

the cheap and universally applicable treatment suggested in the editorial. It can be an effective long term treatment for many patients with renal failure, but limitations emphasise the inadequate provision of facilities for maintenance haemodialysis.

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- 1 Gokal R. Who's for continuous ambulatory peritoneal dialysis? *BMJ* 1993;306:1559-60. (12 June.)
- 2 Blagg CR. The US renal data system and the case-mix severity study. *Am J Kidney Dis* 1993;21:106-8.
- 3 Teehan BP, Schlifer CR, Brown JM, Sigler MH, Raimondo J. Urea kinetics and clinical outcome on CAPD. A five year longitudinal study. *Advances in Peritoneal Dialysis* 1991;6: 181-5.
- 4 Tattersall JE, Doyle S, Greenwood RN, Farrington K. Kinetic modelling and underdialysis in CAPD patients. *Nephrol Dial Transplant* 1993;8:535-8.

The grossest failures of peer review

EDITOR,—I was disappointed to see the usually meticulous Bernard Dixon trotting out the often quoted but false legend that Hans Krebs's paper on the tricarboxylic acid cycle was originally rejected by *Nature*.¹ It was not: as Krebs writes in his autobiography, the editor replied regretting that the journal had sufficient letters for six or seven weeks and suggesting that if Krebs did not mind the delay he would keep it and hoped to use it.²

Can we hope that this tired old chestnut will ever be buried? Unfortunately, it is probably too attractive to be discarded: it contains all the elements that the public would like to believe are characteristic of science—a genius junior, a fundamental discovery, and a delay in recognition because of a non-percipient referee and editor. Yet at least two of the better, and true, anecdotes about the errors of peer review concern other Nobel prize winners: the original paper that described Dane particles (hepatitis B virus) was rejected when the referee described its illustrations as showing nothing more than dirt on the microscope slide (E Huth, personal communication, 1990); and the better documented rejection of the original description of radioimmunoassay led its discoverer to comment in later years, "the truly imaginative are not being judged by their peers. They have none!"³

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- 1 Dixon B. The grossest failures of peer review. *BMJ* 1993;307:137. (10 July.)
- 2 Krebs H. *Reminiscences and reflections*. Oxford: Clarendon Press, 1981.
- 3 Yalow R. Competency testing for reviewers and editors. *Behavioural and Brain Sciences* 1982;5:244-5.

Health of ethnic groups

EDITOR,—In her review¹ of the book *The Politics of 'Race' and Health*² Ghada Karmi misrepresents my chapter. She writes: "Both Raj Bhopal and Trevor Sheldon make the point that, hitherto, research into the health of ethnic minorities in its approach and methods has been muddled at best and racist at worst." I do not believe, and I did not write, that such research has been racist, and I repudiate her statement. Research into the health of ethnic groups is conceptually difficult and technically demanding and requires advanced skills in the interpretation of data, which, in my view, is why it has not yielded the expected dividend.

Karmi writes: "Bhopal makes the extraordinary claim . . . that the 'voluminous' British research into ethnic health has not made a single advance in our understanding of the causes of disease in ethnic groups." I have clearly stated that descriptive work on ethnic group and health can yield hypotheses for detailed study but that research in ethnic minorities has seldom progressed beyond the generation of hypotheses. I actually wrote, "Indeed, I cannot recall a single solid advance in our understanding of the causes of disease which can be attributed to such research [into the health of ethnic groups]." I was writing about fundamental advances in understanding about the causes of disease (not about differences in risk factors by ethnic group). Karmi's words differ from mine in an important way.

In refuting my "extraordinary claim" Karmi highlights the syndrome of insulin resistance and its relation to diabetes in people from south Asia. In a manuscript submitted for publication I and a colleague, Peter Senior, have written, "Even when testable hypotheses have been proposed they have largely remained untested. One exception to this generalisation is the insulin resistance hypothesis for coronary heart disease; a hypothesis of profound importance for both general and ethnic minority populations alike." Independently searching for contributions from British research into the health of ethnic groups to fundamental understanding of the causes of disease, both Karmi and I concur on one theme: the insulin resistance hypothesis. Is that coincidence, or are there few examples?

