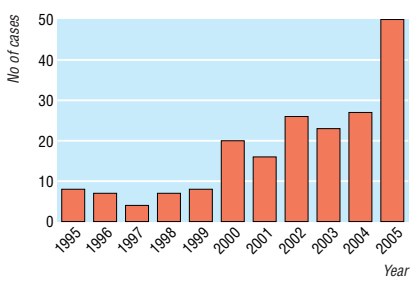
Letters

Empyema thoracis is still increasing in UK children

Editor—An increase in empyema thoracis complicating pneumonia in children was reported from the West Midlands in 1997[1] and has since been confirmed in several other centres in the United Kingdom, Europe, and North America. Most culture positive cases in the United States are related to infection with *Streptococcus pneumoniae* serotype 1.[2] This is also the most common causative organism in the UK where most cases are culture negative as shown by using pneumococcal polymerase chain reaction and serotype specific enzyme linked immunosorbent assays.[3] Until recently, serotype 14 was responsible for most invasive pneumococcal disease in UK children, so the dominant serotype seems to have shifted considerably.

We have observed a further progressive increase in cases since 1997; over the past 12 months the number of cases requiring surgical intervention nearly doubled, to 48 per year. The figure shows the numbers of children requiring surgical intervention who represent 90% of total referrals to our regional centre. Our referral practice and our management policy have not changed over the past decade. In some of our cases the severity of the underlying pneumonic process seems to have increased, with associated lung necrosis and cavitation.[4]

The UK government recently announced the introduction of universal paediatric vaccination with the heptavalent pneumococcal conjugate vaccine suitable for use in infants. This vaccine does not contain antigen for serotype 1. Introduction of this vaccine to the United States in 2001 has been associated with a substantial decline in overall pneumococcal invasive disease but an increase in empyema cases in children, with a doubling of cases between 2000 and 2005 compared with the previous five years in one major centre.[5] The causative organisms responsible for this increase include serotypes 1, 3, and 19a, as well as other non-vaccine serotypes. A causal relation between vaccination and this increase has not been proved, but this possibility cannot be dismissed, and it is likely that the incidence of this problem will now increase yet further in the UK.



Numbers of surgically managed cases of empyema in northeast England, 1995-2005

We are pleased that the Health Protection Agency will introduce an enhanced programme of pneumococcal surveillance for paediatric empyema in England and Wales, including polymerase chain reaction and serotyping in culture positive and culture negative cases. This will allow for close monitoring of the problem on a national basis.

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Competing interests: None declared.

1 Rees JMH, Spencer DA, Parikh D, Weller P. Increase in incidence of childhood empyema in West Midlands, UK. *Lancet* 1997;349:402.
2 Byington CL, Spencer LY, Johnson TA, et al. An epidemiological investigation of a sustained high rate of pediatric parapneumonic empyema: risk factors and microbiological associations. *Clin Infect Dis* 2002;34:434–40
3 Eastham KM, Freeman R, Kearns AM, et al. Clinical features, aetiology and outcome of empyema in children in the north-east of England. *Thorax* 2004;59:522-5.
4 Ramphul N, Eastham KE, Freeman R, et al. Cavitatory lung disease complicating empyema in children.. *Pediatr Pulmonol* (in press).
5 Byington CL, Korgenski K, Daly J, Ampofo K, Pavia A, Mason EO. Impact of the pneumococcal conjugate vaccine on pneumococcal parapneumonic empyema. *Pediatr Infect Dis J* 2006;25:250-4.

More on pneumonia

Clinical judgment is also needed with CURB score

Editor—Commendably, Owen et al are committed to reducing inappropriate intravenous antibiotic prescribing but we are concerned by some of their assumptions.[1] Although the guidelines from the British Thoracic Society state that patients with a CURB-65 score of 0 or 1 are likely to be suitable for home treatment, Hoare and Lim have recognised that clinical judgment is also needed.[2] Similarly, recent guidance from the Department of Health and Health Protection Agency on the management of Panton-Valentine leukocidin associated staphylococcal pneumonia has stated that CURB-65 may be misleadingly low in fit young adults.[3] In a study in our own institution over the last year (in preparation) five of 40 patients with a CURB-65 score of 1 at presentation required care in a high dependency unit or intensive care unit.

