September 11 on suicide and homicide in England and Wales. He argues that when tackling violence in our society, the current Government may plan services on the basis of information that is misleading and flawed.

The data used in my paper – in excess of 130 000 unnatural deaths (E950–959 and E980–989, excluding E988.8) – were obtained from the ONS in 2002 then updated in 2003; 7400 of these deaths were classed by the ONS as manslaughter and unlawful killing (homicide; ICD–9 E969).

It was clearly pointed out in my paper that routinely collected data was a major limitation of the study, but I had to accept the nationally collected data from ONS as reliable and as complete as possible. It should be pointed out that before 1993, ONS data were based on year of registration of death but the data that were actually used in the analysis relating to September 11 related to the year when suicide and homicide occurred.

The paper made no reference whatsoever, implicitly or explicitly, to homicide trends in England and Wales since 1979. The only comment about trends in homicide was made in relation to seasonal variations to show that the reduction in homicide noted after August was not related to the events of September 11 but merely represented some seasonal pattern. The higher homicide figures that Dr Rowlands quoted may have been, as he rightly pointed out, the result of notification of deaths that actually occurred in earlier years.

Dr Rowlands has used the paper to make a political point about 'a Government currently determined to medicalise violence'. I fail to see the relevance of his otherwise valid comment to this paper, the first and so far the only available literature on the effect of September 11 on suicide and homicide in countries other than the USA.

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Mental health and psychiatric research in Brazil

Saxena *et al* (2003) have shown the underrepresentation of low and middle-income countries on the editorial boards of ten leading psychiatric journals, based on a World Health Organization report. Horton (2003), Editor of *The Lancet*, has presented some evidence of publication bias against diseases of poverty studied in developing countries. Wilkinson (2003), formerly Editor of the *British Journal of Psychiatry*, has suggested that the absence of representation on the Editorial Board does not necessarily bias an editor's decision-making. However, Catapano & Castle (2003) have shown that research papers from developing countries represent a very small proportion of the publications (<2%) in important psychiatric journals, which has remained the same for 10 years. We argue that Brazil, a middle-income country, is progressively improving its scientific production and reaching the standards of high-income countries.

We have assessed the mental health scientific production of Brazilian postgraduate programmes between 1998 and 2002 using a Brazilian Ministry of Education database. The eight doctoral programmes in psychiatry and psychobiology, all in state institutions, have awarded 183 PhDs and this has resulted in publication of 1664 scientific articles in journals; 605 of these in journals indexed by the Institute of Scientific Information (ISI). The production of ISI-indexed papers doubled in this 5-year-period. The mean impact factor of the ISI-indexed journals where articles were published was 1.82 (range 0.01–29.51); 64% were published in journals with an impact factor >1. The number of Brazilian articles in psychiatry and psychology (442) published between 1998 and 2003 corresponds to 10% of France's (4129) production, but the impact factors are very similar: 4.48 and 4.83, respectively (data from ISI, reported on http://in-cities.com/countries).

Although health problems in developing countries account for over 90% of the world's potential life-years lost, only 5% of global health research funds are devoted to these problems (Mari *et al*, 1997). The investment channelled to postgraduate and human resource educational programmes in Brazil has assured the country a modest but continuous contribution to the worldwide production of knowledge in health. It is expected that the quality of the scientific production of countries such as Brazil will influence editors' decision-making and overcome eventual 'institutional racism' (Horton, 2003).

Declaration of interest

J.J.M. and E.C.M. are Editors and R.A.B. is an Associate editor of *Revista Brasileira de Psiquiatria*.

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One hundred years ago

The attitude of the legal profession towards the medical profession

IN a letter published in THE LANCET of Feb. 27th, p. 611, Dr. E. MAGENNIS, writing of the conduct of barristers in Ireland, deplored the disappearance of that courteous treatment of the medical witness which once characterised cross-examination but which at the same time did not prevent the most vigorous investigation of the facts, and he drew attention to the unwarranted impertinence, frequently amounting to positive insult, which appears to arise from the assumption that the medical witness must not only be prejudiced but ready to give perjured evidence on behalf of the party employing him. There are many who agree with Dr. MAGENNIS, and who will add that the discourteous treatment of the medical witness is not altogether

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confined to the Irish courts, although they may admit that such conduct is comparatively rare in England and that in either country it is not that of advocates of high standing and repute. Others, again, are ready to call attention to the contradictions of medical witnesses and to regret that in some instances these should be of a character to bring discredit to the medical profession. In this case, however, as in the others, the man who deserves blame is the exception rather than the rule; he is not one of those who should be taken as types of an honourable profession. The medical profession is at a disadvantage when we compare it with others which are called upon to supply expert evidence in courts of law, and this in more respects than one. Expert evidence is not evidence of fact, it is evidence of opinion based upon scientific knowledge. Medical men give evidence of fact when they speak in the witness-box as to physical conditions which have come under their actual observation; when they draw inferences from those conditions as to the duration of injuries, as to the amount of incapacity produced, or as to the cause of them so far as these points lie outside the limits of their knowledge, they then become expert witnesses. In the same capacity, for the most part they testify as to the mental condition of persons of doubtful sanity. These are examples of occasions upon which medical witnesses express opinions which they are qualified to give but which may well differ from those of other equally well-qualified persons who have looked at the same facts from a different point of view or who, holding different opinions upon doubtful topics, have a perfect right to express them. All such witnesses are entitled to be treated by members of the bar with the respect due from one learned profession to another. . . . The disadvantage, however, which particularly affects the medical profession is that its evidence is the expert testimony which is most often required. We have referred to some of the commoner kinds of expert evidence other than that of medical practitioners, but the engineers, the experts in art, the graphologists, and the chemists, who give evidence during any year, can hardly approach in number the medical witnesses who have to give evidence in cases of all kinds and to submit to cross-examination. Hence it has happened no doubt that the suggestion of readiness to espouse a side has been more often levelled against the medical witness than against others. All evidence of opinion is liable to be contradicted by the holders of opposite views upon the same scientific subject. The differences of human opinion have been proverbial from very early times in the history of the human race. In the law courts they are most commonly observable among medical men, and in the law courts the temptation is always present to the advocate to discredit the evidence against him by all means in his power, even by the imputation of corrupt motives by word or manner. It is not, however, the duty of the advocate to win the cause of his client *per fas atque per nefas*. As Sir ALEXANDER COCKBURN avowed upon a well-known occasion, amidst the cheers of his brother lawyers, the arms which he wields he should use as a warrior, not as an assassin. It rests with the judges, and with the honourable men in their profession in Ireland and elsewhere, to see that none among them gives occasion for such criticism as that of Dr. MAGENNIS to which we have referred.

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Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey.

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