the cheap and universally applicable treatment suggested in the editorial. It can be an effective long term treatment for many patients with renal failure, but limitations emphasise the inadequate provision of facilities for maintenance haemodialysis.

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The grossest failures of peer review

EDITOR,—I was disappointed to see the usually meticulous Bernard Dixon trotting out the often quoted but false legend that Hans Krebs's paper on the tricarboxylic acid cycle was originally rejected by *Nature*.[1] It was not: as Krebs writes in his autobiography, the editor replied regretting that the journal had sufficient letters for six or seven weeks and suggesting that if Krebs did not mind the delay he would keep it and hoped to use it.[2]

Can we hope that this tired old chestnut will ever be buried? Unfortunately, it is probably too attractive to be discarded: it contains all the elements that the public would like to believe are characteristic of science—a genius junior, a fundamental discovery, and a delay in recognition because of a non-percipient referee and editor. Yet at least two of the better, and true, anecdotes about the errors of peer review concern other Nobel prize winners: the original paper that described Dane particles (hepatitis B virus) was rejected when the referee described its illustrations as showing nothing more than dirt on the microscope slide (E Huth, personal communication, 1990); and the better documented rejection of the original description of radioimmunoassay led its discoverer to comment in later years, "the truly imaginative are not being judged by their peers. They have none!"[3]

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Health of ethnic groups

EDITOR,—In her review[1] of the book *The Politics of 'Race' and Health*[2] Ghada Karmi misrepresents my chapter. She writes: "Both Raj Bhopal and Trevor Sheldon make the point that, hitherto, research into the health of ethnic minorities in its approach and methods has been muddled at best and racist at worst." I do not believe, and I did not write, that such research has been racist, and I repudiate her statement. Research into the health of ethnic groups is conceptually difficult and technically demanding and requires advanced skills in the interpretation of data, which, in my view, is why it has not yielded the expected dividend.

Karmi writes: "Bhopal makes the extraordinary claim . . . that the 'voluminous' British research into ethnic health has not made a single advance in our understanding of the causes of disease in ethnic groups." I have clearly stated that descriptive work on ethnic group and health can yield hypotheses for detailed study but that research in ethnic minorities has seldom progressed beyond the generation of hypotheses. I actually wrote, "Indeed, I cannot recall a single solid advance in our understanding of the causes of disease which can be attributed to such research [into the health of ethnic groups]." I was writing about fundamental advances in understanding about the causes of disease (not about differences in risk factors by ethnic group). Karmi's words differ from mine in an important way.

In refuting my "extraordinary claim" Karmi highlights the syndrome of insulin resistance and its relation to diabetes in people from south Asia. In a manuscript submitted for publication I and a colleague, Peter Senior, have written, "Even when testable hypotheses have been proposed they have largely remained untested. One exception to this generalisation is the insulin resistance hypothesis for coronary heart disease; a hypothesis of profound importance for both general and ethnic minority populations alike." Independently searching for contributions from British research into the health of ethnic groups to fundamental understanding of the causes of disease, both Karmi and I concur on one theme: the insulin resistance hypothesis. Is that coincidence, or are there few examples?

Finally, how valid is Karmi's statement that the subject of race "provides the last respectable refuge for the left, whose views have otherwise become passé"? My research is done to improve the health and health care of people from ethnic minorities, not for political reasons. I believe that my peers working in this field have the same motivation.

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Management of trauma

EDITOR,—R Snook should not be so pessimistic about trauma care in the United Kingdom.[1] Since the Royal College of Surgeons of England published a report on the subject in 1988[2] several notable developments have taken place. The government responded to the report by funding the experimental trauma centre at the North Staffordshire Royal Infirmary as well as establishing an evaluation study by Professor Brian Williams in Sheffield. Early results seem encouraging.

The course on advanced trauma life support was introduced to the United Kingdom by the Royal College of Surgeons of England in 1988.[3] This educational initiative is changing practice in resuscitation rooms nationally. Though not all major accident and emergency departments have a consultant, 110 consultants in accident and emergency departments have successfully completed a course and many are now instructors in advanced trauma life support. Even more consultant anaesthetists and orthopaedic surgeons have attended a course; this shows the multidisciplinary nature of the team, which is necessary for optimal outcome for patients.

Driscoll showed that the team approach in managing patients in the shortest possible time improves survival.[4] Recently the team concept has been further enhanced by the course on advanced trauma nursing, which has the same core content; this results in joint certification by both the Royal College of Nursing and the Royal College of Surgeons of England. Cooperation between the Royal College of Surgeons of England and the Royal College of Physicians and Surgeons of Glasgow has increased the number of instructors in advanced trauma life support—a necessary step, particularly as the Royal College of Surgeons of England will shortly require candidates to have a current certificate in advanced truma life support before they can take the final fellowship examination.

