Saturday 9 May 1998

BMJ

Britain's new strategy for tackling drugs misuse

Shows a welcome emphasis on evidence

News p 1411

The UK government is to be congratulated on the launch of its new drug strategy,[1] but probably not for the reasons it might expect. The greatest praise is due not so much for any specific policy proposal—these are rather predictable—but for the discipline and integrity the government has shown in preparing a national drug strategy that is more seriously committed to evidence than to rhetoric. With such a principle established the government is now well positioned to revise the strategy as new evidence becomes available and to advance drug policy in a manner similar to the advancement of evidenced based medicine. In this we hope that the government will establish the same requirements across all sectors—in prevention and enforcement as well as in treatment.

In 1997-8 the total government drug related expenditure was estimated at £1.4 billion ($2.2 billion), 62% of it spent on enforcement activity.[1] Yet the strategy document points out that much of this is reactive and not specific to drugs. The rest of the spending is split, with 13% on treatment, 12% on prevention, and 13% on international supply reduction. Thus, 75% is spent on enforcement and supply reduction and 25% on prevention and treatment. The minimum costs of the social problems generated by severely dependent drug misusers alone are about £3-4 billion annually.

Just under half of young people report ever having consumed an illegal drug; most of this is accounted for by cannabis, but a substantial minority have consumed amphetamine, ecstasy, or lysergic acid (LSD). Only a tiny minority of these go on to be dependent users. Nevertheless, the numbers seeking help for drug problems have continued to climb, prisons are now recognised to have a large population with a history of serious drug problems, and up to half of young homeless people may have a serious drug or alcohol problem. At last there is some recognition that poverty, inequality, and social exclusion contribute to serious drug problems. The criminal justice system is heavily burdened with people with serious problems: 60% of people arrested tested positive for illegal drugs, nearly 20% of them for opiates. At a conservative estimate, the general costs to the criminal justice system of drug related crime are at least £1 billion every year.

The results from the National Treatment Outcome study that followed 1100 new entrants into treatment reported that 664 addicts committed 70 000 offences over the three months before they entered treatment.[2] At one year's follow up there were major reductions in drug use and criminality. The researchers estimate that, mainly through reduced criminality, £3 is saved for every £1 spent on treatment and that this saving occurs across a range of treatment modalities.[2] By comparison, other international studies have consistently reported that enforcement strategies have net costs—and that fact alone should make us challenge the overall distribution of resources between enforcement and efforts to treat and prevent.

When the idea of an anti-drugs coordinator, or drugs tsar, was mooted considerable concern was expressed that such a position indicated a drift towards a greater emphasis on rhetoric and a shift away from the more public health focus of the previous decade.[3] That public health focus has successfully contained the spread of HIV among injecting drug users, resulting in the UK having one of the lowest rates of transmission among injecting drug users in the world. The new strategy places great emphasis on crime prevention, but to the credit of the coordinator and his deputy they have grasped the importance of treatment as a key part of the response and recognised the cost effectiveness of treatment by comparison to other approaches.

Nevertheless, the challenge remains to see what capacity this strategy will have to effect change. Rightly, the strategy emphasises drug prevention among the young, but the evidence for the effectiveness of such prevention activities is unfortunately weak. Good information that will reliably inform and guide strategy is lacking. The US strategy relied on national indicators of reported drug use among young people and, on these measures, reported success—while indicators of severe harm climbed unabated. A greater emphasis on and development of indicators of harm, such as rates of positivity among arrested people and levels of problems in the prison population and among other groups of socially excluded people, might help begin to address some of the serious inadequacies of policy to date. The prevention side of the policy remains weak, with no clear tools to tackle prevention. Indeed, the strategy document fails to come clean on the paucity of current options. A serious commitment to researching more effective prevention strategies is needed if progress is to be made over the next 10 years. A balanced policy needs to consider different control options for different drugs and needs to recognise that tobacco and alcohol are a serious part of the problem.

The proposal to build stronger partnerships across the different sectors and in particular between criminal justice, health services, and social services poses a challenge to all sectors. However, this is a timely challenge

BMJ 1998;316:1399–400

for the treatment and rehabilitation services to respond to and develop innovative working methods with new partners and with new resources to support such innovation. Building an informed and self critical but adaptable drug policy requires a long term strategy with appropriate investment in research and evaluation; we hope that this is the first step in an evolving and practical 10 year strategy.

Michael Farrell *Senior lecturer*
John Strang *Director*
National Addiction Centre, Institute of Psychiatry, London SE5 8AF
(m.farrell@iop.bpmf.ac.uk)

---

[1] President of the Council. *Tackling drugs to build a better Britain. The government's ten year strategy for tackling drugs misuse.* London: Stationery Office, 1998. (http://www.official-documents.co.uk/document/cm39/3945/3945.htm)

[2] Gossop M, Marsden J, Stewart D, Rolfe A. *NTORS at one year.* London: Department of Health, 1998.

[3] Strang J, Clee WB, Gruer L, Raistrick D. Why Britain's drug czar mustn't wage war on drugs. *BMJ* 1997;315:325-6.

