect of choose and book. *Clin Otolaryngol* 2006;31:327-30.

Cite this as: *BMJ* 2009;338:b1060

MOBILE PHONES IN HOSPITAL

Resurgence in memorial postmortem photography?

During a night shift I was called to confirm the expected death of an elderly male patient on an open ward. The relatives were expecting a doctor to come, and they got up to temporarily leave the bay when they saw me arrive. As they were leaving, I noticed one of them quickly take a picture of the dead man with his mobile phone.¹ The patient had a nasopharyngeal airway in situ and had not yet been cleaned by the nursing staff. I thought it was slightly odd behaviour and mentioned it to a colleague, who said that she too had seen a relative taking a picture of a recently dead relative using a mobile phone.

Photographs of the dead, particularly religious leaders, are still taken and distributed in other parts of Europe but not, so far as I am aware, in the UK. Memorial postmortem photography was once popular in Britain in the Victorian era, but photographs were generally formalised, with the patient being dressed up and often having their family included with them in the photograph. They were not candid shots of an unprepared still warm body.

Are these witnessed incidents isolated events? Or is the comparatively covert and instant nature of the mobile phone camera allowing people to respond to stress in a way that comforts them, but society may deem unacceptable and morbid?

Patrick B M Burch GPVTS SHO, Freeman Hospital, Newcastle upon Tyne NE7 7DN
Patrick.Burch@doctors.org.uk

Competing interests: None declared.

- 1 Derbyshire SWG, Burgess A. Use of mobile phones in hospitals. *BMJ* 2006;333:767-8.

Cite this as: *BMJ* 2009;338:b1063

NICE UPDATE ON BREAST CANCER

Immediate breast reconstruction should be challenged



KLAUS GOLDBRANDSEN/SPL

The tenet that immediate breast reconstruction improves health related quality of life underlines the increasing practice of breast reconstruction internationally.^{1,2} However, there is no good clinical evidence to support this. A systematic review of relevant journals showed a lack of level I evidence—2% randomised controlled trials, 15% cohort studies, and 80% case reports—and a threshold of methodological rigour of levels IV and V.³

Systematic review of whether breast reconstruction improves health related quality of life for women facing mastectomy did not show an improvement in all domains.⁴ Two single centre randomised controlled trials showed no difference between immediate and delayed breast reconstruction and between types of delayed breast reconstruction regardless of radiotherapy.⁴ The nine prospective longitudinal cohort studies and the 23 retrospective cross sectional studies showed inconsistent results.⁴

Heightened awareness is needed to produce the highest levels of scientific evidence to inform the correct choice for patients and clinicians. To this end, the British Association of Surgical Oncology has instigated the successful national breast reconstruction audit. A feasibility study evaluating women's acceptance of randomisation when undergoing immediate and delayed latissimus dorsi breast reconstruction has also been launched.⁵ The proposed Cancer Research UK and BUPA Foundation funded multicentre quality of life after mastectomy and breast reconstruction trial (QUEST) in the UK will assess the impact of the type and timing of breast reconstruction on quality of life after mastectomy.⁵

Zoë Ellen Winters consultant senior lecturer in breast surgery and head, Breast Reconstruction HRQL Group, Clinical Sciences South Bristol, University Hospitals of Bristol NHS Foundation Trust, Bristol BS2 8HW
Zoe.winters@bristol.ac.uk

Competing interests: ZEW is the chief investigator of QUEST.

- 1 Mayor S. NICE updates guidance on medical and surgical treatment for early and advanced breast cancer. *BMJ* 2009;338:b815. (25 February.)
- 2 Cordeiro PG. Breast reconstruction after surgery for breast cancer. *N Engl J Med* 2008;359:1590-601.
- 3 McCarthy CM, Collins ED, Pusic AL. Where do we find the best evidence? *Plastic Reconstructive Surgery* 2008;122:1942-7.
- 4 Potter S, Winters Z. Does breast reconstruction improve quality of life for women facing mastectomy? A systematic review. *Eur J Surg Oncol* 2008;34:1181. (Abstract P63.)
- 5 Potter S, Winters ZE. The QUEST study: a multicentre randomised trial to assess the impact of the type and timing of breast reconstruction on quality of life after mastectomy. *Breast Cancer Res* 2008;10(suppl 2):P87.

