

Britain's first minister of public health

National centre for public health is needed

EDITOR—Like Noel Olsen, we welcome the appointment of a minister for public health¹; structural and policy changes are clearly required to strengthen the effectiveness of public health. The broad policy options raised by Olsen should not, however, distract attention from the need to help existing public health services do a better job.

"Public health" is too often identified with the activities of public health doctors, who now spend most of their time rationalising clinical services. Can a country with an unrivalled record in achieving value for money from its clinical services do no better in public health? National policy on prevention is greatly weakened in practice by the scant attention given to developing scientific and professional infrastructures commensurate with the difficulty of achieving goals that include, for example, mass behavioural change, although the NHS research and development programme clearly emphasises some aspects. The operational public health services use most of the public health pound as best they can. This generally means working in settings that are physically and professionally isolated, with limited scientific support and derisory opportunities for further education.

Many scourges of the public's health are improving dramatically: coronary heart disease and stomach cancer, for example. Some, like obesity, are worsening, while others, like uptake of smoking by young people, are failing to improve. Some are bedevilled by confused objectives—alcohol policy, for example. New screening procedures will require research and implementation if their cost effectiveness is to be maximised. The tasks facing public health are as complex as those facing clinical medicine and require commensurate investment, both in the underlying science and in the professional development of those assigned to tackle them. The minister's intention to reduce health inequalities will not be realised unless greater attention is given to the ways and means.

The exemplary model used for communicable diseases suggests the need for a scientifically strong national centre for public health, to provide greater coordination by redeploying existing expenditure. It would form the hub of a network extending through national and regional public health

institutes to the operational public health services. It would allow the full range of public health sciences to be focused on public health action.

The centre would complement the activities of the Communicable Disease Surveillance Centre, Health Education Authority, Office for National Statistics, cancer screening programmes, Sports Council, and new food standards agency. It would also establish collaborative relationships with national bodies in, for example, injury prevention. But its main purpose would be to provide a framework for the coordinated deployment of existing resources for the public's health, to be responsible ultimately for achieving sensible targets under the new minister's public health strategy.

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1 Olsen N. At last, a public health minister. *BMJ* 1997;314:1498-9. (24 May.)

National public health research and development programme is needed

EDITOR—Like Noel Olsen we welcome the appointment of a minister of public health; much needs to be done to improve the state of the public health.¹ Many of the determinants of health, such as social justice and education, are not the responsibility of the Department of Health. The new minister will face a massive task as the health advocate across all government departments. Improving the public health is nevertheless the main task of the Department of Health. For it to do

this we must create a public health culture in the nation within which an evidence based health service can thrive.

In 1969 Morris described the role of the then new "community physicians" (now public health doctors), saying that they were population based medical scientists and advocates for the health of the local population.² Demanding workloads, restrictions on staff, and limited educational opportunities meant that community physicians failed to evaluate health services and new technologies adequately. This left a vacuum within the health service, which has been filled to some extent by the national research and development programme for health services research—unfortunately separate from, but parallel to, the structures for public health.

Perhaps what is now needed is a national public health research and development programme. This could include research and development support for health promotion, public health nursing, local government health services, communicable disease services, disease registers, screening programmes, and prevention programmes in primary care. The Department of Health would need resources for such a scheme, but it must take the lead in developing and managing the programme in collaboration

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with the academic community. Unless such action is taken there is a risk that we will focus on health services research and cost containment rather than ways to improve the public health.

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1 Olsen N. At last, a public health minister. *BMJ* 1997;314:1498-9. (24 May.)

2 Morris JN. Tomorrow's community physician. *Lancet* 1969;i:811-6.

White paper on public health is needed to give coherent approach across all sectors

EDITOR—The appointment of Tessa Jowell as Britain's first minister of public health is a sign of the new Labour administration's recognition of the impact of the broader determinants of health.¹ But recognition alone will not be enough. To create a healthier population will require action to reduce the inequalities in health that arise from poverty, unemployment, poor education, and inadequate housing and a recognition by policy-makers in these areas of the impact of their actions on health.

Noel Olsen calls for regulation and a royal commission,¹ but the Association for Public Health believes that the first step should be a white paper on the public's health to determine a coherent approach across all sectors, not just within the NHS. The white paper would consider how to bridge the boundaries between government departments with a health dimension and promote the use of health impact statements at national and local levels. It would also identify ways to ensure closer cooperation between health and local authorities, voluntary agencies, and primary health care teams over the joint development and implementation of sustainable public health strategies.

Taking this approach would enable the necessary action within the NHS to be placed in a wider framework that takes account of the factors that influence how healthy individuals and populations are. But taking this broader perspective would not mean the abrogation of responsibilities by health services. A white paper would allow reassessment of and discussion about the new relations between all parts of the service—primary and secondary care, teaching and research, health authorities and trusts—as well as relations with others such as local authorities.

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No consensus seems to exist about when caesarean section is medically indicated

EDITOR—In his editorial on maternity services James Drife condones an increase

in caesarean section rates on two grounds, which are unsound.¹ Firstly, he argues that successful litigation for failure to do a caesarean section would cost more than many additional sections. This may be true, but most developmental delay is unrelated to mode of delivery, so more sections would not necessarily prevent litigation, and we have no evidence that a policy of increased caesarean section would prevent disability. Secondly, Drife's two sources for the views of well informed women are a letter in the *Lancet* that gave a sketchy description of the hypothetical views of London obstetricians of uncertain age and parity, most of whom were presumably men, and the "bulging postbag" of the *Independent on Sunday* (a newspaper with a low circulation). Neither source could be described as representative.

The wide variation in caesarean section rates reported by the Audit Commission suggests that there is no consensus among obstetricians about when a caesarean section is medically indicated. Even if there were, women might wish to listen also to the views of midwives and of the majority of women who have happily delivered vaginally.

