a response to sound of 35-40 dB free field; hence toilet paper and bells are out, as they emit 60 dB on quiet use. It is necessary to cover the frequency range, and therefore to use high-frequency sounds (Manchester rattle or Nuffield), low frequency sounds (a metal spoon on a cup rim), a voice producing high-frequency sounds ("ss") or low sounds ("oo"), and speech at 35-40 dB using a minimal voice. This form of testing combined gives us the distraction test, needing one person on the "front" to distract and plateau the babe's attention, and one "behind" to give the stimuli. If the baby fails the test and does not respond at a level of around 35-40 dB, then the sounds can be raised and an objective assessment made of the level necessary for response. The idea of distraction with one hand and putting in sounds with the other, especially if it is a cup and spoon, belies belief. The distraction test as described can be used for babies of 7-18 months, and is a very useful method of testing when babies have missed being screened until late.

Contrary to Dr Valman's opinion that the commonest reason for a child failing is lack of interest, I would say the commonest reason is a mild secretory otitis media. After this come immaturity resulting in fixing on the distractor or lack of attention to sound, and social deprivation and lack of stimulation making sound less meaningful to the child—and, of course, from this test you hope to pick up your profoundly deaf child in infancy, and hopefully your partially deaf child who has a high-frequency loss but normal hearing in the low frequencies.

This testing is now done in many parts of the country with a clinical medical officer and a health visitor, or two health visitors. I think it is important if a baby fails that he should be examined by a doctor. Mild upper respiratory troubles often may be quite silent as far as the mother is concerned and give rise to hearing losses. If these are not found in the early months and years you have all the attendant problems of glue ear, lack of attention to sound, delayed language, and lack of learning by the time the child approaches school age.

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* * We sent this letter to Dr Valman, whose reply is printed below.—Ed, *BMJ*.

SIR,—Dr Gumpel's letter provides some additional information which complements my brief description of hearing tests. To ensure that the infant had moved his head to the test sound and not by chance it is essential that some form of distraction is used. This can be provided by a health visitor facing the child or by a loud sound (a bell or toilet paper) produced by the examiner. The latter method has the advantage that it can be performed by those unfortunate health visitors, family doctors, and consultant paediatricians who do not have a "distracting" health visitor constantly available. I failed to mention that the most effective form of distraction is provided by an older sibling, especially a toddler. To avoid disrupting the test it is best to advise that he should be left at home.

I had assumed, apparently in error, that if an infant did not respond to the test sounds he would be examined with an auroscope to detect wax or otitis media. I agree with Dr Gumpel

that if an infant fails to respond to test sounds he should be seen by a doctor, who should examine the ears.

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Chemoprophylaxis for contacts of *Haemophilus influenzae* meningitis

SIR,—Dr Mary P Glode and others (29 March, p 899) recently published an account of secondary cases of *Haemophilus influenzae* meningitis. They followed up 126 consecutive cases presenting over a three-year period at Boston Children's Hospital. Four secondary cases were identified in 171 household contacts aged less than 5 years old occurring within a month of the index case. They concluded that this confirmed the opinion of Ward *et al*¹ about giving chemoprophylaxis to children under 5 from the households of cases of *haemophilus* meningitis.

Both of these papers report experience in the United States, where *H influenzae* is the commonest cause of bacterial meningitis.¹ This is because of an absolute increase in the number of cases of meningitis due to this organism in recent years.^{2,3}

In Great Britain the meningococcus is the commonest cause of bacterial meningitis, even in children.⁴ We have recently reviewed all cases of bacterial meningitis admitted to East Birmingham Hospital from 1968 to 1977 and also the discharge figures for the entire Birmingham Area Health Authority from 1969 to 1978. *Neisseria meningitidis* caused over twice as many cases of meningitis as *H influenzae* and was the commonest cause of meningitis in children under the age of 5. The annual fluctuation of notifications of meningococcal meningitis was significant at the $p < 0.001$ level (see accompanying table). Three patients with bacterial meningitis at East Birmingham Hospital had a history of contact with meningitis and two of these had meningococcal meningitis. The third case had a sterile cerebrospinal fluid and blood culture but there was a petechial rash suggesting meningococcaemia.

Epidemics of meningococcal disease have recently been reported from England⁵ and from the United States.⁶ The mortality in these epidemics was 19% and 31% respectively.

Chemoprophylaxis for contacts of meningococcal meningitis is thus based on sound evidence of major epidemics and fluctuations in annual incidence, not on sporadic secondary cases, a picture which is endorsed by our results. It is entirely inappropriate to compare this with the experience reported by Dr Glode and her colleagues.

Even if we allow for this, the case for chemoprophylaxis for child contacts of *H influenzae* meningitis is not strong. Turk⁷ reported a detailed study on contacts of infections due to *haemophilus* type B. All of 11 families with three or more children had at

least one member with raised titres of antibody to *H influenzae* at the time of the index infection, suggesting that the organism had been in the family for some weeks. Nasal carriage of the organism persisted for up to six months, not only in family contacts but also in the index cases following treatment. It is therefore possible that children under 5 would still be at risk after a course of chemoprophylaxis and that prophylaxis for the whole family is required, a much larger undertaking.

