well has been the use of stop dates on older peoples' warfarin prescriptions, for example for DVT.

If you are not already using this process, I encourage you to get up to speed on modern medication delivery.

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Nurse-led management of hypertension

We read the paper of Voogdt-Pruis *et al*[1] with interest, since we have recently reviewed the literature for nurse interventions in primary care management of hypertension. We would like to offer the following observations:

Firstly, although no previous study has reported from the Netherlands there have been reports of similar studies from Scotland,[2,3] and England.[4,5] Three of these demonstrated improvements in blood pressure control with nurse-led interventions,[2,3,5] while the other did not.[4]

The authors[1] conclude that their findings support the involvement of practice nurses in cardiovascular risk management. This is based on the demonstration mainly of non-inferior outcomes; however, this can only be justified by inclusion of formal cost effectiveness analysis. Few previous studies of nurse-led care in hypertension have reported cost data, and those UK studies that have done found higher costs associated with nurse involvement, due to increased time spent offsetting the expected savings on salary costs.[6,7] Therefore, further studies must be undertaken that include formal economic evaluation and determine whether the increased cost of nurse-led interventions represents good value for money in terms of improvements in patient health outcomes.

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Circumcision

The article by Anwar *et al*[1] in the many senses of the word. It presented a comprehensive review of the religious beliefs behind the practice of circumcision and, I confess, educated me about the HIV risk. The debate around availability of a safe service in the UK, is obviously an important one. I feel the authors let down their argument in the last paragraph. They say it is a doctor's duty 'to carry out said decision to the best of our ability'. They appear to have made this statement on a one issue basis, without considering the wider ethics. Doctors do not automatically carry out a patients' decision — take for instance the issue of abortion.

However, while the article raises a number of points for discussion I feel that one is omitted. In the case of religious circumcision it is not the patients' decision. A baby boy is the child of parents with particular beliefs, but cannot be said to hold those beliefs at that age. As was pointed out in the article, in the UK there is no medical justification for circumcision, *per se*. There is the need for the profession to consider the possibility that if we assist in a religious circumcision then the boy, at 18, might sue us for 'the cruellest of cuts'. Not every child of Jewish or Islamic parents keeps the faith.

The authors are to be congratulated on bringing this issue to the fore and, hopefully, stimulating further debate.

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The essay on circumcision in the January 2010 issue of the *BJGP* was very interesting.[1] Certainly as far as the Jewish relationship to the topic is concerned it was well informed and demonstrated much insight. However, there is one aspect of the Jewish tradition that was not mentioned and that is the considerable grasp of the genetics of haemophilia displayed in the laws relating to circumcision. If a mother is unlucky enough to lose two sons from failure of the penile wound to stop bleeding, then the commandment to

circumcise is abolished for any subsequent sons. However, not only is this exemption applied to the children of that mother, but if any sister of that mother produces a son or sons then circumcision should not take place. However, the children of any brothers of the afflicted mother's progeny are not exempt, nor so for the children of any of the father's siblings. This set of rules clearly demonstrates an understanding that the bleeding disorder is transmitted through the mother's genetic contribution.

Had the advisers to the Russian Royal House, descendants of Queen Victoria, been equally well informed, the course of European modern history might have been quite different!

Of course with modern treatments available and males with haemophilia now able to survive to reproductive age, the genetic pattern may be modified, but this does not diminish respect for the powers of observation possessed by the early semitic tribes who established the original rules.

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The article on circumcision made interesting reading.[1] However, in defining clinical indications for surgical procedures we must tread carefully. We as physicians have a duty of care to the patients (vulnerable children) and we must firmly adhere to the principle 'first do no harm'. Infection, scarring, and anaesthetic reactions are all potential complications for a procedure with no clinical indication other than cultural/religious. The medicolegal issue is raised if and when a problem occurs. Medicolegally, liability arises when complications occur for the GP (in referring) and for the surgeon in carrying out the circumcision. It is an issue in the Republic of Ireland for parents of children that they have to wait on an 'elective surgical list' for a procedure they (the parents) feel is necessary in early infancy. We had a tragic death in 2003 of a 4-week-old infant of Nigerian parents who died from bleeding complications following a home circumcision. The man who carried out the procedure was ultimately found 'not guilty of reckless endangerment' by a jury of his peers. Interestingly, the judge directed the jury that 'they could not bring their white Western values when they decide this case'. One would hope that such leniency would be shown to the medical profession should complications occur!

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Authors' response

In reply to the letters received, it would appear that the article has been largely misunderstood. Clearly, our assumption that an issue such as circumcision does not largely polarise opinion is far from the truth. However, the actual point of the article was not to raise issues of ethics regarding the correctness, or otherwise, of neonatal circumcision, nor to impose it as a compulsory procedure. As stated in the closing paragraphs, we were merely making suggestions of a logistical and socio-political nature. We agree wholeheartedly that the articles in the *BMJ* were far better at discussing whether circumcision was an abuse on the rights of the child,[1] but that was never the purpose of our article.

The advice to the authors of the emotive letters received would be to take a more pragmatic approach to the issue, and indeed the article. As it stands, neonatal circumcision is not technically recognised, by any of our professional bodies, as a 'barbaric and inhumane'[1] act, and nor is it illegal. What was aired in the article was the view that the current regulation of the procedure by private practitioners may leave something to be desired, and a possible solution was posited, numbers were not exactly crunched, but reducing complications post-procedure would presumably reduce costs to the NHS.

Now, we would obviously welcome a debate on the morality and ethics surrounding the issue of medical intervention/surgery, major or otherwise, in neonates and children, but this was not the piece for that. The point being made was noted by one respondent himself, in that there is a role in harm reduction.[2] The bottom line remains that circumcision is currently legal; circumcision is also currently poorly regulated. Suggestions were made as to the way forward. Our 'extraordinary argument'[2] is not actually an argument — our role IS to advise, but ISN'T, currently, to legalise or outlaw any medical procedures. We can advise what is and isn't legal, but of those procedures that are legal, our professional duty is merely to advise and then carry out patients' wishes.

We were obviously delighted to receive the responses, but apologise for the ambiguity that may have been present within the article. The points made would be better saved for an article, when written, that is actually discussing the ethics of circumcision.

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