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Fatal methadone overdose

Drug services in Manchester were unfairly accused

EDITOR—Emyr W Benbow and colleagues' letter might lead readers to conclusions that would be most injurious to doctors working in drug services in Manchester.¹ It could be read to imply that these doctors cause needless deaths through sloppy practices and that for commercial reasons they have collaborated in preventing open inquiry. There are few allegations more harmful to a doctor's reputation. It is disappointing that the *BMJ* published this letter without first consulting those implicated and allowing them the chance to reply in the same issue.

I work as a consultant with drug services in a neighbouring district. Through long familiarity with the drug services in Manchester, I am convinced that such allegations lack foundation. Its prescribing procedures adhere to a high standard, and its consultants, like all specialists in addiction, have the same interest in research that might reduce the death rate among people who use opiates.

There is no mystery about the increase in deaths related to methadone overdose. Opiate users are at a high risk of sudden death, with an excess mortality of about 15 times the expected rate. The number of opiate users receiving methadone treatment has increased rapidly nationally and particularly in Manchester. This has caused those in addiction services to be justifiably proud because methadone treatment improves health, reduces social disruption, and

decreases long term mortality.² Stimson has argued that with other measures it has averted an epidemic of HIV-1 infection in the United Kingdom.³

Since a greater proportion of this high risk group is receiving methadone treatment, more deaths would be expected because methadone is implicated. It is disappointing that methadone treatment has not done more to reduce the rate of sudden death, but the rate among opiate users has fallen slightly.² Further improvement will probably follow initiatives to improve the inadequate first aid response of opiate users to overdose in their peers.⁴ Collaboration between addiction specialists and pathologists will also be valuable, but it will not be promoted by hostile correspondence. Benbow and colleagues accuse doctors in Manchester of overlooking a conflict of interest because their clients reside within the jurisdiction of the City of Manchester coroner. If this can truly be described as a conflict of interest I hasten to disclaim it for myself as my district lies within another jurisdiction.

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1 Benbow EW, Roberts I, Cairns A. Fatal methadone overdose. *BMJ* 1997;314:975. (29 March.)

2 Carnwath T. Methadone works. *Druglink* 1996;11(3):14-5.

3 Stimson GV. Has the United Kingdom averted an epidemic of HIV-1 infection among drug injectors? *Addiction* 1996;91(8):1085-8.

4 Strang J, Darke S, Farrell M, Ali R. Heroin overdose: the case for take-home naloxone. *BMJ* 1996;312:1435-6.

Sloppy prescribing cannot be totally blamed for deaths from methadone overdose

EDITOR—Although increasingly popular as the mainstay of treatment for people addicted to opiates, the prescribing of methadone to opiate misusers remains controversial.¹ Emyr W Benbow and colleagues' recent letter² continues to link the two main findings of their published study.³ Although there has been an increase in deaths from methadone overdose in Manchester, the data do not, as suggested, confirm a causative link between these deaths and an increase in methadone prescribing.^{2,3} Several explanations are possible, but further research is necessary before the increase in deaths can be ascribed to sloppy prescribing of methadone. Neither Benbow and colleagues' letter nor their published study provided information on whether adult deaths from overdoses of diverted methadone occurred in people who used other opiates habitually.^{2,3} They also did not provide data on the quantity and combination of drugs used in instances where methadone is alleged to have been partly responsible for the death.

It is well understood that opiate addiction is not without risks,⁴ including that of overdose, and that a large minority of those addicted have severe mental health problems and may use the drug to commit suicide. As the number of people addicted to opiates rises, and the supply of methadone increases to meet that need, the potential for those deliberately or accidentally overdosing on methadone may rise.

A balance has to be struck between enabling people who misuse drugs to regain self esteem and move away from a drug dominated lifestyle and establishing a draconian regimen to prevent any leakage of licit prescribing into the community. It must be remembered that prescriptions are frequently provided to support people who are no longer using illicit drugs, and who are working. Methadone is rarely used by people not already addicted to opiates, except by accident,¹ and the tragedy of children taking the drug could be reduced if childproof containers were universally adopted for dispensing the drug.

Further research is needed. In contrasting the client centred and public health approaches the shift from detoxification to prescribing for maintenance has been oversimplified. The reality is that a transition has been implemented through widely differing patterns of prescribing and dispensing, and it should be possible to compare drug related deaths in such areas. However, the wider picture must not be forgotten. Research repeatedly shows that methadone maintenance policies are successful in dealing with the public health concerns of HIV and hepatitis prevention and in reducing crime in the community.⁵

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Authors' reply

EDITOR—In December Merrill et al had a letter published in the *BMJ*¹ about our recent paper on fatal methadone overdose in Manchester.² This letter could be read to imply that our only criterion for attributing death to methadone toxicity was blood concentration—and an inappropriate concentration at that. As such we found the letter's content hostile and a slur on our professional standards. We were especially disappointed that we were not allowed the chance to reply in the same issue.

We thought our letter mounting a vigorous and appropriate rebuttal was clear and unambiguous.³ We were therefore surprised to read the letter by Tom Carnwath, who brings a vivid imagination to bear on our words. Even a cursory reading of our letter shows that our comments about sloppy practices refer to the suboptimal prescribing, dispensing, and storage of methadone identified by Strang et al,⁴ and there is clearly no implication in our letter that such practices are more prevalent in Manchester than elsewhere. Our account of the difficulties in obtaining information does not accuse anyone of being deliberately obstructive

but should rather be read as an indictment of management practices that force clinicians to favour management strategy over scientific inquiry. Our informants were not reluctant to provide information but merely concerned that they would fall foul of retributive managers if it became known that they had done so.

We agree with Gabbay and Perry that there is much more to be learnt about the relation between methadone and sudden death. They are correct to point out that the close correlation between methadone usage and deaths from methadone is not proof that one leads to the other, but you must admit it looks like an attractive hypothesis. We agree that an appropriate balance between client centred and public health approaches should be sought, and we said so in the original version of our manuscript³: you can hardly avoid oversimplification when, at the *BMJ*'s request, you condense 2000 words into 600.

We have no difficulty at all in accepting that methadone has many benefits, but it is not a miracle cure⁵; our concern is that no one should dismiss deaths from methadone as unavoidable until it has been shown that they really cannot be avoided. We do not even for a moment imagine that Carnwath and Gabbay and Perry would take a nihilistic view of deaths from methadone. Others do, and they might read their letters differently.

