

with important public health implications, has given rise to a need for information on its spread. Serum residues from the study of infection A, together with the epidemiological database, provide the ideal resource. Their use is justified on the grounds that (a) further collection of serum samples from the community would be unethical while suitable samples are available, (b) the whole community would benefit from the provision of important epidemiological data on infection B to public health authorities, and (c) absolute anonymity of people who participated in the study of infection A could be assured. The study is conducted and data presented, after the use of a geographical information system, in the form of precise maps of the distribution of infection B by subpopulation within the community. Molecular "fingerprinting" through phylogenetic analysis^{3,4} reconstructs the pattern of the epidemic, with its origin and spread from sector to sector. If infection B was measles no one would raise an eyebrow; substitute HIV infection and alarm bells ring.

Although anonymity for the individual has been maintained, social stigma can apply to sections of a community and not just to individuals. International ethical guidelines advise that investigators should protect groups as well as individuals from possible harm or disadvantage, including adverse criticism relating to sensitive information.² How should these principles be put into practice? At what mapping resolution does "community confidentiality" become a problem? Does informed consent need to be obtained from communities, and, if it does, who should be their representative? We believe that more discussion is needed to determine how to disseminate and use information in ways that support community rights.

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Long term care in later life

A mixed economy of care is necessary

EDITOR,—On behalf of the hundreds of thousands of residents and staff living and working in private nursing homes I take issue with the implication of one of the questions in J Grimley Evans's editorial on long term care in later life: "Should profit making nursing homes join tobacco companies and manufacturers of antipersonnel mines as industries in which decent people do not buy shares?"¹ I assume that Grimley Evans has chosen these latter two industries for comparison because they make products that maim or kill people. I know of no evidence showing that private nursing homes maim or kill elderly people. Their rates of admis-

sion, length of admission, and mortality are comparable to those of voluntary or state nursing homes, as is shown by the most authoritative survey of long term residential care.² If Grimley Evans has evidence to the contrary he should share it with us.

Grimley Evans describes private nursing homes as "inadequately regulated." Yet private (and voluntary) homes are subject to a stringent registration process and twice yearly independent inspections. State nursing homes are not bound by any such regulation, and most commentators, right across the political spectrum, agree that by far the most pressing reform is to create a "level playing field" by regulating state homes in precisely the same way as private and voluntary homes are regulated.

Perhaps Grimley Evans objects to the principle of making profit from caring for elderly people. If so, does he condemn his medical colleagues who practise privately, specialist builders, private hospitals, manufacturers of specialist equipment, and all those who provide support services to elderly people, such as caterers? Indeed, perhaps Grimley Evans should consider his own position. As a professor with merit awards he earns considerably above a bare living wage and might therefore be said to "profit" from elderly people.

Grimley Evans rightly raises the serious issue of funding of long term care. The debate has moved on, however, from the old public versus private divide. The future lies with a mixed economy of care, in which all three sectors have an important role. Each needs to teach and learn from each other in an area in which asking questions is much easier than providing real solutions.

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- 1 Grimley Evans J. Long term care in later life. *BMJ* 1995;311:644. (9 September.)
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Best providers should win contracts irrespective of their ownership

EDITOR,—Although J Grimley Evans's editorial on long term care in later life raises important issues, some of his assumptions and emotive language undermine the spirit of the open and informed debate that we so desperately need on the future of long term care in Britain.¹ Although it is useful for commentators to acknowledge the diversity and range of philosophies of ownership in the independent sector—indeed, much of Britain's independent health and social care sector relates to such traditions as cooperation, mutuality, and charity—the debate should surely be the best way to ensure that people's needs are met. Indeed, the future demands a move away from the old and sterile world of the "them versus us," "public versus private" rhetoric beloved of politicians and activists on all sides.

Three quarters of all nursing and residential care homes in Britain are now provided by the independent sector,² and a recent study by the University of Kent based on costs for 1993-4 found that NHS care for elderly people was over 92% more expensive (residential care provided by a local authority was found to be 31% more expensive).³ Accordingly, one must ask whether Grimley Evans should not instead be calling for a boycott of all statutory providers.

I believe that when statutory authorities fund care they must guarantee real choice and start to contract for care packages and not simply buy beds. A nationally agreed system for scoring dependency should also be introduced throughout Britain, which would be used to assess need and specify treatment and packages of care. Above all else, commentators should be primarily concerned

with quality and cost irrespective of ownership: in the future, the best providers should win contracts irrespective of their ownership.

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Accessing the Internet is far from easy

EDITOR,—According to Andrew Millman and colleagues, "accessing the Internet is very easy,"¹ but tales of woe in articles and correspondence in British magazines devoted to the Internet tell another story. Who is telling the truth?

My attempts to get dial up connection to the first Internet service provider I tried took several weeks because of an almost complete lack of advice, difficult access to a helpline, and overloading of the service provider (one of the major ones). The email software was cumbersome and almost unusable. When it proved impossible to log on, the automatic redialling facility was an advantage, but I abandoned this provider after several occasions on which over 500 attempts to log on failed.

