same false positive rate are used^{2,4} the "consumer" confidence in the risk is likely to be enhanced.

We are prospectively evaluating use of the maternal serum marker free β human chorionic gonadotropin in a screening programme (in conjunction with maternal serum α fetoprotein concentration). Though the study is not complete, preliminary data from screening 6000 pregnancies have shown that of the nine fetuses in this population confirmed cytogenetically to have Down's syndrome, eight were identified by the screening programme—that is, a detection rate of 89%. To achieve this detection rate 330 women whose fetuses did not have the syndrome were identified as having a risk greater than 1 in 300. This is equivalent to a false positive rate of 5.5%. What is even more surprising is that of these 330 women at increased risk, 294 (89%) took up the offer of amniocentesis. This figure remained fairly constant across the bands of risk, with 91.4% uptake for a risk greater than 1 in 100, 90.8% for a risk greater than 1 in 200, and 89% for a risk greater than 1 in 250.

Clearly, rates of uptake of amniocentesis will vary as a result of many factors, of which efficiency of detection and confidence in the screening programme are but two. Clinicians and managers should be clear of the errors in making comparisons and projections from less efficient screening protocols.

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High purity factor VIII concentrates and HIV infection

SIR,—E E Mayne¹ rightly criticises John D Cash's article² about high potency factor VIII concentrates. Cash has caused much confusion among financial managers in the NHS, who are establishing contracts for the care of haemophilic patients against a background of direct funding for HIV infection.

The choice of the clotting factor concentrates used for replacement treatment in patients with haemophilia is one of the main considerations in their clinical management. It is of particular concern for patients with HIV infection because of the potential detrimental impact of alloantigenic proteins on the immune system. Although one previous study showed no decisive benefit,³ there is now convincing evidence that high purity concentrates slow immunological deterioration in haemophilic patients infected with HIV.⁴ Twenty asymptomatic HIV positive haemophilic patients were assigned randomly to receive a high purity product or to continue treatment with an intermediate purity product. After 96 weeks the CD4+ lymphocyte count had fallen significantly in those who had continued to receive the intermediate product but had not fallen in those receiving the high purity product; the difference in mean CD4+ counts between the two groups at the end of the study was $0.25 \times 10^9/l$. We have monitored a cohort of 111 HIV positive haemophilic patients for 11 years⁵ and have shown that the differences in the

rate of progression to AIDS are largely explained by differences in the rate of fall of the CD4+ count⁶; the median slope of the CD4+ count for this large group was $-0.08 \times 10^9/l$ a year. Thus a difference in CD4+ count of $0.25 \times 10^9/l$ represents a three year decline in an average haemophilic patient infected with HIV.

The only complication of treatment with high purity factor VIII concentrate so far has been the greater than expected prevalence of inhibitor formation, particularly in children.⁷ New inhibitor formation has not been described in haemophilic patients with HIV infection: in fact, the level of inhibitor often falls in these patients.⁸

Are we justified in withholding high purity factor VIII concentrate from haemophilic patients with HIV infection? The cost of using this concentrate, which is more expensive, should be part of the overall cost of the care and treatment of HIV infection in haemophilic patients. High purity factor VIII is comparable to antiviral treatment for these patients: it is not a cure, but it does seem to delay the progression of HIV disease. In conventional medicine we would test this strategy by a larger controlled trial, but haemophilic patients with HIV infection do not live long enough to wait for the results of another study. The continuing tragedy of AIDS in haemophilic patients is a reminder of the inadequacy of delayed decision making. It will be another tragedy if we cannot afford to implement technological advances that offer optimum management of this devastating disease.

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Could an outbreak of poliomyelitis occur in the UK?

SIR,—A V Spedding and E Gradwell report a case of fatal acute poliomyelitis diagnosed at postmortem examination.¹ Though we agree with the need for examination of the spinal cord in these cases, it is important not to overlook virological investigation to search for both polioviruses and other enteroviruses that may cause poliomyelitis-like syndromes.² The World Health Organisation recommends that two faecal samples collected 48 hours apart, or colonic contents at postmortem examination, should be cultured for virus.³ Neither was done in this case.