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Patients receive an inadequate dose of antidepressants for an inadequate period

EDITOR—K Milligan considers our comments on the prescribing of low doses of antidepressants to be misleading because some patients get these drugs for indications other than depression.^{1,2} Our study showed that less than 1% of subjects received an adequate dose of tricyclic antidepressants for an adequate period (>90 days). Our argument would stand even if the limits of credibility were stretched to suggest that half of prescribing was for indications other than depression. Our analysis was the most generous possible since a therapeutic dose at any time classified a subject's treatment as therapeutic. Also, only 29% of subjects receiving selective serotonin reuptake inhibitors received an adequate dose for an

adequate period, so these drugs are also imperfectly used.

Our work classified treatment as therapeutic or subtherapeutic according to published guidelines.³ M V Moore and Robert S Tan clearly disagree with these guidelines, but the evidence that they cite is thin in comparison with the evidence used to formulate the guidelines.¹ In the study that Moore cites as evidence that lower doses work the median dose was 125 mg amitriptyline, with a mean of 119 mg.⁴ In other words, at least half of subjects received doses of at least 125 mg, which is close to the recommended dose. By contrast, 93% of amitriptyline prescribed in the community is for doses that are lower than 125 mg (Medicines Monitoring Unit, unpublished data).

Until better evidence is available the treatment of depression must be based on the therapeutic doses that were intended to be given to patients in randomised studies and not on post hoc subgroup analyses of doses that were achieved.

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Advice on long term corticosteroid treatment may be misleading

EDITOR—A recent issue of *Current Problems in Pharmacovigilance*, distributed by the Committee on Safety of Medicines and the Medicines Control Agency to all medical practitioners in the United Kingdom, rightly emphasises the precautions necessary during long term treatment with corticosteroids.¹ However, the definition of long term treatment as more than seven days could be considered misleading. According to the guidelines, withdrawal after such treatment must be gradual—tapering off over weeks or months. This has major implications for the use of short course oral steroid treatment in patients with asthma and chronic airway disease, who commonly continue treatment for 10 to 14 days. Such periods have been shown to be necessary in many patients to identify a response and maximise benefit. Published studies and common clinical experience show no detrimental effects of abruptly stopping steroid treatment after periods of up to two weeks.^{2,3}

If interpreted literally these guidelines are contrary to everyday practice and to the advice of the British Thoracic Society⁴

—advice which was recently confirmed in another Department of Health publication.⁵ Furthermore, this change will cause unnecessary anxiety to patients and has worrying legal implications. We suggest that the Committee on Safety of Medicines should modify the advice it has issued.

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Is it time to stop searching for MRSA?

Follow up screening within the community needs clarification

EDITOR—The articles by Barry Cookson and E L Teare and S P Barrett on methicillin resistant *Staphylococcus aureus* (MRSA)^{1,2} added to the nationwide debate between clinicians, infection control teams, trusts, and purchasers.

Recently, after a large outbreak of MRSA in our local teaching hospital, all colonised patients were treated and followed up by screening within the community. Clearance of MRSA was defined as three consecutive negative cultures of swabs from the nose, throat, perineum, and any lesions and of urine if the patient had a catheter, starting five days after the completion of treatment.

To determine whether this approach achieved clearance and prevented readmission of colonised patients we audited the records of 63 patients with MRSA who were discharged into the community over a period of six months. Fifty four patients were over the age of 60. Four were discharged to nursing homes, seven to residential homes, 45 to their own home, and seven to unknown destinations. Forty six were cleared of MRSA colonisation by the criterion defined above—34 after one treatment, two after two treatments, and 10 after three treatments. Eleven patients were readmitted to hospital during the study—seven were still negative for MRSA and four were recolonised.

While acknowledging that bacteriological culture can lack sensitivity,² we believe that this approach helped to prevent reintroduction of the organism into the acute hospital environment. We propose to follow up this cohort for another six months to examine this further.

We look forward to commenting on the revised British guidelines for infection control, but we would welcome clarification on the need for follow up screening within the community. A recent publication on

guidelines for the control of infection in residential and nursing homes³ states that treatment regimens started in hospital for MRSA should be completed but does not make any recommendations about the follow up of such patients. The follow up undertaken in this community had the important benefit of raising the profile of infection control, particularly in nursing and residential homes. We hope to capitalise on this by developing agreed infection control standards with matrons and managers of local homes.

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- 2 Teare EL, Barrett SP. Is it time to stop searching for MRSA? Stop the ritual of tracing colonised patients. *BMJ* 1997;314:665-6. (1 March.)
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Selective screening for MRSA should be considered

EDITOR—As methicillin resistant *Staphylococcus aureus* (MRSA) seems to be no more virulent than methicillin sensitive *S aureus* (MSSA) E L Teare and S P Barrett suggest that these organisms should not be treated differently.¹ However, this raises the question of the role of screening for MSSA as well as MRSA, rather than supporting a policy of not screening for either.

Since the 1950s the asymptomatic nasal carriage of *S aureus* has been known to lead to an increased incidence of wound infection with *S aureus* postoperatively.² This has recently been highlighted in a study of patients undergoing cardiothoracic surgery³; other studies in patients undergoing dialysis and in those who are HIV positive have shown a clear link between colonisation with *S aureus* and bacteraemia.⁴ In addition, several of these studies also show a significant reduction in the incidence of wound infection and bacteraemia after the eradication of nasal *S aureus* with mupirocin ointment. Although the development of resistance to mupirocin is of concern, it has tended to occur after the indiscriminate or prolonged use of mupirocin rather than its short term application.⁴ A case can thus be made for the selective screening of people at high risk of colonisation with MRSA and MSSA and the targeted use, along with strict adherence to basic hygiene measures, of eradication treatment. Whether one goes further in attempting to control MRSA specifically depends on other issues such as the implications for antibiotic prophylaxis and the therapeutic difficulties and increased costs of treating established MRSA infection.⁵

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Healthcare workers are at risk from policies for controlling MRSA

EDITOR—The articles by Barry Cookson and E L Teare and S P Barrett on the management of asymptomatic carriers of methicillin resistant *Staphylococcus aureus* (MRSA), particularly in healthcare workers, may have sidestepped some important considerations.^{1,2} Once such consideration is the ethical dilemma of treating an otherwise healthy carrier who is being denied clinical access to patients. In this case the treatment is of no direct benefit to the person. Also the risk of an adverse effect means that this practice undermines the fundamental ethical tenet of not to knowingly cause harm. No other parallel exists in therapeutics or medicine. The case for treating close contacts of meningococcal disease is one analogy, but this strategy is to prevent disease and the risk of treatment is considered acceptable.

