children. How would the authors explain this finding?

I concur that it would be wise to recognise the need to integrate antidiarrhoeal treatment with nutritional rehabilitation and home care follow up, but even more important perhaps would be to compare those who had treatment and nutritional rehabilitation with those who had treatment but no follow up or nutritional rehabilitation. My personal experience of working in mission hospitals in the rural areas was that scarce Health Service resources were deployed to follow up these children who had suffered from diarrhoeal illness with no attempt to ascertain whether such management made any difference in the overall mortality. The ethical issue did not arise, as a reasonable number used to refuse nutritional rehabilitation after recovery from the acute illness. Those who refused rehabilitation could be compared with those who accepted nutritional rehabilitation.

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¹ Chen LC, Chowdhury AKMA, Huffman SL. Anthropometric assessment of energy protein malnutrition and subsequent risk of mortality among preschool age children. *Am J Clin Nutr* 1980;33:1836-45.

* *We sent this letter to the authors, who reply below.—ED, *BMJ*.

SIR,—Our study was based on children who had been admitted to hospital, and being a selective group they had limitations when compared with other groups like those of Chen *et al*.

For children under 2 years, the effect of malnutrition on mortality was not striking. The observed lower rate in the severely malnourished children may have been due to random fluctuations. There was only one death out of 37 cases in that group; had there been two deaths, the mortality would have been the highest. Our interpretation, however, took into account this possibility of random fluctuation.

In Bangladesh breast feeding is almost universal and is usually prolonged beyond infancy; the median length of breast feeding is 30 months. If there had been little or no breast feeding in Bangladesh the pattern of mortality in malnourished children under 2 years discharged after treatment for diarrhoea would, in our opinion, have been quite different.

We agree with the suggestion that impact of follow up and health education of patients with malnutrition who have had diarrhoea is of great importance and may improve the chances of survival. As this is a busy hospital follow up and education had not been carried out routinely. A similar study is being prepared.

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Twelfth rib syndrome

SIR,—I would agree with Mr Derek G Machin and Mr John M Shennan (15 October, p 1142)

that intercostal neuralgia should be a part of the differential diagnosis of a pain in the loin. I also agree with Dr T F F Casale (15 October, p 1142) that resection of a rib is seldom indicated.

I must, however, protest as strongly as I can about Dr Casale's deplorable neologism "dorsatica." The sciatic nerve takes its name from the ischium and the suffix "-a" could well be an abbreviation of "-algia," although the Oxford English Dictionary does not refer to it; so, the term "sciatica" is soundly based and has been in common use for more than 200 years. If pressed I would accept "dorsalgia" as a rather prissy way of describing a pain in the back but "dorsatica" has neither sound roots nor any clear meaning. May it forthwith perish without trace.

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Breast feeding and atopic eczema

SIR,—Your recent leading article on breast feeding and atopic eczema (17 September, p 775) contains several statements with which I disagree. Dr Atherton concedes that many studies have had design faults which have led to inconsistent results, but he seems to disregard these same faults by placing great reliance on those studies which "have fairly consistently shown a protective effect"¹⁻³ The statement which follows shortly afterwards: "If, then, breast feeding is protective . . ." in my opinion overstates the case on the available evidence.

In many ways the whole problem of breast feeding and subsequent development of eczema lends itself better to a retrospective study. The reason for this is the impossibility of obtaining a properly controlled prospective population that has been randomly allocated to either method of feeding. There can never really be random allocation of feeding methods because of both maternal and infant variables. On the maternal side, the decision to breast feed or not is probably made in early pregnancy, if not before, and depends on all sorts of social, family, and individual factors such as socioeconomic environment, presence or absence of previously breast fed siblings, and belief in what is best for the child.⁴ Probably the presence of a previous atopic sibling is also taken into consideration. On the infant side, the artificially fed child is more likely to come from a worse socioeconomic environment, to be of lower birth weight, and to have suffered complications during pregnancy or the perinatal period. There is a one way effect of "less healthy" infants selecting themselves towards artificial feeding. Such problems make the design of a prospective study a daunting prospect, and randomisation is therefore most unlikely.

None of the prospective studies mentioned¹⁻³ have taken any real consideration of social class into account. Dr Atherton admits that social class may be important as there is some evidence that atopic children may be more likely to come from "better" socioeconomic backgrounds. I wonder if he has considered the possibility that such an increased risk might even be due to the greater prevalence of breast feeding in this group? This is not a serious suggestion but illustrates my point that no useful conclusions can be

drawn unless subjects are matched for social class and other variables to minimise any effects which they exert.

There is also the considerable problem of observer bias in such prospective studies, none of which have so far been conducted in a blind fashion. It is difficult to see how such blind assessment could ever be reliably incorporated into a future study, which, in addition to the difficulty with initial randomisation, must increase the problems of interpretation considerably.

