home. The code of practice produced by the working group will provide helpful guidance for health professionals in evaluating both advance statements and advance directives (refusals of treatment).

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1 Robertson GS. Making an advance directive. *BMJ* 1995;310: 236-8. (28 January.)

Measles campaign

EDITOR,—Towards the end of last year Elizabeth Miller[1] questioned whether Britain could match the results reported from measles immunisation campaigns in less industrialised countries.[2] Ninety two per cent of 7·1 million children aged 5 to 16 were immunised in England through the measles and rubella immunisation campaign last November. Of the 172 district health authorities or NHS trusts, 37 achieved coverage of >95%, 96 achieved coverage of 90-95%, 31 achieved coverage of 85-90%, six achieved coverage of 80-85%, and two achieved coverage of <80%.

Since the beginning of November last year the Public Health Laboratory Service has been able to use salivary antibody diagnosis to confirm measles in suspected cases. There were more than 100 positive reports in November and December last year. By 1 April this year, despite more than 800 samples having been tested, there had been only 21 confirmed cases, with full details available in 21. Only one case occurred in a child whose age was covered by the campaign; that child's parents had withheld consent. All other cases were in children under the age for routine immunisation (9); children under 5 who had received one dose of measles, mumps, and rubella vaccine previously (3); or people aged 17 or over (8).

The purpose of the campaign was to prevent an expected epidemic. There can be little doubt that this has been achieved. Early indications are that in most areas transmission of measles among schoolchildren has been interrupted.

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1 Miller E. The new measles campaign. *BMJ* 1994;309:1102-3. (29 October.)
2 Measles elimination in the Americas. *Bull Pan Am Health Organ* 1992;26:271-4.

Injury to child pedestrians

EDITOR,—Ian Roberts concludes that the key to preventing injuries to children by motor vehicles is a change in transport policy.[1] He argues his case on the basis that the recent decrease in death rates probably reflects reduced exposure (fewer pedestrians), that personal characteristics are not strong predictors of injury, that education has had little effect on rate of injury, and that traffic management has been shown to work.

While transport policy is a key item on the agenda for preventing injury to pedestrians, other factors are also important, particularly until transport policy alters. These include children's knowledge, attitudes, and behaviour; parental attitudes to prevention of childhood injury, and towards giving permission for children's independent activities; enforcement of current traffic legislation; and optimum traffic management and environmental design based on current traffic policy. Whatever the ultimate solution, many of the factors that have been identified as contributing to accidents are behavioural.[2] For example, most children are running across the road when an accident occurs[3] and pedestrian fatalities are associated with alcohol drinking.[2]

Measuring the direct benefits of educational programmes is difficult. Nevertheless, accident records of the members of traffic clubs—children who received six monthly educational programmes on traffic safety—showed lower accident rates than for non-members (P Schioldborg, fifth congress of the international federation of pedestrians, Gello, Norway, 1976). Innovative educational programmes (and their evaluation) will continue to be necessary pending major environmental change.

Roberts equates pedestrians with walkers. For instance, he states that the higher rate of injury in children from poor families and those without access to a car may be because they walk more. Activities other than walking, such as playing in the street, are likely to be equally if not more important.

We are engaged in a study of children's risk behaviour and exposure to risks. Our preliminary observations indicate considerable differences in patterns of play by age, sex, and socioeconomic circumstances, and it would be surprising if such differences did not relate to injury rates.

While agreeing with the thrust of Roberts's editorial, we believe that a broad and balanced approach combining educational, regulatory, technological, and environmental components is essential to prevent childhood accidents. Narrowly focused health promotion has met with failure in other areas, and an integrated approach is essential.[2,3]

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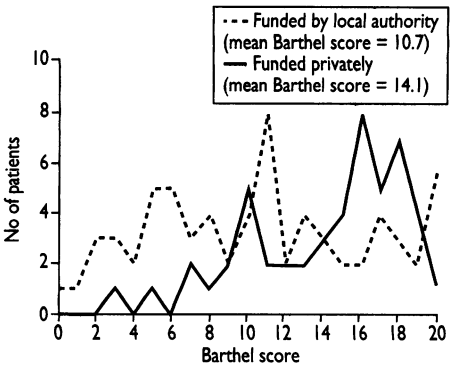
1 Roberts I. Injury to child pedestrians. *BMJ* 1995;310:413-4. (18 February.)
2 Heraty MJ. *Review of pedestrian safety research.* London: Transport and Road Research Laboratory, Department of Transport, 1985.
3 Grayson G. The identification of training objectives: what shall we tell the children? *Accid Anal Prev* 1981;13:169-73.
4 Kelly MP, Charlton BG, Hanlon P. The four levels of health promotion: an integrated approach. *Public Health* 1993;107: 319-26.

