ation ensures that roughly equal numbers move into arms 1 and 2 and also removes the possible bias introduced by the doctor choosing subsequent treatment. Patients are also less likely to be lost to follow up. Mortality figures will be analysed on an intention to treat basis.[1] We will also be able to compare survival in patients in arm 1 with that in the subgroup of patients in arm 3 who continue to take bromocriptine or are redrawn to arm 1; this will compare the benefits of starting with levodopa versus starting with bromocriptine. In addition, we can use data for patients redrawn from arm 3 to increase the power of analysis of survival in arms 1 and 2.

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1 Pocock SJ. *Clinical trials: a practical approach.* Chichester: Wiley, 1983.

Computer project in Wessex

EDITOR,—John Warden's report of the findings of the Commons public accounts committee concerning the abandoned computer project in Wessex, which cost £43m,[1] compels me to write of the medical advice offered to the health authority at that time. I was chairman of the regional medical advisory committee from 1983 to 1987. Repeatedly, as was minuted, the committee expressed grave anxieties over the value of this project and that the expenditure would jeopardise services for direct patient care. This culminated in a letter, which I wrote, to the regional general manager on 7 May 1987, requesting that the project be placed before the regional health authority as an agenda item.

It was not until 1992, through the researches of BBC South Television, that I learnt that the letter had reached the regional health authority on 8 July 1987 only as an item "presented for information." It was accompanied by a summary of the information group's meeting on 10 June (attended by the then chairman of the health authority), which formally adopted the plan; and by a paper written by the programmes manager and dated 2 June, which supported the investment in the project and ended "[it] should therefore be seen as an essential contribution towards improving services for direct patient care." Neither document referred to our committee's grave anxieties.

Perhaps there are crucial lessons for the NHS today in this saga of errors and misdemeanours. The headlong rush to highly paid commercial management should not be allowed to obscure the advice offered by those—nurses and doctors—who care for patients.

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1 Warden J. Managers put technology before patients, say MPs. *BMJ* 1994;**308**:11-2. (1 January.)

Safe blood?

Saving lives costs money

EDITOR,—A few months ago two French doctors went to prison because of a governmental failure to prevent blood products contaminated with HIV being given to patients despite there being the technology available to detect the virus in donated blood. The high cost of doing the tests and throwing contaminated blood away was given as the excuse for causing disease in patients.

A few weeks ago Dr Gunson, the director of the English National Blood Transfusion Service, reassured the public that the German UB plasma scandal could not happen here as we had the safest blood transfusion service in the world. He based this on our screening of individual blood donation units for viruses at source with the latest technology and throwing away any units testing positive.

How the world changes. This week my local blood transfusion director told me that the government has decided that it is too expensive to test blood for hepatitis B core antibody in those testing negative for hepatitis B surface antigen. As a result, blood for transfusion is not as safe as it could be, and the risk of transmitting hepatitis B to patients is higher than it need be. Hard luck if you go yellow, get liver failure, or go on to develop cirrhosis or hepatocellular carcinoma unnecessarily.

Now the *BMJ* tells us it is not worth screening for HTLV types I and II despite an estimated 100 donors being bled each year in Britain whose blood is capable of transmitting the virus and causing disease in patients.[1] Each unit of donated blood may be split into red cells, platelets, and plasma; thus many more than 100 patients each year could become infected from those original 100 contaminated donations. Apparently we cannot (will not) afford to screen for a virus capable of causing leukaemia, lymphoma, or spastic paraplegia in those receiving a blood transfusion.

As a haematologist I am charged with providing safe blood for use in patients in my hospital. If asked I can't reassure patients any more, and I don't think Dr Gunson can brag any more either.

Saving lives costs money. If the current preoccupation with cost-benefit analysis continues then by reductio ad absurdum (and politicians seem quite capable of daft and extreme policies) there won't be any lives to save. Is this what the modern health service is coming to?

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1 Dalgleish AG. Human T cell leukaemia/lymphoma virus and blood donation. *BMJ* 1993;**307**:1224-5. (13 November.)

HTLV-I infection is crippling

EDITOR,—M Brennan and colleagues[1] and A G Dalgleish[2] conclude that the low prevalence of infection with human T cell leukaemia/lymphoma virus type I (HTLV-I) in Britain means that screening blood donors for antibodies to this virus is not cost effective. Though we accept the economic arguments, the consequences of such a policy can be tragic for patients who are infected.

A 61 year old white man developed acute myeloid leukaemia. He entered remission after one course of intensive combination chemotherapy. Seventeen days after a second consolidation course (with high dose cytarabine) he had an episode of confusion. In the following months he developed a spastic paraparesis and detailed investigations failed to show a structural, vascular, demyelinating, or metabolic cause. Spastic paraplegia associated with HTLV-I infection was diagnosed after a positive result was obtained on serological testing.

A blood sample obtained before transfusion was negative for antibody to the virus, showing that he had definitely seroconverted to HTLV-I. He had no known risk factors for infection with the virus apart from having received transfusions of blood and platelets from 127 donors during his treatment for acute myeloid leukaemia. The particular donor concerned was not identified.

His acute myeloid leukaemia has been in remission for five years, and he is at a low risk of relapse. He is, however, severely disabled as a result of his HTLV-I infection, which he almost certainly acquired from a blood transfusion.

The Department of Health compensates patients who can be proved to have contracted HIV infection from a blood transfusion or blood products but has declined to consider any compensation for HTLV-I infection. If Britain considers that screening donors is not cost effective it should set up a system to compensate the few patients who suffer as a consequence of this policy.

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2 Dalgleish AG. Human T cell leukaemia/lymphoma virus and blood donation. *BMJ* 1993;**307**:1224-5. (13 November.)

Few German blood donors are paid

EDITOR,—There is no excuse for the misconduct in the handling of blood products by German companies and in the regulation of HIV tests of blood products in Germany: it is a scandal. But Marcela Contreras's letter requires comment.[1]

Contreras focuses on paid blood donors and gives the impression that they are a major problem in Germany, implying that most blood donors in Germany are paid and therefore not really volunteers. This is not true. Eighty per cent of the four million blood donations in Germany are obtained through the German Red Cross Society,[2] which uses only voluntary unpaid blood donors (who usually get a sandwich and a drink). Thus only a small proportion of blood donations are paid for (the blood transfusion centres of university hospitals usually pay about DM50 (£20)).

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Access to specialist palliative care

EDITOR,—In his review of David Clark's book *The Future for Palliative Care,* Geoffrey Hanks writes that roughly 15% of the 160 000 patients who die of cancer each year in Britain have access to specialist palliative care.[1] This is by no means the full picture.

The hospice information service conducts an annual survey of the palliative care services of Great Britain and the Republic of Ireland. In the survey for 1991 there was an 88% response to the questionnaire that we sent to the 185 inpatient palliative care units open during that year.[2] It showed that about 28 000 people died in those units during the year. Most died of cancer, making up some 17% of the 164 000 deaths from cancer (the others died of AIDS, motor neurone disease, and other diseases). Many more patients, however, were admitted and subsequently discharged during the advanced stage of their illness: there were about 49 000 admissions during the year. Some patients were admitted more than once before their death, but this figure indicates that