In Newcastle major difficulties and problems for healthcare workers have emerged. Not only has there been an increase in cases of contact irritant dermatitis but there has been one case of a serious adverse drug reaction in a member of staff treated with a systemic antibiotic. Over six months about 60 members of staff who nurse and tend patients with MRSA colonisation have attended one of our occupational health departments with varying degrees of hand dermatitis. This is probably from increased handwashing. Forty nine members of staff also tested positive for the carriage of MRSA and were offered either topical or systemic antibiotic treatment. Topical treatment increases the risk of contact dermatitis and further adverse reactions to antibiotics.

The basis of the current policies is the protection of patients, but current evidence suggests that most patients are not at an increased risk of MRSA. There is therefore an urgent need to adopt a national strategy for controlling MRSA that balances the need to protect vulnerable patients against the need to protect the health of healthcare workers.

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Practical guidelines are needed for healthcare workers

EDITOR—I was interested to read E L Teare's and S P Barrett's views on the unhelpfulness of tracing staff and patients colonised with methicillin resistant *Staphylococcus aureus* (MRSA).¹

During routine screening of all new junior doctors at my hospital I was found to carry MRSA. I have been suspended from work as an orthopaedic senior house officer for over two months and have lost accreditation for the job. The antibiotics necessary to eradicate the carriage of MRSA, often only transiently, have a high risk of unpleasant side effects. The effect on morale is substantial, and the costs to the trust of screening, treatment, and locum cover are considerable.²

From my own experience and a study of recent published work, I suggest the following guidelines on screening, treatment, and absence from work. Firstly, screening for MRSA routinely in all new staff is inappropriate if there is no reason to believe that they are responsible for an outbreak.² MRSA is not the plague that many fear. Its virulence is essentially the same as non-resistant staphylococcus which colonises up to 30% of staff.³ Screening for throat carriage seems particularly unnecessary as there is little evidence to suggest that this causes outbreaks at all.

Secondly, an evidence based treatment protocol should be in place if screening is practised. There is no point in screening if it is unclear what is to be done when a positive result is obtained. In the case of throat carriage, antibiotics should be used early as there is no proved benefit from treatments such as povidone-iodine mouthwash.⁴ There should also be a clearly identified person responsible for the management of the case to ensure consistency of information, advice, and treatment.

Thirdly, only those carriers working in critical areas may need to be suspended from work,⁴ and should that happen practical alternatives must be offered such as anatomy demonstration or research. An identified senior member of medical staff should be available for advice and help on such possibilities for continuing education. The trust should continue to pay the suspended doctor all applicable additional duty hours throughout and not just for the duration of sick pay.

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Isolating patients with MRSA can have long term implications

EDITOR—E L Teare and S P Barrett raise some valid concerns about screening for methicillin resistant *Staphylococcus aureus* (MRSA) in hospital and the subsequent isolation of colonised patients.¹ We wish to highlight a number of additional problems arising from our experience with elderly patients in hospital.

Most of our patients with MRSA are not identified after screening specifically for *S aureus*. Most cases are found incidentally when specimens, particularly swabs from leg ulcers, are taken as part of a screen for infection during a period of intercurrent illness or functional decline. In most of these cases *S aureus* has not been pathogenic. Despite this, important changes in management—namely, isolation—immediately occur.

Rehabilitation is seriously hampered by isolation. This is because access to paramedical treatment areas is restricted and contact with rehabilitation staff becomes more difficult and time consuming. Resistance to community placement is often considerable. Length of stay inevitably increases. Many patients are extensively colonised, and topical eradication treatment is rarely successful. In such circumstances potentially toxic systemic treatment may be advocated, although this is of uncertain benefit to the patient. We believe that informed consent must then be considered.

The psychological impact of spending weeks in isolation is considerable and these patients receive much less stimulation than their uncolonised counterparts. Morale declines, anxiety rises, and close relatives worry. One patient became depressed and another patient in long term care with multiple antibiotic intolerance spent the rest of her life in isolation. In addition, patients with MRSA who attend our day hospital are transported there separately, mix freely while they are there, but are then re-isolated on return to hospital.

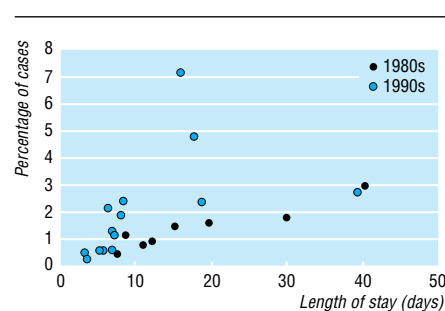
In the absence of better evidence that elderly patients with MRSA represent a risk to others we would agree that policies for their management require radical review.

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- 1 Teare EL, Barrett SP. Is it time to stop searching for MRSA? Stop the ritual of tracing colonised people. *BMJ* 1997;314:665-6. (1 March.)

Risk analysis can identify those patients needing isolation

EDITOR—In their debate of the different approaches for dealing with methicillin resistant *Staphylococcus aureus* (MRSA), Barry Cookson and E L Teare and S P Barrett failed to state the context of their stance.^{1 2} They should have mentioned the time and the place, taking into account all prevalences of MRSA, and risk factors such as the number of immunosuppressed people, availability of isolation facilities, staffing levels, and intensity of antibiotic use.



