primary care setting is the cornerstone of community psychiatry.² This should particularly be true in the United Kingdom with its tradition of comprehensive general practice. Current plans for future psychiatric services include community services devolving from psychiatric hospital units. True community and primary care initiatives are the exception. Though the Griffiths report envisaged primary care doctors taking on the role of key worker for patients with chronic mental illness,³ in one survey only 16% of general practitioners said that they would agree to act as key workers while the rest said that they would prefer community psychiatric nurses to do so.⁴

It should be possible for general practitioners to be funded to establish registers of patients with chronic mental illness and to provide much of the care they require—social and welfare needs as well as physical care. Much of this work could be done by practice based community psychiatric nurses, again if funding was provided. Psychiatrists could then take the role of a true consultant, working increasingly in primary care, helping to coordinate services, and concentrating their efforts on the most needy cases. In this way continuity of care could be improved and services would be more accessible and acceptable to patients.

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Treating bony metastases

SIR,—C Baughan asserts that single fraction external beam radiotherapy for bone metastases may sometimes be detrimental.¹ We disagree, however, with the arguments cited against single palliative treatments.

Baughan states that the oedema that may follow high dose single treatments could exacerbate threatened or actual spinal cord compression, yet early neurological deterioration is unusual in patients given 12.5-15 Gy as a single treatment with corticosteroid cover (W P Makin, first international consensus workshop on radiation therapy in the treatment of metastatic and locally advanced cancer, Washington, DC, 1990). In addition, the 4.5 Gy dose per fraction often given in fractionated courses of palliative radiotherapy, though capable of causing or increasing oedema, does not seem to increase the risk of cord compression.

Baughan states that more severe acute bowel side effects may occur with single fractions, yet in the study cited,² though the group given single treatment experienced more nausea, it was of shorter duration and the daily subjective record over one month showed no difference in gastrointestinal upset between the two fractionation groups. In a randomised trial we have found no difference in acute bowel toxicity between patients receiving a single treatment or five fractions (M N Gaze *et al*, first international consensus workshop on radiation therapy in the treatment of metastatic and locally advanced cancer, Washington, DC, 1990).

Though the tumour killing dose from a single treatment is less than that from a fractionated course, this is not a major factor in palliation of bone pain. Shrinkage of tumour alone cannot

explain the response seen within 24 hours of hemibody irradiation³ or the efficacy of a single dose as low as 4 Gy.⁴ The similar levels of pain relief achieved in patients with radiosensitive and radio-resistant tumours would not have been observed if killing of tumour cells was the principal analgesic mechanism.⁵ Though reassurance and counselling are important aspects of clinical practice, protracted fractionation cannot be justified merely as an opportunity to provide emotional support.

There are no data to support Baughan's statement that fractionated radiotherapy probably offers a longer duration of pain control, although current studies may indicate some cases in which this is true. The claim that fractionated treatment may be better "value for money" is wholly unsupported by evidence from clinical trials and has not been subjected to adequate audit, which must include marginal cost-benefit analysis—this is especially important with the large capital costs and fixed costs of radiotherapy departments.

The unanswered questions about radiotherapy fractionation are better addressed by prospective trials and careful audit than by nebulous clinical impressions.

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Threatening miscarriages and new advice on anti-D immunoglobulin

SIR,—It has taken three years for the Department of Health to produce fresh advice on the problem of threatening miscarriages,¹ and general practitioners will be disappointed that the new regulations are no easier to follow than the ones that they supersede. Hidden in a recent eight page article on anti-D immunoglobulin in *Prescribers' Journal* is paragraph 4.5.2, which could easily be overlooked.² The working party of the United Kingdom's National Blood Transfusion Service now recommends that anti-D immunoglobulin should be given within 96 hours of the onset of any bleeding in the first 12 weeks, but only if a rhesus negative woman apparently has a viable pregnancy. No evidence is given to support this ex cathedra statement.

I challenged the need for anti-D immunoglobulin in first trimester miscarriages in 1988.³ Subsequently, two haematologists stated that there was no evidence that it was required before the 12th week of pregnancy.^{4,5} One of them was on the working party that produced the new guidelines, so it is especially difficult to understand why anti-D immunoglobulin is still recommended for these women. The logistical implications of this are considerable as every year in the United Kingdom probably at least 200 000 women bleed in early pregnancy. This is assuming over 600 000 births, a miscarriage rate of 15%, and that about 15% of women with viable pregnancies have bleeding (of whom one seventh (15 000) will be rhesus negative). So general practitioners are now expected to discover within four days which of these 200 000 women with bleeding need to have anti-D immuno-

globulin because there is ultrasound evidence of a viable pregnancy.