Preventing recurrent coronary heart disease

We need to attend more to implementing evidence based practice

General practice
pp 1430, 1434

Following the publication of several recent large studies (4S, CARE, and WOSCOPS), there is little doubt about the importance of prevention in patients with coronary heart disease, though controversy still exists about its value in patients without symptoms. General practitioners are in a favourable position to take on the task of secondary prevention, since most have a continuing relationship with their patients, and these patient contacts offer opportunities for measuring cardiovascular risk factors. Nevertheless, preventive care in general practice is haphazard,[1 2] and in this issue Campbell et al confirm this shortfall (p 1430).[3] The question that therefore arises is how to implement the new evidence on preventing coronary heart disease effectively in general practice.

An audit in 95 practices in the Netherlands showed that many general practitioners had a critical attitude towards integrating prevention into practice[4] and that few practices were sufficiently well organised to provide effective preventive services. Thus, efforts to implement prevention should be directed both at individual general practitioners and at the organisation of services. A controlled trial in these 95 practices studied the effects on the organisation of cardiovascular preventive care of visits to practices by facilitators, who trained practice nurses to set up preventive clinics.[5] Compared with practices which just received feedback on their preventive care, the intervention practices improved care significantly, both the way it was organised and the recording of cardiovascular risk factors.

In a well designed and encouraging study in 19 general practices in Scotland, again by Campbell et al (p 1434),[6] implementation of preventive care for patients with coronary heart disease was also achieved by such an organisational measure. Almost 2000 patients were identified, and 71% agreed to be randomised. Half were invited to attend nurse led prevention clinics (attendance rate 82%); the other half received usual care. Within a year the intervention group showed important benefits. Nevertheless, some questions emerge from this study.

Firstly, are the benefits of the drug interventions—aspirin, β blockers, angiotensin converting enzyme inhibitors—additive? Since the interaction between these drugs is not established, it is possible that current candidates for cholesterol lowering drugs might not need such treatment if they had received adequate alternative intervention targeted at other risk factors.[7] Secondly, the fact that nearly a third of the patients did not wish to participate in the trial, and that 18% of invited patients did not attend the clinic, is worrying. There might be a selection bias in favour of more motivated patients, and patients of lower socioeconomic status—already a vulnerable group[8]—might be overrepresented among non-participants. A complementary strategy through case finding seems necessary to reach all patients with coronary heart disease. The literature on implementing evidence based change tells us that multifaceted interventions, targeted at specific obstacles to change, are effective in inducing change.[9 10] Because the traditional ways of organisation within general practice seem to be an obstacle to efficient prevention, giving a central role to nurses or practice assistants may be an effective approach. However, we need to evaluate these new models.

How, therefore, might we evaluate a preventive strategy that combines nurse led clinics and case finding by the general practitioner? Firstly, it is questionable whether randomisation and analysis at patient level, as was done in Campbell and colleagues' study, is adequate in this type of study. Individual professionals' behaviour influences patient management to the extent that patients seen by the same professional cannot be assumed to be independent, and therefore the professional should be the unit of analysis and thus the unit of randomisation. Moreover, patients in the control group may try to cross over to the intervention group, or general practitioners may improve their care for all patients. To compare the effect on different groups of patients, randomisation, or at least equivalence, at the level of the practice or individual practitioner should be achieved.

Secondly, studies should describe variances between and within practices, general practitioner and patient characteristics, and any local problems at the interface between primary and secondary care because these might help clarify suboptimal medical management. Thirdly, implementation methods should be cost effective. The balance between the costs of nurse led clinics and their effects should be determined. Costs are usually influenced by local factors, and therefore the external validity of study findings needs to be

BMJ 1998;316:1400–1

discussed. In the study of Campbell et al the high incidence of coronary heart disease in Scotland and the discussion of the WOSCOPS study in the media might have had an extra motivating effect on patients, nurses, and doctors. Evidence based guidelines on preventing coronary heart disease in general practice need to be complemented by evidence based implementation.[10]

Trudy van der Weijden *Senior researcher*
Richard Grol *Professor*

Centre for Quality of Care Research, Department of General Practice, Universities of Maastricht amd Nijmegen, the Netherlands
(Trudy.vanderWeijden@hag.unimaas.nl)