A second service provider supplied an incorrect password, which prevented me from logging on, and a helpline was repeatedly engaged. There was no reply to two faxed requests for help, but I obtained a response after sending a letter by post. I abandoned this provider after repeated inability to log on and access the system.

A third service provider could not be contacted by telephone (it was repeatedly engaged) and failed to reply to fax or posted requests for information.

With a fourth service provider, for reasons that it could not explain, email was selectively undeliverable to Manchester University and there were frequent problems with logging on.

I am currently trying a fifth service provider; the early signs are promising. I have not counted the many hours spent in this exercise, but at present I would advise only serious computer enthusiasts with plenty of spare time to attempt to access the Internet from home. The truth is that access to the Internet is at present far from easy. The reasons include rapid expansion in the number of people wishing to access the Internet, which exceeds the ability of service providers to expand their services; user unfriendly software; and poor support.

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- 1 Millman A, Lee N, Kealy K. The Internet. *BMJ* 1995;311: 440-3. (12 August.)

"Probiotic" remedies are not what they seem

EDITOR—"Probiotics," usually called "acidophilus," are claimed to contain "friendly" intestinal lactic bacteria, regular consumption of which confers health benefits.¹ As a previous report showed that dietary products sold in the United States as containing *Lactobacillus acidophilus* either contained no viable lactobacilli or contained organisms other than *L. acidophilus*,² we investigated the microbiological content of 13 brands of probiotics bought over the counter in Britain.

The preparations were cultured for lactobacilli on MRS agar (Unipath, Basingstoke, Hampshire), for enterococci on m-enterococcus agar (Difco, East Molesey, Surrey), and for anaerobes on Columbia agar (Unipath) plus 5% whole horse blood. Either one whole tablet was crushed in a sterile mortar or the content of a capsule (opened under aseptic conditions) or a weighed amount of powder (approximately 500 mg) was suspended in 10 ml of MRS broth, blended with a Vortex mixer for 1 minute, and allowed to stand for 30 minutes; viable counts were made from the supernatant fractions. Plates were incubated for 48 hours at 37°C. As many colony types as possible on each medium were counted and identified with 50CH, API Strep 20, and API rapid ID 32A kits (bio-Mérieux, Basingstoke, Hampshire), as indicated.

Only two products (B and H) matched their labelled microbiological specifications qualitatively and quantitatively (table). The 11 other brands did not contain *L acidophilus*, contained extra species, or lacked a listed species, or numbers were less than a tenth of those stated. Four brands (C, E, G, and K) contained bacterial species not stated on the label (*Enterococcus faecium* in two, *Pediococcus pentosaceus* in two). Five brands (A, F, J, K, and L) did not contain the listed *L bifidus* (which was reclassified as a *Bifidobacterium* sp (an obligate anaerobe) more than 20 years ago.³ Oral probiotics may be beneficial in certain specific conditions—for example, *Saccharomyces boulardii* or *B bifidum* plus *Streptococcus thermophilus* in diarrhoea.^{4,5} But claims made on the labels of some of the products tested here—"maintains a healthy

digestion," "improves digestibility and assimilation of food," "keeping the intestinal contents sweet," "assist . . . general well-being," "protects skin . . . against harmful microbes," "builds immunity"—are not supported. The *British National Formulary* states that "lactobacillus preparations are valueless" in acute gastrointestinal infections.

In conclusion, the public and health professionals should be aware that the labelling of some probiotics may be misleading, in terms of both the microbiological content and possible beneficial effects.

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Microbiological characterisation of 13 probiotics

