of new hospitals focus strongly on increasing efficiency, minimising risk and improving access. However, there is less confidence that improving well-being is sufficiently high on the agenda.

We know what can be achieved on a smaller scale. For example, the King's Fund's scheme, Enhancing the Healing Environment (EHE), has shown how good design can make a real difference, affecting the quality of life of patients, staff and visitors.[7] Launched in February 2000, the EHE is the largest single investment – nearly £2.25 million – that the King's Fund has ever made in London's hospitals. The programme was designed to encourage and enable nurse-led teams to work in partnership with service users to improve the environment in which they deliver care. It has two main elements:

- multidisciplinary teams, led by a nurse, and including estates and facilities staff, arts coordinators and, increasingly, patient representatives
- a £35,000 grant for each team to undertake a project to improve their patients' environment.

The evaluation of the scheme shows that there are significant long-term benefits from improving hospital settings, including reducing vandalism and violence, helping patients recover more quickly, creating a positive ambience and feelings of calm and well-being, improving staff morale and motivation, and helping staff recruitment and retention.

Using the creative energy of designers and architects together with a growing body of research knowledge, our future hospitals should provide inspiring, health-enhancing environments for generations of patients and professionals. It will be interesting to see if and when such advances are applied to community healthcare settings, where many front-line health workers still work in the poorly lit, poorly ventilated, gloomy rooms with peeling paint that the new hospitals have consigned to memory. As Florence Nightingale once commented, 'Little as we know about the way in which we are affected by form, colour, by light, we do know this, that they have a physical effect'.[8]

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letters
TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by email to: Clinicalmedicine@rcplondon.ac.uk.

Sex is dangerous

Editor – Professor Adler's article (*Clin Med* Jan/Feb 2005, pp 62–8) clearly describes the devastating effect of HIV/AIDS in certain parts of Africa. Professor Adler also draws attention to the mixed response of the South African government to the crisis in their country.

Since 2000, I have been working on and off in a rural area of South Africa, Hlabisa, that has been hit hard by HIV. Without trying to explain or justify what has happened here over the past few years, I would like to outline the current situation on the ground which, I think, is one of great hope.

Hlabisa is situated in northern KwaZulu/Natal. The sub-district has a total population of around 220,000 people; HIV prevalence is around 20% but rises to 40% in antenatal women.

Our hospital became accredited as a site for antiretroviral treatment (ART) in August 2004. We started our first group of patients on therapy in September 2004 and we now have 150 patients on therapy and are adding around 20 a week. At three months review, 13/14 of the first group of patients had undetectable viral load and a rise in CD4 count. The AIDS department of our hospital has gone from a place of despair to a place of hope.

We started giving therapy in one of the sub-district's 15 clinics several weeks ago, and, with no advertising, nine people came on the first day and 27 on the second.

Apart from these early programme successes, there seems to have been a change in the way people perceive HIV. With more openness, less stigma, and more people coming forward for HIV testing, there will be vastly increased opportunities for prevention.

Despite what has gone on in the past, I

feel that it is now important that the global medical community fully supports South Africa's national, provincial and district health departments in the rollout and sustained delivery of HIV/AIDS prevention and treatment services.

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Regulation of clinical research

Editor – As a clinician with an interest in the field of immunotherapy, I read with interest the articles by Professors Warlow and Gennery (*Clin Med* Jan/Feb 2005, pp 33–8; *Clin Med* Jan/Feb 2005, pp 39–41) regarding the increasingly bureaucratic environment that regulates investigator-led research. Too often, regulatory authorities apply restrictive criteria based on a model of product development that is better suited to the drug industry than to an academic research institute (ie a patented commercial product to be manufactured by a company), resulting in spiralling costs and inevitable delays, even for phase one studies.

One cannot help but wonder who stands to gain from such an approach. Certainly not those patients who remain refractory/intolerant of conventional remedies, who are usually only too willing to enter clinical trials. Nor the academics who might be better off changing their scientific thrust and concentrating on bench-top or animal-based research. These are generally easier to perform and fund, and are more likely than clinical trials in human subjects to be published in high-impact journals.

However, it should be noted that it is in the interests of established pharmaceutical companies to support a regulatory framework that discourages investigator-led studies of new biotherapies. The trend towards over-regulation will particularly affect those clinician scientists who are attempting to explore innovative non-drug therapies that have potentially fewer side effects than conventional strategies. This includes non-pharmaceuticals, such as therapeutic and prophylactic cell-based immunotherapies, eg adoptive immunotherapy and certain vaccine formulations. Unless there is regulatory understanding, research will inevitably skew away from such novel approaches, with subsequent over-concentration on those drugs being developed by large pharmaceutical companies.

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Perceptions of disease

Editor – I was fascinated by the very clear exposition of the problem of symptoms and perception of disease by Dr Donaghy (*Clin Med* Nov/Dec 2004, pp 541–4), but perhaps one aspect of this was underemphasised. Deconditioning – the opposite of training – may also contribute to the imbalance between symptoms and physical impairment. As Dr Donaghy points out, there are many reasons for the disproportionate perception of the severity of disease, besides the obvious frank malingering including 'compensationitis', and what used to be called 'poor moral fibre'.

A patient attending, for the first time, with back pain might be resentful at an apparent lack of concern on the doctor's part. Another doctor might take the easy way out and unconsciously try to please by ascribing breathlessness to a totally unwarranted diagnosis of emphysema, which acquires immortality in the notes and can never be undiagnosed in the patient's mind. Often, new symptoms have a disproportionate impact, simply because they are new. Each of these may set up a vicious circle of decreased activity and reactive depression on the one hand and decreased fitness and a real increase in symptoms on the other. The deconditioning then becomes independent of the precipitating factor and so it will persist, even if the latter is removed. The implications of this to clinical practice are that the initial management is critical, and to medico-legal practice that even where the acute 'compensationitis' was malingering, the chronic phase might reflect genuine symptoms.

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Euthanasia and trust

Editor – Your editorial in the last issue (*Clin Med* March/April 2005, p 93) intimated that you received many letters on the difficult issue of assisted dying. It is not my intention to join the debate, at least not in this letter. But I would like to get the facts straight, as the situation in the Netherlands (and now also Belgium) has often been misrepresented. Therefore I would like to correct the abundantly hedged but still potentially misleading sentence in your text that reads: 'Several correspondents have observed that experience in Holland suggests that at least some patients with serious diseases or disabilities fear their doctors who may regularly offer euthanasia.' In the Netherlands euthanasia is not uncommonly requested by patients with terminal illness and sometimes granted, but never offered.

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