---

1 Family Heart Study Group. Randomised controlled trial evaluating cardiovascular screening and intervention in general practice: principal results of British family heart study. *BMJ* 1994;308:131-20.
2 Bradley F, Morgan S, Smith H, Mant D. The Wessex Research Network (WReN): preventive care for patients following myocardial infarction. *Fam Pract* 1997;14:220-6.
3 Campbell NC, Thain J, Deans HG, Ritchie LD, Rawles JM. Secondary prevention in coronary heart disease: baseline survey of provision in general practice. *BMJ* 1998;316:1430-4.
4 Hulscher MEJL, Drenth BB van, Mokkink HGA, Wouden JC van der, Grol RPTM. Barriers to preventive care in general practice: the role of organizational and attitudinal factors. *Br J Gen Pract* 1997;4:711-4.
5 Drenth BB van, Hulscher MEJL, Mokkink HGA, Lisdonk van de EH, Wouden JC van der, Grol RPTM. Effects of outreach visits by trained nurses on cardiovascular risk-factor recording in general practice: a controlled trial. *Eur J Gen Pract* 1997;3:90-5.
6 Campbell NC, Thain J, Deans HG, Ritchie LD, Rawles JM, Squair JL. Secondary prevention clinics for coronary heart disease: randomised trial of effect on health. *BMJ* 1998;316:1334-7.
7 Avins AL, Browner WS. Lowering risk without lowering cholesterol: Implications for national cholesterol policy. *Ann Intern Med* 1996;125:502-6.
8 Lynch JW, Kaplan GA, Cohen RD, Tuomilehto J, Salonen JT. Do cardiovascular risk factors explain the relation between socioeconomic status, risk of all cause mortality, cardiovascular mortality, and acute myocardial infarction? *Am J Epidemiol* 1996;144:934-42.
9 Wensing M, Weijden T van der, Grol R. Implementing guidelines and innovations in general practice: which interventions are effective? *Br J Gen Pract* 1998;48:991-7.
10 Grol R. Personal paper. Beliefs and evidence in changing clinical practice. *BMJ* 1997;315:418-21.

Economic globalisation and its effect on health

Some diseases could be eradicated for the cost of a couple of fighter planes

Letters p 1456

BMJ 1998;316:1401–2

According to World Bank figures Tanzania ranks as one of the world's poorest countries,[1] yet its commercial centre, Dar es Salaam, is one of the most expensive cities in the world in which to live[2]—because expatriates on developed world salaries have helped to fuel living costs. An even greater irony is that for Tanzania and many developing nations net flows of wealth remain, as in colonial days, from poor to rich.[3] Far more is spent on servicing national debt than on services such as health or education.[4] These are perhaps some of the less expected features of globalisation of the world economy.

At the eighth congress of the World Federation of Public Health Associations last October in Arusha, Tanzania, a recurring theme was the advance of globalisation and its adverse effects on health.[5] Professor Kris Heggenhougen of Harvard Medical School argued that the continual search for cheaper labour by multinational companies promotes widening income differentials, and in their search for new markets companies sell damaging products to developing countries.

Delegates heard that the basketball player Michael Jordan is paid more by Nike in one year for advertising training shoes than the combined annual wages of the 30 000 Indonesians who make them. While tobacco companies are being prosecuted in the United States they are ruthlessly expanding their markets in low income countries such as Tanzania.[6,7] With the demise of the cold war Western arms companies seek to support their profits through selling more arms to low income countries. Since 1945 the vast majority of the deaths directly or indirectly due to armed conflict have been among the world's poor.[8] Efforts within low income countries to implement rational drug policies through lists of essential drugs have met with resistance from multinational pharmaceutical companies. These companies continue to focus most of their efforts in the developing world on the promotion of "non-essential" drugs[9] and on occasions have undermined the efforts of governments to implement national drugs policies.[10]

These are of course selected examples of economic globalisation. An unfair selection? Perhaps. Economic orthodoxy asserts that globalisation is both inevitable and desirable: interfering with the free movement of capital hinders the very processes that will bring better standards of living and health for all. A counterargument is that what we are seeing at the moment is very far from "free trade," but a world economy increasingly dominated by a small number of multinational giants able to dictate the conditions of trade.

Whatever your point of view, the past 20 years has undoubtedly seen an increase in the gap between the world's rich and poor.[3,4] At the Arusha congress Gro Bruntland, former prime minister of Norway and nominated as the next director of the World Health Organisation, noted that many countries continue to struggle with diseases that could be eradicated for the cost of "a couple of fighter planes."

By its very size and momentum economic globalisation presents formidable challenges to the promotion of health. Global problems demand global responses. Coordinated, forthright, and determined advocacy by health workers and their associations at national and international levels could and should play a much greater role in mobilising public and political opinion and in bringing pressure to bear on multinational companies and international economic bodies. Their advocacy should include the promotion of "essential public health functions"—a basic package of services that should be available to all populations. It should also include the promotion of a health research agenda led by the health and policy needs of countries who bear the brunt of the world's ill health: currently much research in poor countries is determined by the rich.

Like it or not, the signs are that economic globalisation will continue apace. Where should we look for the leadership to match this? The World Health

Organisation, perhaps the most obvious place, has been much maligned recently for being ineffectual in the face of international economic pressure. Let's hope this will now change under its new leadership. The onus is also on other international organisations with an interest in public health, such as the World Federation of Public Health Associations, to play a more forthright role. Individual healthcare professionals can play their part by lobbying their national organisations to become effective international partners in this fight.

