unthinking demand to be told everything breeds mistrust.

The press protects its sources so why should not the employer protect the victim of chance? To do otherwise also encourages cover-up. Misinformation does not only arise from malice on the part of the originator but also from premature enforced disclosure of what are literally half-truths. Any consequent lack of clarity sows seeds for misinterpretation by the recipient.

Too much information can overwhelm. Knowledge is often best gained from an appropriately controlled flow through a good teacher. Paternalism implies advising whilst withholding some information for the benefit of the recipient. I can imagine situations where I would welcome this. Paternalism may not be for Dr Kemm, but he cannot deny that trust is essential for a successful paternalistic relationship. It is perhaps because the modern cult of the individual encourages neither trust nor humility that paternalism now has such a bad name.'

His reply led to an animated conversation about paternalism. Perhaps the editor will agree to publish it one day.

Coemgenus

Driving restrictions after stroke: doctors' awareness of DVLA guidelines and advice given to patients

Editor – The recent letter by Goodyear and Roseveare (*Clin Med* January/February 2003, pp86–7) highlights the poor standard of advice given about fitness to drive by many clinicians. (Incidentally, the stroke and TIA standards quoted are for car drivers: they are more stringent for the drivers of large vehicles.) A parallel study of psychiatric patients, showing similar results, was published recently.[1] The widespread failure to provide appropriate advice about driving and other safety critical tasks reflects the low priority this issue is currently given within the clinical consultation. In turn, this prevents both patients and society from achieving a sound balance between personal mobility and public safety. Those working in transport and occupational medicine are very familiar with this common shortcoming.

There are several initiatives underway to address this.

- A considerable programme of research to improve the evidence base on certain common safety critical conditions such as diabetes, cognitive impairment and visual defects is in progress. This will provide a clearer rationale for advice to patients and may even enable some of those now restricted to be considered fit to drive.
- Funding has been allocated to produce better guidance for health professionals. This will cover acute conditions, recovery from surgery and the use of medication, as well as medical licensing standards. A series of complementary patient information leaflets, downloadable from the Internet, is also envisaged.
- Studies of the attitudes of health professionals to advice on driving safety are proposed to identify the barriers to its provision and how they can best be overcome.

There is already close cooperation with clinical specialists on driving standards through the Secretary of State's six Honorary Medical Advisory Panels on Fitness to Drive. The provision of a clearer understanding of safety critical fitness throughout clinical training, coupled with improved information and raised awareness should, it is to be hoped, make sound advice on preventing accident risk to self and others an integral, and even perhaps an auditable, part of good medical practice.

Reference

1 Wise I, Watson J. Postal survey of psychiatrists' attitudes to driving and mental illness. *Psychiat Bull* 2001;**25**: 345–9.

TIM CARTER
Chief Medical Adviser, Department for Transport, London

HEATHER MAJOR
Senior Medical Adviser, Driver and Vehicle Licensing Agency, Swansea

Editor – The audit by Goodyear and Roseveare (*Clin Med* January/February 2003, pp86–7) was very interesting. However, the authors failed to differentiate between Group 1 (Ordinary) and Group 2 (Vocational) driving requirements. They have only mentioned about the requirements for Group 1/Ordinary driving licence holders. People with Group 2 entitlement cannot drive for 12 months following a stroke/TIA. They can be considered for licensing after this period if there is a full recovery, provided there is a satisfactory medical report including an exercise ECG testing. This is to identify any significant underlying coronary artery disease in a patient who has already had a stroke/TIA.

We are currently doing the same audit because we too felt that this information is very scanty in the case notes. We have incorporated in our 'stroke care pathway checklist' the driving status and the advice given, in order to remind doctors to establish the driving status and give appropriate advice.

Reference

1 Drivers Medical Unit, DVLA. *For medical practitioners: at a glance guide to the current medical standards of fitness to drive*. Swansea: DVLA, July 2002.

SUJOY KHAN,
Senior House Officer

DARSHAN DE SILVA,
Senior House Officer

KANTHAYA MOHANARUBAN,
Consultant Physician, Internal Medicine

Withybush General Hospital, Pembrokeshire

Consent with understanding: a movement towards informed decisions

Editor – In the recent paper by Mayberry and Mayberry (*Clin Med* November/December 2002, pp 523–6), the authors rightly affirm that the basis of informed consent is 'the need to understand the information ... and an ability to retain that information for a period'.