Cooperation between the American National Association of Emergency Medical Technicians and the Royal College of Surgeons of England has resulted in the establishment of a training programme on prehospital trauma life support in the United Kingdom. This course, designed primarily for ambulance staff, again promotes the rapid assessment and resuscitation sequence of advanced trauma life support, which will further enhance care.

Trauma is the commonest cause of death below the age of 35. While the British Heart Foundation and the Imperial Cancer Research Fund flourish, the recent launch of the Trauma Foundation has not been without difficulty. A recent mailshot to all consultants involved in the care of victims of trauma drew a poor response. If the medical profession is not interested how can we expect the public to support us?

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Substance misuse and suicide

EDITOR,—Merete Nordentoft and colleagues and Keith Hawton and colleagues showed an association between substance misuse and the risk of subsequent completed suicide.[1,2]

Substance misuse is a growing problem among the adolescent population,[3] yet the services for treating this group remain fragmentary. The adolescent misuser may be referred to the statutory adult substance misuse services or to the child and adolescent psychiatry services or may be seen by a variety of non-statutory agencies; there is debate on occasion as to which service should accept clinical responsibility.

During 1991-2 the Northern Regional Drug and Alcohol Service made contact through outreach work with a number of young people engaging in high risk behaviour in terms of substance misuse. Many of this group were reluctant to approach services themselves, not perceiving their substance use as problematic. In an endeavour to address this situation, an adolescent substance misuse clinic was established in early 1992 as a joint venture between the statutory services in Newcastle upon Tyne and an independent organisation, Streetwise, which offers advice and support to young people aged 13 to 25. The clinic was sited in the more informal setting of the Streetwise project to increase its accessibility to young people. The operation of this clinic focused attention on points of difference with regard to confidentiality, consent to assessment and treatment of a young person under 16 years of age, and child protection

issues which may emerge when a statutory service and a voluntary organisation work together. These issues were debated and a set of guidelines were established for all staff involved in the project.

The service provision for adolescents with substance misuse problems could progress by the establishment of formal links between the adult substance misuse and child adolescent psychiatry services, the development of training programmes for staff interested in working in this area, a willingness to work alongside voluntary agencies, and clarification of the issues relating to assessment and treatment of young people under 16.

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Information overload

EDITOR,—When sorting through an ever increasing pile of unread journals I listed all I received (table). I know from talking to colleagues that many receive a similar range of general and specialist journals. To receive them is one thing; to read them is another. It is obviously desirable that we should keep up to date with all matters of general and professional interest to us, but how can any doctor, unless retired, find the time to read through so many, let alone remember a fraction of what he or she has read? Furthermore, what is to be done with the beautiful glossy publications whether or not you read them? Because I have bound copies going back, in some cases, to the 1930s I keep the *British Journal of Surgery* and the journals of the two royal colleges of surgeons. The others I give away to anybody who is prepared to take them, or throw away.

Surely in this computerised age a better method of targeting information more accurately should be available. Is the time not approaching when, apart from the throw away daily newspaper, the printed journal will become obsolete? All journals could be made available in computerised form. With increasing computer literacy many doctors could use their own computer terminals for scanning contents pages and reading articles of interest to them. Those who are not computer literate could be supplied by librarians with the contents pages of journals that interest them. They could then ask either to see on a visual display unit or to receive a print out of any papers they wish to read. Such a scheme must in the long term be considerably cheaper than the present production of publications; there should be a saving in the vast amount of waste paper; and, most importantly, doctors would not become overwhelmed with information they could neither read nor absorb.

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Details of journals received and source

