Paediatric intensive care beds: the problem is distribution rather than numbers

EDITOR,—In the past few weeks the media have brought to the public's attention the apparent lack of provision of both paediatric and adult intensive care services in Britain. In July 1993 Shann noted that Britain's paediatric intensive care service was extraordinarily fragmented and suggested that it would be better to have 12-14 large paediatric units each with 14-16 beds.[1] In November that year a working party of the British Paediatric Association made recommendations for improving the provision of intensive care services for children.[2] While agreeing with most of Shann's comments, the report concluded that paediatric intensive care units should have a minimum of eight beds. We suspect that Shann is correct and that bigger units are the best way to provide care.[3]

Since November 1994 we have provided 16 beds to cater for the needs of critically ill children. Other units have perhaps not been as fortunate. Currently (March 1996) there are reputedly 31 centres (197 beds) in Britain that purport to offer paediatric intensive care. Among these centres the median number of beds is 5, with the first and third quartiles being 4 and 7·5 beds respectively. Indeed, only three units have more than 14 beds, and 23 of the centres fail to meet the British Paediatric Association's recommendation regarding the minimum size of a unit.

We are convinced that centralisation of beds into large centres, with the additional medical and nursing staff required to support them, will improve the care of critically ill children. Indeed, if the service were to be centralised along the lines suggested by Shann it is questionable whether more beds would be required than already exist (14×14=196 beds). Currently, although the 31 centres claim to have 197 beds in total, because of a shortage of skilled nurses many of the beds are closed. We believe that larger units are better placed to meet seasonal demands. To illustrate this we have compared the rate of refused admissions to our unit for two periods (1992-3, when the unit operated with seven beds, and 1994-5, when initially 11 and then 16 beds were open). The rate has fallen dramatically since the unit expanded: in the past two years only 12 (2·4%) of 498 children have been refused, compared with 40 (15·2%) of 264 in 1992-3 (Fisher's exact test, $P < 0.0001$; odds ratio 7·23 (95% confidence interval 3·7 to 14·1)).

If it is the aim of specialists in paediatric intensive care in Britain to look after virtually all critically ill children they must first be in a position to admit them.[2] For this to be accomplished in the most clinically efficient and cost effective manner, small units need to be closed or amalgamated, or both, to meet the needs of the population.

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1 Shann F. Australian view of paediatric intensive care in Britain. *Lancet* 1993;342:68.
2 British Paediatric Association. *Report of a multidisciplinary working party on paediatric intensive care.* London: BPA, 1993.
3 Murdoch IA, Bihari DJ. Paediatric and adult intensive care in Britain. *Lancet* 1993;342:498.

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words and no more than five references (including one to the BMJ article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.

See editorial and news

Publishing research supported by the tobacco industry

BMJ should come off the fence

EDITOR,—John Roberts and Richard Smith argue the case against journal editors who decline to publish the results of research sponsored by the tobacco industry.[1] The position that they adopt is apparently principled, ethically based, and scientifically rational. It is, however, completely misguided. Research sponsored by the tobacco industry is not bad research in itself. The peer review process should ensure that it is well founded in purely scientific terms. The tobacco industry does not, however, fund research from philanthropic motives. It funds research to learn how to be better at what it does, to influence the debate about tobacco use, and, importantly, to influence researchers. The suggestion that researchers are immune to such influences is a noble but highly unrealistic thesis. Surely the unfortunate episode of the Health Promotion Research Trust, which was funded by the tobacco industry, should have taught us about the perils of supping with this particular devil.[2]

Roberts and Smith equate refusal to publish the results of research sponsored by the tobacco industry with a ban on the scientists and restriction of the freedom of the press. It is difficult to see how the editorial decision by the journals in question is other than an expression of the freedom of the press to print—or in this case, not to print—as they judge fit. It would be much more a matter for concern if they were forced to print something against their better judgment.

The struggle to control the menace of tobacco is not one in which scientific argument will achieve decisive progress. That phase has passed. The struggle against tobacco is, whether the *BMJ* likes it or not, a political struggle and crosses party political lines. The BMA plays an important part in this fight. The *BMJ*, on the other hand accepts advertising, and income (albeit small), from the tobacco industry.[3] I am sure that I am not alone in regretting this inconsistency. If the *BMJ* cannot summon up the courage to come down off the fence it should at least refrain from criticising those who do.