Cite this as: *BMJ* 2009;338:b1067

ON CRITICISING ISRAEL

Response from author of original paper

Freedland challenges my comparison of the number of Palestinians killed by the Israeli Defence Force (IDF) with those killed in 9/11.^{1,2} B'Tselem recorded 2952 fatalities for the period in question (2000-4)³; Freedland's figure is just half of this total (1508) and presumably reflects the exclusion of what B'Tselem categorises as "Palestinians who took part in hostilities."

Freedland is at risk of uncritically recycling figures that promote self-exculpating IDF mantras. B'Tselem must depend in part on what the IDF tells them: should the IDF's categorisation of those that it has killed be regarded as disinterested reportage?

So who are "Palestinians who took part in hostilities"? Police officers, like the 20 year old recruits slaughtered recently at their inauguration parade? Anyone involved in the Hamas administration in Gaza, which has many ordinary functions? Friends or families of Hamas officials, or anyone who happens to be present in a Hamas building when Israel bombs it? How many of the 2000 slain children (2000-9) would the IDF include? What also of B'Tselem reports of a persistent pattern of "targeted killings" of unarmed men or, if armed, not attempting to use them? Were the Israeli bombs that hit Gazan hospitals, medical laboratories, schools, administrative buildings, the university, factories and thousands of homes expecting to find this category of Palestinian there?

Only a small minority of fatalities could be described as fighters who die in action on the field of battle.

Derek A Summerfield honorary senior lecturer, Institute of Psychiatry, Maudsley Hospital, London SE5 8BB
derek.summerfield@slam.nhs.uk

Competing interests: DAS has had academic and humanitarian involvement with Israel/Palestine since 1992.

- 1 Freedland J. Commentary: Toughen up. *BMJ* 2009;338:b524. (24 February.)
- 2 Summerfield D. Palestine: the assault on health and other war crimes. *BMJ* 2004;329:924.
- 3 btselem.org. Press releases/statistics 2003-4.

Cite this as: *BMJ* 2009;338:b1076



Al-Quds hospital, south of Gaza city

Commentator's reply

Summerfield suggests that, by relying on data from the Israeli human rights organisation B'Tselem, I am "at risk of uncritically recycling figures that promote self-exculpating IDF mantras."¹ After all, he asserts, "B'Tselem must depend in part on what the IDF tells them."

This is a serious charge to level at an organisation that has won international praise for its fearless monitoring of the Israeli occupation. Fortunately, it is false. I showed Summerfield's letter to B'Tselem's communications director, Sarit Michaeli. Here's an extract from her reply; the full version is published on bmj.com:²

"B'Tselem's modus operandi in cases of Palestinians killed by the Israeli security forces is to send a field worker to the scene of the killing, or if that isn't possible, to the hospital or family home. The purpose of the field research is to get as much information as possible about the event, in the form of eyewitness testimonies, videos, pictures, maps, medical and other documentation, etc. . . ."

"Although B'Tselem tries to get a hold of all relevant information, it does not accept at face value statements by either Palestinian or Israeli sources. Therefore, it goes without saying that B'Tselem does not depend on information from the Israeli army—quite the opposite: B'Tselem often refuses to accept the military's version of events, and this refusal has enabled it to expose many cases in which Israeli soldiers and Border Police officers unlawfully killed and injured Palestinians."

On that basis, B'Tselem—which, to reiterate, is involved in extensive, on-the-ground, forensic work on this topic—says that "approximately half" of those Palestinians killed were combatants. Summerfield, an academic based in Britain, insists that such combatants make up only "a small minority." B'Tselem puts the Palestinian civilian death toll for the period under discussion at 1508. Summerfield insists it exceeds 3000. I know whose figures I would prefer to rely on.

Jonathan Freedland columnist, *Guardian*, London N1 9GU
freedland@guardian.co.uk

Competing interests: JF is a director and trustee of Index on Censorship, which campaigns for freedom of expression. His mother was born in Palestine in 1936.

- 1 Summerfield DA. Response from author of original paper. *BMJ* 2009;338:b1076.
- 2 Michaeli S. Response from B'Tselem. Rapid response to Freedland J. Commentary: Toughen up. www.bmj.com/cgi/eletters/338/feb24_2/b524#210531

Cite this as: *BMJ* 2009;338:b1077

Stop de-legitimising Israel and politicising your journal

Why do you keep singling out Israel for its alleged human right abuses?¹

If you want to be fair and balanced, why do you not invite papers on genocide in Darfur, mass murder of Tibetans, ethnic cleansing of Serbs in Kosovo, gender apartheid in much of the Arab world, destruction in West Papua, the effects of the brutal Moroccan occupation on the inhabitants of West Sahara, or, for that matter, mass murder of innocent civilians and war crimes by British and NATO troops in Afghanistan and Iraq?