Correlation of length of stay with percentage of cases of MRSA

We have been dealing with MRSA in east London since the 1970s. Given the strong association shown between antimicrobial use and the carriage of resistant organisms,³ hospitals ought to be a breeding ground for MRSA. From April 1987 to March 1989 and April 1993 to March 1995 we monitored the number of MRSA cases by consultant practice in our hospitals. This investigation was intended to establish the relation between length of inpatient stay and the acquisition of MRSA, and whether this had changed with time.

In the earlier survey 178 inpatients were identified with MRSA, of whom 55 were elderly. During this period 4634 elderly patients were admitted representing a prevalence in the elderly population of 1.19%. Of the 455 cases of MRSA found in the later survey, 239 were in elderly patients. During this period 5815 elderly patients were admitted representing a prevalence in the elderly population of 4.11%.

In the earlier survey the correlation of MRSA acquisition with the length of stay was highly significant ($P < 0.0001$) with a correlation coefficient of 0.942; in the later survey the correlation coefficient had decreased to 0.535 (figure). Consistent with these correlations, in the 1980s there were no cases of MRSA in samples from our community indicating that MRSA was no longer exclusively a hospital organism.

In response to these changes, when dealing with MRSA we now use a risk analysis approach⁴ which takes into account the various clinical and infection control factors (the context) to prioritise which patients need isolation. Thus as the prevalence or other factors change with time, the number of cases isolated will change accordingly.

The new national guidelines should also take the context into account so that any one of a range of approaches may be appropriate.

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- 1 Cookson B. Is it time to stop searching for MRSA? Screening is still important. *BMJ* 1997;314:664-5. (1 March.)
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Constant vigilance is needed to halt the emergence of resistance to vancomycin

EDITOR—E L Teare and S P Barrett's statement that methicillin resistant *Staphylococcus aureus* (MRSA) is endemic and there is no justification for MRSA screening on present evidence,¹ relies on the assumption that *S aureus* will remain susceptible to the glycopeptide group of antibiotics—namely, vancomycin and teicoplanin.

This is an unrealistic expectation as the emergence of vancomycin resistance among enterococci has already occurred. It is only a matter of time until MRSA becomes resistant in the clinical setting, albeit by a different mechanism. This has already been achieved by Noble et al who in 1992 achieved the conjugative transfer of vancomycin resistance from a strain of *Enterococcus faecalis* to *S aureus* in the laboratory.² An *S aureus* mutant that is highly resistant to vancomycin has also been achieved by increasing vancomycin concentrations in a stepwise manner; paradoxically there was a parallel decrease in the methicillin minimum inhibitory concentration.³ The clinical significance of this has yet to be appreciated, but the possible implications of vancomycin resistance developing in an MRSA are extremely worrying.

Owing to advances in medicine, surgery, and the care of premature neonates pool of immunocompromised patients is enlarging. Many of these patients have central lines or prosthetic grafts, or both, and as a consequence infections with coagulase negative staphylococci have increased steadily. As these strains are acquired in hospital and are usually methicillin resistant there has been an increased use of glycopeptide antibiotics to treat these patients. As such there is increasing selective antibiotic pressure.

The resistance of coagulase negative staphylococci to glycopeptides has been shown since 1981.⁴ There have also been recent reports of teicoplanin resistance in *S aureus*, although the organism remained susceptible to vancomycin.⁵

How soon vancomycin resistant MRSA will occur is a matter of conjecture. But if, as Teare and Barrett suggest, we abandon the infection control policies that have been set up for MRSA we leave ourselves with no defences against the spread of vancomycin resistant *S aureus* when it emerges—as it surely will.

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Basic hygiene should help contain MRSA

EDITOR—E L Teare and S P Barrett argue that it is time to take a pragmatic approach to methicillin resistant *Staphylococcus aureus* (MRSA) containment by ensuring that standard infection control precautions are implemented throughout hospitals.¹

Guidelines on the control of MRSA, as well as vancomycin resistant enterococci and *Clostridium difficile* associated diarrhoea, have all emphasised the central importance of hand washing. This is not surprising since effective handwashing is believed to be the key factor in preventing nosocomial infection. Nevertheless, studies of healthcare workers have shown that compliance with handwashing recommendations is often poor, particularly among medical staff.² Educational interventions to improve handwashing may also prove disappointing.³ A lack of confidence in healthcare workers' ability to perform simple infection control procedures may therefore be one reason why hospital infection control teams will continue to search for MRSA.

The recent second national prevalence survey of infection in hospitals showed that for every 386 acute beds there is only one infection control nurse, some of whom are part time. This figure falls short of the 250 beds per infection control nurse suggested by the organisers of the study of efficacy of nosocomial infection as a requirement for cost effective surveillance and infection control.⁴ Though ward based link nurses may prove helpful, they should not obviate the need for formally trained infection control nurses. Similarly, many single handed consultant microbiologists also acting as hospital infection control doctors are finding their dual role increasingly onerous.⁵ Until infection control teams are adequately staffed, their ability to encourage high standards of infection control by all healthcare workers is likely to be limited.

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- 1 Teare EL, Barrett SP. Is it time to stop searching for MRSA? Stop the ritual of tracing colonised people. *BMJ* 1997;314:665-6. (1 March.)
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Environmental hygiene is an important part of control

EDITOR—The debate by Barry Cookson and E L Teare and S P Barrett on the control of methicillin resistant *Staphylococcus aureus* (MRSA) is timely.^{1,2} Our experience confirms the impression that EMRSA-16, an epidemic strain, is highly virulent and has a particular predilection to colonise and infect the respiratory tract.³ Since April 1995, this strain has colonised or infected at least 1000 patients in Plymouth, causing 58 bacteraemic infections. This contrasts with our experience of EMRSA-12 (the so called Plymouth MRSA), which has colonised about 1300 patients since 1986 but caused only eight bacteraemias.