Nigel Unwin, George Alberti, Terry Aspray,
Richard Edwards *(Newcastle upon Tyne, UK)*
Jean-Claude Mbanya, Eugene Sobngwi *(Yaounde, Cameroon)*
Ferdinand Mugusi, Seif Rashid, Philip Setel,
David Whiting *(Dar es Salaam, Tanzania)*

c/o Department of Medicine, University of Newcastle Medical School, Newcastle NE2 4HH (n.c.unwin@ncl.ac.uk)

---

1 World Bank. *Social indicators of development.* Baltimore: Johns Hopkins University Press, 1996.
2 Asian cities world's dearest, survey finds. *Irish Times* 1997;Aug 5.
3 Harrison P. *Inside the third world: the anatomy of poverty.* 3rd ed. London: Penguin, 1993.
4 Todaro M. *Economic development.* 5th ed. New York: Longman, 1994.
5 World Federation of Public Health Associations. *Health in transition.* Arusha: WFPHA, 1997.
6 Kigotho AW. Cigarette companies shift their sights to Africa. *Lancet* 1997;350:792.
7 Kingman S. Tobacco sales soar in developing countries. *BMJ* 1995;311: 1321.
8 Sidel V. Towards a better world: the international arms trade and its impact on health. *BMJ* 1995;311:1677-80.
9 Hartog R. Essential and non-essential drugs marketed by the 20 largest European pharmaceutical companies in developing countries. *Soc Sci Med* 1993;37:897-904.
10 Kanji N. Action at country level: the international and national influences. In: Kanji N, Hardon A, Harnmeijer J, Mamdani M, Walt G, eds. *Drugs policy in developing countries.* London: Zed Books, 1992.

Does the WHO have a role in Europe?

There is more to "Europe" than you might think

News p 1408

In 1988 an observer could be forgiven for asking whether the World Health Organisation had any meaningful role in Europe. Indigenous malaria, the classic focus of international health action, had long been eradicated. Non-communicable diseases were increasing but were viewed largely as a matter for individual countries, which were believed to have the capacity to respond. There was little demand for international input into health sector reform because, although East and West pursued different ideologies, no scope existed for constructive dialogue between them. The WHO did support many valuable networks, but some were arguing that this role could be undertaken by the European Union.

So have things changed? The European region of the WHO covers the same geographical area as it did 10 years ago (though it is easy to forget that this extends from Reykjavik to Vladivostok), but the political environment has changed enormously, bringing huge implications for health in its wake. The most obvious manifestation is fragmentation. The division of Czechoslovakia, Yugoslavia, and the Soviet Union have caused the region to expand from 31 to 51 countries. This fragmentation produced an immediate need for a concerted international public health response as wars erupted in Yugoslavia, Albania, the Caucasus, Moldova, and Tajikistan.

Even where change was peaceful, there were major socioeconomic upheavals. Especially in the former Soviet Union, the break up of established trading links led to recession. The policy of full employment became unsustainable, but its loss was especially harsh because of the many non-wage benefits associated with employment and because there were no safety nets of social protection.[1] Countries such as Poland, Hungary, and the Czech Republic were able to take advantage of the new situation through trading links with the West, leading to considerable improvements in diet and consequent reductions in deaths from heart disease.[2] In contrast, in the former Soviet republics the health effects were almost universally negative, with death rates increasing most in those regions experiencing the most rapid transitions.[3]

Political change also affected Soviet style healthcare systems, which at least provided basic care for all. Most have effectively collapsed, and the social insurance systems that are being imported from the west to replace them often take little account of local capacity for implementation.[4 5]

So what has this meant for the WHO? In 1988 it was almost inconceivable that, within a decade, it would have to provide emergency relief programmes in war zones in Europe. An uneasy peace now reigns over many of the areas that experienced conflict, but recent events in Kosovo remind us how fragile this peace is.[6]

As the veil of Soviet secrecy has lifted, the WHO has highlighted the widening disparities in health in the European region.[7] In 1995, a 15 year old Icelandic boy could expect to live for a further 63 years; his Russian counterpart could expect only 44 years. Nearly 7% of infants born in Turkmenistan will die before they reach 5; in Iceland the corresponding figure is 0.4%. The failure of previous policies is all too apparent in many former Soviet republics, but what limited local capacity that did exist to address these challenges has been depleted by emigration, so that the need for international support is now widely accepted, with programmes such as the WHO's EUROHEALTH playing an important part. A better understanding of the factors that give rise to these disparities will benefit not only the countries most affected. For example, recognition of the contribution of binge drinking to cardiovascular deaths in Russia is forcing a reappraisal of the effects of different patterns of alcohol consumption in the west,[8] and those working on poverty in the United Kingdom may learn from the improvements seen in diets in parts of central Europe.

The almost universal reform of systems of health care also creates a role for the WHO, which can be a source of evidence based policies[9] in an area where

BMJ 1998;316:1402–3

there is a real danger that one set of ideological "certainties" will be replaced by another. The WHO's Ljubljiana charter has provided an agreed set of principles for change.[10] It is not only in the east that greater use of such evidence is desirable.