Unfortunately, the availability of ultrasound is not good. In April I wrote to a random sample of 100 practitioners in England and Wales about their local service. Seventy per cent stated that it was not easy to get an urgent ultrasound examination done within two to four days.

General practitioners depend on expert advice but also need to understand why the viability of the pregnancy is important. In November 1990 I was asked for my opinion on new draft regulations. I considered that, on the evidence available, the advice was inappropriate and difficult to follow. Subsequently I have been unable to discover from the Department of Health representative if any other general practitioners were consulted. It seems odd that all this effort and expense should go into countering a risk whose reality has never been shown. We need to know how many cases of haemolytic disease would be prevented by this policy and at what cost. The Department of Health must now spell out exactly how we should deal with the practical realities of implementing its recommendation. Otherwise uncertainty will continue and its advice will be ignored.

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We don't have a computer

SIR,—P H Stanley's article,¹ in which he describes how his practice manages without a computer, is challenging.² The type of argument used could equally well be used to show that general practitioners do not need a car because they could make their visits on a bicycle. If Stanley is happy spending the whole of his life in his village he may well need only a bicycle, but for those of us who wish to make longer journeys a car is at least desirable if not essential.

Stanley lists several factors, which he uses to compare his practice with neighbourhood practices, but he does not go on to explore the much wider advantages that a computer system might provide. It is interesting to note the bias in his table, in which he says that repeat prescriptions are almost abolished in his practice. In fact, this is untrue; all that happens is that several repeat prescriptions are signed at once, albeit usually in the patient's presence. This is analogous to a computer system that has a limit on the number of repeat prescriptions that will be issued, and both systems should be described as repeat prescribing.

I accept that in his highly organised practice many of the simple tasks that a computer can perform are efficiently done with manual systems and that to use a computer you have to reach a level of organisation that might facilitate many of these tasks without the computer. This, however, is O level computing. The huge advantage of the more advanced computer systems that use coding is their ability continuously to audit the quality of care provided in the practice. Simple protocols can easily and comprehensively be applied for a wide range of conditions, and at the touch of a button once a year your success at managing the range of chronic conditions can be assessed. Stanley's practice may well engage in some form of audit, but to audit, for example, diabetic, asthma, hypertension, and cardiac clinics every year would

be very time consuming. In our practice once these regular audits have been set up (not a particularly long task in itself) they take only a few minutes.

With audit becoming compulsory and with the acknowledgement of many doctors that continuous regular audit is essential our practice is glad that it has bought a car rather than continuing to rely on a bicycle.

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Education on AIDS during biology classes

SIR,—In response to pressure to include teaching on HIV and AIDS in the national curriculum the Secretary of State for Education, Kenneth Clark, announced in the House of Commons on 24 October that in future school biology classes would include teaching about AIDS. Though this is a welcome step, Mr Clarke misses the key point. Clearly, it is important that young people have accurate information about what HIV is and how it spreads, but most school aged young people know how HIV is transmitted.^{1,2} What they need is time to reflect on their knowledge and its implications for their future sexual and recreational lifestyles. They also need the skills to adopt and sustain behaviours that will protect them from infection in future.³

Health educators, including specialists in HIV and AIDS, have argued that HIV infection needs to be addressed in the context of teaching on sexually transmitted diseases, sexual health, and relationships.⁴ These are subjects that should be covered in classes on personal and social education by well trained, supported, and resourced specialist school health educators. Teaching about the mechanics of infection in biology, though interesting and educational, cannot provide the opportunity school pupils need to discuss the complex and sensitive issues surrounding HIV infection. The outcome that health educators seek, and will continue to lobby for, is the allocation of core curriculum time to personal and social education.

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Advertising infant formulas in hospitals

SIR,—The promotion of infant formula in hospitals as described by Charles Price and Kate Jackson¹ and observed in other NHS hospitals illustrates again how reluctant companies that manufacture baby food are to abide by the spirit and letter of the code of marketing of breast milk

substitutes drawn up by the World Health Organisation and Unicef.² These companies contributed to the drafting of the code and have repeatedly promised to comply with it. The code was strongly supported and promoted by the United Kingdom's Department of Health. It was drawn up to remove commercial pressures from infant feeding and to protect parents, babies, and health workers from such pressures, to which we are all vulnerable.