We would be concerned if blind adherence to a score designed for mortality prognostication without reference to the current or deteriorating physiological state of the patient resulted in patients being managed inappropriately, and we believe that if CURB-65 is used then decision making should also allow for the inclusion of clinical judgment as suggested by Hoare and Lim.

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Competing interests: None declared.

1 Owen D, Shiner T, Sivakumar R, Dent R, Hilton C. Pneumonia. *BMJ* 2006;332:1213. (20 May.)
2 Hoare Z, Lim WS. Pneumonia: update on diagnosis and management. *BMJ* 2006;332:1077-9. (6 May.)
3 McCartney C, Cookson B, Dance D, Day C, Duerden B, Elston T, et al. *Interim guidance on diagnosis and management of Panton-Valentine leukocidin-associated staphylococcal infections in the UK*. London, Department of Health, 2006. www.dh.gov.uk/AboutUs/MinistersAndDepartment Leaders/ChiefMedicalOfficer/Features/FeaturesArticle/fs/en?CONTENT_ID=4133761&chk=oW8s4w (accessed 24 May 2006).

"Surviving Sepsis" campaign may contradict CURB score

Editor—Owen et al highlight the possibility that intravenous antibiotics may be overprescribed to patients with non-severe community acquired pneumonia.[1] The guidelines of the "Surviving Sepsis" campaign for managing severe sepsis and septic shock recommend "intravenous antibiotic treatment should be started within the first hour of recognition of severe sepsis, after appropriate cultures."[2]

Some of the literature referenced by the Surviving Sepsis campaign uses the fulfilment of two out of four of the criteria for the systemic inflammatory response syndrome and a systolic blood pressure less than 90 mm Hg as indicative of sepsis. Given the difference between these criteria and CURB criteria, a patient apparently not deemed suitable for intravenous antibiotic treatment of pneumonia by the CURB criteria could be recommended for aggressive treatment of sepsis (including central venous and arterial access) by the campaign's guidelines.

This apparent contradiction illustrates the continued importance of overall clinical assessment in our increasingly guideline driven management of patients.

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2 Dellinger RP, Carlet JM, Masur H, Gerlach H, Calandra T, Cohen J, et al. Surviving sepsis campaign (SSC) guidelines for management of severe sepsis and septic shock. *Crit Care Med* 2004;32:858-73.

Treatment of MRSA in community acquired pneumonia

Editor—Hoare and Lim's update on the diagnosis and management of community acquired pneumonia does not mention methicillin resistant *Staphylococcus aureus* (MRSA),[1] which is becoming more common in the community as a true community associated organism, in patients in residential care, and in those discharged from hospital. Patients who have newly acquired MRSA often develop further infections unless carriage is cleared. One study showed that in the 18 months after first colonisation, over one quarter of individuals developed further MRSA infections, many of which were pneumonias.[2] All MRSA strains are resistant to penicillins and cephalosporins; over 90% of hospital associated strains are resistant to quinolones, and over 70% are resistant to erythromycin and clarithromycin.[3] Treatment regimens advised in the article are inappropriate when MRSA is a likely pathogen.

At Plymouth Hospitals NHS Trust in the past year 39% of all MRSA bacteraemias presented in the community, nearly half of all serious MRSA infections were in patients not previously known to be colonised, and nearly 20% of residents of nursing homes admitted to the orthopaedic service were colonised. With such high levels of unidentified carriage in the community, empirical treatment for MRSA pneumonia in many groups at risk seems prudent.

Recent UK MRSA treatment guidelines advise the use of vancomycin or linezolid for proved MRSA pneumonia.[3] Doxycyline is well tolerated and over 95% of MRSA strains are sensitive to it, as well as most of the atypical pathogens that Hoare and Lim suggest should be treated with the poorly tolerated antibiotic erythromycin or its more expensive relative clarithromycin.

