Africa can solve its own health problems. Africa needs less globalisation and more real assistance . . .

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All you need is cognitive behaviour therapy?

Critical appraisal of evidence base must be understood and respected

EDITOR—The article by Holmes and the accompanying commentaries essentially aim to explore the evidence for the efficacy and effectiveness of the psychotherapies and how this should be applied in everyday clinical practice.[1] It is ironic that the arguments against cognitive therapy include numerous instances of idiosyncratic use of research evidence.

Firstly, for example, in his commentary Bolsover selects three studies to support his view that the evidence base for cognitive therapy is weak. We would challenge him to apply his arguments to the seven systematic reviews of cognitive therapy in the Cochrane Database and the Database of Abstracts of Reviews of Effectiveness.[2]

Holmes and also Bolsover cite a single paper to suggest that cognitive therapy is less effective in the real world of clinical practice than in university based clinical trials. This caricature may have applied to some trials conducted 30 years ago but is irrelevant now. To give just two examples, recent trials of cognitive therapy for chronic depression specifically recruited individuals who were depressed despite adequate trials of pharmacotherapy and psychotherapy.[3] Also, the Cochrane review of cognitive therapy for schizophrenia includes examples of "real world" interventions.[4]

Holmes argues that leading cognitive therapists are starting to question aspects of their discipline. However, these critiques are quoted out of context; the criticisms actually refer to the need to adapt the basic cognitive model to enhance its effectiveness for other disorders. Far from being a weakness, the critical appraisal of cognitive therapy by its practitioners is an important reason why it has been systematically evaluated in such a wide range of conditions.

We agree with Holmes that it is unhelpful to evaluate psychotherapies by using only the research methods applied to drug trials. If clinicians and researchers aspire to an evidence based health service, however, they must accept two challenges. First is the challenge of evaluating what they think they do. We look forward to the evidence base of the psychodynamic psychotherapies developing, to allow more valid comparisons between the different approaches. Until then there is no escaping the robust evidence that exists for the use of cognitive therapy across clinical conditions and settings and the fact that much of this research is clearly applicable to the NHS. The second challenge is for clinicians and commentators to understand and respect the critical appraisal of the evidence base. Regrettably, some of the contributors to this series of articles have failed in this.

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1 Holmes J. All you need is cognitive behaviour therapy? [With commentaries by R Neighbour, N Tarrier, RD Hinshelwood, and N Bolsover.] *BMJ* 2002;324:288-94. (2 February.)
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Integrated biopsychosocial approach will be treatment of choice

EDITOR—Despite being a psychiatric trainee interested in ultimately doing further psychoanalytic training I was dismayed by the lack of balance in the debate presented by Holmes and the commentaries to his article.[1]

Cognitive behaviour therapy is effective for a wide range of conditions and is patient friendly. Whether it is useful in severe mental illness depends largely on what is being attempted. Furthermore, it can be a useful intermediate step towards later psychoanalytic treatment.

Even if the popularity of cognitive behaviour therapy was the result of a superior marketing policy there is a substantial amount of research by which to judge it. Unfortunately, the same cannot be said about psychoanalytic psychotherapy. Although psychoanalysis has a vast literature base, it almost entirely consists of subjective opinion backed up through the use of selected case reports or material. Although this is clinically helpful, psychiatrists cannot generalise from it with any confidence. This is not only because we cannot say whether these patients are representative of our practice population but also because, even if they were, it is doubtful that we could replicate the intervention.

The time has come for the psychoanalytic camp to prove that a psychodynamic approach can work in NHS psychiatry. Bateman and Fonagy have shown that it can be done.[2 3] Moreover, although I agree that there is a limit to the extent that one can objectify the subjective, I do not think that this should stop us from attempting to do so. The time has come for us to clarify further what it is about the relationship that is therapeutic and to find a way of measuring relational change. Once found, let us apply this, not only to research in the psychotherapies but also to psychopharmacology, as there is little doubt that a drug prescription is more than simply the prescription of a drug.[4]

There will never be a time when there is a single panacea for mental illness; an integrated biopsychosocial approach will always be the treatment of choice.