Success of NHS and Community Care Act 1990 for elderly people

EDITOR,—Victoria Ajayi and colleagues suggest that the reforms relating to the NHS and Community Care Act 1990 have improved arrangements for discharging elderly people from hospital in the borough of Hammersmith and Fulham.[1] This is in contrast to an article by Tonks in 1993, which outlined major concerns regarding community care for frail and elderly people.[2]

We recently evaluated admissions to nursing homes from the community and from hospitals in Aberdeen since 1 April 1994 (one year after the reforms under the act were implemented) to assess whether selection bias occurred according to whether patients were funded by their local authority or privately. One hundred and nineteen patients were evaluated, of whom 69 were funded by local authorities and 50 privately. The investigators thought that only 81 patients were clearly appropriately placed. Furthermore, a significantly lower proportion of those with private funding were clearly appropriately placed (28 (56%) *v* 53 (77%), P=0·017), and the Barthel score (a measure of dependency—the lower the score the greater the dependency) was significantly higher in the privately funded group (mean (SEM) 14·1 (0·56) *v* 10·7 (0·68), P<0·001 on *t* test, P=0·001 on Mann-Whitney test) (figure).



Barthel score in patients funded by their local authority or privately

In conclusion, selection bias seems to operate in favour of privately funded patients with a lower level of dependency; this disadvantages patients who require institutional nursing care but need help with funding from their local authority. Hence, for this group of patients the reforms under the community care act are not a success. More rigorous control of the assessment of patients requiring placement in a private nursing home is needed to obviate such bias.

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1 Ajayi V, Miskelly FG, Walton IG. The NHS and Community Care Act 1990: is it a success for elderly people? *BMJ* 1994;330:439. (18 February.)
2 Tonks A. Community care fails the frail and elderly. *BMJ* 1993;307:163.

The Gulf war syndrome

EDITOR,—Tony Revell's letter concerning the 200 personnel now assessed by the Ministry of Defence raises more questions than it answers.[1] Not the least is why it has taken over four years for the Ministry of Defence to start assessing these men and women when so many complaints were made soon after their return from the Gulf in 1991. Since 98% are (by the Ministry of Defence's own submission) suffering from something, perhaps Revell's medical service should have taken them more seriously in the first place.

The Ministry of Defence should beware, however, of assuming that the diversity of conditions listed implies no link. Three factors are common to all those personnel who have been assessed so far: all were in the Gulf; all were given a large number of inoculations, often in a hurry; and all took nerve agent pretreatment sets (pyridostigmine bromide tablets) as protection against biological and chemical warfare. It is at least possible that one causative link is damage to the immune systems of some individuals. Given that certain immunisation materials were prepared in a non-commercial environment (and details have been classified as secret, even to parliamentary questioners) and that the administration of these materials in the desert seems to have left a lot to be desired, this theory should be tested. If the immune systems of Revell and myself were compromised, even temporarily, we would be vulnerable to different bugs, yet the cause would be the same.

The high incidence of psychiatric conditions

(36%) should also be viewed with concern. Changes in personality can be induced by exposure to chemicals; some people may be more susceptible than others. Many men reported serious side effects after taking nerve agent pretreatment sets, including enhanced aggression. These reports should be investigated thoroughly.

We must protect our troops as well as possible in modern warfare. That implies an objective approach to all complaints after service in a particular field. It is to be hoped that the Ministry of Defence will now ensure thorough research into its own findings, preferably through civilian and NHS establishments.

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1 Revell T. The Gulf war syndrome. *BMJ* 1995;**310**:1073. (22 April.)

Transferring the costs of expensive treatments

Guidelines may clarify responsibility for prescribing

EDITOR,—Bromley Health has looked at ways of dealing with the transfer of expensive treatments from secondary to primary care.[1] As a unified district health authority and family health services authority, it is ideally placed to deal with general practitioners' concerns, such as cost shifting, by making changes in the contracts with providers.

Bromley Health's approach has been to draw up a list of drugs to be prescribed by hospital doctors and not by general practitioners. This advice is founded on clinical responsibility and not cost and is based on a document from the NHS Management Executive.[2] The advice given is that "when clinical, and therefore prescribing, responsibility for a patient is transferred from hospital to GP, it is of utmost importance that the GP has full confidence to prescribe the necessary drugs." The test in confidence is whether the general practitioner "can monitor treatment and adjust the dose if necessary." For example, monitoring of growth hormone treatment or the adjustment of the dose of erythropoietin is done by a specialist, and therefore the specialist should issue all necessary prescriptions.

The list of drugs is managed by Bromley Health's prescribing committee. It is envisaged that new drugs will be reviewed for inclusion—for example, when limited trial data exist, as in the case of interferon beta, or when the place in treatment is not fully established, as with dornase alfa. But the prescribing committee relies on evidence from regional specialist advisory committees, and, with their passing, purchasers will need to collaborate to obtain specialist advice.

One barrier has been communication between hospital managers and hospital doctors. While managers accepted that the consultants should prescribe if the general practitioners felt unable to, the doctors continued to defend their directorate budget as they had been instructed not to overspend.

There is a cost to Bromley Health. The guidance that specific drugs should be prescribed entirely by the hospital doctor will be reflected in the contracts with providers. The contract price will include the cost of these drugs and will therefore reflect the full cost of treatment. By deliberately limiting access to the general practitioners' drug budget, which is not cash limited, Bromley Health will have to increase financial resources for the purchase of hospital services.

