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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