

in their conclusions because of inadequate methodology. This is as true for conventional as unconventional therapies, but it is often easier to make the point for unconventional therapies because trials have proven so often to be of poor quality. We should all be concerned that a systematic review is used to support acupuncture in back pain when only open and not blinded studies show an effect,¹ or that a Cochrane review can conclude that evidence supports the use of acupuncture when there is no evidence to support it.² We believe that readers should make their own judgements about the evidence based on objective criteria of quality, validity and size, and not on subjective comments by authors who are believers.³ As we have pointed out before for acupuncture,⁴ authors' conclusions do not always agree with their data, but this is also true for conventional interventions.

Secondly, we chose to use sham acupuncture controls and ignore waiting list controls because this makes sense. If, as we have pointed out before,⁵ the benefits of acupuncture can be obtained without needles, a whole range of very interesting questions are raised. One would be the ethics of sticking needles into patients when the needles cannot be shown to contribute much to benefit, but do contribute to harm.⁶

Thirdly, we are not the first to point out that meta-analysis of small and inadequate trials can generate the wrong answer. Ioannides did the same when he pointed out that such meta-analyses were much more likely to be false than true.⁷

Finally, Lewith and colleagues might be surprised to find that we agree with them that acupuncture may be clinically valuable for some patients in whom nothing else helps, and we would not wish it to be unavailable to them. Moreover, we feel that there is a defence of complementary (and other) therapies that cannot be shown to work on average in conventional clinical trials, perhaps because of the relative insensitivity of those clinical trials in some circumstances.⁸ That defence depends upon the response of individuals, not the average, especially when few of us are average in our response to therapies, and when there can be marked inter-individual variability.⁹ This defence has yet to be made in detail. It is important that it is

made, because it also has high relevance to therapy limitations imposed by fourth-hurdle organisations. For acupuncture, it will be a more sound defence than relying on inadequate clinical trials, and may provide study designs that allow a better evidential case to be made for it.

A MOORE, S DERRY, H MCQUAY
Pain Research, Nuffield Department of
Anaesthetics, University of Oxford,
The Churchill, Oxford

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Who's for five nine-hour shifts a week?

Editor – Am I the only 'little boy' standing in the crowd shouting at the Emperor? The ten week roster that Horrocks and Pounder have invented seems to pay more attention to 'evidence' and less to the interests, experience, training and well-being of the next generation of young doctors. As someone who came through the end of 1:2 house jobs, 1:3 and 1:4 senior house officer and registrar jobs (long weekends and exhaustion compulsory) I think the proposals in their article (*Clin Med* September/October 2006 pp 440–2) are a recipe for govern-

ment and management glee, further medical team disintegration (if that is possible) and even more junior doctor disillusionment. Learning to be a physician has never been easy, nor should it be. I believe the juniors of today are just as committed, passionate and caring as every generation before them. Given all the evidence we have, should it not be them who choose how and when they work instead of enforcing rotas which remove any chance of social, professional and individual advancement? Is it not time for us all to point out that the Emperor really has lost all his clothes?

ADAM FEATHER
Royal College of Physicians Tutor
Newham University Trust

In response

I am delighted that there is some debate. I recall the 'good old days' having worked 3:5 as a house physician, and only moved to a 1:3 rota when a senior registrar. But things were different then: firstly, most juniors below the rank of registrar lived in the hospital and would know their patients and those whom they were covering for the night; secondly, registrars usually did not rotate and they lived close to the hospital; thirdly, patients were managed much less intensively than now; finally, the hospital pace was much slower and activity was less intense – for example, patients could die peacefully.

The stark contrast now is that the average English hospital has 227 medical inpatients, 32 medical admissions per 24 hours, and at 2 am this activity is covered only by a specialist registrar and two lower grades. This intensity of work and responsibility can only be effective if covered by doctors who have prepared for the night shift.

This situation is caused by the combined implementation of the European Working Time Directive (EWTd) and the New Deal. The former is health and safety legislation enforced by the criminal law, and the latter is a product of negotiations between the BMA and the Department of Health. To be frank, European and British politics make it extremely unlikely that either can be changed in the foreseeable future.

Hence I would implore consultants, junior doctors and additional medical staff

to get involved in the intricate design of rotas that minimise the undoubted difficulties; if more help is needed for these doctors in terms of support, then the case must be made. Training and clinical work must be about 20% more efficient in the next three years – this will cost money, and medical staff have to write their business plans now. It is easy to construct a bad rota – for example, seven successive 13-hour night shifts – and this is what will happen if rota design is left to the most junior person in the Human Resources team. Doctors can take charge: in 1970 I finished my 3:5 rota at Guy's by designing a new rota that was implemented immediately.

Keep an eye on the EWTD area of the Royal College of Physicians website – we post up-to-date ideas and reports, which should help rota design.¹ All reports can be downloaded free of charge.

ROY POUNDER

Lead for the European Working Time Directive
Royal College of Physicians, London

Reference

- 1 Royal College of Physicians. European Working Time Directive news. www.rcplondon.ac.uk/news/EU/index.asp#EWTD

The placebo effect

Editor – Your recent editorial (*Clin Med* 2006;6:433–4) does not make direct reference to the Concise Oxford English Dictionary's first definition of placebo, 'opening antiphon of the vespers for the dead'. The second definition is 'a medicine to humour rather than cure the patient'. The first meaning was brought to my attention during a research project when a patient was told he would be given a placebo but after consulting his dictionary expressed some concern about the proposal!

ROBERT LOGAN

Physician, Hutt Valley District Health Board
Lower Hutt, New Zealand

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Communicating information on cardiopulmonary resuscitation to hospitalised patients

Background

National guidelines recommend readily available written information on cardiopulmonary resuscitation (CPR) for hospitalised patients.¹ Data on the uptake of such written information, however, are limited. In 2004 we explored the strategy of placing a CPR summary document adjacent to patients' beds.² The document contained basic information on CPR and encouraged the reader to request a detailed information leaflet. Our study showed reluctance on behalf of the patients to request further information or initiate discussion on CPR but provided no reasons for the poor response.

Aim

The aim of this second study was to determine whether patients fail to notice the summary CPR document or are reluctant to obtain further information on CPR. The reasons for limited uptake of detailed information on CPR were also explored.

Methods

This prospective questionnaire study was approved by the Trust Ethics Committee. An A4 summary document on CPR² along with the decision-making process was the

first document in the patient's folder on the stroke unit. On the elderly care acute ward it was displayed prominently on the wall over the head-end of all beds. It encouraged the reader to seek further information from a detailed CPR information leaflet which was available through the nursing staff.²

Competent patients were randomly invited to participate in the study and verbal consent was obtained. The questionnaire gathered information on whether the patients examined, read and understood the summary document, and if they requested the detailed CPR information leaflet. It also asked for reasons, if any, for not requesting the detailed information leaflet.

Results

The mean age was 82.7 years (range 37–96); there were 49 females and 14 males. Fifty-four per cent had seen the summary document and 53% of those who noticed it acknowledged reading and understanding it. A detailed CPR information leaflet was requested by 28% (Table 1). The reasons for not requesting the detailed leaflet were explored. Three patients found the basic information on the summary document adequate, two were content to leave the decision to their doctors, one found the information too complicated, one felt that she already knew enough, two were not interested, and five did not give

Table 1. Results of the questionnaire.

	Elderly care ward (n=37)	Stroke unit (n=26)	Total (n=63)
Summary document seen	17/37	17/26	34/63 (54%)
Summary document read and understood	6/17	12/17	18/34 (53%)
Detailed information leaflet requested	1/6	4/12	5/18 (28%)