

facilities of taking into account the comparative purchasing power of currencies outside the Organisation for Economic Cooperation and Development,⁴ and the countries' large "black economy." But people in most types of occupation, both manual and non-manual, seem to work in the black economy. Relative deprivation was seen not necessarily in relation to direct income distribution but in relation to privileges such as the ability to travel abroad or access to Western goods, privileges that in the West are related to income.

Eastern Europe will be a testing ground for Wilkinson's hypothesis in view of the introduction of market forces, which will widen income differentials appreciably.

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- 1 Wilkinson RG. Income distribution and life expectancy. *BMJ* 1992;304:165-8. (18 January.)
- 2 Boys RJ, Forster DP, Józán P. Mortality from causes amenable and non-amenable to medical care: the experience of eastern Europe. *BMJ* 1991;303:879-83.
- 3 Józán P. *Studies in mortality differentials: an ecological study of mortality differentials in Budapest. Part 1.* Budapest: Central Statistical Office, 1987.
- 4 Parkin D. Comparing health service efficiency across countries. *Oxford Review of Economic Policy* 1989;5:75-88.

Bone banks

SIR,—HI Atrah's proposal that bone banks should be developed by the national blood transfusion services¹ will be warmly welcomed by those who have recently expressed concern at the lack of tissue banking facilities in the United Kingdom compared with Europe and North America.²

About 18 months ago the directors of the Scottish National Blood Transfusion Service concluded that it would be in patients' best interests if tissue banking, starting with bone banking, was developed on a national (Scottish) basis within the transfusion service's centres. This programme has now been fully commissioned, and bone banking is a feature throughout Scotland. There is little doubt that the regional blood transfusion centres' skills with regard to good manufacturing practice for biological agents for therapeutic use have played a major part in securing a rapid and successful outcome to the first phase of this coordinated development of tissue banking nationally. Success would not have been possible without the enthusiastic collaboration of local orthopaedic surgical teams.

Further plans are now emerging for an integrated programme of multitissue banks in the regional transfusion centres in Scotland. The support of the British Blood Transfusion Society, which might encourage the creation of a special interest group directed towards tissue banking, would also be an important contribution to this development.

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- 1 Atrah HI. Bone banks. *BMJ* 1992;304:68. (11 January.)
- 2 Phillips GO. Tissue banking in Europe. *Lancet* 1991;338:1514-5.

Organ donation from intensive care units

SIR,—Sheila M Gore and colleagues' audit of organ donation from intensive care units shows that much can be done to increase the number of organ donors from such units.¹ The authors, quite rightly, state that age is no limit to corneal donation. We wish to emphasise that corneas can be donated up to 24 hours after death and can be

easily retrieved by the local ophthalmologist from donors in the mortuary or other place of rest. This is not the case with the other organs mentioned in the audit and means that there is a much larger number of potential corneal donors outside intensive care units. In Greater Manchester last year 122 corneas were donated, of which only 22 came from intensive care units or through transplant coordinators.

The only principal exclusions for corneal donation are transmissible infections such as HIV and hepatitis B virus infections. Previous corneal disease and ocular surgery may make the cornea unsuitable for transplantation, but such eyes are still extremely valuable for research into ocular disease. If these facts were known by all medical practitioners and staff dealing with dying patients and the recently bereaved the number of corneal donations could increase considerably. Often the potential for corneal donation is overlooked when other organs are unsuitable for donation because of the patient's age or coexisting disease or malignancy. Nationally coordinated eye banks and associated scientific staff can assess donated corneas for freedom from infection and tissue quality. The fact that corneal donation can go towards salvaging the sight of many potentially blind patients is often a great comfort to the relatives of the person who has died.

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SIR,—The confidential audit of intensive care deaths in England and Wales initiated by the Department of Health has further clarified the means by which organ donation can be increased.¹ As only 6% of families of potential donors were not asked about organ donation, required request legislation would have little impact. Sheila M Gore and colleagues suggest that an increase of up to 7.7% (100/1300) in organ donation could be achieved by reducing delays in the performance of tests for brain stem death. Other recent studies have shown a larger potential increase from increasing the number of patients being ventilated, but this would have important implications for resources.^{2,3}

The Department of Health's audit shows how opt out legislation would result in a considerable increase in organ donation. Allowing for a 2% opt out rate (as in Belgium), an increase in organ donors of 32.8% (630) would have been produced.

