after another is potentially hazardous; it is better to stick to the devil we know than to flirt with one we don't know.

New drugs are often presented as having therapeutic advantages or less toxicity than their predecessors, yet a critical appraisal of the research undertaken does not usually justify such claims. Statistically significant differences between drugs or between one or more of the numerous variables measured, even in a meticulously conducted trial, can occur by chance alone. The skilful presentation of these should not be accepted as the cue for adopting a new fashion in prescribing. Neither should we be intoxicated by our own clinical impressions because if it requires a large sample and sophisticated methodology to demonstrate differences between drugs it follows that none of us has the mental apparatus to elicit these differences in routine clinical practice.

It is therefore sound practice to (1) use those established drugs that have been in use for the longest period of time, as any longer-term unwanted effects are more likely to have been recognised; (2) learn the difficult task of using them skilfully; (3) adhere to these principles until at least two or three meticulously conducted trials, fulfilling those criteria that have become well established in pharmacological research, have shown unequivocal advantages, including less toxicity, of the new drugs over the old; and (4) resist the pressures that will be put upon us to try the new drug for ourselves.

Paradoxical though it may sound, the main danger of "trying it for yourself" is that good results will probably follow. When dealing with conditions that run a fluctuating course or that are influenced by numerous non-specific factors, including changing drugs and the enthusiasm of the physician, the laws of chance will guarantee that good results will follow in a number of cases. The danger is that they are then attributed to the pharmacological action of the new drug as a post-hoc error of thinking and a stimulus is thereby given to the spread of a new fashion—perhaps with a drug that eventually turns out to be as toxic as its predecessors.

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[1] Brewer, C, *British Medical Journal*, 1975, **4**, 409.

"New" operations for cataract extraction

SIR,—Wide publicity has been given recently to reports from a congress and elsewhere of "new" procedures of cataract extraction. Through the mass media assertions have been made of their facilitating the playing of golf and other games within 24 hours of operation. These procedures have also been the subject of a leading article in the *BMJ* (25 June, p 1616), which perhaps did not emphasise sufficiently that no one method is generally applicable to the surgical treatment of cataract.

Regrettably, this publicity has given rise to widespread anxiety and apprehension on the part of patients, who are unable to understand why their personal professional advisers are often less than enthusiastic when asked about the "new" operation for their own individual problems. The fact is that these procedures have been in use for a number of years and are by no means free from their own specific complications and difficulties. They have been discarded by some surgeons who had used them for an appreciable time.

Your assistance in underlining the undesirability of wide publicity in the mass media which may lead the public to demand of its doctors inappropriate treatment and procedures would render signal service.

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Compulsory wearing of safety belts

SIR,—We would suggest that those who oppose the compulsory wearing of safety belts on the grounds of interference with the freedom of the individual should be given freedom of access to an accident and emergency department late at night and at the weekends, when an appreciable part of the time of the medical staff is spent suturing wounds of the face inflicted by shattered windscreens in patients who were not wearing safety belts. Much has been made of the reduction in mortality which can be achieved by the introduction of compulsory safety belt wearing. This is indeed important but represents only a small proportion of the total morbidity and the accompanying physical, social, and psychological misery which follows accidents in which car occupants have omitted to fasten their safety belts.

The records of all patients involved in road traffic accidents who attended the accident and emergency department of this hospital in July 1977 were studied. Of the 41 patients, 70% were not wearing safety belts and of these, 50% required surgical toilet for the repair of lacerated wounds (mostly to the head and face). Of the 30% who were wearing safety belts, only 15% required surgical toilet of lacerated wounds.

More detailed studies would be required to ascertain the cost in terms of time and money expended by the NHS. Sadly such surveys would give no idea of the distress caused to those on whom these wounds had been inflicted. If the politicians are genuinely looking for economies in the Health Service, this is one area of many where enormous savings could be effected without in any way jeopardising other essential services.

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Campylobacter-associated diarrhoea in Southampton

SIR,—We have investigated the occurrence of campylobacter infections in Southampton over a four-month period from April this year. A total of 860 faecal samples from patients with acute gastrointestinal symptoms were examined for microaerophilic vibrios using a selective blood agar containing vancomycin, polymyxin, and trimethoprim (VPT agar) and incubated at 43°C under microaerophilic conditions as described by Dr M B Skirrow (2 July, p 9). Campylobacters of the *C coli-C jejuni* group[1] were isolated from 36 patients (4·2%) and two healthy carriers. Twenty-two specimens were from adults and 16 from children under 15. Routine techniques for detection of faecal pathogens on the 860 samples gave 24 isolates of salmonellae (2·8%), eight of shigellae (0·9%), and six (0·7%) of enteropathogenic *Escherichia coli*. These figures suggest that during four summer months in Southampton gastrointestinal infection with campylobacter was as common as the combined total of the commonly reported faecal pathogens. Our figures represent more than 15% of the 253 campylobacter isolations reported during the same period in England and Wales (PHLS Communicable Disease Reports).