The issue of screening is complex. The work of Coello et al does not prove that screening for asymptomatic carriers in itself helps bring about control of an outbreak.⁴ Furthermore, it is becoming increasingly difficult to manage carriers when they are identified. When an infection is endemic there are often insufficient side rooms to permit isolation of carriers, and attempts to eradicate strains which tend to colonise the throat (such as EMRSA-16) and are resistant to mupirocin, often fail. We have seen several patients who have developed jaundice when treated with rifampicin and fusidic acid,⁵ and we no longer believe that this combination of systemic antibiotics can be justified merely to eradicate carriage. Carriers are thus unintentionally stigmatised but effectively left untreated. We believe that screening for carriers may be worth while when EMRSA has been introduced only recently to a unit, but it has little to offer once the infection is established. Screening may, however, contribute to the investigation of clusters of infection and help to provide feedback to staff of high risk areas, as discussed by Barry Cookson.¹

Although there is remarkably little hard evidence to support many of the interventions used to prevent the spread of infections in hospitals, most people would agree that handwashing and environmental hygiene are important. In our experience these simple measures are often ignored. Unfortunately, mass screening often diverts the attention of infection control staff away from these fundamental aspects of infection control.

Since current policies and guidelines are clearly failing to control MRSA, it is time to reassess the way in which the limited resources for infection control are used. We agree with Cookson that some MRSA strains are highly virulent and therefore need to be controlled. Like E L Teare and S P Barrett, however, we hope that the new national guidelines will place less emphasis on ritual screening and more on education and monitoring of basic hygienic practice.²

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- 1 Cookson B. Is it time to stop searching for MRSA? Screening is still important. *BMJ* 1997;314:664-5. (1 March.)
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Should oral contraceptive users be screened for factor V Leiden?

Oral contraceptives are not the only effective contraceptives

EDITOR—In their paper on the prospect of screening potential oral contraceptive users for the thrombogenic variant factor V Leiden, Jan P Vandenbroucke and colleagues conclude that such a strategy would “deny effective contraception to about 5% of white women while preventing only a small number of fatal pulmonary emboli.”¹ Their persistent use of the term “oral contraceptives” fails to distinguish clearly between progesterone only and combined oral contraceptive preparations, which have quite different thrombogenic risk profiles. Furthermore, the authors imply that oral contraception is the only effective contraception. This is both erroneous and unhelpful. While screening for factor V Leiden might deny 5% of white women the opportunity of using the combined pill, it does not necessarily preclude them from using depot or oral progesterone, intrauterine devices, or barrier methods, all of which are effective in appropriate circumstances. The authors’ comment about the “related strain due to unappealing methods of contraception” reflects personal prejudice, not scientific fact.

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- 1 Vandenbroucke JP, van der Meer FJM, Helmerhorst FM, Rosendaal FR. Factor V Leiden: should we screen oral contraceptive users and pregnant women? *BMJ* 1996;313:1127-30. (2 November.)

Author's reply

EDITOR—Of course alternatives exist. We mentioned them specifically when discussing the situation of a woman with a history of thrombosis, thereby showing that we are aware of the difference between combined and progestogen only pills. There are, however, some objective differences. As a whole, progestogen only contraception is slightly less effective than the combined pill. Moreover, progestogen only pills are associated with a higher incidence of menstrual irregularity, which is difficult for some women to accept and may lead to anxiety and repeated pregnancy tests. Also, regular pill use may be more crucial than with combined preparations. Of all contraceptives,

the combined hormonal contraceptive is the most commonly used, with the highest acceptability and compliance. All barrier methods are effective when used by highly motivated and better educated people. Their “across the board” contraceptive performance is again less, however, than that of hormonal contraception. Finally, there is a subjective element in the acceptability of different modes of contraception, and this should not be overlooked when contraception is prescribed.

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Benefit of using polymerase chain reaction to test blood donations will be considerable

EDITOR—It is unfortunate that in attempting to summarise a complex situation regarding the potential role of the polymerase chain reaction in blood transfusion Adam Legge has overinterpreted my views.¹ Although undoubtedly more costly than serological testing, use of the polymerase chain reaction does not involve a “quantum leap” in cost, but more a quantum leap in the organisation, logistics, and operational aspects of transfusion microbiology.

The benefit of testing blood donations with the polymerase chain reaction is not “dubious.” On the contrary, because of the current streamlining of the blood service, better microbial surveillance and collation of data have enabled us to calculate residual microbial risk more accurately than ever before. The benefit will indeed be small in terms of extra infectious units detected because we are fortunate in already having an extremely safe blood supply.

A subtle but important further point is that the introduction of the polymerase chain reaction has not been predicated in the first instance by a perceived need to test individual labile blood components. Instead, the requirement is regulatory and relates to fractionated pooled plasma products. Since the blood service will be undertaking this it is obviously appropriate to apply any benefit of enhanced blood safety to individual components. We are fully aware that this will be a challenging process. Because of improvements in the consistency and organisation of operational procedures nationwide, however, the blood service is confident that the challenges will be met cost effectively by testing of computer based automated pooled blood samples with the polymerase chain reaction.

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Local research ethics committees

BMA's advice about approval of clinical audit studies is confusing

EDITOR—The burden on Brighton's local research ethics committee is likely to get worse.¹ One international medical journal of reference, in its advice to authors, has introduced a new caveat: “prospective ethics approval should be acquired for papers based on clinical audit data.”²

The caveat is based on two contradictory paragraphs in the BMA's *Ethical Issues in Audit*.³ Paragraph 4.4 says: “audit is intended to influence the activities of an individual or team, i.e. [it is] local; but research attempts to influence medical practice as a whole.” This seems to mean that if you publish nationally the results of a clinical audit then the work cannot be regarded as local but as an attempt to influence practice as a whole—that is, it must be regarded as research and therefore will require ethical approval. On the other hand, paragraph 6.1 states: “There is no need to consult local research ethics committees on matters which are appropriately classified as audit.”³ We are confused.

The BMA should resolve the issue as soon as possible and certainly before local research ethics committees are bombarded with demands for prospective ethical approval of all clinical audit studies intended for publication.