Journal	Subject	Publisher	Source/payment	Frequency
BMJ	General medical	BMJ Publishing Group	Membership of BMA	Weekly
Drug and Therapeutics Bulletin	General medical	Consumers' Association	Free	Fortnightly
BMA News Review	General medical	BMA	Membership of BMA	Monthly
Health Care Management	General medical	MCB University Press	Free	Monthly
Hospital Update	General medical	Reed Business Publishing	Free	Monthly
Prescribers' Journal	General medical	Department of Health	Free	Bimonthly
Health Trends	General medical	Department of Health	Free	Quarterly
Journal of Medical Defence Union	General medical	Medical Defence Union	Membership of Medical Defence Union	Quarterly
British Journal of Surgery	Surgery	Butterworth-Heinemann	Fellowship of Association of Surgeons	Monthly
Surgery	Surgery	Medicine Group	Free	Monthly
Annals of the Royal College of Surgeons of England	Surgery	Royal College of Surgeons of England	Fellowship of Royal College of Surgeons of England	Bimonthly
Journal of the Royal College of Surgeons of Edinburgh	Surgery	Royal College of Surgeons of Edinburgh	Fellowship of Royal College of Surgeons of Edinburgh	Bimonthly
World Journal of Surgery	Surgery	Springer International	Membership of International College of Digestive Surgery and International Surgical Society	Bimonthly
Current Medical Literature—General Surgery	Surgery	Royal Society of Medicine	Free from Smith-Kline Beecham	Quarterly
Gut	Gastro-enterology	BMJ Publishing Group	Membership of British Society of Gastroenterology	Monthly
Alimentary Pharmacology in Therapeutics	Gastro-enterology	Blackwell	Free from Glaxo	Bimonthly
Current Medical Literature—Gastroenterology	Gastro-enterology	Royal Society of Medicine	Free from Astra Pharmaceuticals	Quarterly
Current Medical Literature—Paediatrics	Paediatrics	Royal Society of Medicine	Free from Glaxo	Quarterly
British Journal of Intensive Care	Intensive care	Ashley Wallace	Free	Monthly

Interpreting inflammatory changes in cervical smears

EDITOR,—Wanda L Parsons and colleagues claim that a report of inflammatory changes in a cervical smear cannot be used to predict the presence of cervical infection reliably.[1] We disagree. In our laboratory the sensitivity and specificity of cytological examination for six pathogens were 60-100%.[2] Recently 32 pathogens have been classified as causing sexually transmitted diseases.[3] Parsons and colleagues looked for only eight of these. It is therefore incorrect for them to conclude that no infection was present despite the inflammatory changes in cervical smears. Only six pathogens (*Trichomonas vaginalis, Candida* species, *Gardnerella vaginalis, Chlamydia trachomatis*, herpes simplex virus, and human papilloma virus) can be detected by cervical smear testing, on the basis of the presence of micro-organisms or typical cytomorphological changes. Other pathogens may produce non-specific inflammatory changes and hence cannot be detected unless specific culture or immunological tests are carried out.

A possible reason for negative findings on smear testing despite positive cultures is that recently acquired or minimal infection may give rise to a positive culture because conditions in a laboratory are ideal for growth and multiplication and possibly the smears are obtained before inflammatory changes have developed in the cervical and vaginal cells. Longitudinal studies in these women may show inflammatory changes in smears on follow up. Parsons and colleagues observe that a history of sexually transmitted disease was obtained in similar percentages of women with and without inflammatory changes. The same may not, however, apply for current sexually transmitted disease. Secondly, the percentage of women with multiple sexual partners was higher in the group without inflammation. This is possible if more of the women in this group had used contraceptives, particularly condoms, or if those with a history of sexually transmitted disease or with multiple sexual partners had been treated more commonly than the others. This may result in a small number of inflammatory smears despite risk factors being present. The smear will show inflammatory changes only if infection is present at the time of collection. Thus the interpretation that cytological changes do not reflect infection in the cervix or vagina is wrong.

Although cytological examination cannot substitute for any other definitive diagnostic method, it is a useful screening test in developing countries because other tests are usually not available or are expensive. A single smear is useful in the identification of six sexually transmitted diseases, cervical intraepithelial neoplasia, and some parasites[4]; it can also be used for immunocytochemical studies for a definitive diagnosis.

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Family planning clinics

Most give a good service

EDITOR,—We read with horror the personal view describing the lamentable attitudes and unhelpfulness of some of the staff of a family planning clinic attended for postcoital contraception.[1] We wish to disassociate the vast majority of family planning clinics in general and the Margaret Pyke Centre in particular from the one described.

Over half of new patients who come to our clinic requesting emergency contraception choose thereafter to attend long term. Our follow up rate is high, and we are pleased to offer advice on family planning, preconceptional advice, and general reproductive health care within a single clinic. Especially in view of *The Health of the Nation*'s targets to decrease teenage pregnancy, it is essential that all family planning services in Britain, whether provided by local family planning clinics or in primary care, are completely "user friendly" and provide emergency contraception and all relevant follow up in a non-judgmental way.

We agree with the statement that "women are praised more for producing babies than preventing them." As obstetricians we were frequently rewarded with bottles of champagne or whisky. Neither of us can recall being given a bottle for helping a couple not to have a baby. This is a feature of all preventive medicine, however sympa-