Detailed histories based on a questionnaire used by King[2] were obtained from patients. Diarrhoea was the main complaint in 32 out of 36 of the isolate-proved cases. (Of the 38 stool samples received 8 were liquid and 14 semiformed.) The duration of the diarrhoea was ascertained in 27 cases. Twelve patients had severe diarrhoea for more than three days and two gave a history of chronic diarrhoea; in one of these the diarrhoea had started 2-3 months ago and lasted five weeks and the other had had several episodes over a year. All the patients except two complained of general malaise and 19 out of 25 had temperatures between 39 and 40°C. Five patients complained of sore throat, two had bad coughs, one presented with urticaria, and one with swollen lymph nodes in the neck. Nine of the 36 patients were in hospital at the time of diagnosis: four were children with abdominal pain who had been admitted to the paediatric surgical unit, and at appendicectomy two were found to have acutely inflamed appendices and two had acute mesenteric adenitis; three others were children who had been admitted to the paediatric wards with diarrhoea and abdominal pain; the remaining two were adults in whom the infection was an incidental finding one being a 73-year-old woman who had presented with a stroke and diarrhoea and subsequently died and the second a 28-year-old woman who had been admitted because of recently diagnosed diabetes during pregnancy. This last patient was transferred from the antenatal ward to an infectious disease ward, where she was treated with oral neomycin. Faecal cultures were negative five days later and a normal baby was delivered by forceps after induction at 37 weeks. No cases of diarrhoea occurred in the admission ward or among the staff.

In addition to ascertaining clinical information the questionnaire was aimed at discovering factors of possible epidemiological significance. Four people gave histories suggestive of the infection having been contracted abroad. One patient associated the onset of her diarrhoea with eating fresh chicken in Spain and another with the eating of a water-grown vegetable; eight out of 12 people who had had the same vegetable were similarly affected. We assume that in the remaining 32 cases the infection was acquired in the United Kingdom. *Campylobacters* of the *C coli-C jejuni* group have been isolated from chickens in England, but in three family outbreaks (eight cases and two carriers) and in questioning 13 out of the remaining 19 patients chickens could not be directly implicated, though one patient had handled fresh chickens. Five children, however, gave histories suggesting that they could have acquired their infection from environmental sources; two had dug worms for fishing bait, two had been on biological field courses, and one had been camping in the New Forest. Sea-water samples collected from the Solent coast were filtered through 0·45-μm Millipore membranes and the latter incubated on the selective antibiotic media for 16 hours at 43°C. Six out of 13 samples gave campylobacter-like colonies on the VPT agar. Dark-ground and electron microscopy showed organisms which were similar to the human isolates. Five of these six strains were agglutinated by human sera from two people previously infected with campylobacter. Two patients with diarrhoea gave a history of contact with cage birds; in one case the bird had died, and a second patient bred canaries and a campylobacter strain was isolated at 43 C from the canary pen, but all the birds were healthy.

Our findings suggest multiple sources of infection and that environmental spread, especially in contaminated water, may be a factor in the epidemiology of human campylobacter infections of the *C coli-C jejuni* group. It may be that the known avian excretors of campylobacters are responsible for our seawater isolates, but the fact that a sewage-polluted sample also grew campylobacters is suggestive of the strain having come from a human source. Clearly a strain identification scheme is required to distinguish between isolates before source tracing can be carried out efficiently.

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[1] Véron, M, and Chatelain, R, *International Journal of Systemic Bacteriology*, 1973, **23**, 122.
[2] King, E O, *Journal of Infectious Diseases*, 1957, **101**, 119.

Campylobacter-associated diarrhoea in Edinburgh

SIR,—We were interested to read the correspondence in your columns following Dr M B Skirrow's article (2 July, p 9). Since his earlier report[1] we have examined 196 stools submitted from general practice for enteric pathogens, including *Campylobacter* spp. In addition we have examined specimens from 50 asymptomatic individuals (not matched for age and sex). Our results are summarised in the accompanying table.

Pathogens isolated from 146 faecal specimens

Presumptive pathogen isolated	No (%) of positive samples from:	
	196 patients with diarrhoea	50 controls
Salmonella sp	5 (2·5)	0
Shigella sonnei	19 (6·7)	0
Giardia lamblia	13 (6·6)	0
Campylobacter sp*	17 (8·7)	0

**C coli* of Veron and Chatelain[2]

Campylobacter organisms were the only presumptive pathogens that were isolated from 14 (7·1%) specimens and vomiting was not a feature of the illness in these patients. In two cases campylobacter organisms were isolated in association with giardia cysts and in one case with *Salm agona*.

In contrast with Dr Skirrow's results and those of Dr B A S Dale (30 July, p 318) we found that 47% of our patients were children of less than 10 years of age (7 male and 1 female); we recognise the limitations of the small sample size.

