

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 ($14 \times 14 = 196$ 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.

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."²

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

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