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1 Roberts J, Smith R. Publishing research supported by the tobacco industry. *BMJ* 1996;312:133-4. (20 January.)
2 BMA. *Smoking out the barons: the campaign against the tobacco industry.* Chichester: John Wiley, 1986.
3 Scally G. Advertising for doctor to work in tobacco industry. *BMJ* 1992;305:427.

A higher principle is at stake than simply freedom of speech

EDITOR,—John Roberts and Richard Smith suggest that the *American Journal of Respiratory and Critical Care Medicine* and the *American Journal of Respiratory Cell and Molecular Biology* should reverse their recent ban on research sponsored by the tobacco industry.[1] They suggest that if some studies are systematically suppressed then we will reach false conclusions: "Because peer review cannot guarantee the validity of a study and because bias operates very subtly, many journals, including this one, print authors' funding sources alongside papers. By doing so, the journals ensure that the ultimate peer reviewers, practising doctors, can use that information to make up their own minds on the validity and usefulness of a piece of research."[1]

Ideally speaking, these points have a lot in their favour. But imagine the (not unlikely) scenario after a ban on tobacco advertising throughout the developed world—not just, as now, in a few progressive countries like Norway, Finland, and New Zealand. The tobacco industry would seek every opportunity to promote its products and stem the tide of medical and scientific opinion. Revenue not spent on advertising would become available for other promotional strategies, including scientific and medical research.

Imagine a 10-fold or 20-fold increase in expenditure on research by the tobacco industry. This would easily outstrip the expenditure on research allocated by less partial agencies. The "very subtle" bias operating today would become a bias so large as to throw completely into question the cumulative validity of such a pro-tobacco research programme. And publication of the names of sponsoring bodies would be insufficient to enable "practising doctors," or anybody else for that matter, to make up their minds on the validity and usefulness of so much, biased research.

A stronger line now can lead only to better quality—that is, less biased—scientific understanding of tobacco and health in the future. In adopting such a policy across the board, science and medicine would give the tobacco industry the clear and coherent message that scientists and

doctors are not prepared to accept gifts derived from the spoils of legalised carnage. Surely a higher order principle is at stake here—not simply freedom of speech but freedom to live a healthful life, unimpaired by diseases and early death attributable to tobacco.

The *Journal of Health Psychology*, which I edit, will not be accepting articles on research supported by the tobacco industry. I encourage the *BMJ* and other independent journals with an interest in promoting health to adopt the same policy.

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1 Roberts J, Smith R. Publishing research supported by the tobacco industry. *BMJ* 1996;312:133-4. (20 January.)

It's folly to allow the enemy access to your camp

EDITOR,—John Roberts and Richard Smith cite a variety of arguments to support their assertion that medical journals should not ban research sponsored by the tobacco industry.[1] Their comparison between research sponsored by tobacco companies and that sponsored by drug companies (and the suggestion that some of the latter might be "suspect") is invalid. In contrast to tobacco, drug company products can be shown to have some beneficial effect. In certain circumstances side effects may outweigh these, but formal licensing and monitoring arrangements exist, which, if applied to tobacco, would have resulted in its withdrawal 30 years ago. Drug companies do not produce and market substances that they know have no medically beneficial effect, and competition between rival companies is often the basis of medical advance. This cannot be said of the tobacco industry.

A further specious comparison made by Roberts and Smith is that it might be equally unacceptable to receive government money acquired through "unjust taxation policies." This, unlike the fact that tobacco kills people, involves a value judgment. I would not suggest that journal editors become involved in personal value judgments. Clearly, however, they are able to recognise the medical facts about tobacco.

Perhaps the most superficially compelling argument in the editorial is the assertion that a ban on the publication of research supported by the tobacco industry is not compatible with the ideal of freedom of information and might even result in an unbalanced scientific conclusion. If the tobacco industry were at all interested in a valid scientific conclusion this would be a reasonable argument. When collectively the industry is prepared to enter into reasoned scientific debate then medical publishing should be prepared to give some credence to its efforts. Organisations or individuals who do not meet these criteria should be treated as the enemies of medicine, health, and truth. It is surely folly deliberately to allow the enemy access to your camp.

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1 Roberts J, Smith R. Publishing research supported by the tobacco industry. *BMJ* 1996;312:133-4. (20 January.)