Or, if you prefer to be viewed as a political publication with a certain political agenda, why don't you state so explicitly?

Ilia Rochlin graduate student, Cypress, CA, USA
irochlin@tuiu.edu

Competing interests: None declared.

- 1 Delamothe T, Godlee F. What to do about orchestrated email campaigns. *BMJ* 2009;338:b500. (24 February.)

Cite this as: *BMJ* 2009;338:b1075

Editor's note:

Of 50 rapid responses criticising our articles on orchestrated campaigns, 11 made this point. In response, we have compiled data on the *BMJ*'s coverage of conflict zones (http://bmj.com/cgi/eletters/338/feb24_2/a2066#210412—

A thicker skin may not protect

Freedland fails to make an adequate distinction between, on the one hand, emails and letters that are directed to an author and point to differences of fact or opinion, and, on the other, responses that attack the editorial policy or the financial interests of the journal and seek to prevent expression of the views objected to.¹ The first is a continuation of debate and is to be welcomed—although a thicker skin will help to deal with gratuitously offensive responses.

Dispute about facts and their interpretation is an essential step towards unravelling the truth. The second type of response is an attempt to silence debate and the thickest of skins can have no effect here. Freedland says that he received >3000 emails when he wrote in support of Obama's election, but that did not affect Freedman's position or freedom as a journalist, and I doubt that it even led to any lost sleep. That was in no way comparable to the pressure exerted on the publishers of *World Medicine* that led to its closure and Michael O'Donnell's loss of his job.² As Mearsheimer and Walt have shown,³ the pro-Israel lobby in the US clearly does seek to shut down debate on the Palestine/Israel

situation and indeed does not limit its activities to the US: recall its successful pressure on the Oxford Union to revoke the invitation of Norman Finkelstein to a debate in 2007.

Such practices are anti-intellectual and dangerous. Freedom of expression is far too important; moreover it will be indispensable if a just solution in the Middle East is ever to be found.

David E Pegg professor, Biology Department, University of York, York YO10 5YW dep1@york.ac.uk

Competing interests: DEP is a member of BRICUP (British Committee for the Universities of Palestine).

- 1 Freedland J. Commentary: Toughen up. *BMJ* 2009;338:b524. (24 February.)
- 2 O'Donnell M. Commentary: Standing up for free speech. *BMJ* 2009;338:a2094. (24 February.)
- 3 Mearsheimer JJ, Walt SM. *The Israel lobby and US foreign policy*. New York: Farrar, Strauss and Giroux, 2007.

Cite this as: *BMJ* 2009;338:b1073

In praise of a thick skin

In his commentary on Sabbagh's article Freedland urged the *BMJ* to "grow a thicker skin."^{1,2} I think it must always have had one, although its journalists have never lost their sensitivity to the sufferings of humanity around the globe as a result of conflicts. As there have always been medical consequences arising from political decisions, how can any medical journalism worthy of the name avoid reporting and discussing them?

I hope that questions relating to the effects on health of the Israeli occupation will continue to be reported on and discussed by the *BMJ* and other medical journals. And indeed not only the effects for the health and wellbeing of Palestinians. On a recent tour of the West Bank with several medical colleagues and other health professionals, I heard from a senior psychiatric colleague how greatly Jewish Israeli society is itself suffering in various sociopsychological ways as a direct result of the brutalising effects of the conflict.

There is a vast amount more one could write—and should write—about the problems of trying to run basic hospitals under the occupation, about shortages of supplies, staff problems simply getting to work, and so on. And this is not even to mention all the horrors of the recent onslaught on Gaza. My recent tour was my second in 5 years, and served to highlight just how much things have got worse in terms of health care, education, the economy, and more.

Brian Robinson retired NHS psychiatrist, Milton Keynes MK5 6WB gbr2004uk-mw@yahoo.co.uk

Competing interests: BR is a signatory, Statement of Jews for Justice for Palestinians, and founder member, British chapter of Israeli Committee Against House Demolitions.

- 1 Sabbagh K. Perils of criticising Israel. *BMJ* 2009;338:a2066. (24 February.)
- 2 Freedland J. Commentary: Toughen up. *BMJ* 2009;338:b524. (24 February.)

Cite this as: *BMJ* 2009;338:b1074