Although not mentioned in the British Thoracic Society's guidelines, in Plymouth doxycyline is used in addition to a penicillin to treat atypical pathogens. This has the additional benefit of providing some activity against unidentified MRSA infections. When conventional antibiotic treatment has failed or in patients who are intolerant of penicillins, an oral respiratory quinolone (levofloxacin) is used. In such patients who are at increased risk of MRSA infection—for example, elderly people or patients with a history of carriage, etc—we suggest intravenous vancomycin or linezolid be added as it should be for patients with severe pneumonia who are at risk. When MRSA pneumonia is subsequently confirmed, conversion to a regimen as recommended in the UK guidelines would be appropriate in most patients.

With rising rates of MRSA infections in the community we urge other providers to consider the use of empirical treatment with a tetracycline or vancomycin in community acquired pneumonia in high risk patients when MRSA cannot be ruled out.

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1 Hoare Z, Lim WS. Pneumonia: update on diagnosis and management. *BMJ* 2006;332:1077-9. (6 May.)
2 Huang S, Platt R. Risk of methicillin resistant Staphylococcus aureus infection after previous infection or colonization. *Clin Infect Dis* 2003;36:281-5.
3 Gemmell CG et al. Guidelines for the prophylaxis and treatment of methicillin resistant Staphylococcus aureus (MRSA) infections in the UK. *J Antimicrob Chemotherap* 2006;57:589-608.

Pulmonary tuberculosis: diagnosis and management

Interferon test is new advance in diagnosis . . .

Editor—Campbell and Bah-Sow downplay the role of new advances in the diagnosis of pulmonary tuberculosis.[1] This is surprising as new techniques such as the interferon test are the first advance in this area for many years. Unlike the Mantoux test, this test does not test positive in those who have had BCG vaccination.[2] It can also differentiate *Mycobacterium tuberculosis* from other mycobacteria and is therefore a more specific test for diagnosing latent tuberculosis.[3]

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1 Campbell IA, Bah-Sow O. Pulmonary tuberculosis: diagnosis and treatment. *BMJ* 2006;332:1194-7. (20 May.)
2 Diel R, Nienhaus A, Lange C, Meywald-Walter K, Forssbohm M, Schaberg T. Tuberculosis contact investigation with a new, specific blood test in a low-incidence population containing a high proportion of BCG-vaccinated persons. *Respir Res* 200617;7:77.
3 Kunst H. Diagnosis of latent tuberculosis infection: The potential role of new technologies. *Respir Med* 2006 Apr 29; [Epub ahead of print].

. . . and barrier nursing is recommended in management

Editor—Campbell and Bah-Sow say that barrier nursing is not necessary, except for patients with multidrug resistant tuberculosis, who should be managed in a negative pressure room vented to the outside.[1] They also assert that patients should be discharged home unless clinically imperative. According to guidelines on tuberculosis from the National Institute for Health and Clinical Excellence (NICE), barrier nursing and isolation are recommended until three sputum tests are negative.[2]

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1 Campbell IA, Bah-Sow O. Pulmonary tuberculosis: diagnosis and treatment. *BMJ* 2006; 332: 1194-7. (20 May.)
2 National Institute for Health and Clinical Excellence. Tuberculosis. Clinical diagnosis and management of tuberculosis, and measures for its prevention and control. Clinical guideline 33. Available at: www.nice.org.uk/page.aspx?o=CG033NICEguideline (accessed 25 May 2006).

Benefits of family mealtimes for nursing home residents

SIPA PRESS/REX

Study is step in the right direction

Editor—Nijs et al show the beneficial effects of family style mealtimes on the health of nursing home residents.[1] Many elderly people in nursing homes, despite excellent clinical care, experience poor nutritional status associated with poor dentition, depression, and disease related malnutrition. Family members become distressed watching their elderly relatives decline in such a way.

The solution has always been to provide high protein and energy dietary supplements from pharmaceutical companies which, although carefully formulated, are of debatable palatability and uptake. Importantly, they are prescribed by doctors at enormous cost to the health service, and evidence of their effectiveness is limited.[2] Food based interventions are not ineffective: appropriate studies simply have not been done. This research is a step in the right direction. Jamie Oliver, could you make nursing homes your next project?