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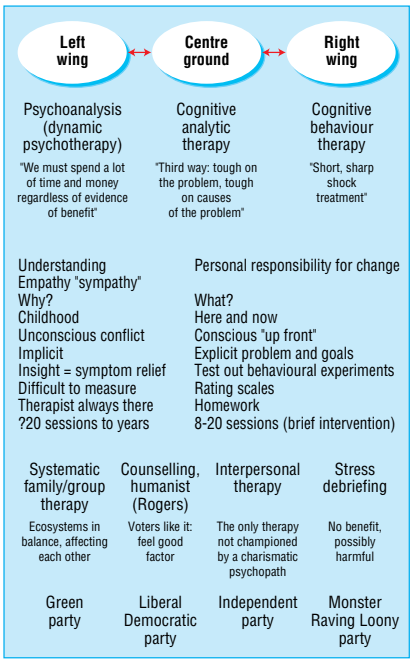
Political range of psychotherapies has emerged

EDITOR—It seems from the article by Holmes and the accompanying commentary by Tarrier that a political range of psychotherapies is now emerging (figure).[1] On the left wing we have traditional Freudian psychodynamic therapy, which addresses the causes of human distress through an understanding of unconscious conflicts rooted in the past. It contains an implicit assumption that gaining insight will lead to clinical improvement. Such "black couch" therapy, as championed by Holmes, usually takes many months or years. The message exhorted is that we should spend a lot of taxpayers' money on it despite a lack of evidence of benefit.

On the right wing lies cognitive behaviour therapy, as originally promoted by Beck.[2] It asks what can practically be done by addressing specific problems in the present. It is time limited (usually 8-20 sessions in total) and emphasises personal responsibility for change ("homework").

Where does this leave other psychotherapies? Cognitive analytic therapy occupies the centre ground as the New Labour of talking treatments ("Tough on the problem, tough on the causes of the problem").[3] The Independent party (interpersonal therapy) and the Green party (family and group psychotherapies) emphasise that individuals depend on each other for effecting lasting change. The favourite, however, is surely non-directive counselling. Like the Liberal Democratic party, it has popular local support (counselling within primary care), although this "feel good" factor wanes in general elections (randomised trials of efficacy).[4] Finally, stress debriefing after trauma has been widely embraced as the Monster Raving Loony party option, with good evidence of no benefit, and even possible harm.[5]



Political spectrum of psychotherapies

Psychotherapists and politicians have much in common. They presume a relationship of trust and believe that real change can be achieved by talking. They seldom answer questions directly, and use silence as a therapeutic tool. Grand inquisitors such as Archie Cochrane and Robin Day, if they were alive today, would be impressed with the range of talking treatments now available. For voters and patients alike, "You have never had it so good."

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1 Holmes J. All you need is cognitive behaviour therapy? [With commentaries by R Neighbour, N Tarrier, ED Hinshelwood, and N Bolsover.] *BMJ* 2002;324:288-94. (2 February.)
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Summary of responses

EDITOR—The debate on cognitive behaviour therapy and its accompanying commentaries prompted an outpouring of self examination by psychoanalysts and others who believe in the psychodynamic approach to psychotherapy. In a cluster of 18 letters they asked: What do we do? How can we measure it? How can we show that our treatments work? What is psychotherapy anyway?[1]

Nick Totton, a psychotherapist, took it one step further: "psychological distress" is not a medical condition, he writes. "The unpalatable truth seems to be that if society really wants to address the causes of psychological distress it needs to look at its ways of dealing with emotion, with relationships, with work, and with sexuality."

He, and others, including Michael van Beinum, a child psychiatrist, also argued that generating evidence for psychodynamic psychotherapy is difficult when traditional comparative trials don't work. They offered a variety of reasons: clients have multiple problems, clients seek out the therapist that suits them, treatment is open ended and defined by the relationship between client and therapist, and randomised trials take no account of meaning or of language, both of which are important to psychoanalysis. Van Beinum suggested that qualitative research would be a reasonable alternative.

Should therapy be evidence based anyway? Defenders of cognitive behaviour therapy, sitting smugly on a mountain of their own evidence, were clear that it should. John Taylor, a clinical psychologist, echoed Tom Sensky and Jan Scott and Brian Darnley (above) when he accused traditional psychotherapists of feeble excuses and delaying tactics. Is it unreasonable, he wonders, for people to ask whether a client with a personality disorder is still cutting herself after two years' treatment and "good progress" in her relationship with her therapist?

The turf war doesn't end with the evidence, or lack of it. Both sides accused each other of squawking to attract the attention of policy makers to secure funding for their ideas and ultimately their jobs. Two letters, though, were more conciliatory. Rhona Sargeant, a senior registar in psychotherapy, writes: "Evidence based medicine appears to have given us something to argue about. Of course evidence is important, but I believe we are abusing it in order to fight an interprofessional battle, fuelled by pressure on resources." Patients who need psychotherapy are needy and challenging to treat, she continues. Managers see them as expensive. We need a united front. There are plenty of different needs to go around.

