paper and not simply publishing a selection of the best of the rapid responses. Hence our preference for brief, readable letters supplemented with pictures and summaries of responses.

We ask that all letters to the editor, even those that are ostensibly on new subjects, be posted on bmj.com first. Letters that seem not to be in response to a recently published article can usually be sent as a response to an older article containing one or more key words, and such an article can easily be found by using the search facility on the home page. We no longer wish to receive responses by email or on disk but would prefer that readers post their own responses. We are always happy to help in posting, but we haven't the resources to post every response that arrives on paper, on disk, or by email, which means that some valuable opinion never reaches the forum.

Rapid responses are easy to send and are retrievable through the search facility.[1 9] They are a vibrant and lively means of communication and are posted every day, usually within 24 hours of arrival. Consider them publications—for example, the signed informed consent of patients is required if any information gleaned from the doctor-patient relationship is described, and a signed form must be sent to us before we can post responses with any patient's details.[10] A declaration of competing interests is also obligatory. Rest assured, however, that once you have jumped through these hoops your rapid response, like every one before and after it, is eligible for publication in the paper journal, and its fate there is usually decided within four weeks after posting.

Although space on bmj.com is unlimited, the number of pages allocated to letters in the paper journal is strictly limited to five or six weekly, except in exceptional circumstances. In one three week period we posted an average of 185 responses and published an average of 18 letters in a week, or just under 10% of responses. The maximum word count was 400 words. By lowering this figure to 300 words this year, four rather than three letters should fit on to a page. At one fell swoop letters will look more inviting, and we should be able to increase our acceptance rate and publish letters more quickly, ideally within six weeks of acceptance.

Three hundred words is the new maximum, but let it not become the optimum as the old limit seems to have done. The shorter the better. I am, for example, constantly impressed by letters to the editor in the *Times* for their conciseness and how few words can make me smile or think. In one letter, Corlett uses only 43 words, including citing the original news item, to ask whether people giving wrong answers to a spelling quiz (instead of the first 20 to send in correct answers) should receive a copy of the self styled "indispensible" *Times Style and Usage Guide*.[11] His letter contains five fewer words than my paraphrasing and is infinitely more witty. Similarly, the *BMJ* needs the unique voices of its readers to sound loud and clear. Please send your response to bmj.com first. Remember that we can allow only 300 words for each letter in the paper journal but also that brevity is worth the effort: "If you would be pungent, be brief; for it is with words as with sunbeams—the more they are condensed, the deeper they burn."[12]

Sharon Davies *letters editor, BMJ*

(sdavies@bmj.com)

I thank my family and colleagues for their help in preparing this editorial.

Competing interests: None declared.

1 Delamothe T, Smith R. Twenty thousand conversations. *BMJ* 2002; 324:1171-2.
2 Correspondence. Legalising active euthanasia and physician assisted suicide. *BMJ* 2002;324:846-8.
3 Correspondence. What do you think is a non-disease? *BMJ* 2002; 324:912-4.
4 Correspondence. Getting more for their dollar: Kaiser v the NHS. *BMJ* 2002;324:1332-5.
5 Correspondence. Storm over screening for prostate specific antigen. *BMJ* 2002;324:1392-4.
6 Correspondence. Preventing stroke with ramipril. *BMJ* 2002;325:439-41.
7 Correspondence. Adrenal insufficiency after treatment with fluticasone. *BMJ* 2002;325:836-8.
8 Correspondence. Screening for domestic violence. *BMJ* 2002;325:1417-20.
9 Tip: What are rapid responses? bmj.com/misc/tips/tip5.shtml
10 Consent form. bmj.com/collections/informed_consent/draft_f.shtml
11 Corlett J. Dispelling doubt (letters to the editor). *Times* 31 Oct 2002:25 (col 5).
12 Quotations page. Robert Southey (1774-1843). www.quotationspage.com/quotes/Robert_Southey (accessed 14 Dec 2002).

Testing new pharmaceutical products in children

A positive step, but ethical concerns remain

Ideally all medicines that could benefit children should be licensed for this purpose. To date this has been the exception rather than the rule, resulting in children becoming therapeutic orphans sometimes with tragic consequences. Many medicines prescribed for children, whether in hospital or primary care, are either unlicensed or off label (used for an indication, age, dose, or route of administration outside the terms of the product licence).[1 2] Other problems surround the prescribing, dispensing, and administering of medicines to children.[3] Many difficulties could be overcome if manufacturers were obliged to test their products on children as well as adults.

In the United States a "carrot and stick" approach has been adopted to achieve this end.[4] The carrot is the "paediatric exclusivity provision," which grants an additional six months of patent protection or market exclusivity to companies that voluntarily test the relevant drug on children. The stick is the "paediatric rule," a later requirement by the Food and Drug Administration that companies test their products on children under certain circumstances. These include the likelihood of (1) usage in a substantial number of children, (2) meaningful therapeutic benefits, (3) risk to children in the absence of labelling (licensing), (4) usage in different paediatric age groups. Recently this rule has been challenged successfully, principally on the grounds that the Food and Drug Administration exceeded its authority in imposing these requirements on drug companies, leaving uncertainty about how the increased testing of medicines is to be achieved.[5]

BMJ 2003;326:64–5

Although including children in trials has benefits, technical, practical, and ethical problems remain.[6] Technically it will be necessary to develop further non- or minimally invasive techniques for pharmacokinetic and pharmacodynamic assessments. Pharmacodynamic assessments are required to determine accurate dosage even in clinical trials. This is especially important in children whose metabolism of drugs and sensitivity of end organs to them vary considerably with age and stage of development. Practical difficulties arise from the small number of children with specific disorders, the need to study different ages, the formulation of drugs, and problems of recruitment.