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1 Nijs KAND, de Graaf C, Kok FJ, van Staveren WA. Effect of family style mealtimes on quality of life, physical performance, and body weight of nursing home residents: cluster randomised controlled trial. *BMJ* 6;332:1180-4. (20 May.)
2 Milne AC, Avenell A, Potter J. Meta-analysis: protein and energy supplementation in older people. *Ann Intern Med* 2006;144:37-48.

Protecting mealtimes may similarly benefit elderly inpatients

Editor—The study by Nijs et al of Dutch elderly nursing home residents showed that

improving the ambience at mealtimes prevents a decline in body weight.[1] A decline in nutritional status during hospital stay may be the result not only of illness but also of problems with feeding and catering policies, such as poor environment, lack of help with eating, and interruption of meals by procedures and ward rounds.[2] Another reason is limited time available to eat each meal in the hospital.[3]

In the United Kingdom protecting mealtimes is an imaginative solution to improve nutrition of hospital patients in the better hospital food programme of the Department of Health. We conducted a pilot study in two medical wards for elderly patients at Castle Hill Hospital in West Yorkshire to check the effect of protected mealtimes in elderly hospital patients. The intervention was protection for an hour during lunchtime and evening mealtimes. It was an open study with four months interval between control (17 patients) and intervention (22 patients).

We found that protecting mealtimes helped in preventing weight loss (0.19 kg/week compared with 0.25 kg/week) and reduction in hand grip strength (0.53 kg *v* 0.60 kg). Mid-arm circumference increased with mealtime protection (0.03 cm/week), whereas a reduction (0.02 cm/week) occurred in the control group (P = 0.056). Interestingly, we did not find protecting mealtimes to improve the food intake (calories: 1121/day *v* 1275/day; protein: 44 g/day *v* 50 g/day).

Similar studies showed equivocal results in the past among elderly hospital patients as mentioned by Milne et al.[4] As the protection of mealtimes has consequences for medical care an equivalence trial would be worth while.

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1 Nijs KAND, de Graaf C, Kok FJ, Staveren WA. Effect of family style mealtimes on quality of life, physical performance, and body weight of nursing home residents: cluster randomised controlled trial. *BMJ* 2006;332:1180-4. (20 May.)
2 Allison S. Institutional feeding of the elderly. *Curr Opin Clin Nutr Metab Care* 2002;5:31-4.
3 Sydner YM, Fjellstrom C. Food provision and the meal situation in elderly care-outcomes in different social contexts. *J Hum Nutr Dietet* 2005;18:45-52.
4 Milne AC, Avenell A, Potter J. Improved food intake in frail older people. *BMJ* 2006;1166. (20 May.)

Ethnic misclassifications hamper progress in research

Editor—McDowell et al review the evidence for ethnic differences in susceptibility to adverse drug reactions to cardiovascular drugs.[1] They concluded that patients from different ethnic groups have different risks for adverse reactions to cardiovascular drugs and that ethnic group may be one determinant of harms of a given treatment, either because it acts as a surrogate measure of genetic make up or because cultural factors alter the risk.

Clearly, there are important issues that are worth discussing with regard to this study's approach of ethnic classifications and its conclusions. The ethnic differences in health are not easily explained, and better definitions and terminology, and greater attention to population heterogeneity are a prerequisite for scientific progress.[2] The heterogeneity of African descent populations,[2] Asian,[3] and white[4] populations has long been pointed out. Some journals, including the *BMJ*, have also set standards by publishing explicit guidelines for the use of race and ethnicity. Despite this, broad terms such as black, Asian, or non-black are still entrenched in scientific writing.

The continuing use of broad terms in epidemiology and public health may reflect pragmatic reasons such as small study numbers; but the need for simplicity should be weighed against the dangers of stereotyping and incorrectness. The authors' conclusion that ethnic group may be one determinant of harms of a given treatment in the individual patient because it acts as a surrogate measure of genetic make up is worrying given the nature of ethnic classifications in their study.

Ethnicity and health researchers should move beyond the straightforward black-white category that was the dominant and limiting approach for most of the 20th century and access the substantial ethnic diversity that typifies the population under study.