S O Cameron and colleagues express concern about the possibility of a wild poliovirus type 3 strain causing an outbreak in the United Kingdom.⁴ It is difficult to assess the risk of such an outbreak in the United Kingdom and it is certainly not possible on the basis of their small, selected

serological study. The most recent survey of antibodies to poliovirus, done on 995 serum samples collected in England and Wales in 1984-6, showed an overall prevalence of antibody to poliovirus type 3 of 83%.⁵ Since then, however, uptake of vaccine has improved, reaching 93% by November last year.⁶ Only one outbreak due to poliovirus type 3 has been reported in a well vaccinated population (in Finland⁷), and this was against a prevalence of antibody to type 3 virus in children of 60% and use of subpotent inactivated poliovaccine rather than live attenuated vaccine, as in the United Kingdom.

In England and Wales the control of poliovirus infection is monitored at two levels. Vaccine coverage is assessed quarterly through the COVER programme.⁸ Information on suspected cases of poliomyelitis is obtained from four sources: notifications, laboratory reports, death certificates, and (since last year) reports to the British Paediatric Surveillance Unit. Twenty one cases of paralytic poliomyelitis were identified from 1985 to 1991, of which 13 were associated with vaccine and five were imported. The source of infection was not identified in three cases, but no wild poliovirus of indigenous origin was isolated during this period. The two deaths attributed to poliovirus infection since 1985 were both deaths of young infants with severe congenital immune deficiency who had received oral poliovaccine.

We agree with the need to consider poliomyelitis in all cases of flaccid paralysis including the Guillain-Barré syndrome. They should be investigated virologically, and cases of suspected poliomyelitis should be reported to the Communicable Disease Surveillance Centre or the Communicable Disease (Scotland) Unit at an early stage.

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Setting a strategy for health

SIR,—In discussing setting a strategy for health Alwyn Smyth rightly emphasises the social model as an alternative to the economic view of rationing.¹

Health economists seek to maximise the health benefit per unit cost, usually on the basis of quality adjusted life years.² In the NHS this would inevitably result in selected low priority services being withdrawn, as has been proposed in Oregon. The social model of resource allocation, whereby everyone is deemed worthy of treatment and resources are limited across the board, has a lot more going for it. This approximates to the current

situation. The consumer is reasonably happy with it, it is politically acceptable, and it is probably more equitable. It does, however, mean that we must accept the inevitability of waiting lists as a method of rationing.

Well managed waiting lists, for all their problems, are a good method of rationing. They are explicit and can be regulated to ensure that they are equitable. Furthermore, they are reasonably acceptable to the public: far better to be on a waiting list than to be told that an operation on the NHS will never be done under any circumstances.

Our view is that economic dogma has held sway for too long in health care. Yet when the hard decisions are being made in health authorities and health boards the dogmatists are nowhere to be seen. We should now formalise the social model of resource allocation along lines that have been suggested previously.³ With this method economic appraisal is but one of the four variables—with government priorities, consumer opinion, and formal needs assessment—that determine resource allocation. We would thus ensure that the NHS was, as Smyth puts it, “an element of the national apparatus of justice.”

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Searching published reports

SIR,—Ray Jones states that authors ought to review published reports,¹ but this is not feasible when they are presenting results of original research in the usual 2000 word paper, and especially not in a short report in the *BMJ*. A review of publications requires a dedicated article.² With our 600 word short report our priority was to include important details of the method and results, thus allowing only a few brief references to other reports.³

In the domain of access to medical records the 31 papers that Jones cites as a large number seem to us to be remarkably few, given that there are 44 medical specialties⁴ and that these papers address such diverse questions as patients' anxiety, the number of records lost, and corrections to the records.¹

We stand by our assertion that with regard to patients' attitudes after they have seen their records no study before ours had systematically examined the influence of demographic data and diagnosis. The reference that Jones cites as counter to this deals with physicians' censoring of computer held records and takes no account of patients' attitudes.⁴ Furthermore, as all these patients were diabetic the effect of diagnosis could not be evaluated, and the demographic data are presented in a non-numerical manner with no evidence of statistical testing. When we wrote of systematically examining the influence of demographic data and diagnosis we had in mind controlling for confounding factors to evaluate the contribution of a specific variable.¹