One correspondent from outside the United Kingdom (there were only two) was also dismayed by the squabbling. Christopher Booth, a psychiatrist from British Columbia, says patients all get on far better over there.

Several letters argued that the *BMJ*'s "debate" was biased against cognitive behaviour therapy. The responses were, if anything, the opposite. Six of the best letters (good points tightly argued and supported with references) came down firmly in defence of cognitive behaviour therapy. For example, Colin Espie, a professor of clinical psychology, says that cognitive behaviour therapy is an effective treatment for insomnia according to 50 randomised trials, two meta-analyses, and a systematic review. John Taylor mentions using cognitive behaviour therapy to treat violence, sexual agression, and antisocial behaviour, and Steve Williams, a general practitioner, writes that cognitive behaviour therapy works, and works long term, because it teaches patients to be their own therapist.

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1 Electronic responses. All you need is cognitive behaviour therapy. bmj.com 2002 (http://bmj.com/cgi/content/full/324/7332/288 (accessed 19 May 2002).

The limits of psychiatry

Psychospirituality will benefit heathcare staff

EDITOR—Double's paper is thought provoking.[1] He may like to know of initiatives aimed, at least in part, at bringing about a synthesis of psychiatry and antipsychiatry. This is in terms of human spirituality.

For the past two years there has been a spirituality and psychiatry special interest group within the Royal College of Psychiatrists (www.rcpsych.ac.uk/college/SIG/spirit), whose membership now stands at close to 500. Spirituality is the forgotten dimension, not only of mental health care[2 3] but also of general health care.[4] In the group we seek to clarify the meaning of spirituality, defined by Murray and Zentner as "a quality that goes beyond religious affiliation, that

strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes essentially into focus in times of emotional stress, physical (and mental) illness, loss, bereavement and death."[5]

Although there are obvious overlaps, we are at pains to distinguish spirituality, which is universal and unifying, from religion(s), which are essentially sociocultural phenomenons and potentially divisive. We are looking closely at the relevance of spirituality in mental health care, supported by an extensive and growing evidence base. We are interested in "new paradigm" research methods.[1 3 4] We seek to promote spirituality in terms of skills and attitudes as well as knowledge. We are increasingly aware of the benefits for healthcare practitioners—reduced stress levels, improved work satisfaction, and protective effects against burnout, alcohol and substance misuse, and marital and family breakdown—of acquiring and developing spiritual skills.[3]

I am pleased that Double has taken this step in opening up the debate.

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1 Double D. The limits of psychiatry. *BMJ* 2002;324:900-4. (13 April.)
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People with ADHD are not lazy, unmotivated, and irresponsible

Editor—Double is concerned about whether treating attention-deficit/hyperactivity disorder (ADHD) with stimulant drugs properly addresses issues of self responsibility that underlie the disorder.[1] As a medical student with the disorder, I am concerned that statements like this indicate a distressing attitude towards patients.

My teachers called me "unmotivated," "lazy," and "irresponsible" in primary school. Double's generalisations recall the painful telephone calls and letters that my parents received. But things began to change after my diagnosis with the disorder at age 8 and subsequent treatment with stimulant drugs.

Sixteen years have passed since my diagnosis, and I am now a medical student with a degree in molecular biology. Extensive community service, competitive swimming, and amateur street performance are among my activities outside the classroom. Nevertheless, I still use methylphenidate every day to help manage my disorder. I have never used stimulant drugs as a "displacement strategy for improving family and school life." Rather, I have dedicated my life to the study and treatment of the disorder.

My story is not unique: there are plenty of very successful adults with attention-deficit/hyperactivity disorder, and many of us have benefited greatly from stimulant drugs. Unfortunately, we still face popular misconceptions, which stigmatise the disorder as being a mere failure of self discipline, despite our collective accomplishments. Indeed, on the very day that Double's article was published in the *BMJ* it was quoted on public internet message boards by posters who believe that the disorder is a hoax.

It is disappointing to see such views expressed by a psychiatrist in a respected medical journal. I am certain that I echo the sentiments of successful people with attention-deficit/hyperactivity disorder when I say that I have come too far, worked too hard, and accomplished too much to be called lazy, unmotivated, and irresponsible all over again.