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1 McDowell SE, Coleman JJ, Ferner RE. Systematic review and meta-analysis of ethnic differences in risks of adverse reactions to drugs used in cardiovascular medicine. *BMJ* 2006 ;332:1177-81. (20 May.)
2 Agyemang C, Bhopal R, Bruijnzeels M. Negro, Black, Black African, African Caribbean, African American or what? Labelling African origin populations in the health arena in the 21st century. *J Epidemiol Community Health* 2005;59: 1014-8.
3 Senior PA, Bhopal R. Ethnicity as a variable in epidemiological research. *BMJ* 1994;309:327-30.
4 Bhopal R, Donalson L. White, European, western, Caucasian, or what? Inappropriate labelling of research on race, ethnicity and health. *Am J Public Health* 1998;88: 1303-7.

Self harm in Goth youth subculture: authors' reply

Editor—Our paper generated varied comments.[1] The definition of "Goth" is contentious but covers a wide range of musical tastes, social groupings, and aesthetics.[2] Our paper, as is clear from the title, refers to younger Goths; the results may not apply to all Goths.

Our contribution is a first step towards producing an evidence base to test the hypothesis that engagement with Goth subculture could have positive rather than negative consequences for some young people, rather than relying on media speculation.

Some contributors have suggested that the association between self harm and Goth subculture may be accounted for by other factors. This is unlikely, since we adjusted for the strongest and most relevant correlates of self harm found in other studies of young people. Others have said that our results were not valid because of the small numbers involved. Our paper underwent a formal statistical review before publication. Furthermore, while the media focused on the 25 young people who were unambiguously identified as Goth, nearly 8% of our representative sample had identified with Goth subculture, in varying degrees of intensity, and were three to four times more likely to harm themselves than the other participants.

It has also been said that by adopting a quantitative approach we may have missed contextual factors and that the high rate of self harm found among Goths is a form of decoration, analogous to body modification. We dispute this on two grounds. Firstly, since those who harmed themselves were asked why, we know that most, regardless of youth subculture, did so to relieve anxiety, anger, and other negative emotions. Secondly, although cutting could be interpreted as some form of subcultural display, such an argument is difficult to sustain in relation to attempted suicide.

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1 Letters to Young et al. Self harm in Goth youth subculture. *BMJ* 2006;332:1215-6. (20 May.)
2 Wikipedia contributors, 'Goth', Wikipedia, The Free Encyclopedia, 10 May 2006, 07:57 UTC, http://en.wikipedia.org/w/index.php?title=Goth&oldid=52455549 (accessed 10 May 2006).

Can general practitioners compete with big business?

Changing drivers in the NHS

Editor—The Langwith case reached the High Court over whether there was an obligation to activate section 11 of the 2001 Health and Social Care Act, in this particular case.[1] The act states, among other things, that patients should be involved in the development and consideration of proposals for changes in the "way" in which their services are provided.

The national debate on privatisation is a separate issue, but the publicity given to this case has been an important part of informing people how the culture and the drivers are changing in the NHS. Although, when we put in our bid, we had no idea of what was about to happen, we subsequently


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allowed our bid to be used as an illustration of process.

I believe that the NHS belongs to the electorate and not to the government or professionals. It is worrying that the views of the electorate have not yet been sought, nationally, on the profound implications of allowing multinational companies entry into the NHS. It is beyond belief that there has been no meaningful debate in Parliament. There are clearly arguments on both sides and the electorate should be given the opportunity to air them. There is a basic need for a risk assessment, if nothing else. Merely redefining general practitioners as "private" and saying that they must become more commercial to compete does not address the ethical weakness that the principle had already been conceded without a public debate. Hoping that "hybrids" will emerge is not a robust approach to a profoundly moral issue.

We need to face up to the reality that it may be impossible to have a private sector that can deliver public service values as its priority—and still survive. So, perhaps it's time to talk.

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Competing interests: EDB is a general practitioner involved in a local bid to run Langwith surgery and the lead general practitioner for patient liaison in her present practice. Recently she became a member of Keep Our NHS Public.