The studies which Dr Atherton has chosen to disregard, presumably because they were retrospective,^{5,6} have in my opinion given us more reliable information. In both of these there was an attempt to allow for social class differences, and adequate numbers were considered. Although these were not strictly speaking blind studies the diagnosis of eczema was made separately from the information on infant feeding to minimise observer bias. The overall conclusion of these studies is that there is no demonstrable protective effect on the development of atopic eczema.

I am not convinced that there is any hard evidence to support Dr Atherton's conclusions. One problem, which already exists in clinical practice and which surely will be exacerbated by Dr Atherton's article, is that of the mother who has been encouraged to breast feed to prevent eczema and who for one reason or another is unable to do so.

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¹ Chandra RK. Prospective studies of the effect of breast feeding on incidence of infection and allergy. *Acta Paediatr Scand* 1979;68:691-4.

² Matthew DJ, Taylor B, Norman AP, Turner MW, Soothill JF. Prevention of eczema. *Lancet* 1977;ii:321-4.

³ Saareinen UM, Kajosaari M, Backman A, Slimes MA. Prolonged breast feeding as a prophylaxis for atopic disease. *Lancet* 1979;ii:163-6.

⁴ Sauls HS. Potential effect of demographic and other variables in studies comparing morbidity of breast fed and bottle fed infants. *Pediatrics* 1979;64:523-7.

⁵ Kramer MS, Moroz B. Do breast feeding and delayed introduction of solid foods protect against subsequent atopic eczema? *J Pediatr* 1981;98:546-50.

⁶ Taylor B, Wadsworth J, Golding J, Butler N. Breast feeding, eczema, asthma, and hay fever. *J Epidemiol Community Health* 1983;37:95-9.

ABC of sexually transmitted diseases

SIR,—Although the acquired immune deficiency syndrome is the most recent sexually transmitted disease described in male homosexuals (29 October, p 1279), it must be emphasised that sexually acquired enteric infections are considerably more common in homosexuals. Among these infections amoebiasis and giardiasis are probably the most common,¹ and, as Professor Michael W Adler points out, *Shigella* species may be transmitted sexually; typhoid fever,² threadworm,³ and, more recently, *Strongyloides stercoralis*⁴ infections have been described, however. Infections due to enteric pathogens in homosexuals are often multiple and sometimes recurrent.

The sexual history taken in homosexual patients should include questions on preferred sexual acts in order to assess the risk of faecal ingestion. In addition to the more common symptoms of sexually transmitted diseases, other complaints associated with enteric infections such as diarrhoea, abdominal pain, and flatulence must be sought. More than one

stool specimen should be sent to the microbiology laboratory for microscopical examination and culture, particularly in patients where the initial faecal examination yields a pathogen or a non-pathogenic protozoa, as this may be an indication of the presence of other enteric parasites. The importance of laboratory diagnosis cannot be overemphasised, especially in patients with gastrointestinal symptoms, as many enteric pathogens, such as *Entamoeba histolytica* and *Giardia lamblia*, are resistant to antibiotics commonly in use for the more conventional sexually transmitted diseases.

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- ¹ Quinn TC, Stamm WE, Goodell SE, *et al.* The polymicrobial origin of intestinal infections in homosexual man. *N Engl J Med* 1983;309:576-82.
- ² Dritz SK, Bratt EH. Sexually transmitted typhoid fever. *N Engl J Med* 1977;296:1359-60.
- ³ McMillan A. Threadworms in homosexual males. *Br Med J* 1978;3:367.
- ⁴ Sorvillo F, Mori K, Sewake W, Fishman L. Sexual transmission of *Strongyloides stercoralis* among homosexual men. *Br J Vener Dis* 1983;59:342.

Honorary senior registrars

SIR,—I read with interest the article by Dr A O Sobo and others (8 October, p 1078) on the plight of potential honorary senior registrars and the illuminating figures from the north east. According to the college commentary of the Royal College of Physicians, but differently reported in the *BMJ* (6 August, p 438), the Joint Consultants Committee, firstly, has apparently recommended that university posts should be granted senior registrar status, which hints at an "I'm all right" attitude by the universities. Secondly, employees of "reputable" fund giving bodies may be offered the status, if the posts have educational and manpower approval. As these posts are funded for a limited period, each person, rather than the post, will have to obtain ad hominem accreditation for his own approved course of training, which at the moment is usually granted by the Joint Committee on Higher Medical Training only if the post carries senior registrar grading. Catch 22. And are other national, "disreputable," grant giving bodies to be treated differently, such as Action Research, British Digestive Foundation, British Heart Foundation etc?

Finally, those unlucky enough to be funded only "for a specific project," which is inaccurate as this is true for almost all grants, should not be entitled. Why not? They, like all junior medical research workers, give up several thousand pounds a year to do their demanding work. This is the product of private enterprise working in research, often with younger NHS consultants conceiving the ideas, and the project growing or shrivelling depending on results. A healthy way to fund research.