1 Double D. The limits of psychiatry. *BMJ* 2002;324:900-4. (13 April.)

Dangerous severe personality disorder is controversial non-disease in psychiatry

Editor—In exploring the limits of psychiatry Double stops short of examining the implications of the reform of the Mental Health Act.[1] This is unfortunate as one of the most controversial non-diseases in psychiatry—dangerous severe personality disorder—would have been scrutinised.

In common with many so called non-diseases,[2] dangerous severe personality disorder is not welcomed by most doctors.[3] But it is unlike many of the non-diseases referred to in the paper. These seem to be mainly conditions that doctors view as trivial complaints, although patients find them distressing and seek help. By contrast, dangerous severe personality disorder may lead to an indefinite time in hospital for a patient who has not committed an offence, and there is no treatment.

In my view, dangerous severe personality disorder is a political non-disease. It does not exist in any internationally recognised classification or psychiatric textbook and is not being campaigned for by any user group. It benefits neither doctor nor patient. I therefore suggest an extra axis for the international classification of non-diseases: the aetiology of the non-disease. This could include self diagnosis (allergy to the 21st century, adult attention deficit disorder, etc), iatrogenic non-disease (tranquillisers for bereavement), commercial non-disease (antidepressants for normal shyness), and political non-disease.

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Renal transplantation

Spain's system for procuring organs operates in hospitals

Editor—In his review of renal transplantation Andrews emphasises Spain's excellent results in the procurement of cadaveric organs for transplantation.[1] The transplantation organisational system there operates in hospitals, unlike the systems of other countries, which operate outside hospitals.[2] We disagree with Andrews that this organisational system involves a heavy investment, and we even doubt whether it costs more than the British or German systems, to which he refers and whose cadaveric donor rates are 2.5 times lower.

The organisation and professionalism of organ procurement in hospitals has allowed Spain to increase its cadaveric donation rate progressively each year over the past 13 years,[2] even despite the large reduction in deaths from traffic crashes that has occurred throughout the European Union. The increase in cadaveric kidneys for transplantation has been accompanied by a reduction in the number of patients on the waiting list, without the need to resort to living donors; less than 1% of the renal transplantations performed in Spain involve a living donor.[2]

Having the cadaveric organ procurement system in hospitals is an important factor leading to the excellence of the different phases of the procedure: detecting potential donors; diagnosing brainstem death early; providing adequate physiological maintenance of the cadaver; obtaining family authorisation of the donation; and distributing the organs for transplantation.[2 3] Several factors affect graft survival rates: the early diagnosis of brainstem death; adequate maintenance of the donor; strict and early treatment, with constant haemodynamic and metabolic monitoring; and the speeding up of removal, selection of recipients, and the implantation process to prevent additional renal damage.

With donors under the age of 60 we have achieved an actuarial survival of the graft at 1 and 5 years of 89% and 85% respectively. With donors older than 60 the figures are 87% and 81% respectively. There has never been a non-functioning kidney. The main cause of graft loss after the first year has been the death of the recipient (with functioning graft).[4] We have obtained similar outcomes when transplanting the kidneys of elderly donors into young recipients.[5] These results are similar to those obtained by most groups with living donors.

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1 Andrews PA. Recent developments: Renal transplantation. *BMJ* 2002;324:530-4. (2 March.)

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Cadaveric heart beating donor rates vary from region to region in United Kingdom

EDITOR—In his review of renal transplantation, Andrews compares cadaveric donation rates in Spain and the United Kingdom.[1] Donor rates in Spain have increased to 33.6 donors per million population thanks to a well organised network of transplant coordinators in each hospital.

Andrews documents in contrast the United Kingdom's donation rate of 13/1000 000. This relatively low national donation rate is worthy of further analysis. Recent data from UK Transplant show large regional variations in solid organ donor rates per million population in England for 2000-1 as follows[2]: Eastern 5.7, London 15.2, North West 13.9, Northern and Yorkshire 16.2, South East 13.8, South West 8.5, Trent 10.7, and West Midlands 12.4

These figures mask even greater differences. The Northern and Yorkshire region is served by two transplant units: Newcastle, which serves the Northern region, and Leeds, which serves Yorkshire. The cadaveric heart beating donor rate for the Northern region for 2000 and 2001 averaged 20/1000 000 per year (Transplant Coordinators, Freeman Hospital, Newcastle, personal communication).