Bromley Health hopes that its guidelines will clarify responsibility for prescribing. Moreover, by avoiding the separation of prescribing from the assessment of treatment, hopefully it will ensure that treatment is effective and appropriate.

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1 Crump BJ, Panton R, Drummond MF, Marchment M, Hawkes RA. *Transferring the costs of expensive treatments from secondary to primary care. BMJ* 1995;**310**:509-12. (25 February.)
2 NHS Management Executive. *Responsibility for prescribing between hospitals and GPs.* London: Department of Health, 1991. (EL(91)127.)

Review of funding is long overdue

EDITOR,—The Child Growth Foundation wishes to ask why it is only now that doctors are calling for an urgent review of the impact of transferring the costs of expensive treatments from secondary to primary care.[1] To guarantee the Department of Health's promise that patients would get the drugs they needed regardless of cost a review was needed when biosynthetic growth hormone was introduced in 1985. In fact, we wrote to the then prime minister, Margaret Thatcher, predicting that a prescribing problem would occur once this expensive drug came on the market.

We believed that the problem might be resolved after the House of Commons health committee expressed hope that someone in the Department of Health was addressing the issue, but nothing emerged.[2] We trust that doctors will succeed where our parliamentarians have failed.

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2 NHS Executive. *Prescribing expenditure: guidance on allocations and budget setting for 1995-6.* Leeds: NHSE, 1995. (EL(95)8.)

Future of intensive care

EDITOR,—The recent headlines concerning the lack of intensive care beds in the United Kingdom reflect a longer term crisis that has afflicted intensive care since the first intensive care units were established around 30 years ago.

Intensive care units in Britain are still staffed by consultants, many of whom have undergone no systematic training in the specialty, and by resident rotating junior staff, who spend just enough time in the intensive care unit to learn what it is about before moving on. The royal colleges have been talking about training in intensive care for around 10 years now; they have formed one committee after another, written reports, and even established a few training posts, but essentially the situation is unchanged.

Inadequate sessional time is allocated to intensive care so that 24 hour consultant cover is generally achieved by individual consultants sacrificing their free time, and on occasion by subsidy from helpful anaesthetic departments. The plight of consultants in intensive care units is made worse by the fact that often junior staff are thrown into the unit without training, and it is not surprising that the treadmill of intensive care life militates against the development of their academic activities.

Units are too small, so that full time intensivists cannot be justified, and consultant cover is generally provided by consultant anaesthetists working in the unit one day a week or possibly one week in four or five. Neither situation allows the development of clinical teaching or research expertise in the specialty.

In Europe, North America, and Australasia, intensive care medicine is a fully fledged specialty, sometimes allied to anaesthesia, medicine, or surgery, but with formal training programmes, specialist registration, and academic departments to promote research. In the United Kingdom the Intensive Care Society has valiantly tried to develop intensive care on a multidisciplinary basis and has had notable success in the audit of outcome from intensive care. Nevertheless, progress in developing the specialty has been hamstrung by the perceived divided loyalties of physicians and anaesthetists working in intensive care and, more importantly, by the sectional interests and jealousies of the royal colleges.

To elucidate the attitudes of practising consultant "intensivists" we circulated a qustionnaire to 566 consultant members of the Intensive Care Society. From 325 replies (90% anaesthetists) there was an overwhelming desire for intensive care to be recognised either as a separate specialty (24%) or as a distinct subspecialty of both medicine and anaesthesia (50%). A total of 69% of respondents wished the specialty to be governed by an intercollegiate faculty or a college of intensive care; 76% wanted a diploma examination, either a European diploma or a diploma of an intercollegiate faculty rather than of a single college. Most importantly, over 75% of respondents felt that at least two years' dedicated experience of intensive care work was required before accreditation.

There is clearly a consensus among those who work in intensive care that the current state of this increasingly important branch of medicine cannot continue. Intensive care must be recognised as a distinct specialty and the royal colleges must establish an intrercollegiate faculty or facilitate reorganisation, formalise training, and stimulate academic activity in intensive care with the utmost urgency.

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Communicating with non-English speaking patients

EDITOR,—In a multicultural society and one in which modern travelling has made it easy to commute, in any country the medical services may be faced with a patient who does not speak the national language. Our *International Translation Guide for Emergency Medicine* helps medical staff to evaluate and examine patients, can facilitate communciation between the travelling public and health care providers of a different culture and language, and also can lead to an adequate doctor-patient interaction.[1]

Voluntary organisations have produced leaflets in different languages, but this book attempts to help the patient from the moment he or she enters into a dialogue with a health care provider. The book is simple and can be used for combinations of two languages—English, Russian, Hindi, Italian, French, German, Spanish. No knowledge of more than one language is required. It is in the format of questions and yes-no answers. Although the book could be translated into more languages, in its present form it can be used in emergency departments and general practices worldwide, and its simplicity and usefulness will be appreciated by medical and nursing staff.

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1 Bodiwala GG, McCaskie AW, Thompson MM. *International translation guide for emergency medicine.* Oxford: Butterworth-Heinemann, 1992.