If the posts within a region are to be limited, although as Dr Sobo and colleagues point out this will do little to help the manpower problem, then should all registrars and lecturers applying for senior registrar status be subject to a selection process by a regional training committee, so that an empty "slot" could be filled by an applicant supported by a university, the NHS, or a research fund?

It is a shabby way to treat these research workers and their supervisors. I do hope that the Joint Consultants Committee, BMA, and

colleges will think again and consider a fairer solution.

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Business management for the NHS?

SIR,—I was disturbed by the leading article (5 November, p 1321) on the Griffiths management inquiry. There must be some sympathy for the view that the service is over-administered, but are the recommendations suggested curative? Will they be in the best interests of patients?

Doctors should ask questions as they read the document—"not a report . . . recommendations on management action"—a major re-organisation, but by the back door. "Speed of implementation is essential," so read quickly and with care, and question.

If we admit that political responsibility is implicit in the taxpayer picking up the Health Service bill, to what extent should that control be exerted and what expertise do we (the public as well as the profession) demand? All the chairmen of authorities are nominated and the chairmen will appoint the general managers. Who will they appoint? Can we assume that there are enough doctors thought to have management skills or willing to spend considerable time managing? The former medical superintendents—were they readily acceptable to colleagues? Can we be sure that whatever has been implied verbally, the doctor will be the manager in the near future, or the distant future? The inquiry pays lip service to the importance of doctors, but does it contain enough evidence to reassure the profession of its participation? We are told that the authority chairman will nominate the most suitable candidate irrespective of discipline. Consensus management is obviously unpopular, but let us not forget that at present there is 50% medical input.

Furthermore, are business skills relevant to a service organisation? Is management in large business without fault, or is success being better than one's business competitors. Who are patients' competitors?

Before saying that the BMA is more welcoming than others, have we yet examined the inquiry carefully? I have recently held a peripheral regional meeting and have been asked to convey grave reservations to BMA headquarters. The time for consultation is short and all should consider the inquiry urgently and with care.

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Open letter to John Patten

SIR,—Mr Mike Daube is to be warmly congratulated on his open letter to Mr John Patten (29 October, p 1289). He describes with irrefutable logic both the medical and the moral arguments for a more effective stance against the all conquering tobacco industry. There will be objections, of course, to his recommendations, usually from vested interest, but even from within our profession. We have all read letters from doctors who see tobacco as a form of population control, and even a partial answer to the geriatric dilemma. Nevertheless, most of us would surely wish

to be associated with Mr Daube's message to the new Under Secretary of State at the Department of Health and Social Security.

The much lamented Sir George Young, the best junior health minister we have ever had, will not be easy to emulate. Let us hope that Mr Patten takes heed and displays both humanity and political courage during the term of his office.

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Mental Health Act Commission and the code of practice

SIR,—Dr P D Rohde (29 October, p 1318) makes telling points on section 5 of the Mental Health Act 1983 and on reports to mental health review tribunals passed to patients; though in the old days doctors and social workers could intimate that such reports should be withheld from patients on grounds of distress to them: I did not know such intimation was now precluded. Is it?

May I be permitted a demur on his other two points? Firstly, on the question of the right to treat. Dr Rohde's belief that section 29 of the 1959 Act and section 4 of the 1983 Act constituted a "72 hour order" always was and still is wrong. There is ample evidence that it was an emergency order for the old section 25 when the avowed intention of the legislators, on removing the magistrate from detention provisions outside the courts, was that detention should result from the recommendations of two doctors. Only under conditions of dire emergency and when the second recommendation was unobtainable could one recommendation detain: the second recommendation must be obtained as quickly as possible and never later—a concession—than 72 hours. This necessity is, in my opinion and rightly, highlighted by the section 56 restriction of treatment on section 4 and other short term orders. I find it hard to believe that any self respecting hospital accepting psychiatric patients at weekends (St Mary Abbot's included) has not on call a consultant who can visit and change section 4 to section 2 within hours: in the meantime get the emergency under control with medication regardless, as Dr Rohde's adviser suggests.

Secondly, I would challenge Dr Rohde's view of patients in the community, though the new position is more complicated. The one night readmission on the ground of "legal" rather than proper clinical need of a 1959 Act section 26 patient on statutory leave was an undesirable and unnecessary gimmick. The right answer was a guardianship order allowing the guardian to order the patient's continuation of treatment as he would order his under 14 year old child. Under the 1983 act relevant guardianship provision (section 8(1)(b)) the guardian may "require the patient to attend . . . for . . . medical treatment. . . ." The 1981 DHSS document *Reform of Mental Health Legislation* (Cmd 8405) opined dogmatically (para 44) "that the guardian will clearly not have implicit power to consent to treatment on behalf of the patient." Lawyers might well argue against this opinion: that it would be absurd to enact statutorily the bringing of the horse to water but failing to make him drink; that a requirement to attend for medical treatment implies acceptance of the treatment