Ethically, the obligation to act in a child's best interests entails protecting children from both the potential risks of research and the harms produced by the use of inadequately tested drugs, as well as respecting their autonomy. To satisfy these requirements drug trials should be scientifically and socially valid, adequately powered, of favourable risk-benefit ratio, subject to independent ethical review and informed consent, and conducted to an appropriate standard.[7] But inevitably, pharmaceutical studies carry risks of physical or psychological harm that may be difficult to quantify. Acceptance of some risk is necessary for therapeutic advances to occur, for example, in the treatment of acute lymphoblastic leukaemia.[8] Difficulties in recruitment may mean that studies lack the statistical power to answer the questions they pose. In contrast large studies are expensive and, if commercially sponsored, may tend to favour the drug tested. Commercially funded research understandably includes drugs that are likely to have high volume sales—for example, antibiotics—or high unit costs, such as surfactant.[8] Research ethics committees must assess all these factors but do need sufficient expertise in paediatrics to do so safely and effectively.

Obtaining adequately informed voluntary consent for participation in a drug trial requires the children's assent or consent, commensurate with their understanding and experience, with or without the permission or consent of their parents.[8] Imparting sufficient, comprehensible information to distressed parents and ill children is difficult and leads to questions of their competence to make decisions. Understanding of such terms as randomisation, trial, and placebo may be imperfect.[9] Parents may accept drug treatment as being the only hope for their child irrespective of the risks entailed; they may feel obliged to researchers and believe that refusal to enter a trial will compromise their child's treatment.[4] Doubt therefore exists whether truly informed consent is possible, especially in acute life threatening situations.

These factors and issues raised by the Bristol and Alder Hey inquiries and the Griffiths's report have created a climate in which the testing of medicines in children poses difficulties. Overcoming them is essential if children are to benefit from the development of safe effective drugs. One possible solution would be to introduce legislation such as that in the United States. But such legislation may not in itself lead to a greater number of children being enrolled in drug trials or deal with the difficulty in obtaining sufficiently informed consent. Moreover, the exclusivity provision has been criticised as benefiting the interests of companies rather than children.[4] An alternative, but long term, strategy is the greater involvement of children and their families in the planning and implementation of research projects, which should have notable educational impact.[10] This approach could both increase recruitment and satisfy the criteria for informed consent.

In the meantime, those who prescribe for children should use drugs that are licensed or accepted as offering the best possible prospect of benefit by a responsible body of medical opinion. Equally they have a duty of advocacy on behalf of children, supporting the therapeutic orphans who, like fictional character Oliver Twist, are saying: "Please sir, we want some more."

Alastair G Sutcliffe *senior lecturer in paediatrics*

Royal Free and University College Medical School, London WC1E 6BT

Competing interests: None declared.

1 Turner S, Longwith A, Nunn AJ, Choonara I. Unlicensed and off-label drug use in paediatric wards: prospective study. *BMJ* 1998;316:343-5.
2 McIntyre J, Conroy S, Avery A, Corns H, Choonara I. Unlicensed and off label prescribing of drugs in general practice. *Arch Dis Child* 2000;83:498-501.
3 Sutcliffe AG. Prescribing medicines for children. *BMJ* 1999;319:70-1.
4 Steinbock R. Testing medicines in children. *N Engl J Med* 2002;317:s1462-70.
5 Gottlieb S. Testing of drugs in children ruled unlawful by US judge. *BMJ* 2002;325:920.
6 Lantos J. The inclusion benefit in clinical trials. *J Pediatr* 1999;134:130-1.
7 Royal College of Paediatrics and Child Health; Ethics Advisory Committee. Guidelines for the ethical conduct of medical research involving children. *Arch Dis Child* 2000;82:177-82.
8 Stephenson T. New medicines for children; who is protecting the rights of the child? *Curr Paediatr* 2002;12:331-5.
9 Snowdon C, Garcia J, Elbourne D. Reaction of participants to the results of a randomised controlled trial: exploratory study. *BMJ* 1998;317:21-6.
10 Hart C, Chesson R. Children as consumers. *BMJ* 1998;316:1600-3.

Racism and health

Antiracism is an important health issue

Discussion of racial discrimination in medicine has concerned mainly recruitment and career development.[1 2] This has overshadowed a growing literature showing an association between racism, morbidity and mortality.[3–7] Racism may be aetiologically important in the development of illness.

Racism stems from the belief that people should be treated differently because of a few phenotypic features. Racism can manifest as individual or group acts and attitudes or institutionalised processes that lead to disparities. Racism is common: in one national survey in the United Kingdom, 25-40% of participants said they would discriminate against ethnic minorities; an estimated 282 000 UK crimes were racially motivated in 1999; and a third of people from ethnic minorities constrain their lives through fear of racism.[8 9] Disparities between ethnic minority and majority groups in housing, education, arrests, and

BMJ 2003;326:65–6