We must hope the Department of Health appreciates the importance of its own audit and strives to reduce the waiting list for organ transplants with the same enthusiasm as waiting lists for minor surgical procedures.

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- 1 Gore SM, Cable DJ, Holland AJ. Organ donation from intensive care units in England and Wales. *BMJ* 1992;304:349-55.
- 2 Feast TG, Riad NH, Collins CH, Golby MGS, Nicholls AJ, Hamad SN. Protocol for increasing organ donation after cerebrovascular death in a district general hospital. *Lancet* 1990;335:1133-5.
- 3 Salih MAM, Harvey I, Frankel S, Coupe DJ, Webb M, Cripps HA. Potential availability of cadaver organs for transplantation. *BMJ* 1991;302:1053-5.

SIR,—Sheila M Gore and colleagues' paper reporting their audit of deaths and organ donations in intensive care units¹ should, at last, lay to rest previous allegations that large numbers of potential donors in intensive care units were being missed.²

The part of their conclusion relating to a reduction in relatives' refusal is correct but that suggesting prompter testing of brain stem death is questionable. Delays relate to the initiation of tests and the interval between them. In my experience in several British hospitals the first and second sets of tests are generally carried out within one to three hours of each other.

The practicalities of initiating tests are related to several factors, which may not be apparent to those who do not perform them. There is no way of ensuring that effects of sedative, analgesic, and anaesthetic drugs have passed other than by waiting for an adequate period.³ This period is open to clinical opinion, and staff must therefore err on the side of caution. The difficulties in predicting outcome after brain injury, particularly in younger patients, lead to wide variation in the duration of active management.

Tests should be seen to be done after careful consideration of the patient during the daytime, which effectively rules out at least 12 hours of any day. Equally importantly, discussions with relatives, who increasingly are delayed by travelling long distances, are best carried out in daylight hours. Confidence in tests is improved, among less informed observers, if they are seen to confirm brain stem death in most cases. In many cases the patient's hopeless prognosis is evident from the outset and any treatment is probably as much for the benefit of relatives and other attending staff as for the patient. In such cases a delay allows them time to appreciate the situation fully, and in this period the relatives' response to requests for organ donation may change from being initially negative to positive.

Careful handling of relatives, who in a distressed state may become aggressive and confused, is essential if bad publicity related to occasional cases is to be avoided. A perception that tests are performed too promptly may repeat the fiasco of 1980, when adverse publicity on *Panorama* produced a pronounced decline in organ donation.^{4,5}

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- 1 Gore SM, Cable DJ, Holland AJ. Organ donation from intensive care units in England and Wales: two year confidential audit of deaths in intensive care. *BMJ* 1992;304:349-55. (8 February.)
- 2 Chisholm GD. Time to stop the softly softly approach on organs for transplantation. *BMJ* 1988;296:1419-20.
- 3 Bodenham A, Park GR. Care of the multiple organ donor. *Intensive Care Med* 1989;15:340-8.
- 4 Bradley BA, Brooman PM. *Panorama's* lost transplants. *Lancet* 1980;ii:1258-9.
- 5 Palls C. Medicine and the media. *BMJ* 1980;281:1064.

Rationing

SIR,—Unfortunately, as it reads like "three cheers for rationing," Richard Smith's editorial could be misunderstood by managers and the lay public.¹ It misleads them further by conflating three different kinds of rationing—that entailed in clinical decisions to withhold treatment in certain cases; that entailed in planning priorities in the NHS; and that now advocated in disqualifying, not on clinical but on economic grounds, whole groups of people from the treatment they need and, in plain words, consigning them to death or unrelieved invalidism.

Perhaps bemused by "democracy in all its messy splendour," Smith idealises the capacity of nurses, managers, and the public to make judgments with regard to all three types of rationing. Unfashionable as it is to say that doctors know best, they still do often know better than anyone else, including philosophers and economists, about these matters.

It is a cliché, since Foucault, to say that all "disciplines" are influenced by ideology. When economists—for example, Cam Donaldson and Gavin Mooney, writing on needs assessment and