- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Functions of the Clinical Standards Advisory Group

SIR,—The Clinical Standards Advisory Group is a statutory body whose members are drawn from the medical, nursing, midwifery, and dental professions.¹ Its functions include advising the health ministers in the United Kingdom on standards of clinical care for NHS patients and on access to, and the availability of, services.

The group was set up last year and has been carefully considering what work it should undertake. The first four specific studies that it proposed were studies of (a) access to, and the availability of, four selected specialist services—namely, neonatal intensive care, paediatric leukaemia, cystic fibrosis, and coronary artery bypass grafting; (b) urgent and emergency admissions to hospital; (c) services to people with diabetes; and (d) the management of normal labour in maternity units.

The health ministers have now agreed to these proposals² and have welcomed the group's intention to undertake preparatory work on other subjects, including infections acquired in hospital and community health care for elderly people.

To succeed the Clinical Standards Advisory Group needs the support and cooperation of the caring professions. Critical to that success will be confidence in its members and in its method of working. Its members are appointed by health ministers from nominations by the royal colleges, colleges, and faculties, plus the chairpersons of the standing advisory committees with observers from other key bodies.³ For each study a team consisting of members of the group and coopted clinicians and researchers will gather detailed information from a representative sample of NHS units. The committee steering each study will now discuss in detail how to take forward this work within a framework of principles agreed by the group at its meeting on 30 January. These general principles include the need to ensure that the confidentiality of information provided to the study teams is respected and the anonymity of individuals assured.

The Clinical Standards Advisory Group is not an inspectorate. It is an advisory body without statutory powers to compel NHS bodies to give them access to premises or records. I have written to the chairmen of all NHS bodies in the United Kingdom, asking them to cooperate with the group's national work and inviting them to consider whether there are any matters on which they would ask the group to advise. The group's purpose, whether it is responding to a request from health ministers or from NHS bodies, is neither to inspect the work of local clinicians nor to accredit local services. Practising clinicians should be reassured, therefore, that those conducting the studies are competent professionals and that confidentiality is assured. I hope that they will be regarded as colleagues.

Ministers are in no doubt of the importance of the advisory group. William Waldegrave has said: "[it] will play a crucial role in maintaining—and where possible, improving—the high standards of clinical care provided to NHS patients."⁴ To this end the government has made available to the group just over £2m for 1992-3. Mr Waldegrave has also promised that the advisory group's reports to ministers will normally be published, together with a response from the government.

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- 1 *NHS and Community Care Act 1990*. London: HMSO, 1990. (Section 62.)
- 2 Written answer. Clinical Standards Advisory Group. *House of Commons Official Report (Hansard)* 1992 Jan 16;201:col 627. (No 41.)
- 3 *Clinical Standards Advisory Group Regulations 1991*. London: HMSO, 1991. (Statutory instrument No 578.)
- 4 Department of Health. *William Waldegrave announces chairman and members of the Clinical Standards Advisory Group*. London: DoH, 1991. (Press release H91/136.)

Quality of drinking water

SIR,—We share Alison Walker's concerns about the health risks of drinking water.¹ The media have not only urged the government to ensure that water resources are not contaminated but have also contributed to the recent increase in consumers' concern about the quality of tap water. Mineral and spring waters are advertised as natural and perceived by many as safer than tap water. Sales have tripled in Britain in the past five years, with the current market amounting to £297 million.

The Natural Mineral Water Regulations 1985 implement the European Council directive 80/777EEC on the exploitation and marketing of natural mineral waters.² This requires all natural mineral waters to be officially recognised and prescribes conditions for the exploitation of natural mineral water sources.

We conducted a survey to determine the bacteriological quality of bottled water (mineral and spring) marketed in the United Kingdom. During October and November 1990 we bought 34 bottles of still and 35 bottles of carbonated (sparkling) spring and mineral water from local retail outlets all over Norfolk. After assessing the results we sampled a further 35 bottles of still water.

No coliforms, *Escherichia coli*, or faecal streptococci were detected in 100 ml volumes of any of the 104 samples. One colony of *Pseudomonas aeruginosa* per 100 ml was detected in four samples. Fifty (72%) of the still waters had total viable counts of over 1000 colony forming units/ml whereas 32 (92%) of the carbonated waters had counts of below 100 colony forming units/ml. Gram negative organisms isolated included *P. fluorescens*, *Agro-*

bacterium radiobacter, *Acinetobacter calcoaceticus*, *P. testosteroni*, and *P. pickettii*.

The survey confirmed previous findings.³ It was reassuring that no evidence of faecal contamination was detected. Bottles of carbonated water had much lower total viable counts, and this correlates with the known antibacterial activity of carbon dioxide in water.⁴ Although the organisms isolated are not pathogenic under normal conditions, they can be responsible for infections in certain debilitated or immunosuppressed patients.

We suggest that despite their perceived purity and safety bottled waters offer no demonstrable bacteriological advantage over tap water. Still waters cannot be recommended for debilitated or immunocompromised people, nor, as Hunter and Burge stated,³ should they be used as an alternative drink for infants.

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- 1 Walker A. Drinking water—doubts about quality. *BMJ* 1992;304:175-8. (18 January.)
- 2 Ministry of Agriculture, Fisheries, and Food. *The Natural Mineral Water Regulations. Statutory instruments No 71*. London: HMSO, 1985.
- 3 Hunter PR, Burge SH. The bacteriological quality of bottled natural mineral water. *Epidemiol Infect* 1987;99:439-43.
- 4 Stickler DJ. The microbiology of bottled natural mineral waters. *J R Soc Health* 1989;109:118-24.

Health and the environment: pesticides

SIR,—The series on health and the environment touches on problems associated with industrial and agricultural environmental health impact assessments, including the uncertainty of information available for such assessments. The methods used in environmental health impact assessments merit more detailed coverage by health journals if effective strategies for a healthy environment are to be implemented.¹

Environmental health impact assessments and audits examine "the assessment of human health and welfare impacts . . . integral to ecological and economic considerations"² and should consider alternatives to proposed actions that avoid adverse effects on health as well as long term and possible irreversible impacts. Industry and the government in developed and developing countries should make greater efforts to use environmental health impact assessments.

Use of pesticides illustrates the value of environmental health impact assessments and audits.³ The presence of pesticides in ground water has been well documented in the United Kingdom, as Alison Walker reports,⁴ but many studies of