We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

MAURO FERMARIELLO/SPL

NICE ON CHILDHOOD UTI

Nasty processes produce nasty guidelines

The guideline from the National Institute for Health and Clinical Excellence (NICE) on urinary tract infections (UTI) in childhood[1] was welcomed in a *BMJ* editorial.[2 3] Most readers will assume it was based on evidence correctly analysed by medical statisticians, robustly peer reviewed, and openly debated. As this is a controversial subject, dependent more on small studies than randomised controlled trials, many will imagine that it represented consensus following wide consultation, as stated.[1] Sadly, all these assumptions are wrong.

The NICE guideline committee signed highly restrictive secrecy agreements, and its two paediatric nephrologists did not consult with the British Association for Paediatric Nephrology, whose members hold diverse views. I was a peer reviewer but was not treated as one. My first draft review identified major flaws, was supported by the association, and delayed publication by six months. However, I was allowed to see the committee's adjustments only after strong insistence, signing a secrecy document, and accepting that it would ignore my responses. The errors persist.

The guidelines were derived from an inadequate review of the literature. The authors misused statistics and reached beyond the evidence to make erroneous conclusions based on flawed logic. Some seemed to reflect opinion rather than fact. The committee's own figures showed that nitrite screening has a mean sensitivity of about 50%, so will miss half the cases, yet it[1] and Watson[2] advise its use unreservedly. Similarly, both promote the use of ultrasound rather than dimercaptosuccinic acid (DMSA) scans, despite their own data showing DMSAs to be much more sensitive; on average ultrasound misses half the scars. They also view DMSA as invasive even though it requires only a single venepuncture and has the radiation burden of one abdominal x ray. Both advise a temperature cut off of 38°C for investigating infants' urines without clear evidence, and both assume that a lack of evidence for prophylactic antibiotics equates to evidence against their benefit, which many paediatricians dispute.

NICE guidelines result in uniformity of practice; clinicians "are expected to follow them."[4] Unifying practice before a consensus emerges is absurd. Scientific debates are not resolved by secrecy and decree but by patient research and genuinely open discussion. The premature imposition of inappropriate guidelines will stifle new clinical developments. For example, our unit runs a direct access service,[5] which seems to be reducing renal scarring rates (despite Watson's assertion that most scars are congenital[2]). If we are all forced into one mould based on poor analysis of evidence, we will miss the opportunity to make important advances.

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Competing interests: None declared.

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Author's reply

The guideline on urinary tract infection (UTI) in children from the National Institute for Health and Clinical Excellence (NICE) will precipitate debate, but hopefully cause less consternation than that expressed by Coulthard (previous letter). The published clinical guideline runs to 150 pages and 271 references with many systematic reviews.[1]

We can all quote observational studies that don't pass the scrutiny of evidence based medicine, but perhaps we should remember that the 1991 Royal College of Physicians guidelines were produced by 18 "experts" at a one day consensus meeting with medical audit in mind.

Achieving a further consensus has been difficult, with imaging modalities changing from intravenous urogram and micturating cystogram for all to ultrasound, radionuclide imaging, and more selective cystograms. At the same time, recognition has been increasing that a lot of what we called reflux nephropathy is reflux associated damage in association with congenital dysplastic and obstructive kidneys.

The algorithms that were devised didn't really distinguish between upper tract and lower tract infection. As most children only have a single episode and recover there has been legitimate concern about over-investigation. The NICE guideline helps us focus on important groups—young people and patients with unexplained fever, atypical UTI, or recurrent UTI. Prompt diagnosis and treatment are emphasised, but debate will continue about the relative merits of microscopy and dipsticks. One point to bear in mind is that UTI is a combination of symptoms and growth of organisms from an appropriately taken urine sample. Clinical decision making can be difficult, but the NICE guidelines clearly state that "the guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer." This may certainly be appropriate in the debated area of antibiotic prophylaxis. A recent Cochrane review quoted only two small studies where no significant differences in risk for UTI were found between antibiotic prophylaxis and no treatment.[2] We urgently need a controlled trial in this area, especially as compliance with long term prophylaxis is probably worse than we think and some

parents and carers express concern about long term usage. However, children are our priority and we must justify to them the taking of the nasty medicine and the need for potentially nasty invasive tests.

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Competing interests: None declared.