We have routinely cultured our specimens on selective media at 25°C as well as 42°C in order to look for the presence of those members of the genus *Campylobacter* which grow at low temperatures. Included in this group is *C fetus* ss *intestinalis*, mentioned by Dr N A Simmons and Mr F J Gibbs (23 July, p 264), which has been shown to be present in birds. We have found none of these low-temperature growers in our human samples. It seems, therefore, that, although members of the genus *Campylobacter* may be an important cause of diarrhoeal illness in Britain, the epidemiology of this disease is as yet largely uncertain.

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[1] Skirrow, M B, PHLS Communicable Diseases Report, 25 February, 1977.
[2] Veron, M, and Chatelain, R, *International Journal of Systematic Bacteriology*, 1973, **23**, 122.

Inhumanity to man

SIR,—The medical staff committee of this hospital commends the change of editorial policy which has taken place in respect of the recognition of the needs of the chronically psychiatrically disabled patient in the community and which is expressed in your recent leading article (3 September, p 591).

The plight of this group of patients has increased since the hostel function of mental hospitals has been whittled away. It is unfortunate that the only sanctuary that our society can find for so many such individuals is in the asylum of the prison service. Since 1961 this very unsatisfactory situation has escalated as a result of persistently erroneous planning based on false premises, a policy with which the Department of Health and Social Security has persisted in spite of protests from clinicians. The result of this policy has been to remove unremittingly the ability of the psychiatric hospital to care for its chronic population.

False hopes and promises have been made in respect of an alternative service—for instance, the Government made great play with the commitment that the local authorities and the social services would undertake in respect of this group of patients following the passing of the Social Services Act in 1972. In fact, far from realising these hopes, there has been a persistent failure to provide adequate hostel places or to give even minimal support to those patients discharged from psychiatric hospitals.

A further pious hope that has proved to be wholly fallacious was based on the proposition that psychiatric units in district general hospitals would be able to replace the facilities offered by established psychiatric hospitals. The members of this committee who have worked in a general hospital psychiatric setting are only too aware of the incapacity of such hospitals to offer the total range of facilities which are provided by the traditional mental hospital. However, the DHSS chooses to ignore the impoverishment of services which would result from a planning commitment wholly to the district general hospitals and continues deceitfully to refer to an expanded service in the general hospital as a reason for not proceeding with improvement in the mental hospitals. This intransigent attitude has tended to undermine the confidence of staff, particularly nursing staff, working with the chronically ill psychiatric patient.

Moreover, we note that many such patients who have been discharged from the psychiatric hospitals, or who are being cared for as day patients by the district general hospitals, live in accommodation which is often characterised by highly unsatisfactory debilitating squalor.

Finally, it is our opinion that the DHSS has pursued a policy of surreptitious reduction of facilities, particularly nursing facilities, in respect of the psychiatric hospitals. Our experience suggests, and the work referred to in your leading article shows, that the present policies of the DHSS should be reversed, that as soon as the economy allows the inpatient provision of the psychiatric hospitals should be increased by 10%, and that both financial and personnel resources should be redirected to meet this need.

N E CRUMPTON
Chairman
ISABEL C A MOYES
U V NAYLOR
V L DOUGHTY
J F BRANDON
Members,
Medical Staff Committee

Broadgate Hospital, Beverley, N Humberside

****We are not aware of any change in our editorial policy regarding the treatment of the mentally disabled. On the contrary, if Dr Crumpton and his colleagues will consult the six previous leading articles that we cited they will find that it has remained virtually consistent throughout the past 10 years.—ED, *BMJ*.

The community physician: will he survive?

SIR,—The paper by Drs W H Parry and J E Lunn (27 August, p 589) makes gloomy reading but serves to remind the rest of the profession of the effects of a drastic reorganisation on those of their colleagues who have been personally affected.

For those of us attracted to preventive medicine who chose careers in public health it has been evident that the separation of treatment services from preventive activity is artificial and undesirable. We therefore accepted that a reorganisation to bring about a functional unification between "prevention" and "cure" was the next logical step. Equally we are aware that to pursue the achievement of prevention of disease and promotion of health simply through medical treatment services is impossible. Environmental control and housing and social and educational policy remain important influences on health. It is therefore important to ensure that an appropriate medical voice is heard in the places where these matters are discussed, and decisions taken.

For this reason there is a need for an organisational link between the NHS and the two-tiered local government structure. The community physicians' involvement in both these fields of activity was foretold by Professor J N Morris.[1] A career as "epidemiologist, administrator of local medical services, and community counsellor" combined with the traditional medical officer of health's function of "teacher, watchdog, and trouble-maker" were the terms he used to describe the community physician. The future seemed rosy, so why the gloom revealed in Drs Parry and Lunn's analysis?

The fact is that few of us are able to follow the Morris model. Community medicine has been subordinated to institutional management. Almost in spite of itself the hospital service has an insatiable appetite for administration, and the mere fact that community physicians are involved in management teams ensures that the day-to-day running of the service becomes their all-absorbing preoccupation. It is a hard struggle to find any