a considerable clinical and economic burden, as we indicated in our editorial.

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- 1 Armstrong AL, Thomas G, Wallace WA, Green D. Vertebral fractures. *BMJ* 1992;304:1308. (16 May.)
- 2 Cooper C, Melton LJ. Vertebral fractures. *BMJ* 1992;304:793-4. (28 March.)
- 3 Ettinger B, Black DM, Nevitt MC, Rundle AC, Cauley JA, Cummings SR, et al. Contribution of vertebral deformities to chronic back pain and disability. *J Bone Miner Res* 1992;7:449-56.
- 4 Cooper C, Shah S, Hand DJ, Adams J, Compston J, Davie M, et al. Screening for vertebral osteoporosis using individual risk factors. *Osteoporosis Int* 1991;2:48-53.

Adrenaline in allergic emergencies

EDITOR,—We disagree strongly with Gregory Y H Lip and Malcolm J Metcalfe's view that the correct route for administering adrenaline during allergic emergencies is by an intramuscular injection.¹ The intravenous (rather than intramuscular or subcutaneous) route is best under these circumstances as it is safe and effective and a therapeutic response is both rapid and assured. During hypotension the absorption of drugs given intramuscularly and subcutaneously may be unreliable; furthermore, uptake of adrenaline given intramuscularly may be delayed. Venous access is usually not difficult to secure as vasodilatation is a major pathophysiological characteristic of anaphylaxis. Lip and Metcalfe state that absorption after intramuscular injection is "rapid and usually adequate if reasonable circulation is present." This seems highly questionable, considering that hypoperfusion is characteristic of anaphylaxis.

Concerns for the potential dangers of intravenous adrenaline are largely misfounded; like any drug, adrenaline can be dangerous if given incorrectly. If given in a controlled titrated manner at a dose of 5-8 µg/kg in a dilution of 1:10 000, however, it is safely and rapidly delivered to its site of intended action. Of course, by the nature of its sympathomimetic action adrenaline may cause arrhythmias, but in anaphylaxis so might hypoxaemia, hypotension, and the effects of mast cell mediators. Anecdotal reports often cited by those who claim that intravenous adrenaline is hazardous either do not comment on the speed of injection of the dose given² or fail to exclude other causes of the arrhythmias witnessed.³ We conclude that when adrenaline is required in an anaphylactic emergency it should be given in the correct dose intravenously.

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- 1 Lip GYH, Metcalfe MJ. Adrenaline in allergic emergencies. *BMJ* 1992;304:1443. (30 May.)
- 2 Roberts-Thompson P, Heddle R, Kupa A. Adrenaline and anaphylaxis. *Med J Aust* 1985;142:708.
- 3 Sullivan TJ. Cardiac disorders in penicillin-induced anaphylaxis. Association with intravenous epinephrine therapy. *JAMA* 1982;248:2161-2.

Vaccination and immunisation

EDITOR,—The Health Education Authority seems to be out of step with the World Health Organisation in wishing to discard the term vaccination.¹ The World Health Organisation uses

"immunise" to refer to the process of conferring immunity, while "vaccinate" means administering a vaccine. There may be an important difference between the two. The two terms help us to remember that children who are "vaccinated" are not necessarily "immunised." Though this distinction may not be obvious to members of the public, it is valuable for health professionals and should be preserved.

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- 1 Cooke B. Immunisation, not vaccination. *BMJ* 1992;304:1313. (16 May.)

The GMC on performance

EDITOR,—Richard Smith mentions my bill in his editorial on the General Medical Council's proposals for performance assessment.¹ I have made it clear that whatever merits these proposals may have—in any case, as Smith points out, they would take some time to implement—I do not believe that they meet the major gap in the existing disciplinary procedure. This gap is greatly to the disadvantage of the profession itself, let alone the public.

Smith states that my bill would "produce a lesser charge than serious professional misconduct." This is not the case, although critics of my bill have on occasion implied or stated that it is so. The bill itself states that where in the course of an inquiry into a prima facie case of serious professional misconduct the professional conduct committee of the General Medical Council judges that a fully registered person has "behaved in a manner which cannot be regarded as acceptable professional conduct, the Committee may, if they think fit, direct that the registration shall be made conditional in accordance with the foregoing subsections of this section [36]."

Thus the preliminary proceedings and the prima facie charge of serious professional misconduct remain, and it would still be open for the professional conduct committee to find that any demonstrable conduct of a practitioner does not amount to serious professional misconduct. At the moment, however, if the committee finds that the misconduct is not acceptable professional conduct, as indeed it did in the case of Alfie Winn, which Smith mentions, it is debarred by law from taking any action other than the variable publicity.