1 National Collaborating Centre for Women's and Children's Health. *NICE guideline—urinary tract infection in children: diagnosis, treatment and long-term management*. London: RCOG Press, 2007.
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IMPROVING STROKE OUTCOME

Apply science, not politics

Markus leaps from a discussion about outcomes to a plea to reorganise acute stroke care to improve access to thrombolysis.[1] Not one patient received thrombolytic treatment in the studies he quotes, but such subtleties will be lost in the political hubbub about the NHS letting us all down yet again. It is frustrating that after 25 years' research, we have only one drug treatment, alteplase, which seems to work, and we only manage to give it to 2% of our patients, but we should not put all our eggs in this basket.

About 1 in 8 patients would expect to obtain major benefit from thrombolytic treatment, so even if we could increase the proportion treated to 20%, about 1 in 40 patients would benefit overall. To achieve this, Markus suggests that patients receive "rapid ambulance assessment" and perhaps half would be transferred to "specialised stroke centres," some distance away.[1] What of the patients not transferred and condemned to "second class care" in their local hospital? This would presumably include anyone over 80 (over 30% of patients with acute stroke) as there is insufficient evidence of benefit for alteplase to be licensed in this age group. What of the many patients rushed to the specialist hospital in the hope of getting clot busting treatment but found to be unsuitable? The logistics are nightmarish, and the sense of frustration among those whose hopes are dashed would be fertile soil for media mischief. Inevitably, the risks and limitations of alteplase would be ignored, and it would become yet another wonder drug being denied to thousands of NHS patients.

The only proved effective treatment for most patients with stroke is specialist, multidisciplinary team based, stroke unit care.[2] Good coordination, communication, and continuity of care are essential ingredients, and these would be put at risk if large numbers of patients received acute care and rehabilitation in different trusts, looked after by different teams. There is no reason why patients with acute stroke, admitted to any reasonably sized hospital, should not have access to immediate brain scanning and expert assessment, if necessary via telemedicine links, but we need to develop these services quickly and quietly, without hyperbole and fuss.

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Competing interests: None declared.

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DRUG MISUSERS AND INCENTIVES

Methadone works if used properly

Stevenson, a senior British forensic doctor, observes that methadone treatment does not work, contrary to 40 years of high quality research showing that it does.[1]

The reason can be found in the lack of adherence to evidence based clinical guidelines in much of the United Kingdom.[2] With some notable exceptions, UK addicts are routinely given dose schedules that are contrary to guidelines (such as mean doses of less than 40 mg daily in place of double that found in well run clinics). These advise strict dose supervision for new and unstable patients with an effective dose range from 60 mg to 120 mg daily after careful induction starting with no more than 40 mg daily.[3]

Hong Kong, Australia, and New Zealand may be the only places where methadone has been available for over 30 years under reasonably open access and with a largely evidence based approach. Uniquely, all three have very little HIV in their large injecting populations. Few would believe this is coincidental (although hepatitis C has been a different and as yet unanswered story).

The question of whether addicts should receive incentives in treatment should be decided by practical research, not moralist opinions.[4 5] Methadone treatment is already one of the most cost effective things we do in medicine and probably compares with washing hands. It would seem logical to raise the abysmal standards of practice in the UK and then examine incentives to improve results still further if needed.

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Competing interests: AB charges a fee for administration of drugs in the treatment of addiction.

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POPULATION GROWTH

Colonialism never dies

Interesting to see that old colonial opinions still flourish at the *BMJ*. Having decided that African women are intelligent enough to hold down jobs but not to bottle feed safely, thereby putting countless babies at risk, they are now to be told to limit their families.[1]

Africans like having large families. No doubt that will change in time, but that should be determined by the people themselves, not by Europeans, who like having long haul holidays and driving large cars and are not prepared to give them up. The options suggested for limiting population growth include contraception, which presents problems with choice of method and access and "safe abortion." If that takes off in Africa with the enthusiasm that it has in this country the annual health budget will be mopped up.

How about doing what the Africans want? In my experience, although the death of a child is mourned, it is, in time, accepted. Funds should be diverted from keeping children alive to ensuring optimum health for their parents by establishing some form of health facility in every area, supplying medical assistants with bicycles, ensuring a safe supply of front line drugs, and discussing, intelligently, the problem of safe childbirth—and maybe improve the roads so that women can get to hospital or teach village practitioners to do caesarean sections.

How about tackling the problem of the tsetse fly that devastates large areas of Africa, which not only causes trypanosomiasis (said to be increasing), but also means no draught animals and no dairy products? If

all conferences and advocacy groups were dismantled there might be enough money to free Africa of this scourge and liberate much productive land. But then there wouldn't be much in it for the drug firms, conference centres, caterers, and all those agencies that keep academics in business.

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Competing interests: None declared.