Finally, how valid is Karmi's statement that the subject of race "provides the last respectable refuge for the left, whose views have otherwise become passé"? My research is done to improve the health and health care of people from ethnic minorities, not for political reasons. I believe that my peers working in this field have the same motivation.

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- 1 Karmi G. The politics of 'race' and health. *BMJ* 1993;306: 1552-3. (5 June.)
- 2 Bhopal RS. Future research on the health of ethnic minorities: back to basics: a personal view. In: Ahmad WU, ed. *The politics of 'race' and health*. Bradford: Race Relations Research Unit, 1992:51-4.

Management of trauma

EDITOR,—R Snook should not be so pessimistic about trauma care in the United Kingdom.¹ Since the Royal College of Surgeons of England published a report on the subject in 1988² several notable developments have taken place. The government responded to the report by funding the experimental trauma centre at the North Staffordshire Royal Infirmary as well as establishing an evaluation study by Professor Brian Williams in Sheffield. Early results seem encouraging.

The course on advanced trauma life support was introduced to the United Kingdom by the Royal College of Surgeons of England in 1988.³ This educational initiative is changing practice in resuscitation rooms nationally. Though not all major accident and emergency departments have a consultant, 110 consultants in accident and emergency departments have successfully completed a course and many are now instructors in advanced trauma life support. Even more consultant anaesthetists and orthopaedic surgeons have attended a course; this shows the multidisciplinary nature of the team, which is necessary for optimal outcome for patients.

Driscoll showed that the team approach in managing patients in the shortest possible time improves survival.⁴ Recently the team concept has been further enhanced by the course on advanced trauma nursing, which has the same core content; this results in joint certification by both the Royal College of Nursing and the Royal College of Surgeons of England. Cooperation between the Royal College of Surgeons of England and the Royal College of Physicians and Surgeons of Glasgow has increased the number of instructors in advanced trauma life support—a necessary step, particularly as the Royal College of Surgeons of England will shortly require candidates to have a current certificate in advanced trauma life support before they can take the final fellowship examination.

Cooperation between the American National Association of Emergency Medical Technicians and the Royal College of Surgeons of England has resulted in the establishment of a training programme on prehospital trauma life support in the United Kingdom. This course, designed primarily for ambulance staff, again promotes the rapid assessment and resuscitation sequence of advanced trauma life support, which will further enhance care.

Trauma is the commonest cause of death below the age of 35. While the British Heart Foundation and the Imperial Cancer Research Fund flourish, the recent launch of the Trauma Foundation has not been without difficulty. A recent mailshot to all consultants involved in the care of victims of trauma drew a poor response. If the medical profession is not interested how can we expect the public to support us?

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- 1 Snook R. Management of trauma. *BMJ* 1993;306:1539. (5 June.)
- 2 Royal College of Surgeons of England. *Working party on the management of patients with major injuries*. London: RCS, 1988.
- 3 Skinner DV. Advanced trauma life support. *Injury* 1993;24: 147-8.
- 4 Driscoll PA. Trauma: today's problems, tomorrow's answers. *Injury* 1992;23:151-8.

Substance misuse and suicide

EDITOR,—Merete Nordentoft and colleagues and Keith Hawton and colleagues showed an association between substance misuse and the risk of subsequent completed suicide.^{1,2}

Substance misuse is a growing problem among the adolescent population,³ yet the services for treating this group remain fragmentary. The adolescent misuser may be referred to the statutory adult substance misuse services or to the child and adolescent psychiatry services or may be seen by a variety of non-statutory agencies; there is debate on occasion as to which service should accept clinical responsibility.

During 1991-2 the Northern Regional Drug and Alcohol Service made contact through outreach work with a number of young people engaging in high risk behaviour in terms of substance misuse. Many of this group were reluctant to approach services themselves, not perceiving their substance use as problematic. In an endeavour to address this situation, an adolescent substance misuse clinic was established in early 1992 as a joint venture between the statutory services in Newcastle upon Tyne and an independent organisation, Streetwise, which offers advice and support to young people aged 13 to 25. The clinic was sited in the more informal setting of the Streetwise project to increase its accessibility to young people. The operation of this clinic focused attention on points of difference with regard to confidentiality, consent to assessment and treatment of a young person under 16 years of age, and child protection