The reasons for these wide variations require close examination. Possible contributory factors include different practices in intensive care units and differences in the number of and work patterns of transplant coordinators. Although we should aspire to have donor rates approaching that of Spain, even if we achieved a national average of 20 donors per million population, we would have increased the number of cadaver kidneys available for transplantation in the United Kingdom by over 50%. In 2001, 1344 cadaveric kidneys were transplanted in the United Kingdom.[2] A 50% increase would mean an additional 672 kidneys available for transplantation. A renal transplant remains the best treatment for end-stage renal failure and the importance of optimising donation rates cannot be overlooked.

Solid organ donor rates in England, 2000-1

Region	Donor rates (per million population)
Eastern	5.7
London	15.2
North West	13.9
Northern and Yorkshire	16.2
South East	13.8
South West	8.5
Trent	10.7
West Midlands	12.4

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1 Andrews P. Renal transplantation. *BMJ* 2002;324:530-3. (2 March.)
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Africa can solve its own health problems

Africa needs less globalisation and more real assistance …

EDITOR—The only part of Ncayiyana's editorial with which I agree is the end, when he talks about the need to restore a critical mass of African researchers.[1] In the second paragraph, with one sweeping statement ("Granted, Africa's legacy of particularly exploitative colonial occupation by European powers is partly to blame"), he pushes aside centuries of slavery, colonialism, oppression, and neocolonialism; he clearly does not quite understand the psychological and sociological implications of the effects of Western domination on the situation in most African countries. With his exposition of World Bank capitalist ideologies and his quotation of obvious statements by a British minister, his ideological bent becomes clearer.

Africa must certainly pull itself out of its political and economic doldrums. Our leaders have squandered our resources and oppressed us over the years, with or without the tacit support of Western countries, and they lack the political will to improve the health system. We have to make a great effort and try to reorient our people after decades of militarisation and non-accountable governments.

In some instances, however, this effort must be made with the assistance of well meaning developed countries and organisations; they could provide useful help such as education, which is self sustaining and progressive, as opposed to handouts, which always dry up eventually or are diverted. We must praise the *BMJ* for making the journal and articles freely available to all. I wish that more Western organisations would try to help Africa in this way instead of by their globalisation, free market policy, and privatisation.

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… but can it solve these problems itself?

EDITOR—Ncayiyana advocates greater responsibility by Africans for resolving the devastating problems faced by our continent.[1] However, many people are critical of the views of Dollar and the World Bank that the solution to poverty lies in joining the global economic movement.[2] Some countries have benefited from doing so, but such trends are being reversed, and sub-Saharan Africa, which has not benefited, suffers greatly.[3 4]

Ncayiyana concedes Africa's legacy of exploitative colonial occupation and the undisputed fact that Africans themselves must bear some responsibility for lack of development. However, he fails to address the patronage of despotic leaders by powerful nations that has allowed many of those leaders to remain in control. He also fails to mention the neocolonial forces that co-opted African leaders into powerful exploitative global economic processes, leading to vast unpayable debt for the African continent and massive extraction of human and material resources from this once rich continent.

Sub-Saharan Africa houses 10% of the world's population, lives on less than 1% of the global economy, and bears 70% or more of the HIV/AIDS burden and an enormous burden of tuberculosis, malaria, malnutrition, and preventable diseases. This reflects deprivation suffered over many generations.

The escalating extent of extreme poverty in Africa makes it extremely unlikely that the continent can solve its own health and development problems. Exploitation must be avoided, extraction of resources halted, and new approaches to development adopted.[5] The report of the Commission on Macroeconomics and Health, the provision of debt relief, and new commitments to foreign aid are good news for Africa. These imaginative endeavours are as essential as efforts by Africans to sort themselves out if the root causes of Africa's problems are to be effectively addressed.

A narrow biomedical approach to HIV/AIDS is impractical for sub-Saharan Africa. However, denial of the link between HIV infection and AIDS, failure to emphasise that HIV infection is predominantly spread through sexual activity, and unwillingness to use proved medical advances during a devastating pandemic must surely rank among the gravest of irresponsible errors made by politicians.

Africa's great potential for solving its own problems would be greatly helped by a much deeper understanding of the systemic nature of the problems affecting the continent. Privileged elites must understand both their involvement in Africa's plight and the need to provide effective developmental support.

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More units dedicated to women presenting with miscarriage are needed

EDITOR—Luis et al report that most women with miscarriage choose expectant management and that over 80% will require no surgical intervention.[1] Their population was monitored for up to 46 days, with 60% of all miscarriages and 72% of missed or anembryonic pregnancies requiring follow up for over one week. They conclude that as complications were minimal patients should be encouraged to persevere with expectant management. These results look promising, but two important issues—the role of the dedicated miscarriage unit and infective morbidity—were overlooked.

