There are attractive benefits of allocating screening policies to wards rather than individuals. As all participants allotted to each of the screening policies would always be located together trial execution will have been simplified, the risk of contamination reduced, and the bureaucracy of organising individual allocations avoided. The issues concerning consent to be randomised also differ in cluster randomised trials, which will have impacted on the ease of recruiting large numbers.

Simplifications of trial design, however, rarely come without jeopardising internal validity. To ensure proper random allocation the allocation mechanism must be truly random and the allocations concealed at the time they are assigned.⁵ The random element aims to prevent the misfortune of allocation patterns coinciding with, or being influenced by, a factor related to the outcome. Concealment of the allocation prevents the possibility of conscious or subconscious manipulation of individual assignments. There is empirical evidence that unconcealed randomisation leads to overestimation of treatment effects,⁶ manipulation possibly occurring by participants' registrations being delayed until they would receive the preferred treatment allocation or exclusion of eligible subjects whose allotted allocation would be considered unfavourable.

In this trial, despite the use of a random mechanism to assign the intervention switching policies to the wards, the allocation of a mother to a ward was by the standard haphazard (not really

random) process of hospital bed allocation. While such a mechanism may seem difficult to influence it certainly is not concealed. As these criteria are not met the authors cannot *guarantee* that they have allocated the participants to the two groups in an unbiased manner. For the allocation to have been seriously biased, however, it would be necessary for assignments to have been made with some knowledge of each individual's likely outcome, so that the allocation of some mothers carrying babies of higher (or lower) risk could be manipulated in favour of a particular policy. While such manipulation is a reality in poorly randomised treatment trials, there may be situations in trials of preventive and screening interventions when no risk factors can be identified at the time of assignment to intervention and biased allocation is theoretically impossible. The interpretation of this trial relies on just such an assumption.

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- 5 Schulz KF. Randomised trials, human nature, and reporting guidelines. *Lancet* 1996;348:596-8.
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A patient who changed my practice Footsteps and faces

It is said that a bird's eye view changes the perspective even of familiar things, but it was a bed's eye view that changed mine. Completely bed bound, unable to use a commode, I had a peculiar perspective on people passing through the ward. Their comings and goings became a series of footsteps and faces and, if I was lucky, smiles and voices.

I heard footsteps, quick yet purposeful, and a figure came into view. The face looked towards the floor, avoiding eye contact, but I could make out a frown across his forehead. Bustling along, appearing hassled and giving out signals which say, "I'm busy, don't bother me." It's a junior doctor, wearing a white coat with pockets bulging. I don't recognise him. "He's not part of my team," I thought, "but I've seen so many, I'm not even sure who my team is anyway."

More footsteps, sophisticated this time. High heels clicking on the floor, strutting rather than walking. As she comes into view she's not in uniform, no white coat, but an identification badge hangs off her lapel. Her head held high with an air of importance or is it arrogance? Must be a manager of sorts. But I wouldn't know; I've only ever met two. Another walks along, slowly, occasionally pausing. I wait, wondering, will they ever reach my viewing zone? They'd better because I'm intrigued; who are they, why are they walking so slowly? Next, eyes look me up and down, and up and down again just to get a good look, and it's written all over his face.

"What's wrong with her, poor thing, she's so young?"

He avoids my gaze, almost embarrassed but not enough to stop him lingering before moving on.

Who's this now? Purposeful footsteps again but not rushed and definitely not strutting, busy but not overburdened. The footsteps come into view and a face looks at me. Has she got the wrong person? I don't recognise the nurse wearing an agency uniform. But she looks, meets my gaze, and then smiles. A kind smile, one

that acknowledges me and in a split second says, "Hi ... and bye," it says, "I see you lying in bed and I see you as a person with feelings." Suddenly she's gone, but I am left with a warm feeling and my spirits lifted.

Shuffling this time, is it a child dragging his or her feet or an old man in slippers unable to pick his feet up? No, it's too quick for that; who is it? Any second now they'll be visible—oh yes, an anaesthetist. I smile to myself, knowing that I too drag my theatre shoes, but my thoughts are interrupted as the anaesthetist raises his eyebrows and mutters, "Hiya. All right?" "Yes thanks," I reply.

We exchange a nodding of heads and he continues on his way. The interchange took less than 30 seconds yet he was the first person today to speak to me of his own accord. Granted he had to talk to me a few days ago during the preoperative visit but not today; he had other patients to see.

I reflected; you can look at walls and floors with no reaction, but you can't look at someone without evoking a response because people generate thoughts and feelings. From that moment I resolved never again to hide behind my footsteps and face but to reach out to patients and reveal my smile, my voice.

It makes a difference; I know, I was that patient.

Michelle White, *anaesthesia senior house officer, Bristol*

We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.