Thus the professional conduct committee can find the conduct of a doctor towards patients unacceptable but then go on to accept it in practice since it has no legal remedy. But the one I suggest—that of "conditional registration"—is already provided for and used in the existing act. It is less penal than remedial since it would attempt to meet any deficiency of the practitioner in a way most suited to the practitioner's needs.

This modest change would not only be of direct benefit to the profession but add to its reputation of being capable of effective self regulation, which, alas, is not the case at present.

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- 1 Smith R. The GMC on performance. *BMJ* 1992;304:1257-8. (16 May.)

EDITOR,—I read with interest your editorial on the new General Medical Council machinery for dealing with long term poor performance by doctors.¹ I share all your anxieties, but I have a further concern—namely, that this move by the GMC could blur responsibilities and hinder rather than facilitate the taking of effective action. I write

as a clinician who is now involved in management of the service. It seems to me that as a profession we have evaded this issue. Many of the aspects of performance the new regulations cover are the legitimate concern of employing authorities and eventually can appropriately be dealt with only by these authorities. By involving itself in this new role the GMC may merely ensure that neither it nor the health service itself effectively deals with this situation.

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- 1 Smith R. The GMC on performance. *BMJ* 1992;304:1257-8. (16 May.)

EDITOR,—Before the General Medical Council starts disciplining doctors for rudeness and incompetence perhaps it might examine a few cases. I suspect that most of the incidents would feature doctors under extreme pressure—from fatigue, overwork, or unreasonable patients. It is the conditions of our work rather than personal deficiencies that produce conflict and poor performance.

As a general practitioner, I believe that our job is becoming untenable. On the one hand the government, family health services authorities, pressure groups, and members of our own profession are queueing up to complain about our standards; on the other hand we are expected to impose order on a system that allows the public free unlimited access to health care at any time of the day or night.

I do not believe that we can combine unlimited access with a consistently high quality service. If the quality of care is low it is because doctors have compromised their standards to ensure that every patient who presents is seen. To raise standards we need more time with fewer patients, which means placing some limitation on access. I can see no other way of resolving this dilemma.

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Recording HIV status on police computers

EDITOR,—J K Mason's editorial on police practice suggests that information on HIV status is stored on the police national computer with the best of motives.¹ Subsequent letters from A J Lyons,² A Jeaynes,³ and D C Macallan⁴ correctly point to errors in the accuracy of data and the deleterious impact of holding such data.

Possible uses of this information should be looked at more closely. Mason suggests that records are centrally controlled and have strictly limited objectives—namely, to protect members of the public and police by reducing the risk of infection. This belief seems naive, as shown by recent press reports.

The *Evening Standard* recently reported: "almost half of a survey sample of prostitutes working the Kings Cross red light area are drug abusers and of these 75% claimed to be HIV-positive, police said today." This story was taken up by local and national papers. A second report with the headline "Met has Mugshots of Hookers with AIDS" quoted chief Inspector Derek Talbot, saying "of the 50 hard core regulars who work the streets around the station we reckon that three out of four have the virus."⁵

Subsequent discussions with the police at the relevant vice unit revealed that the reports were not based on a specific survey but on the collation of existing police information, including records held on the police computer. This information is there-

fore based on self reports and hearsay. People may have many reasons for informing the police, correctly or incorrectly, about their own or others' HIV status. Such data are inaccurate: there is no justification for using them either in relation to individual HIV status or to population prevalences.

Our investigations into the prevalence of HIV 1 infection among prostitutes throughout London over the past six years have included street based interviews and HIV testing with the consent of participants. We have found much lower prevalences of HIV infection than those quoted by the police.⁷ Unfortunately, such research does not have the same impact on the press as police reports confirming prejudiced views of prostitutes as the major reservoir of venereal disease.

Reports of the prevalence of HIV infection in tabloid newspapers clearly do not have the same rigorous peer review as your own journal, but they may have a greater impact on the lives of those concerned. Prostitutes suspected of being infected with HIV have been the target of violence and abuse.

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- 1 Mason JK. Recording HIV status on police computers. *BMJ* 1992;304:995-6. (18 April.)
- 2 Lyons AJ. Recording HIV status on police computers. *BMJ* 1992;304:1243. (9 May.)
- 3 Jaynes A. Recording HIV status on police computers. *BMJ* 1992;304:1243. (9 May.)
- 4 Macallan DC. Recording HIV status on police computers. *BMJ* 1992;304:1243. (9 May.)
- 5 Delgada M. Police issue AIDS alert over Kings Cross prostitutes. *Evening Standard* 1992 March 17:7.
- 6 Met has mugshots of hookers with AIDS. *Sunday Express* 1992 March 29:3.
- 7 Day SE, Ward H, Harris JRW. Prostitute women and public health. *BMJ* 1988;297:1585.

