heterogeneous nature of the condition and because most data derive from case reports or case series from single centres—large case control studies and randomised controlled trials are scant. The International Collaboration on Endocarditis has been conceived recently to develop a large global database of patients whose clinical, echocardiographic, and microbiological findings have been characterised by using standard methodology. The associated network of investigators and organisational infrastructure will provide the platform for large randomised trials to test therapeutic strategies.[12] This resource offers the opportunity for major advances in our understanding and treatment of infective endocarditis over the next two decades and provides a model on which global collaboration in other disease areas is likely to be based.

Bernard D Prendergast *consultant cardiologist*

Department of Cardiology, North-West Regional Cardiothoracic Centre, Wythenshawe Hospital, Manchester M23 9LT (Bernard.Prendergast@smuht.nwest.nhs.uk)

Competing interests: None declared.

1 Osler W. Gulstonian lectures on malignant endocarditis. *Lancet* 1885;1:415-508.
2 Mylonakis E, Calderwood SB. Infective endocarditis in adults. *N Engl J Med* 2001;345:1318-30.
3 Cabell CH, Jollis JG, Peterson GE, Corey GR, Anderson DJ, Sexton DJ, et al. Changing patient characteristics and the effect on mortality in endocarditis. *Arch Intern Med* 2002;162:90-4.
4 Delahaye F, Rial MO, de Gevigney G, Ecochard R, Delaye J. A critical appraisal of the quality of the management of infective endocarditis. *J Am Coll Cardiol* 1999;33:788-93.
5 Von Reyn CF, Levy BS, Arbeit RD, Friedland G, Crumpacker CS. Infective endocarditis: an analysis based on strict case definitions. *Ann Intern Med* 1981;94:505-17.
6 Durack DT, Lukes AS, Bright DK, and the Duke Endocarditis Service. New criteria for diagnosis of infective endocarditis: utilization of specific echocardiographic findings. *Am J Med* 1994;96:200-9.
7 Sachdev M, Peterson GE, Jollis JG. Imaging techniques for diagnosis of infective endocarditis. *Infect Dis Clin North Am* 2002;16:319-37.
8 Bayer AS, Bolger AF, Taubert KA, Wilson W, Steckelberg J, Karchmer AW, et al. Diagnosis and management of infective endocarditis and its complications. *Circulation* 1998;98:2936-48.
9 Houpikian P, Raoult D. Diagnostic methods, current best practices and guidelines for identification of difficult-to-culture pathogens in infective endocarditis. *Infect Dis Clin North Am* 2002;16:377-92.
10 Lisby G, Gutschik E, Durack DT. Molecular methods for diagnosis of infective endocarditis. *Infect Dis Clin North Am* 2002;16:393-412.
11 Li JS, Sexton DJ, Mick N, Nettles R, Fowler VG Jr, Ryan T, et al. Proposed modifications to the Duke criteria for the diagnosis of infective endocarditis. *Clin Infect Dis* 2000;30:633-8.
12 Cabell CH, Abrutyn E. Progress toward a global understanding of infective endocarditis. Early lessons from the International Collaboration on Endocarditis investigation. *Infect Dis Clin North Am* 2002;16:255-72.

The world's first international tobacco control treaty

Leading nations may thwart this major event

Negotiators from the World Health Organization's 191 member states meet in Geneva this week in an attempt to agree the world's first international tobacco control treaty, the Framework Convention on Tobacco Control.[1] This legally binding treaty would aim to establish principles and guidelines for international tobacco control. It follows a similar format to the 1992 United Nations' Framework Convention on Climate Change and its related protocols such as that signed in Kyoto in 1997. The development of a framework convention on tobacco is important because it is the first time in its history that the WHO has used its treaty making powers. And in the growing debate around trade and health it provides an opportunity to ensure that health is given primacy over commercial considerations when it comes to trade in a product that kills one in every two of its long term users.[2]

A global tobacco control treaty is now essential because the tobacco industry's use of international trade agreements, cigarette smuggling,[3 4] and global marketing techniques has undermined national control measures and rendered them insufficient to control the tobacco epidemic.[5 6] The industry uses similar tactics to penetrate new markets outside industrialised countries, where smoking rates are declining. As a result the tobacco epidemic has grown in size and gradually shifted its focus from high to low and middle income countries. By 2030 tobacco will kill 10 million people worldwide, an increase from the current 4 million.[7 8] Over the same period, the proportion of these deaths occurring in the developing world will increase from 50% to 70%. This shift in disease patterns will add to growing global inequities as the burden of tobacco related disease grows in the South while profits from cigarette sales accrue to companies in the North.

Most countries, particularly the South East Asian and African nations, support a strong convention that would have the potential to halt this public health disaster. But a few key states are obstructing progress by angling for a weaker treaty. These states, most notably those that host the major tobacco transnationals, seem happy to stand by as their companies peddle death elsewhere. Criticism has rightly centred on the tobacco friendly Bush administration.[9] But Japan, whose government is the majority shareholder in the world's third largest tobacco transnational, has been still more overt in its opposition and seems to doubt whether the reduction of tobacco consumption is a legitimate public policy objective. The European Union has also failed to argue for sufficiently comprehensive measures.[10]

Germany, Europe's largest tobacco manufacturer, is mainly responsible for the negative European Union position, although other states have likely sheltered behind it. The negotiating stance of the European Union is based both on its current tobacco legislation and on a shared position agreed between all 15 member states in areas that the legislation does not cover. Existing legislation is weak, largely because successive German governments (with occasional support from other European Union members) have obstructed the passage of effective legislation and, alongside their industry allies, challenged the legality of existing laws in the European courts.[11 12] On other issues, agreeing a shared position inevitably produces the lowest common denominator, particularly when the most obstructive state is one of the most powerful. The problem is exacerbated as the European Union no

BMJ 2002;325:846–7

longer speaks just for its 15 members, but increasingly for the 13 accession countries being pressured to support a position on tobacco control that is often weaker than those they have already adopted.