Until conclusive evidence of the benefit of such chemoprophylaxis is obtained it seems unreasonable to recommend this policy with its considerable risk of inducing resistance to useful antibiotics. Such evidence will be difficult to obtain in this country since, as our figures show, the number of cases is relatively small.

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¹ Ward JI, Fraser DW, Baraff LJ, Plikaytis BD. *N Engl J Med* 1979;301:122-56.

² Fraser DW, Henke CE, Feldman RA. *J Infect Dis* 1973;128:300-7.

³ Haggerty RJ, Ziai M. *Adv Paediatr* 1964;13:129-81.

⁴ Goldacre MJ. *Lancet* 1976;i:28-31.

⁵ Easton DM, Estcourt PG, Brimblecombe FSW, Burgess W, Hass L, Kurtz JB. *Br Med J* 1974;ii:507-9.

⁶ Foster MT, Sanders E, Ginter M. *Am J Epidemiol* 1971;93:346-53.

⁷ Turk DC. *J Hygiene* 1975;75:315-32.

Guidelines for research in children

SIR,—May I take this opportunity of congratulating the British Paediatric Association for its initiative in producing guidelines to aid ethical committees considering research projects involving children (26 January, p 229). For some time issues concerning this matter have been raised with our association—in particular, the responsibilities and role of parents. We have considered this matter at some length and wish to state that we accept the association's main premises.

We should like to draw readers attention to the aspects concerning parental permission and co-operation. Staff do experience difficulties in explaining research procedures. Ways must be found to overcome this fundamental difficulty in order that a parent may fully understand before agreeing to the procedures on behalf of their child. Clearer guidelines are required on the means of ensuring that consent is freely given and that staff explain as fully as possible without raising undue anxiety or confusion. Parents often need more time to talk informally with someone informed but not directly involved in the project.

Signed, witnessed consent forms, as an extension of spoken explanations but not a substitute for them, would safeguard the parents' access to information regarding

Annual hospital discharges for meningitis due to *N meningitidis* and *H influenzae* in Birmingham

Causative organism	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	Total cases
<i>N meningitidis</i>	25	40	23	38	59	42	20	21	17	11	296
<i>H influenzae</i>	21	15	9	18	12	6	11	10	17	10	129

The annual fluctuation for meningococcal cases is significant (χ^2 with 9 df = 65.3, $p < 0.001$); the fluctuation for *haemophilus* cases is not (χ^2 with 9 df = 15.26, $p > 0.05$).

the purposes of the research, the procedures, the risks, the benefits, and the subject's right to withdraw at any stage; and they could give encouragement to parents' to question the researcher and, to remain with the child during procedures. The National Association for the Welfare of Children in Hospital would like to see a wider use of such consent forms and was disappointed that greater emphasis was not given to the parents' role in this matter when it was discussed by Denham *et al.*¹ Our association welcomes the British Paediatric Association's comment "It is an advantage if the parents can be present during the procedure," but we would like to see a firmer emphasis on the child's need for the parents' presence.

NAWCH would like to think that members of all ethical committees are aware of the existence of these guidelines and that when difficult and complicated decisions are under debate concerning medical research on children they will use the Standing Ethics Advisory Committee. We appreciate the British Paediatric Association's anxiety concerning the volume of routine decisions being referred to this committee unnecessarily, but our concern is that those trained and experienced in the care of children should be involved in making their views on these matters more widely known. We share the association's hope that in time, if the standing committee is used appropriately, it will establish some uniformity of policy for research on children throughout the country.

We trust that a dialogue on matters of this kind between those providing a caring service and parents of sick children will build up trust and understanding, which in turn will enhance the provision made.

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¹ Denham MJ, Foster A, Tyrrell DAJ. *Br Med J* 1979;ii:1044.

Services for the mentally handicapped: management of hospitals

SIR,—Previous correspondents on the subject of services for the mentally handicapped have presented a dichotomy of views on the care of the mentally handicapped. These need to be bridged by a broad, eclectic approach.

In practice the majority of mentally handicapped people, with mainly social and educational needs, are and should be cared for in the community. For a small proportion of mentally handicapped people in the categories defined by Dr Ruth M Walters (15 March, p 793) there is no alternative at present to admission to hospital. Existing hospitals for mental handicap are likely to remain for many years to come. For the patients there treatment and training is life in the hospital. All facets of the hospital impinge on the patients for good or bad. Hence the management of the hospital is a powerful therapeutic tool.

In the last 10 years numerous inquiries and advisory reports have criticised the management and lack of direction in hospitals for mental handicap. These are faults of the system rather than of any professional group. The regional and area health authorities are too remote from these hospitals. District management teams lack the expertise to appreciate their special problems. The senior officers in the hospitals

do not have the authority, power, and resources to carry out the changes that they know are desirable. Hence good intentions fail to be translated into action.