Finally, the historical role of international public health, control of communicable disease, should not be forgotten. Diseases such as diphtheria and malaria have reappeared in areas from which they had been virtually eliminated. Cases of tuberculosis, AIDS,[11] and syphilis[12] are increasing dramatically in many parts of the former Soviet Union. This has direct consequences for all of Europe. In the past decade the political map of Europe has changed enormously. So too has the role for international public health, with important implications for all countries in the European region.

Martin McKee *Professor of European public health*
European Centre on Health of Societies in Transition (ECOHOST), London School of Hygiene and Tropical Medicine, London WC1E 7HT (m.mckee@lshtm.ac.uk)
ECOHOST is a WHO collaborating centre.

1 Unicef. *Central and eastern Europe in transition: public policy and social conditions: crisis in mortality, health and nutrition.* Florence: UNICEF, 1994. (Regional monitoring report No 2.)
2 McKee M, Zatoñski W. How the cardiovascular burden of illness is changing in Eastern Europe. *Evidence-based Cardiovascular Medicine* (in press).
3 Walberg P, McKee M, Shkolnikov V, Chenet L, Leon DA. Economic change, crime, and the Russian mortality crisis: a regional analysis. *BMJ* (in press).
4 McKee M, Bobak M, Kalina K, Bojan F, Enachescu D. Health sector reform in the Czech Republic, Hungary and Romania. *Croatian Medical Journal* 1994;35:238-44.
5 McKee M, Figueras J, Chenet L. Health sector reform in the former Soviet Republics of Central Asia. *Int J Health Planning Management* (in press).
6 Weinberg J, Simmonds S. Public health, epidemiology and war. *Soc Sci Med* 1995;40:1663-9.
7 World Health Organisation. *Health for All database.* Copenhagen: WHO, 1998.
8 White I, McKee M. Festive cheer for all? Headaches for alcohol policy makers. *BMJ* 1997;315:1638-9.
9 Saltman RB, Figueras J. *European Health Care Reform: Analysis of current strategies.* Copenhagen: WHO, 1997.
10 World Health Organisation. The Ljubljana Charter on reforming health care. *BMJ* 1996;312:1664-5.
11 Ingram M. Russia is on brink of AIDS epidemic. *BMJ* 1996;313:252.
12 Tichonova L, Borisenko K, Ward H, Meheus A, Gromyko A, Renton A. Epidemics of syphilis in the Russian Federation: trends, origins, and priorities for control. *Lancet* 1997;350:210-3.

Allocating the WHO's resources rationally

One cheer for the WHO's proposed changes in regional budgets?

News p 1408

Next week the World Health Assembly will consider a recommendation from the executive board of the World Health Organisation that will radically change the way that budgets are allocated to the WHO's regions.[1] Until now regular budgets to regions have been based not on objective criteria but on previous practice, so each region's share has remained largely unchanged since the WHO's inception. The recommendation is for a new system to be implemented gradually over three bienniums from 2000-1. This system is based on the United Nation Development Programme's human development index, possibly adjusted for immunisation coverage, which incorporates population statistics of countries calculated according to "commonly accepted methods such as 'logarithmic smoothing.' " These recommendations follow from the report of a special group[2] charged with reviewing regional allocations. This group agreed that more transparent and objective criteria based on needs at country level should be established for these allocations.

The diagnosis of inadequacies in the WHO's budget setting and the proposed solution of a weighted capitation formula (but not logarithmic smoothing) echo those of the seminal Report of the Resource Allocation Working Party (RAWP).[3] RAWP's approach has laid the foundation for resource allocation to health services in England over the past 20 years,[4,5] provided a model for other countries in the United Kingdom,[6] Australasia, and Scandinavia, and has potential for developing countries.[7] RAWP defined its objective as, "to secure through resource allocation that there would eventually be equal opportunity of access for people at equal risk."[3] It then developed a transparent method of distributing resources to health authorities based on their populations weighted by age and standardised mortality ratios. This was a pragmatic approach to that objective.[5,8] How far do the new proposed bases of allocation to the WHO regions compare with those formulated by RAWP?

BMJ 1998;316:1403–4

The WHO group's report does not consider how its proposed methods relate to the functions and objectives of the WHO,[2] though the recommendation notes that the WHO's basic principles are equity and support to countries in greatest need.[1] Weighted capitation formulas make sense in allocating resources by the dominant funder of health care, but the WHO's financial contribution per head is quite small in any country. The functions of the WHO are about promoting best use of health care funded by others. Thus the objective of allocating WHO resources ought to be to maximise benefit from this catalytic role. This might be approached by seeking measures for each country of the gap between its current performance and its potential given the other resources it has available for health care. In addition, the WHO would need to take account of other criteria—for example, the fixed costs of running regional offices (which account for a substantial proportion of available resources); funding (to exclude rich countries with poor health outcomes), and health outcomes (so that countries with high levels of disease have higher priority).

In describing the preferred formula the special group states, "populations are mathematically transformed by squared natural logarithm and multiplied by a 'stretching' factor."[2] In the publicly available documents there is no justification for this choice of function (other than it being "commonly accepted"); the stretching factor is not explained; and no account is given of how the formula uses the various needs variables identified. There is no discussion of how vulnerable the results are to current errors in data[9] or to future biases that may be caused by using these data to determine resources.