A gynaecologist colleague recently informed me that, in view of the recent drive for full information for informed consent, the routine practice in his department is to list on the consent form every possible complication. Even for the most minor procedures, such phrases as 'rarely, perforation of the uterus, colon or bladder' and 'very rarely, death' are used. The onus of imparting this information usually falls on the hapless SHO, who is often very

inexperienced, and may be unable to give the patient a truly balanced explanation. The consultant admitted that a significant proportion of patients, on learning of these unlikely events, refused surgery, perhaps due to an inability to understand the statistical implications of these statements. This in turn may result in prolonged morbidity (and perhaps even increased mortality) for some patients. Are we not in danger of inadvertently converting 'transparent' information into misunderstanding by some patients, resulting in detriment to their health, and loss of trust in the medical profession?

SYLVIA WATKINS
Honorary Consultant Physician, Lister Hospital, Stevenage

Healthy limb amputation: ethical and legal aspects

Editor – Johnston and Elliot believe that amputation is neither legal or ethical in the treatment of patients with amputee identity disorder (AID) whom they describe as 'wannabes' (*Clin Med* September/October 2002, pp 431–5).

It is important that the group of patients referred to is accurately defined. We believe that there is a group of patients with a compelling and persisting desire to have one or more limbs amputated and that current psychiatric treatments are unsuccessful. Their compulsion is so great that many will injure themselves to achieve their desire.

Money *et al* originally described the condition as a paraphilia (Apotemnophilia)[1] but we believe that there is a separate group of patients in whom there is no obvious sexual component in their request and in whom the condition is more akin to gender identity disorder (GID). There is growing evidence that GID is a neuropsychological rather than a psychiatric disorder.[2] It responds poorly to psychiatric treatment but surgery is reported to have a success rate of up to 97%.[3] Our experience of patients with AID suggests that they too do not respond to currently available psychiatric treatment but that surgery appears to be successful.

Johnston and Elliot suggest that surgery should not be carried out until the condition has been fully researched. However, the patients with this condition are very secretive and ashamed of their feelings and we believe that formal trials of treatment are unlikely to be feasible. The authors correctly say that it is difficult to get a realistic assessment of results following surgery. However, we studied three patients who had had elective amputations between 1997 and 2000. All three had required repeated episodes of pyschiatric therapy before surgery but on follow-up after amputation in 2002 none had required further therapy. Research results can only really be achieved by comparing the effects of surgery with other treatments, for which clearly amputation needs to be available.

They also comment that, although the procedures were carried out with full informed consent and that no complaints had been made, the surgeon could still be subjected to legal action for assault. It is difficult to see who could benefit from such an action, particularly as there are many precedents for removal of normal organs where no prosecution has been undertaken. The circumcision of male infants on purely religious grounds is a case in point.

References

1 Money J, Jobaris R, Furth G. Apotemnophilia: Two cases of self demand amputation as a paraphilia. *J Sex Res* 1977;**13**:115–25.
2 Green R, Fleming D. Transsexual surgery follow up: status in the 1990s. *Ann Rev Sex Res* 1990;**I**:163–74.
3 Zhou J, Hofman MA, Gooren LJG, Swaab DF. A sex difference in the human brain and its relation to transsexuality. *Nature* 1995;**378**:68–70.

ROBERT SMITH
Consultant Surgeon, Falkirk and District Royal Infirmary

KEREN FISHER
Consultant Clinical Psychologist, Royal National Orthopaedic Hospital, Stanmore

AIDS and CFS/ME

Editor – Professor Pinching's essay on AIDS and CFS/ME (*Clin Med* January/February 2003, pp78–82) elegantly links science, literature, and medical history. It also in effect solves the dilemma he addresses, namely poor progress in treating CFS/ME.

AIDS was initially the subject of diverse aetiological speculation but the profound lymphopenia was a vital common denominator and would have focussed meaningful research even before the introduction of techniques for defining CD4 T cells.

In contrast, CFS/ME is a syndrome which pervades much of internal medicine despite the best efforts of epidemiologists to define it more precisely. Discrete diseases have already been identified with symptoms which in some forms of presentation would otherwise have satisfied diagnostic criteria for CFS/ME, for example infectious mononucleosis and systemic lupus erythematosus. Research on this important syndrome progresses when the problem can be defined with sufficient precision.

AM DENMAN,
Emeritus Consultant Clinical Immunologist, Northwick Park Hospital, Harrow