Despite overwhelming international support for a strong convention, these key states could have a damaging impact on the final treaty and consequently on global health. Weaknesses in some sections of the convention's current draft text reflect their influence and willingness to advance arguments from the tobacco industry. The text, for example, currently fails to advocate a complete ban on tobacco advertising—the only such measure for which there is a satisfactory evidence base. It also leaves the convention subordinate to international trade agreements, failing to treat tobacco like other uniquely harmful products such as weapons or hazardous waste that cause far fewer deaths but are already governed by specific trade rules.

This situation is no longer acceptable. It is one thing if individual countries decide to put their own citizens' health at risk, but quite another to deny other citizens of the world the right to health. The Framework Convention on Tobacco Control retains the potential to advance global health significantly, and negotiators in Geneva this week must ensure that this potential is not prematurely thwarted. The health community must now exert pressure on governments to support a strong Framework Convention on Tobacco Control and to stiffen the resolve of other governments in Europe to challenge the German position. If the health community falls at its first treaty making hurdle, how can we hope to address the challenges that globalisation poses for health in the future?

Anna B Gilmore *research fellow*

European Centre on Health of Societies in Transition (anna.gilmore@lshtm.ac.uk)

Jeff Collin *lecturer*

Centre on Global Change and Health, London School of Hygiene and Tropical Medicine WC1E 7HT (jeff.collin@lshtm.ac.uk)

Competing interests: The London School of Hygiene and Tropical Medicine is a member of the Framework Convention Alliance, an alliance of civil society organisations working to support the development of an effective Framework Convention on Tobacco Control. JC previously received research funding from the WHO's Tobacco Free Initiative.

1 World Health Organization. Fifth session of the Intergovernmental Negotiating Body, Framework Convention on Tobacco Control, Geneva, 14-25 October 2002. http://www.who.int/gb/fctc/E/E_Index.htm (accessed 14 Oct 2002).
2 Peto R, Lopez AD, Boreham J, Thun M, Clark HJ. *Mortality from tobacco in developed countries: indirect estimation from national vital statistics*. Oxford: Oxford University Press, 1994.
3 Health Committee. *Session 1999-2000. Inquiry into the tobacco industry and the health risks of smoking*. Memorandum by Duncan Campbell in respect of planning, organisation and management of cigarette smuggling by British American Tobacco plc and related issues. London: House of Commons, 2000. http://www.parliament.the-stationery-office.co.uk/pa/cm199900/cmselect/cmhealth/27/0021603.htm (accessed 14 Oct 2002).
4 Joossens L, Raw M. How can cigarette smuggling be reduced? *BMJ* 2000;321:947-50.
5 Yach D, Bettcher D: Globalisation of tobacco industry influence and new global responses. *Tobacco Control* 2000:9:206-16.
6 Collin J, Lee K and Bissell K: The Framework Convention on Tobacco Control: the politics of global health governance. *Third World Quarterly* 2002;23:265-82.
7 World Health Organization. *World Health Report*. Geneva: WHO, 1999.
8 Jha P, Chaloupka F. *Curbing the epidemic: governments and the economics of tobacco control*. Washington DC: World Bank, 1999.
9 Waxman H. The future of the global tobacco treaty negotiations. *N Engl J Med* 2002;346:936-9.
10 Gilmore A, McKee M. Tobacco control policies: the European dimension. *Clinical Medicine* 2002;2:335-42.
11 Gilmore A, McKee M. Tobacco policy in the European Union. In: Feldman E, Bayer R, eds. *Tobacco control and the liberal state: the legal, ethical and policy debates*. In press.
12 Neuman M, Bitton A, Glantz S. Tobacco industry strategies for influencing European community tobacco advertising legislation. *Lancet* 2002;359:1323-30.

Electronic tagging of people with dementia who wander

Ethical considerations are possibly more important than practical benefits

Once again the issue of using electronic tagging to safeguard older people who wander has attracted media attention.[1] It is tempting to see the arguments as simply two sided—one side stressing the need to ensure safety and the other waving the banners of civil liberties and human rights. We think that this is not simply a factual matter but one that touches important values to do with respect for people. The correct position, therefore, is to face the complex dilemma. Decisions about limiting a person's liberty should remain a matter of ethical concern even when technology finally makes the practical management of wandering easier. In electronic tagging the tag is usually a wristband. The circuitry in the tag may either set off a boundary alarm or emit a radio signal that allows the wearer to be tracked down by means of a hand held detector.

The problem of wandering in dementia is not trivial. It causes stress to carers, referrals to psychiatric services and hospital admissions, problems in the hospital environment,[2] and an unknown number of deaths. The prevalence of wandering is over 40%, and in a five year prospective study 44% of wanderers with dementia were kept behind locked doors at some point.[3] Since "wandering"' encompasses a variety of behaviours,[4] a variety of solutions might be applicable.

What, besides electronic tagging, are the other solutions? Carers often find their own solutions—from locked doors to makeshift alarms to constant surveillance. Many people are put on various drugs, with the risk of adverse effects. Relatively few controlled trials have been conducted, and much of the research tends to clump together different behavioural and psychological symptoms in dementia under the

BMJ 2002;325:847–8