Although the underlying objectives and methods are unclear, the group's report does show the impact of its proposals. For country budgets the preferred method would, compared with current allocations, shift resources into Africa, whose percentage of the WHO's total country budget would increase from 30% to 44%, and Europe (2% to 12%) at the expense of the other countries, in particular, South East Asia (whose percentage would fall from 23% to 8%), the Eastern Mediterranean (19% to 14%), and the Western Pacific (14% to 9%). Basing allocations on raw populations in this scenario would, compared with current allocations, shift resources into Europe (whose percentage would rise from 2% to 8%), the Western Pacific (14% to 20%), and South East Asia (23% to 25%) at the expense, in particular, of the Americas (whose percentage would fall from 13% to 9%) and Africa (30% to 25%). Simply applying squared natural logarithms to the raw population data would in comparison redistribute resources from regions with large populations (Africa and South East Asia) to those with small populations (the Americas). Thus the executive board is recommending a method of allocation that produces quite different distributions of WHO's regional budgets than the current distribution or those based on raw populations.

The executive board deserves one cheer for recognising that changing the process of setting budgets ought to be integral to changing the functions of the WHO. But it loses two cheers because the assembly is invited to back changes based on obscure formulas that do not appear to relate to the WHO's objectives.

Gwyn Bevan *Reader in policy analysis*

Department of Operational Research, London School of Economics and Political Science, London WC2A 2AE (G.Bevan@lse.ac.uk)

---

1 World Health Organisation. *Review of the constitution and regional arrangements of the World Health Organization. Report of the special group.* Geneva: World Health Organisation, 1997. (Executive Board 101st session, provisional agenda item 7.3, EB101/7.)
2 World Health Organisation. *Regular budget allocations to regions.* Geneva: World Health Organization, 1998. (Resolution of the Executive Board of the WHO, 101st session, agenda item 7.3, EB101.R10.)
3 Department of Health and Social Security. *Sharing resources for health in England. Report of the Resource Allocation Working Party.* London: HMSO, 1976.
4 Mays N. Geographical resource allocation in the English National Health Service, 1971-94: the tension between normative and empirical approaches. *Int J Epidemiol* 1995; 24 (suppl 1): S96-102.
5 Sheldon TA. Formula fever: allocating resources in the NHS. *BMJ* 1997;315:964.
6 Bevan G, Copeman H, Perrin J, Rosser R. *Health care priorities and management.* London: Croom Helm, 1980.
7 Bevan G. *Equity in the use of health care resources.* Geneva: Division of Strengthening Health Services, World Health Organisation, 1991.
8 Mooney G. *Key issues in health economics.* London: Wheatsheaf, 1994:65-86.
9 Murray CJL. A critical review of international mortality data. *Soc Sci Med* 1987;25:773-81.

Knowing when to say "no" on the student elective

Students going on electives abroad need clinical guidelines

Personal view p 1466

The elective can be one of the most exciting components of a medical student's training. When done abroad, it sometimes offers the opportunity to experience health care in a different cultural and organisational setting and to see diseases that are rarely, if ever, encountered in Great Britain. Other benefits include the maturity that comes from medicosocial understanding, self-reliance, and resourcefulness that the elective experience can provide.[1] Several reports describing activities on electives provide further insight into their opportunities, challenges, and benefits.[2-6]

The increasingly focused medical curriculum in the UK is a key reason to promote the elective. Yet despite its advantages, some concerns remain. The author of a report of his elective alludes to the discomfort felt about suddenly being expected to "see patients" (p 1466).[6] Such concerns are often no different from anxieties experienced by medical students in Great Britain. However, when students travel overseas a well structured and supervised attachment is essential. Poor supervision can place students in positions which are ethically, and perhaps legally, invidious. Pitched into the often frenetic atmosphere of health care in a poor country, students may assume that limited resources and huge health needs justify taking on some of the roles of qualified doctors. This is unacceptable—irrespective of any encouragement which students may receive from members of the host healthcare organisations to which they are attached.

Medical students are not professionally qualified. This is the same in Great Britain as it is elsewhere. Most countries, if not all, will have legal requirements for the registration of medical practitioners analogous to those of Great Britain's General Medical Council. Any student studying in such countries who is unregistered but who pretends to be a doctor does so both unethically and illegally. Whatever their national origin, patients have the right to know that they are being cared for by students who cannot and must not assume responsibility for their diagnosis and treatment. Indeed, such patients also have the right not to participate in the education of students at all.

When in countries where healthcare provision is extremely scarce, students must recognise that there may be pressures to exceed their role. They must not diagnose illness, prescribe, or administer treatment without strict clinical supervision—however "unprofessional" this may feel. Students may not appreciate the dangers of treatment, particularly in countries where familiar medical problems are complicated by unfamiliar levels of poverty. In such circumstances, even with the best of intentions, inadequately supervised students risk doing more harm than good.