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- 1 Pierce E. Are research ethics committees behaving unethically? *BMJ* 1997;314:676. (1 March.)
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National research ethics committee is needed

EDITOR—The activities of local research ethics committees are under increasing scrutiny,¹ and the committees are suffering conflicting pressures from many directions.² We would like to report an extraordinary situation.

Our local research ethics committee will not allow us to take part in a large randomised controlled multicentre clinical trial, of an active drug comparator, without undertaking a major revision of the protocol to include a placebo group. While the use of active drug versus placebo comparators has been a matter of some contention, this particular trial protocol has been accepted without such modification by all 120 other local research ethics committees (including 28 in Britain) to which it was submitted. There is no independent authority to which we can appeal against this decision, and it prompts us to ask what is peculiar about the Oxford local research ethics committee.

The process whereby multicentre clinical studies require the separate approval of every local research ethics committee has

been shown to be a deterrent to research, causing delay and increased costs.³ In addition, the reliability of various committees is thrown into doubt by the great diversity of response to identical protocols.^{4,5}

Multicentre trials are increasingly essential in clinical research, and surely the time is ripe for the establishment of an expert national research ethics committee or a national association of research ethics committees, by which these studies can be considered. Any loss of local autonomy would be more than offset by the more effective and ethical use of limited resources and the increased rigour and consistency of scientific and ethical approach that a national committee would command.

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Three quarters of one French prison population needed immunisation against hepatitis B

See pp 18, 21, 30, 65

EDITOR—From March to December 1995, 411 prisoners sent to Marseilles prison were invited to participate in a programme of vaccination against hepatitis B. A face to face questionnaire was administered by a doctor. In agreement with a previous study,¹ injecting and sexual risk behaviours during the past 12 months were reported frequently by the 391 prisoners (95%) who participated in the study: 164 reported having had more than one sexual partner, 40/308 reported having had at least one injecting drug user as a sexual partner (especially women, 20/88); four declared that they had had homosexual intercourse; and 71 reported injecting drug use (89 over their lifetime)—of these, 19 reported sharing syringes and 27 reported sharing paraphernalia during the past 12 months. The 391 inmates were screened for hepatitis B surface antigen and antibody to hepatitis B core antigen. Five (1%) and 110 (28%) positive results, respectively, were obtained—that is, five times the rate in the French general population.² Among injector inmates, three were positive for hepatitis B surface antigen on screening and 50 for antibodies to hepatitis B core antigen; 17 were positive for antibodies to hepatitis B core antigen but negative for antibody to hepatitis B surface antigen (<10 U/l).

Altogether 292 inmates were negative for antibody to hepatitis B surface antigen and were offered hepatitis B vaccination; 252 agreed to be vaccinated. However, only 175 received the three doses (at days 0, 30, and 60): 70 were discharged or transferred to another prison, 33 refused immediately, and 14 refused the second or third dose. The refusal rate was higher among injector inmates (25/89 (28%); 95% confidence interval 19% to 39%) than among non-injectors (42/302 (14%); 10% to 18%; $P=0.04$). Among the 89 injector inmates eight reported a previous vaccination against hepatitis B but two had actually been immunised. Shorter schedules (days 0, 7, and 30 or days 0, 30, and 180) could be useful, but their efficiency has not been shown in populations with high proportions of men (95%), smokers (80%), injecting drug users (20%), and people with coinfections (with HIV, hepatitis C virus, and tuberculosis).^{3,5}

Validation studies of short immunisation schedules in populations at risk should be carried out before new immunisation strategies are implemented in prisons. These data emphasise that the prevalence of serological markers of hepatitis B virus infection and sexual and injecting risk behaviours among prisoners remains high. They also show that hepatitis B vaccination programmes are feasible in prisons and accepted by inmates.

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Mistake in report: hepatitis B vaccination for drug misusers is recommended

EDITOR—The importance of national hepatitis B vaccination programmes has correctly been identified as a vital public health response to the global epidemic of hepatitis B, and this supports the World Health Organisation's call for universal hepatitis B vaccination by 1997.¹ While the authors of an article about hepatitis B vaccination programmes and the authors of a commentary on the article argued about the relative merits of universal and targeted immunisation

policies,² only scant attention was given to the importance of vaccinating drug misusers and the widespread failure to incorporate hepatitis B testing and vaccination in the practice of so many drug services.^{3,4}

The Drug Treatment Effectiveness Task Force, which was recently convened by the Department of Health, identified universal hepatitis B vaccination for all current and potential drug injectors as an important component of the healthcare response to drug misuse which had been strangely overlooked. Unfortunately, because of an error in the final production of the report, the first print runs (which were widely distributed) contained an incomplete and somewhat bland endorsement of hepatitis B vaccination, whereas the correct wording (which appeared in subsequent, corrected, print runs of the report) contained the following key recommendation: "steps should be taken to ensure drug misusers who inject or are at risk of injecting have better access to hepatitis B vaccinations, with the aim of providing universal coverage."⁵

We wish to draw attention to the correct, more specific, recommendation. We remain concerned that purchasers and providers may have failed to recognise the importance that we believe must be attached to this straightforward method of providing healthcare benefit.

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- 1 Kane MA. Global programme for control hepatitis B infection. *Vaccine* 1995;13(suppl 1):S47-9.
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- 4 Mangtani P, Hall A, Normand CEM. Hepatitis B vaccination: the cost-effectiveness of alternative strategies in England and Wales. *J Epidemiol Community Health* 1995;49:238-44.
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GPs need training in care programme approach more than in supervised discharge

EDITOR—In her editorial on patients in the community Julie K Johnston suggests that up to two thirds of the 5000 psychiatric patients compulsorily admitted at any one time could be suitable for community supervision under the Mental Health (Patients in the Community) Act 1995, which introduced a new power of "supervised discharge."¹ She outlines the implications of the act for, among others, general practitioners, and the need for guidance and training.