1 Arie S. Can GPs compete with big business? *BMJ* 2006;332:1172-3. (20 May.)

NHS privatisation was piloted in prisons

EDITOR—It is no surprise to see NHS general practice being eroded by big business.[1] Doctors advocate for all their patients; politicians (the "owners" of the NHS) have pressures that are often at odds with those of patients and therefore their doctors.

By seeking a system that reduces doctors' responsibility for patients to an employment contract (with minimum and maximum standards set by managers), politicians can have less hassle, perhaps at the expense of reduced patient care but without the electoral risk of providing for free an increasingly expensive product to an increasing number of clients within a limited budget.

In Scotland some years ago, a group of senior prison doctors attempted to bid for the contract to provide health services to Scottish prisoners but were thwarted by a tender process that seemed biased towards a single service provider with a commercial track record. During the run up to the process, proposals to set up a clinical partnership with an academic department of general practice to provide much needed clinical research into custodial medical care failed in the face of the plans to contract out to a "single service provider" by the Scottish Prison Service. From a professional clinical perspective the episode made no sense, but it became much easier to homogenise prisoner care and to downplay prisoner specific issues (such as transmission of hepatitis C) whose solutions might have been seen as controversial.

It is common practice for public bodies to have tender processes that favour big business over small businesses. "Risk reduction" is a term used to camouflage the bias away from professionally led services to easily managed services. In government terms, risk reduction often entails transferring risk away from politically sensitive bureaucratic bodies to patients (including prisoners) whose individual catastrophes are irrelevant to those who foot the bill.

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1 Arie S. Can GPs compete with big business? *BMJ* 2006; 332:1172-3. (20 May.)

Healthcare crisis in Gaza: the BMA responds

See News p 1290

EDITOR—The BMA shares the grave concern that has been expressed about the apparent collapse of the health system in Gaza.[1] It recognises that the freeze on aid and other funds to the Palestinian territories is having a profoundly damaging effect on hospitals and health care in Gaza, where reports have indicated that child malnutrition is also at a worrying level. However, contrary to the assertion that it is ignoring this crisis, the BMA has been active in collecting information and liaising with medical human rights groups, such as the International Federation for Health and Human Rights (IFHHRO) to see how best help might be provided.

The BMA has its own way of approaching such issues. In 1997, the BMA adopted a policy at its annual meeting, strongly opposing all economic sanctions that damage health care, and BMA Council was instructed to call on states to respect the agreed exemptions for medicines, medical supplies, and basic food items. The association has attempted to implement this policy in as fair a fashion as possible. For example, it lobbied strongly over many years against the blockade of medicines to Iraq and had repeated meetings with ministers to focus attention on the very serious health effects of those sanctions. This was a well planned and continued lobby led by the BMA's International Committee.

The damage to the health system in Gaza is no less, but there has been less time to organise a well thought through response that also takes account of the political difficulties, following the Hamas elections and the consequent instabilities.

As initial steps, however, the BMA has indeed called on the World Medical Association to issue a statement about the unacceptable damage being done to the Palestinian health system and is in close contact with colleagues in both Israel and Palestine who are highlighting the problems and organising appeals for donations of medicines.

Through its Brussels office, the BMA has been closely monitoring the EU discussions which are now hopefully leading towards the unblocking of some (albeit) limited aid into Gaza.

Clearly any delay is worrying, but we welcome the fact that the EU has now drawn up plans to provide some funding for Palestinian doctors, teachers, and pensioners in an effort to diminish the humanitarian and political crisis in the occupied territories. Our understanding is that three channels of funding are being proposed: one to provide $6m a month to an existing EU initiative to pay Palestinian utility bills; another to provide $7m a month to meet non-salary costs of essential health, education, and social services; and the third channel could directly pay allowances to employees in some key sectors. Under the plan, we understand that allowances for doctors and nurses are proposed to a level of about $8m a month.

What is needed now is practical help in releasing the aid that is available but has been blocked. The BMA cannot involve itself in political questions but will certainly be encouraging the UK government to influence its EU partners to try and reduce damage to this already fragile health system.

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1 Summerfield DA. Humanitarian crisis in Israeli occupied territories. *BMJ* 2006;332:1276.

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