Brand	Formulation	Composition as stated on label*	Composition when analysed
A	Capsule	>5 × 10 ⁹ { <i>Lactobacillus bifidus</i> <i>L acidophilus</i> <i>L rhamnosus</i> <i>Streptococcus faecium</i> †	2.2 × 10 ⁹ 7 × 10 ⁸ Not detected Not detected 2 strains of <i>L rhamnosus</i> <i>E faecium</i>
B	Capsule	4 × 10 ⁹ <i>L acidophilus</i>	4.7 × 10 ⁹ <i>L acidophilus</i>
C	Capsule	>1 × 10 ⁹ <i>L acidophilus</i>	5.1 × 10 ⁹ <i>L delbreuckii</i> 5 × 10 ⁹ <i>Enterococcus faecium</i>
D	Capsule	2 × 10 ⁷ <i>L acidophilus</i>	1 × 10 ⁴ <i>L acidophilus</i>
E	Powder	>1 × 10 ¹⁰ <i>L acidophilus</i>	2.2 × 10 ⁹ <i>L rhamnosus</i> 1.4 × 10 ⁹ <i>E faecium</i>
F	Tablet (enteric coated)	>5 × 10 ⁷ >5 × 10 ⁷ <i>L acidophilus</i> <i>L bifidus</i>	1.5 × 10 ⁹ <i>L actobacillus</i> spp Not detected
G	Tablet	500 mg‡ <i>L acidophilus</i>	7.8 × 10 ⁷ <i>L acidophilus</i> 4.8 × 10 ⁷ <i>L fermentum</i> 1 × 10 ⁷ <i>Pediococcus pentosaceus</i>
H	Capsule	6.4 × 10 ⁸ <i>L acidophilus</i>	1.2 × 10 ⁷ <i>L acidophilus</i>
I	Capsule	>2 × 10 ⁹ <i>L acidophilus</i> # R	5.4 × 10 ⁷ <i>L acidophilus</i> 8.4 × 10 ⁷ <i>Lactobacillus</i> spp
J	Capsule	2 × 10 ⁹ { <i>L acidophilus</i> <i>L rhamnosus</i> <i>L bifidus</i> <i>S faecium</i>	2.2 × 10 ⁷ Not detected 2 strains of <i>L rhamnosus</i> Not detected <i>E faecium</i>
K	Capsule	2.5 × 10 ⁸ { <i>L acidophilus</i> <i>Bifidobacterium bifidum</i>	3 × 10 ⁷ <i>L acidophilus</i> Not detected 9 × 10 ⁴ <i>L plantarum</i> 4.9 × 10 ⁴ <i>Pediococcus pentosaceus</i>
L	Capsule	2 × 10 ⁹ { <i>L acidophilus</i> <i>L rhamnosus</i> <i>S faecium</i> <i>L bifidus</i>	5 × 10 ⁹ <i>L acidophilus</i> 2.9 × 10 ⁹ 2 strains of <i>L rhamnosus</i> 6 × 10 ⁹ <i>E faecium</i> Not detected
M	Capsule	5 × 10 ⁷ { <i>B breve</i> <i>B longum</i> <i>S thermophilus</i> <i>L rhamnosus</i> <i>L acidophilus</i> <i>L casei</i> subsp <i>casei</i> <i>L bulgaricus</i>	8.6 × 10 ⁸ { 2 strains of <i>Bifidobacterium</i> sp <i>S thermophilus</i> <i>L rhamnosus</i> <i>L acidophilus</i> <i>L paracasei</i> Not detected

*Bacterial count per capsule, tablet, or gram, as appropriate.

†Reclassified as *Bifidobacterium* sp (see text).

‡This species has been renamed *Enterococcus faecium*.

§Not helpful: 500 mg of lactobacilli = 10¹² bacteria.

Deaths in police custody

EDITOR,—During the past 12 months 15 deaths have occurred in police custody in Britain, according to the national police authorities. Forensic investigation has comprised at least a postmortem examination in all cases, and in only one case is prosecution of the police officer concerned pending. It therefore seems that in some circumstances a pathological entity exists that predisposes subjects in police custody to certain forms of natural death. Underlying cardiomyopathies, cardiac valve lesions, and cardiac conduction defects have all been mooted as causes of death. Among potential hypotheses to explain this phenomenon are supranormal secretion of catecholamines and supranormal surges in blood pressure due to the psychological and physical stress of police custody.

I believe that a prospective confidential inquiry into the cause of deaths in police custody should be set up. It is imperative that the BMA is not perceived by the public to be in complicity with the police authorities on this issue. The effect of such a perception on the South African Medical Association in the 1980s was all too evident. We need to ascertain and document the cause of death in all cases. Such an inquiry could serve to identify a hitherto unknown clinical syndrome and allow preventive measures to be taken against deaths in police custody.

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Patients taking stable doses of morphine may drive

EDITOR,—A guide for medical practitioners published by the Medical Commission on Accident Prevention, *Medical Aspects of Fitness to Drive*, has been widely distributed within the medical profession.¹ In a section on drugs acting on the central nervous system it states that "the more powerful narcotic analgesics such as morphine produced marked sedation and patients requiring them should not drive." This has important implications for the quality of life of patients receiving palliative care who require regular doses of morphine to control pain.

Experience in palliative care indicates that the symptoms that occur at the start of treatment with morphine generally resolve within a few days of the dose being stabilised. It is commonly believed, therefore, that patients taking a stable dose may drive without hazard to themselves or other road users. There are, however, few objective data confirming this belief.

Vainio *et al* have recently reported the results of psychological and neurological tests designed for professional drivers of motor vehicles that were conducted in two groups of patients with cancer. Twenty four of the patients were taking slow release morphine orally at regular intervals to control cancer pain, and 25 were free of pain without taking regular analgesics. The mean daily dose in the treated patients was 209 mg (range 60-1100 mg) and had been stable for at least two weeks. The results showed that long term, stable, treatment with morphine at these doses had only a slight and selective effect on functions related to driving and that this effect would not be hazardous in traffic. Hanks, commenting on these findings, suggested reasons why long term morphine for pain should not result in the same degree of sedation that results from single doses in people who do not take opioids regularly.

These findings support the impression of most palliative care physicians that driving need not be