Hospitals for mental handicap are in need of permanent special management or project teams to which are delegated more clearly responsibility, resources, and executive power. These teams should include the senior hospital officers, a member of the district management team, and a representative of the area health authority. These teams should regularly consult with the consumer interests.

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Medical opportunities in France

SIR,—I would be grateful for the opportunity to comment on the article "Medical opportunities in France" (26 January, p 228) since I am at present spending a year in Lyon in the post of *résident médecin étranger* with Professor R Lambert. It is undoubtedly true to say that the French authorities are keen to promote exchanges, and it was therefore unfortunate that you omitted to mention these posts, which perhaps offer the simplest and most satisfactory means whereby a young clinician or research worker can spend a year working in France. There are 13 such posts offered each year by the Hospices Civils de Lyon, and a similar scheme exists for Paris. The posts are salaried, and are offered at *interne* level irrespective of the seniority of the candidate. However, this does not necessarily mean that the work is that of a houseman or senior house officer, since the posts are supernumerary and the duties undertaken depend on the candidate's needs as well as those of the service. In my own case I was fortunate in that Professor Lambert readily agreed to allow me to do laboratory research, while encouraging me to take an active interest in the clinical work of the unit and to continue my training in endoscopy.

The only absolute requirements are that candidates should be under 35 and speak fluent French. This latter is an obvious stumbling block, particularly if clinical work is to be undertaken, but should not be regarded as a deterrent, since the "examination" consists only of an informal chat with a member of the staff of the French consulate and one rapidly makes progress when thrown in at the deep end. In Edinburgh the French Institute runs conversational classes at all levels, including a course in "medical French", and similar help can no doubt be found in other large cities. In any case the sympathy and kindness shown by everyone in France—colleagues and patients alike—provide constant encouragement.

The difficulties of adapting to a different culture and a very different system of health care are not to be minimised, but the rewards are great at both personal and professional levels. French-speaking "Anglophones" are regarded as rare birds in France, and the warmth of the hospitality shown to us has been astonishing. French medicine is in the process of aligning itself with the English-speaking world, and all research is preferentially published in English. This causes grave disquiet to such bastions of conservatism as the *Figaro* newspaper, but readily explains why cross-fertilisation between the two countries is so actively encouraged, and can only be for

the good of the medical and scientific community as a whole.

Advertisements for these posts of *résident médecin étranger* appear annually on most hospital notice boards, but further details could be obtained directly from the Service Scientifique of the Ambassade de France, 41 Parkside, Knightsbridge, London SW1. I can wholeheartedly recommend the experience and would be happy to advise anyone interested in such a venture.

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Stimulation of dorsal column in multiple sclerosis

SIR,—We are delighted that the careful study (29 March, p 889) of Dr C H Hawkes (who was first introduced to spinal cord stimulation when working in this unit in 1976) and colleagues has confirmed our results, and grateful for the implied compliment that our work¹⁻⁶ is so well known that the usual convention of recognition and citation of prior work was not thought necessary. As a matter of record, the first report of "striking changes in bladder function" was by Cook's group in 1977.⁷

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¹ Illis LS, Sedgwick EM, Oygar AR, Sabbahi Awadalla MA. *Lancet* 1976;ii:1383-6.

² Illis LS, Sedgwick EM, Tallis RC. *Proceedings of the VI international symposium on external control of human extremities*. Belgrade: 1978:523-8.

³ Tallis RC, Illis LS, Sedgwick EM. *Proceedings of the VI International Symposium on External Control of Human Extremities*. Belgrade: 1978:575-83.

⁴ Jobling DT, Tallis RC, Sedgwick EM, Illis LS. *Med Biol Eng Comput* 1980;18:48-56.

⁵ Illis LS, Sedgwick EM, Tallis RC. *J Neurol Neurosurg Psychiatry* 1980;43:1-14.

⁶ Sedgwick EM, Illis LS, Tallis RC, *et al.* *J Neurol Neurosurg Psychiatry* 1980;43:15-24.

⁷ Abbate AD, Cook AW, Attalah N. *J Urol* 1977;117:285-8.

Ear syringing

SIR,—On reading through Dr Stuart Carne's article (9 February, p 374) on ear syringing we note that he did not mention the Water Pik as a means of clearing the ear of wax. The Water Pik consists of a small electric motor supporting a bath of water. The motor sucks in the water and emits it as a pulsating jet. Used initially by dental hygienists, it was found to be equally useful for clearing the ear of wax. The strength of the jet of water can be varied depending on the consistency and adhesion of wax in the ear. There is no sucking or squeezing of syringes, no sore thumbs, no leakages over the patient or indeed the doctor. It is a far more efficient method of clearing the ear of wax, and we would warmly recommend it to your readers. Where the wax is hard the ears should, of course, have oil instilled in them one day prior to their being washed out. The Water Pik at present costs about £20 and is available from Teledyne Water Pik, Heathrow House, Bath Road, Cranford, Middx.

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