One of the elective's great virtues is that sometimes students may be able to undertake more procedures than back home. Provided that these are well supervised—even from a distance—and patients agree to be attended by students, there is no problem. A more difficult issue arises when considering what constitutes acceptable supervision. Before beginning their elective, students should be prepared by their medical

BMJ 1998;316:1404–5

schools in Britain to know when to ask for help and what to do when it is not forthcoming.

It might be argued that the dire health needs of some patients encountered on the elective warrants bending the rules. The assumption is that surely some help is better than no help. Is this an acceptable argument? We think not—unless patients require immediate care to save their lives. Here students would be expected to act as good citizens and do their best, but not under the pretence of being "qualified doctors". The dangers of doing so were recently outlined by the *Lancet*, which condemned the few unprofessional aid agencies that have employed medical students for relief activities—even in the face of urgent need.[7]

We are not suggesting a naive approach to the predicaments of poorly resourced countries and that students should go expecting to be treated as if back in their home country. The question is one of moral boundaries—of knowing where to draw the line between those activities which are and are not clinically appropriate. At present, there is little advice published, and related discussions with students only occur on an ad hoc basis. This situation must improve. Medical schools should take the lead in the formulation of clear guidelines and medical students should insist on them before beginning electives where they may be morally and legally compromised.

Students should be taught how to recognise their limitations so that they are adequately informed to know when it is appropriate to say "no" wherever they happen to be learning medicine.

Nicholas Banatvala *Medical adviser*

Medical Emergency Relief International, London W1M 1HW

Len Doyal *Professor*

Department of Medical Ethics, St Bartholomew's and the
Royal London School of Medicine and Dentistry, Queen Mary and
Westfield College, University of London, E1 4NS

---

1 The overseas elective: purpose or picnic? *Lancet* 1993;342:753-4.
2 Stock S. Three months in Paraguay. *BMJ* 1979;2:1274-5.
3 Elswood R. Babies and bananas: on foot in Rwanda. *BMJ* 1979; 2:1559-61.
4 Woodruff PWR. Problems in Peru. *BMJ* 1980;1:32-3.
5 Meakins SJ, Entwistle HJ. My student elective: with the people of Hiranpur. *BMJ* 1980;1:311-3.
6 Molloy K. Elective report: Manali, India. *studentBMJ* 1997;Oct:385-6.
7 Emergency medical aid is not for amateurs. *Lancet* 1996;348:1393.

Male subfertility: is pregnancy the only issue?

Psychological responses matter too—and are different in men

BMJ 1998;316:1405–6

The management of male subfertility is changing radically. The advent of intracytoplasmic sperm injection in particular has given some men the chance to father children even when they have no sperm in their ejaculate. However, the focus on pregnancy as the most important outcome of subfertility treatment appears to have taken place to the exclusion of other outcomes, such as the psychological well being of the couple and, in particular, of the man. Traditionally the little research there has been into psychological responses has focused on women. Recently a start has been made in redressing this imbalance, and it appears that men's experiences of, and responses to, subfertility are fundamentally different from that of their partners.

Recognition of the need to take into account psychological outcomes of subfertility and its management is not new but it seems to have slipped from awareness in the face of fast moving technological developments. Psychological issues do, however, need to be addressed, not only to help couples through the trauma of repeated cycles of treatment, but also for those who never achieve their desired goal.

While debate continues about the funding of expensive and highly stressful clinical interventions, scant resource is generally given to providing psychological help and support for subfertile couples. The Human Fertilisation and Embryology Authority's code of practice stipulates that counselling must now be available to those seeking assisted conception. Such a requirement is mandatory in very few other areas of health care,[1] yet virtually no evaluation of the content, efficacy, or outcomes of counselling services in infertility has been undertaken.

The demand for counselling is complicated by the lack of data on the effects of subfertility on the individuals within a subfertile relationship. Before contemplating the most appropriate counselling interventions for individuals or couples, we need to know what it is that men and women with subfertility experience—and that their experiences and reactions seem to differ. Kedem et al found that subfertile men had lower self esteem and were more anxious than a control group with no known fertility problems.[2] In a study of men attending a specialist male subfertility clinic we found them experiencing high levels of anxiety, feeling "less of a man," and blaming themselves for the subfertility.[3] Life satisfaction was less than they perceived it would be if they had a baby. Expectations of life satisfaction and blame both related to anxiety. These high levels of anxiety persisted 6 weeks and 18 months after clinic attendance and remained regardless of whether a live birth subsequently occurred.[4]

That subfertile men are anxious suggests that their experience is perceived more in terms of threat than loss. Importantly, however, they were not depressed, whereas women have been described as experiencing subfertility as a bereavement,[5 6] consistent with the finding of high levels of depression.[7]

Such data are necessary for devising and evaluating clinically useful counselling strategies. Counselling interventions in subfertility have tended to be based on a bereavement model with the aim of helping couples to mourn the losses associated with their failure to achieve pregnancy. While appropriate to women, this model does not appear to fit the experience of subfertile men, and these new data need to be taken into account when tailoring counselling both to the individual and to the couple. The best counselling intervention for women may alienate men.