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UNHOLY TRINITY

Stance is worst type of spin

I am not alone in my surprise at seeing Delamothe join Dearlove on the moral low ground to support his position on the public and professional impacts of Bristol, Alder Hey, and Shipman.[1] Above the shuffling of closing medical ranks I can catch the words of Hampton's 1983 editorial on the end of clinical freedom, "at best a cloak for ignorance, at worst an excuse for quackery."[2]

Dearlove demands evidence, as if an opiate. Lack of evidence of effect is not the same as evidence of lack of effect. The Department of Health's MORI polls, whose responses are likely to be driven largely by recent direct medical contact, show that 14-17% of patients have reservations or negative opinions about the competence of doctors.[3-5] In the British social attitudes surveys 16% of respondents expressed dissatisfaction with general practice and more with the NHS generally (www.data-archive.ac.uk/findingData/bsaTitles.asp). After Alder Hey, Cancer UK reported a sharp fall in donations of tissue to the national tumour bank for children's cancer, and 3000 families joined in a legal action against the NHS.

To suggest that the political and professional responses to the unholy trinity were a conspiracy between the government and the media is as bizarre as failing to recognise that the actions of individual doctors and hospitals were not isolated events but the alarm symptoms of deeper problems. To caricature all this as an anti-medical machination of the Blair government seems to me the worst kind of medical spin.

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Competing interests: None declared.

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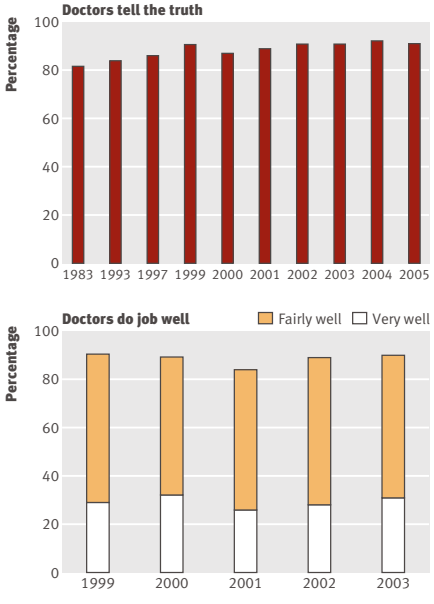
Public trust in doctors undented

The BMA does not take public trust in doctors for granted nor does it underestimate the potential for adverse reactions from the public or patients to events such as Bristol and Alder Hey.[1] Accordingly, it has commissioned regular research via MORI on the issue and did so at intervals during the 1980s and 1990s and on an annual basis between 1999 and 2005. The findings support a conclusion of ongoing trust and belief in medical competence, with little deviation even at times of highly adverse publicity.

The public was asked whether it trusted a variety of professions and occupations to tell the truth. The figure (top) shows the findings for doctors over time. An additional question asked from 1999 to 2003 explicitly prompted respondents over negative publicity on doctors and asked whether in the light of this doctors did a good job. In 2000 specific reference was made to Bristol in the preamble and from 2001 onwards reference was also made explicitly to Alder Hey (figure (bottom)).

Neither set of findings seems to support the view that such events shook the foundations of public trust and professional confidence. Furthermore, respondents with experience of the NHS were more likely to state that they thought doctors did their job very well.



Public's trust in doctors over time

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Competing interests: JF is employed by the BMA.

1 Delamothe T. Why this unholy trinity? Editor's choice. *BMJ* 2007;335:0. (18 August.)

Sticking to standards, not together

If the profession continues to turn a blind eye to underperformimg doctors we should not be surprised if the government takes action.[1]

We have used locum doctors as part of the salvage process for a high health need, inner city practice over the past six months. Some of them missed potential red flags; had poor record keeping, prescribing, and referral practices; and proposed out of date management of chronic conditions. Some from elsewhere in Europe do not know how the NHS works, or how to work in the NHS. Perhaps not surprisingly—since locums are generally unsupervised and unsupported—most do not seem to reflect systematically on their clinical practice.

So far, in this one practice over the past few months, we have referred one doctor to the National Clinical Assessment Service and another for formal investigation. Dozens of others have been referred to their host primary care trusts.

We are unusual in having an assertive quality process, routinely reviewing the day to day work of all our clinicians. And it takes up time and resources which we would rather spend on our patients.

Perhaps this explains why no one else has picked up these issues and these doctors. We think that there is widespread collusion between employers (often general practitioners, sometimes primary care trusts) who want holidays and other staff gaps filled; locum agencies that are apparently oblivious; and other doctors who seem to be in denial about poor performance even when they notice it.

Jones calls for professional unity.[2] Surely this means sticking to standards rather than together?

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