Not to publish research is a slur on those who work for the industry

EDITOR,—John Roberts and Richard Smith are right to castigate the American Thoracic Society for its refusal to publish reports of medical research funded by the tobacco industry while applauding the motives that led to such action.[1] One of the primary objectives of the Faculty of Occupational Medicine, of which I was recently dean, is to encourage research. The faculty urges all occupational physicians to become involved in research into the effects on health of the products, processes, and practices of the companies that employ them—and to publish their work. Much of this research will be undertaken by third parties, especially universities, but all of it will be sponsored by the industry or company concerned. If the principles followed by the American Thoracic Society were to be followed to their logical conclusion no research on those health effects (whether harmful or not) could be published. This might cause legal problems, as products and materials are required, by law, to be assessed for toxicity, and the results must be made public. Who would undertake such work if publication were impossible?

The American Thoracic Society's action is not only counterproductive to the generation of good research in such areas as toxicology, epidemiology, and environmental effects. It is also a slur on the objectivity, integrity, and honesty of doctors and scientists throughout the world who happen to be paid (directly or indirectly) by organisations, including drug companies and health care providers, whose activities are the proper subject of health research. I hope that the society will reverse its decision, encouraged by the view of the Faculty of Occupational Medicine and its opposite number in the United States, both of whose members, along with research institutes of worldwide reputation, could otherwise be seriously affected.

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1 Roberts J, Smith R. Publishing research supported by the tobacco industry. *BMJ* 1996;312:133-4. (20 January.)

See editorial and news

Proposed BAT professorship at University of Cambridge should be opposed

EDITOR,—On 6 March, Cambridge University announced plans for a programme of cooperation with the tobacco and finance conglomerate BAT Industries, which includes the naming of a professorship after the former chairman of BAT, Sir Patrick Sheehy; the award of scholarships to promising international scholars (in part selected by BAT); and the distribution by the university of promotional material bearing BAT's logo. This programme will considerably enhance BAT's efforts to improve its image in Third World markets, so contributing to its cigarette sales of 620 billion a year and to the worldwide death toll from tobacco of three million a year (World Health Organisation's estimate).

While the university's need to attract funds from a wide variety of sources is entirely understandable, this proposal is the cause of widespread concern to members of the Association for Public Health, to many people associated with medicine in Cambridge, and to the major health charities. The Cancer Research Campaign, for example, annually provides grants of £2·3m for research at the university into the causes and treatment of cancer.

Since the proposal has yet to be confirmed there is still time for readers to make their views known within the university or by writing to the vice chancellor, Professor Sir David Williams, at the University of Cambridge, The Old School, Trinity Lane, Cambridge CB2 1TN (fax 01223 339669).

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Tuberculosis in the United Kingdom

Enhanced surveillance is being planned

EDITOR,—Meirion R Evans is right to draw attention to the seriousness of the problem of tuberculosis in the United Kingdom, the need to strengthen activities to control the disease, and the fact that no formal strategic plan for tackling tuberculosis exists.[1] The article implies, however, that little or no work is being carried out in several key areas and ignores several developments that are under way.

Proposals for developing an enhanced surveillance system for tuberculosis have been formulated by a group convened by the Department of Health and led by the Public Health Laboratory Service and are being distributed for consultation. The problems encountered in the United States with the collection of information by the country's enhanced surveillance system, to which Evans refers, make it essential that the development of a new system in the United Kingdom be carefully thought through before implementation. Increasing resistance to antituberculosis drugs has caused considerable problems in the United States and elsewhere, including outbreaks in institutions. These problems have been compounded by the high prevalence of HIV infection in many of these settings.

Recognising the potential for similar problems in the United Kingdom, the Public Health Laboratory Service has reorganised its reference services for tuberculosis bacteriology. The Mycobacterium Reference Unit has moved from Cardiff to Dulwich and is linked with three of the service's regional centres for mycobacteriology, in Cardiff, Birmingham, and Newcastle upon Tyne. All four laboratories will identify mycobacteria and test them for susceptibility to drugs, free of charge, for hospital laboratories in England and Wales. In addition, a surveillance scheme to monitor drug resistance in isolates of *Mycobacterium tuberculosis* sent to one of the reference facilities has been established; it is coordinated by the Communicable Disease Surveillance Centre.

The responsibility for services to control tuberculosis at district level is divided among several groups, and provision has sometimes been inadequate. The picture has been further complicated by the changes in the NHS at local level. In recognition of this, detailed guidance, based on the British Thoracic Society's 1994 code of practice,[2] has been drawn up by a group convened by the Department of Health and will be released shortly. Similar guidance has also been drawn up in relation to the provision of tuberculosis services for homeless people, among whom tuberculosis is more common and successful treatment more difficult to achieve.[3] The absence of a strategic action plan should not be interpreted as indicating that tuberculosis has a low priority.

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