

outcomes study had a range of purposes. The two methodologies have a complementary function and should not be promoted as polar opposites. Each methodology, however, is grounded in a distinct paradigm; in particular, qualitative methods are more concerned with developing adequate conceptual frameworks than with establishing generalisability. We suggest that, although it is common, it is inappropriate to judge qualitative methods from a quantitative standpoint, as Bisset and Chesson are attempting to do.

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1 Anderson R. *The aftermath of stroke: the experience of patients and their families*. Cambridge: Cambridge University Press, 1992.

Elective ventilation of potential organ donors

EDITOR,—Elective ventilation of deeply comatose patients close to death in order to preserve their organs for transplantation is in breach of the common law requirement that medical treatment be directed to the patient's benefit. There is no implication, however, that elective ventilation is harmful to the patient. The legal issue is purely that of the intention of the medical intervention.

This law aims to protect the patient's best interests. Contrary to the point made by Alex Manara and Claire Jewkes, however, the medical community and society have already accepted exemptions to this law.¹ For example, immune deficiency and leukaemia in children are commonly treated by bone marrow transplants from sibling donors. The legal principles involved in bone marrow donation by legally incompetent minors seem identical with those involved in elective ventilation, while the ethical problems seem more difficult. This clinical practice, however, has been widely accepted for decades both in Britain and internationally.

M S Nielsen is right that the underprovision of intensive care facilities in Britain is far from ideal for implementing elective ventilation.² In 1993, however, when most transplant units were in the early stages of considering elective ventilation, 28 donors in Britain had elective ventilation (British Transplantation Society, unpublished findings). In Exeter, from 1988 to 1994, 19 of 57 donors (including two donors of several organs) had elective ventilation (H Riad, personal communication).

Those opposed to elective ventilation should note that the legal exemption being sought is enabling, not prescriptive. When the transplant and intensive care teams are in favour and the next of kin of a suitable patient agree, and if at the critical time the pressure on intensive care facilities permits, elective ventilation should proceed with the highest ethical and clinical standards. The ethics committees of both the BMA and the Royal College of Physicians have approved the ethics of elective ventilation.³

The main clinical uncertainty is the risk of a persistent vegetative state. The British Transplantation Society's protocol has been devised to try to minimise this risk. The society believes that, if elective ventilation were legalised, the initial way

forward should be a carefully audited clinical trial. Subsequently, mandatory registration of all patients entered into elective ventilation protocols would be important. The council of the British Transplantation Society is unanimous in its view that the government should find a mechanism to remove the legal restriction on elective ventilation.

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Doing particular good in today's NHS

EDITOR,—C J Burns-Cox keeps a philosophical directive from Gandhi on his office wall.¹ Colleagues labouring under the burden of managerial politics in today's NHS might prefer something more homespun. My own choice is from the (mad?) English visionary William Blake: "He who would do good to another must do it in Minute Particulars: General Good is the plea of the scoundrel, hypocrite and flatterer, for Art and Science cannot exist but in minutely organized Particulars and not in generalizing Demonstrations of the Rational Power."

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Advice on alcohol consumption has narrow perspective

EDITOR,—The Royal Colleges' advice to the public and the editorial by J Michael Gaziano and Charles Hennekens¹ have taken a narrow perspective of the ill effects of alcohol, and ignored several issues.

The studies concentrate on mortality and not morbidity and even for mortality have inadequate data on accrued risks.¹ Cumulative morbidity resulting in physical diseases (for example, cerebral atrophy) and indirect "hidden costs" (for example, road traffic accidents) are ignored or unknown. For example, alcohol is considered an important factor in 52% of episodes of wife battering, 50% of rapes,² and almost 25% of deaths on the road,³ and the existence of a safe threshold of alcohol intake for these is debatable. The non-drinking victims of alcohol related violence or accidents are not reflected in these studies. While alcohol misusers may reduce their mortality figures, mortality and morbidity rates in non-drinkers may rise because of indirect effects of alcohol.

Whether a "medically sensible limit" brings acceptability to alcohol is unknown, and the cliché may be cleverly used by the alcohol industry. On one side, non-drinkers may begin to drink and occasional drinkers may increase their alcohol intake because alcohol is considered "safe." On the other, heavy drinkers are heeding medical advice to reduce their intake. The end result depends on a complex interplay of factors. There is a significant positive correlation ($r=0.92$) between the population average for alcohol intake, and the prevalence of heavy drinking,⁴ so if there is an increase in the average consumption then a

corresponding increase in the number of heavy drinkers is likely.

The profession previously erroneously identified a safe limit for alcohol to avoid cirrhosis: 160 g per day. The continuing search for a "sensible limit" based on separate organ systems is a myth. We need to look at the problem of alcohol in a holistic manner, which includes morbidity and the cost to society as a whole, before proposing such limits.

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Other factors may have contributed to epidemic of renal failure

EDITOR,—The findings of Mohammed Hanif and colleagues about the epidemic of acute renal failure in Bangladeshi children after ingestion of paracetamol elixir contaminated with diethylene glycol had certainly contributed to a reduction in the incidence of the disease.¹ We faced this type of postfebrile anuric acute renal failure since 1981. Between 1981 and 1991, a total of 1837 children with this illness were admitted to the paediatric renal unit of the Institute of Post-Graduate Medicine and Research, Dhaka—the tertiary referral centre in Bangladesh. In spite of treatment including peritoneal dialysis, the average mortality was 77%.^{2,3} In 1988 the World Health Organisation sent a paediatric nephrologist from Britain who stayed here for three weeks and reported her experience.⁴

A prospective epidemiological study carried out in 610 children admitted to our unit with the disease from July 1988 to June 1991,⁵ showed extreme poverty (85%), illiteracy (70%), ignorance about fluid intake during fever or diarrhoea (98%), and ignorance about the danger of prolonged anuria (99%) among the parents of the affected children.⁵ A clustering of cases (80%) was observed during hot seasons. Over half the children (56%) had received paracetamol along with antibiotics (mainly co-trimoxazole or amoxycillin) and 15% had received paracetamol alone before anuria developed. Many of them received the suspension and tablet forms, not the elixir that could have been contaminated with diethylene glycol. Nine per cent had received homoeopathic and herbal medications; 20% did not have any medication at all.

It is obvious that factors in addition to contaminated paracetamol were responsible for this epidemic. The mortality was 19% in those who were admitted within 24-48 hours after last voiding and 90% in those who came after 48 hours ($P<0.001$). The rise of serum creatinine concentration was directly proportional to the duration of anuria. Needle biopsy in 32 cases showed necrosis, degeneration, and atrophy of tubules, the glomeruli being normal in all of them.

It was concluded that these children had developed ischaemic tubular necrosis following fluid and electrolyte loss. Poverty, illiteracy, ignorance, and the indiscriminate use of drugs were the predisposing factors for the high incidence. Delayed seeking of medical advice and lack of adequate treatment facilities contributed to the high mortality. Extensive propaganda and motiv-