Companies that manufacture infant formulas would not bother to buy advertising space such as posters on hospital walls if it was not effective. One company has spent £3m promoting two brands of infant formula in the United Kingdom so far this year. In the United Kingdom the whole market for baby milk grew in value by 21% in the 12 months to October 1990.³ The Department of Health currently spends £50 000 annually on the joint breast feeding initiative.

One way to address the problem is for purchasing authorities to include initiatives to protect and promote breast feeding in the contracts that they make with provider units. In the division of public health at the Institute of Child Health we have our own policy for implementing WHO and Unicef's code, outlining what we should do in respect of the various articles of the code. This policy includes an agreement not to accept funding for research from manufacturers of infant formulas. Many health workers in developing countries look to institutions in the United Kingdom to set ethical standards. All new staff in our centre are given copies of WHO and Unicef's code and of our divisional policy, and implementation of the policy is monitored.

We suggest that all hospitals should develop their own policies for implementing the code effectively and monitoring compliance with it. The code was designed to protect all infants, including those who are bottle fed. The choice of a substitute for breast milk should be based on clinical criteria and not be influenced by commercial pressures. Paediatricians, obstetricians, midwives, and other health workers have a responsibility to take a lead in this.

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Privatisation on parade

SIR,—Chris Ham writes that growth in private medicine is likely over the next decade owing to the strict control of public expenditure on health that is likely to occur.¹

The view that public spending on health is heavily constrained rests essentially on two implicit assumptions: firstly, that public spending is not to grow as a proportion of gross domestic product and, secondly, that spending on health will not rise as a proportion of government spending. Growth in public health expenditure is therefore at best limited to growth in the gross domestic product.

No doubt unintentionally, Ham gives the false impression that private spending on health care is free from the same restrictions. If, as he suggests, the private sector will grow faster than the public sector it must escape one or both of the above constraints. Consequently, either private spending must rise as a proportion of the gross domestic product, or private spending on goods other than health must fall. But as long as the government maintains public spending as a proportion of the

gross domestic product and gives health the same priority as does the private sector, the public sector will not suffer a relative decline.

There is, however, one other means for private spending to grow faster than public spending: if those who tend to purchase private health care take a larger share of the national income. In other words, a rise in inequality occurs. This has taken place to a substantial degree over the past decade, as Tony Delamothe's article on social inequalities in health illustrates.² I suggest that rising inequality, which Ham does not consider, is an important reason for the recent increase in private health care.

It is fashionable to suggest that the future growth of private health care is somehow an external phenomenon that governments are powerless to prevent. This is untrue, often for reasons not directly related to health expenditure. I have suggested above that total public expenditure—irrespective of actual health expenditure—and inequality of income will have appreciable effects on the growth of private medicine. Even if Labour and Conservative governments were to face the same direct constraints on health spending they offer widely differing policies on public expenditure and inequality.

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SIR,—It is hardly surprising that the public is bemused about "privatisation" when the vast majority of commentators on the NHS develop their arguments from an ill defined premise.

The basic fault is the lack of definition of the NHS and the assumption that it needs to provide services to patients. The fundamental issue of equality of access free at the point of use requires only public arrangement and certainly entails no necessity for public provision. Indeed, it is the failure of quality provision in the past that has led to the current problems and reforms. The inability of such a gargantuan organisation to manage itself well was the cause of most of the problems, and there have been no greater critics of hospital management than the medical profession.

It seems that Chris Ham equates "private" with "profit." In fact, "independent" is a much better word when almost half of the so called private hospitals are registered charities working on a not for profit basis. The structure of ownership has little consequence for patients' care if the providers of the finance are careful enough in their prescription for contractual arrangements. The semantics of "trust," "charity," and "for profit," however, seem more important to the ideologists than the patients who may be treated.

What is clearly important if the maxim of equality of access is to remain and if we are also to retain publicly owned hospitals—which we are—is that equality must be seen to be practised. If it is, it is quite impossible for private patients to be admitted to a trust hospital while access for those in greater clinical need is denied. The arguments about priority for patients of fundholding general practitioners are just the same as those about private practice, particularly in an expanding market.

There is no doubt that private insurance and private practice will increase considerably over the next decade whichever party is in power, and it is important that the rules are set clearly. By all means let us continue to have publicly owned hospitals providing publicly funded services through either health authorities or fundholding general practitioners. Let us also have sensible interdependence between public funding and independent sector provision where it is shown to