Jones has misunderstood our point about the difference between patients given their records without having asked for them and those who ask to see their records, as the reference he gives deals with the first group.⁴ We believe that the second constitutes a different and self selected population who may, for example, be aggrieved by their

medical treatment. As we pointed out, we are aware of only one study of such patients.⁶

Whether authors are prolific or sparing in their use of references depends on personal style, the journal, the length of the article, and the published reports. Studies with poor methodology may be ignored even by review articles. If Jones objects to our use of three references in a short report what about an editorial of about 4000 words in a recent issue of the *British Journal of Psychiatry*, which has only one?⁷

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SIR,—I am delighted to see R Jones opening the debate on the searching of published reports.¹ I would, however, like to correct the widely held notion that Medline is the only relevant bibliographic tool for clinicians. Although it is an excellent index, it has a European rival, Excerpta Medica, which is all too often overlooked. Medline is the cheaper and more accessible of the two but it has a pronounced North American slant. The overlap of journal titles indexed by the two databases is only 36%, and Excerpta Medica indexes far more European and Japanese literature than does Medline. A well structured Medline search will yield a good solid overview of the literature in most areas, but the results are far from comprehensive. Far better to search both databases and even then to acknowledge that one has only covered such published research as has been indexed by these two sources.

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Advance directives

SIR,—Tony Hope discusses the implications of the Patient Self Determination Act in the United States.¹ The distinction between full mental competence and incompetence is not always clear cut, as is probably assumed in the act. This is particularly relevant for patients with uraemia, for whom advance patient directives may not be appropriate.

A 63 year old woman with insulin dependent diabetes was referred for a renal opinion when she presented with advanced renal failure. She was adamant that dialysis would not be acceptable to her at any stage. Repeated advice by her doctors and the renal team led her to “give dialysis a try.” Six months later she was receiving continuous ambulatory peritoneal dialysis and did not regret the decision to accept treatment. Had she been denied dialysis because her initial advance directive was accepted as final she might have died without treatment being offered again. Uraemia is often associated with reversible mental impairment that can be corrected with dialysis.

Complacency on the part of health providers is

an inherent danger if laws similar to the American act are encouraged in Britain. A recent study from North America suggests that strictly following advance directives may not always be in a patient's best interest.² One hundred and fifty mentally competent patients receiving dialysis were asked how much leeway their doctors should have to override their advance directive regarding continuation of dialysis if they developed Alzheimer's disease. Subjects varied in their responses from “no leeway” (39%) to a “little to a lot of leeway” (30%) and “complete leeway” (31%). If 61% of mentally competent patients are willing to let their doctors decide whether treatment should be continued, where lies the justification for encouraging advance directives for treatment?

Perhaps in this instance the “American experiment” should be viewed with traditional British scepticism.

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Paediatrics in the Tropics

SIR,—In the review of the book *Paediatrics in the Tropics*, of which I am a coeditor, G J Ebrahim's final sentence is: “As it stands it is a comprehensive text of paediatric medicine.”¹ As this is what we set out to achieve we are grateful for this acknowledgment. The preceding statement in the review—that “readership has not been defined, which may partly explain why only a few of the problems get a proper airing”—is, however, mystifying as the purpose of the book and the readership are clearly set out in the preface (page xi) as follows:

Recent years have seen an outpouring of publications on primary health care, health economics, health system management, health education and so forth, targeted mainly at developing countries and directed toward community rather than individual needs. These publications are needed and welcomed but a hiatus has developed in books that meet the needs of clinicians, in particular those who meet the whole spectrum of disease in childhood, and who, within the resource constraints of their practice, aspire to share the benefits of modern medical science with their patients. This book attempts to fill that hiatus for doctors in tropical developing countries. It aims to be a helpful companion to those who tend sick, disabled and handicapped children and offers guidance on how to integrate such activity with disease prevention and health promotion in the communities they serve.

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A patient's charter for laboratories

SIR,—M J Stewart has highlighted some non-analytical aspects of the service provided by laboratories in the form of a patient's charter.¹ Though we agree with the general spirit of this charter, there are some constraints that are unlikely to diminish, at least in the near future.

The suggestion that results of less common tests (which presumably include tests of thyroid function, protein electrophoresis, and measurement of concentrations of cortisol, gonadotrophins, and immunoglobulins, etc) should be available