Factors such as the way men's self perceptions are affected by their subfertility problems and the way in which they cope generally are important determinants of anxiety and distress.[8] If subfertility is perceived as a threatening event the experience of achieving a pregnancy or having a child will not necessarily restore feelings of manliness, especially if the child is achieved through assisted conception.

Nor should it be assumed that the need for psychological interventions would disappear if a new panacea for male subfertility were developed. In fact, with changing social roles and gender perceptions, it may even increase. New strategies need to be developed to deal with the counselling needs of men and incorporate them into a model for working with couples with subfertility. More research is needed to meet properly the psychological needs of individuals and couples with subfertility.

L Glover *Clinical psychologist*
P D Abel *Reader in urology*

Departments of Gastrointestinal Surgery and Reproductive Medicine, Hammersmith and Queen Charlotte's NHS Trust, Imperial College School of Medicine, London W12 0NN

K Gannon *senior lecturer in behavioural science*

Department of Human Science and Medical Ethics, St Bartholomew's and Royal London Hospital School of Medicine and Dentistry, London E1 2AD

---

1 Lee S. *Counselling in male infertility.* Oxford: Blackwell Science, 1996.
2 Kedem P, Mikulincer M, Nathanson YE, Bartoov B. Psychological aspects of male infertility. *Br J Med Psychol* 1990;63:73-80.
3 Glover L, Gannon K, Sherr L, Abel P. Distress in sub-fertile men: a longitudinal study. *J Reproductive Infant Psychol* 1996;14:23-36.
4 Glover L, Gannon K, Abel PK. 18 Month follow up of male subfertility clinic attenders: a comparison between men whose partner subsequently became pregnant and those with continuing subfertility. *J Reprod Infant Psychology* (in press).
5 Mahlstedt PP. The psychological component of infertility. *Fertil Steril* 1985;43:335-46.
6 Menning BE. The emotional needs of infertile couples. *Fertil Steril* 1980;34:313-9.
7 Daniluk JC. Infertility: intrapersonal and interpersonal impact. *Fertil Steril* 1988;49:982-90.
8 Glover LF. Psychological aspects of male subfertility and its investigation [PhD thesis]. London: University of London, 1996.

Letters to the editor: the new order

Please respond to articles using website, email, or disk—but not paper

Letters are important to us. They often provide more penetrating critiques of articles than any form of prepublication peer review.[1] If the publication of a scientific article resembles an appearance in court then the letters columns is where the jury of peers records its verdict. Imagine our regret therefore that we have the space to publish only a third of the letters we receive—and those five to six months after the articles to which they refer. Put another way, many of the carefully crafted responses we receive, and the insights they contain, end up in the bin.

The world wide web has rescued us, just as the whole letter publishing enterprise seemed about to collapse under its own weight. Since last week correspondents have been able to respond to articles directly via our website (www.bmj.com) using a response form that is linked to each article. These responses are screened by the editorial department, and our intention is to post all but the libellous, gratuitously rude, trivial, irrelevant, or incomprehensible on the website within 72 hours. Such a commitment might represent the most democratic step this journal ever takes: now everybody in the world with internet access (100 million and rising fast) can read whatever the journal publishes, on the day of publication, and see their response recorded within hours.

Interestingly, some of our first responses have come from patients. The very first gave a patient's perspective on early discharge after surgery for breast cancer.[2 3] If this trend continues we may finally begin to capture the dimension that has been missing from medical discourse for millennia: the experience of patients.

In time we hope to add to the website all comments that we have received on a particular article—however the responses have been submitted. Processing them is easier if they have been submitted in electronic form, which is why we would like authors to turn to paper only as a last resort. Some years ago we started requiring articles in electronic form; we are now doing the same with letters. Though many people lack internet access, most letters we currently receive have been "word processed"—so, even if an email is not possible, providing a disk should present no problem.

Those who worry about the accolade of publication in the paper journal can rest assured that all responses, regardless of medium, will be equally eligible for selection for the paper journal. But they should ponder which contribution is likely to be of more value to the scientific process—entering the hurlyburly of discussion while a topic is "hot" or getting their words into print months after most people's attention has moved on. Equally, those at home with email and the internet should not be too seduced by the speed of the medium: for our readers' sake we hope their responses will be as finely crafted, as well considered, and as well referenced as if they had been written with a fountain pen.

Liz Crossan *Letters editor, BMJ*

lcrossan@bmj.com

Tony Delamothe *Web editor, BMJ*

tdelamothe@bmj.com

email for letters is: letters@bmj.com

---

1 Bhopal R, Tonks A. The role of letters in reviewing research. *BMJ* 1994;308:1582.
2 Bonnema J, van Wersch MEA, van Greel AN, Pruyn JFA, Schmitz PIM, Paul MA et al. Medical and psychological effects of early discharge after surgery for breast cancer: randomised trial. *BMJ* 1998;316:1267-71.
3 Whitlock S. My own experiences with early release from hospital. www.bmj.com/cgi/eletters/316/7140/1267#EL1.

BMJ 1998;316:1406