We recently surveyed key informants at all mental health provider trusts in England as part of a larger study. We obtained responses from 152 informants (representing 84% of all 181 such trusts) between nine and 12 months after the Mental Health (Patients in the Community) Act came into force. At 68 trusts no patient had been made subject to supervised discharge, while one had been at 45 trusts, two at 24, and between three and seven at the remaining 15 trusts. A total of 149 patients—an average of less than one per trust (0.98 (SD 1.23))—were subject to the measure. Extrapolating to the 181 mental health providers, we estimate that 177 patients, or one for every 163 general practitioners in England, might be involved.

Reluctance on the part of general practitioners to be directly involved in supervised discharge would perhaps be reasonable in view of its rarity as a form of community supervision. The possible role of general practitioners in the successful implementation of the care programme approach, the policy governing the community care for an average of 3000 patients in each trust in our survey, is more important, and general practitioners' reluctance to be involved in it should give rise to greater concern.^{2,3} We suggest that Johnston's conclusion about the need for guidance and training is perhaps more appropriately applied to the care programme approach than to supervised discharge, and we emphasise the need for guidance that encourages a more constructive role for general practitioners than that issued to date.³

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- 1 Johnston J. Patients in the community. *BMJ* 1997;314:988-9. (5 April.)
- 2 Grace J, Steels M, Baruah R. General practitioners' knowledge of and views on the care programme approach. *Psychiatr Bull* 1996;20:643-4.
- 3 General Medical Services Committee. *Mentally disordered people: continuing care in the community. Guidance for GPs.* London: BMA, 1996.

Book reviewers reviewed

Reviewers should simply review the book, not try to be clever

EDITOR—I find it irritating that senior colleagues, when asked to do a book review, use the opportunity to display their own vitriolic approach to reviewing rather than simply do what is asked of them. I refer to Colin Robertson's review of *Emergency Triage*.¹ Having attended Manchester triage project's training day and been introduced to the system (which seems to work well in practice), I was disappointed to read Robertson's rather extreme critical view, with which I entirely disagree. I take his point about the lack of references in the book, but are we to assume that he would seek to discredit the advanced paediatric life support manual in a similar fashion for the lack of references throughout its text?²

Life support training constantly emphasises the assessment of airway, breathing, and circulation regardless of the nature of the patient's complaint; thus, contrary to Robertson's opinion, such assessment seems to be an entirely appropriate way of beginning an assessment of a man with testicular pain. Robertson states that Darwinian principles ensure that accident and emergency staff have a certain degree of "nous." Thus it is surely reasonable to expect that the assessor can move rapidly through the discriminators and categorise the patient without referring to the "discriminator dictionary," in much the same way as doctors prescribe paracetamol without needing to refer to the *British National Formulary*.

I find such reviews unhelpful, unnecessary, and not in the least amusing. I suggest that Robertson could devote his writing talents to designing a better system of emergency triage, or perhaps writing a better book, rather than simply exercising his sharp wit.

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- 1 Robertson C. Emergency triage [book review]. *BMJ* 1997;314:1056. (5 April.)
- 2 Advanced Life Support Group. *Advanced paediatric life support. The practical approach.* 2nd ed. London: BMJ Publishing, 1997.

Rather than being irrelevant to British readers, book deserves to be read and reread

EDITOR—It would be a shame if Julian Tudor Hart's idiosyncratic and negative review deterred anyone from reading Frank Davidoff's book *Who Has Seen a Blood Sugar? Reflections on Medical Education*.¹ Davidoff enriches our view of medical education, drawing on the humanities and social and biological sciences to draw out connections and meaning so easily ignored in orthodox training. Content in education is indeed important, but this book is more concerned with how doctors learn and approach problems—hardly a voice from the past. Nothing in these essays negates Tudor Hart's views on continuity of care; indeed, Davidoff emphasises the vital importance of learning medicine in the community. This book is everything to do with human relevance, and it is disappointing that someone of Tudor Hart's breadth of vision has failed to appreciate it. Davidoff explores the complex basis for our thinking about patients' symptoms. Why does Tudor Hart consider this to be irrelevant? It is certainly important to patients, and learning to understand episodes of illness may help keep patients alive to enjoy the longer term care that Tudor Hart promotes.

Far from being "largely irrelevant to most British readers," Davidoff's book deserves to be read and reread by all those claiming an interest in medical education.

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- 1 Tudor Hart J. Who has seen a blood sugar? Reflections on medical education [book review]. *BMJ* 1997;314:985. (29 March.)

Children have rights to medicines

EDITOR—If a medicine was restricted to certain racial groups or to one sex on the basis of information from studies limited to these groups there would be an understandable outcry. Yet one group of the population—children—is denied access to treatment on this basis. This unacceptable situation persists because children have no vote, no spending power, and little voice. John Warden's article on the report by the House of Commons health committee on anomalies and deficiencies in the licensing of medicines¹ highlights what paediatricians have been aware of for many years.^{2,3}

The well intentioned protectionist belief that children should not be exposed to potentially harmful side effects of a medicine until more is known about its effects in adults is specious. Firstly, children differ from adults in their physiology and metabolism of drugs. Secondly, because children have many conditions in common with adults, many paediatricians do and will use medicines for these in an unlicensed fashion. The argument that ethical constraints limit studies in children is grossly overstated. Most ethical concerns can be resolved by giving children rights as people and accepting that parents of young children can speak for them, as they do in studies. We are convinced that children and parents who were given full information would support properly conducted studies of new and existing medicines rather than the present practice of using unlicensed and off label medicines, which is potentially more dangerous.

The relatively small market for children's medicines should not preclude children having the same rights to medicines as adults. The longstanding underprivileged position of children in respect of medicines can be improved by the Medicines Control Agency showing a commitment to children by viewing them as people and according them the same rights to medicines as any other group in society has. As a profession we should insist on this. The *BMJ's* columns would be filled with righteous indignation if any other population group was treated in such a way.

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- 1 Warden J. Loophole exposed in testing of child medicines. *BMJ* 1997;314:698. (8 March.)
- 2 Shirkey H. Therapeutic orphans. *J Pediatr* 1968;72:119-20.
- 3 Rylance G. The therapeutic underprivileged. *Dev Med Child Neurol* 1979;21:399-400.