Expectant management is attractive. It gives the couple time to come to terms with their loss and avoids the risks of surgical evacuation. As 15% of pregnancies miscarry, a move towards community care has important implications for the health service. However, psychological support and preservation of future fertility are important for women with miscarriage. Most of Luis et al's patients still had retained products a week after diagnosis. Only a dedicated unit could provide the continuity of care, input, and counselling skills required to support these patients.

Although no infectious complications were reported, the prevalence of *Chlamydia trachomatis* infection in women who have a miscarriage is 4%, with rates of 6% in women under 25.[2] Expectant management still carries a risk of pelvic inflammatory disease, with its recognised sequelae of ectopic pregnancy, tubal factor infertility, and chronic pelvic pain.[3] As most chlamydial infections and pelvic inflammatory disease associated with chlamydia are asymptomatic,[4] the authors cannot conclude that their patients came to no harm.

We performed a questionnaire based survey of miscarriage services in all 26 consultant led gynaecology and obstetric units in Scotland. Twenty five units responded. Only eight had a designated miscarriage unit. The table shows where women are admitted at present. As a result of this fragmentation clinical practice varied greatly, with 40% of units taking no special precautions against potential *C trachomatis* infection.

Admission policy for women with miscarriage in 25 consultant led gynaecological and obstetric units in Scotland

Place of admission	No of units
Gynaecology ward	9
Designated miscarriage unit	8
Gynaecology and maternity wards	5
Maternity ward	1
Gynaecology ward or acute surgical unit	1
Day surgery unit	1

Studies promoting expectant management have been published since the 1930s, yet it has not been adopted in routine clinical practice. The lack of dedicated units may be a reason. Women presenting with miscarriage are ideally placed for opportunistic chlamydial screening. Dedicated units facilitate innovation, research, and the implementation of protocols such as those that reduce infective morbidity.[5] More dedicated units taking a holistic approach to women's care during miscarriage are needed before expectant management can become a viable option.

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Simple dosage guide for suncreams will help users

EDITOR—The sun protection factor (SPF) of a sunscreen is determined after phototesting in vivo at an internationally agreed application thickness of 2 mg/cm^2. Yet studies have shown that consumers apply much less than this—typically between 0.5 and 1.5 mg/cm^2.[1] This has an appreciable effect on protection, with typical application rates achieving a sun protection factor of perhaps one third of that stated on the product.[2] This mismatch may be one contributing factor why sunscreens have been reported to be a risk factor in melanoma.[3]

No international standard on sunscreens specifies dosage criteria for users, although it is assumed to be 2 mg/cm^2.[2,4] So it is not surprising that consumers do not know how to apply sunscreens effectively. We suggest here a method that would allow users to apply a quantity of sunscreen that would result in closer agreement between the expected and delivered protection.

The "rule of nines" is used to assess the extent of a patient's burns as a percentage of the patient's body surface area. The "fingertip unit" is used to measure the amount of cream or ointment to be used in dermatology: it is a strip of product squeezed on to the index finger, from the distal crease to the fingertip.

Body areas by "rule of nines" for extent of burns

1 Head, neck, and face
2 Left arm
3 Right arm
4 Upper back
5 Lower back
6 Upper front torso
7 Lower front torso
8 Left upper leg and thigh
9 Right upper leg and thigh
10 Left lower leg and foot
11 Right lower leg and foot

With the rule of nines, the body's surface area is divided into 11 areas, each representing roughly 9% of the total (box). Sunscreen can be applied to each of these areas at a dose of 2 mg/cm^2 if two strips of sunscreen are squeezed out on to both the index and middle fingers from the palmar crease to the fingertips. The application of this "two fingers" of sunscreen will provide a dose of the product that approximates to that used during the laboratory determination of the sun protection factor. Such a dosage guide is a means of ensuring that users are protected according to their expectations.

Users in fact are unlikely to be willing to cover themselves or their families with such a copious layer of sunscreen and would prefer to apply half this amount. A less daunting proposition, and the one that we suggest, is therefore to apply one finger of sunscreen, with the corollary that the resultant protection would be only about half that stated on the product. Users should be encouraged to reapply one finger's worth within half an hour of the initial application in order to achieve optimal protection.[5]

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