All's not well at Royal Society of Medicine

EDITOR, — Many fellows will be grateful to you for publishing the news article by Sharon Kingman entitled "All's not well at Royal Society of Medicine."¹ I hope that this will trigger a debate which will enable the society to put its past troubles behind it.

I was the editor of the society's journal between 1975 and 1986. The publications of the permanent staff of the society, which now come under Royal Society of Medicine Services Limited, have been a matter of concern to the fellowship for at least 20 years. Monographs have been published without the relevant section of the society knowing about them. Other publications which bear the society's logo include the proceedings of symposia organised elsewhere by pharmaceutical companies. Not always have the honorary editors of the society had the opportunity to referee these proceedings in accordance with accepted standards. Thus although the use of the society's logo implies the endorsement of the society, in practice such endorsement has not always been given.

Kingman refers to the 15 presidents and chairmen of the academic sections and forums who wrote to the society's president, Sir David Innes Williams, to register their shock and concern. Later she refers to Dr Young losing, by 34 votes to nine, the motion that she should receive salary until the end of the year while an inquiry was held. These votes were cast in the council of the society, which is the society's governing body. How can such contrasting opinions be explained? Only members of council, over half of whom are presidents of sections, can give the reasons for their votes, and I hope that some, who did not support Dr Young, will feel able to join in this correspondence.

In connection with this it must be noted that any debate in council favours the permanent staff who are represented at the expense of those who, like Dr Young, may wish to question the policy of the permanent staff, and who are not represented. The "don't rock the boat" philosophy to which Kingman refers is never far away. The position now, however, is that many fellows feel that Royal Society of Medicine Services Limited should not just be rocked but that it should be capsized. For them the real question is the basis on which a lifeboat should be sent to pick up the survivors.

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- 1 Kingman S. All's not well at Royal Society of Medicine. *BMJ* 1992;304:1201-2. (9 May.)

Eusol: the continuing controversy

EDITOR, — The subtitle of David J Leaper's editorial on Eusol—"still awaiting proper clinical trials"—is inappropriate.¹ Leaper states that "as with many other traditional remedies, [its] value remains scientifically unproved." Eusol, however, is not a traditional remedy but was developed in the laboratory and rigorously subjected to both in vivo and in vitro studies in 1914-5.

My grandfather, Professor A Murray Drennan, was asked while working in the pathology department in Edinburgh to develop an antiseptic that would be effective in reducing the devastating effects of trench foot in the first year of the first world war. The research included studies comparing the effect of Eusol with that of other antiseptics on isolated bacterial suspensions, spore forming organisms, and various devitalised tissues. The potential irritant effects were evaluated with laboratory animals and a clinical study. The clinical study looked at the effects on over 100 patients from the surgical outpatient department and those treated for shrapnel injuries in the local Red Cross unit. An attempt was also made at costing the treatment, which was probably unusual at the time. It was estimated that one gallon of Eusol could be made for one penny. Eusol was developed primarily for treating war wounds and was never patented or commercially produced. It has therefore remained much the cheapest product in treating leg ulcers.

I strongly recommend that Leaper and others should read the report of the original trial, published in the *BMJ* in 1915.²

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- 1 Leaper DJ. Eusol. *BMJ* 1992;304:930-1. (11 April.)
- 2 Smith JL, Drennan AM, Rietie T, Campbell W. Experimental observations on the antiseptic action of hypochlorous acid and its application to wound treatment. *BMJ* 1915;iii:129-36.

EDITOR, — M Beevers's embargo on colleagues' use of Eusol¹ highlights the important issue underlying this debate, which is the degree to which a nurse, doctor, or pharmacist should have the power to prohibit treatment prescribed by a specialist.

It seems that Beevers performed a controlled experiment on one subject (herself), and when she found that full strength Eusol is a primary irritant (hardly a surprise) she took it on herself to persuade the pharmacist to stop dispensing it, even though this was against the wishes of a senior surgical colleague. I hope that Beevers does not check the toxicity of dithranol in the same way or she will want to prohibit that too, even if the dermatologist does find it useful.

How would doctors feel if a nurse told them she was not going to give digoxin to their patients

because she knew of no randomised controlled trials proving its efficacy and had done a controlled experiment on one subject (herself) and found it had side effects?

What would the medicolegal consequences be if a patient died because a consultant could not give a particular treatment because a colleague (nurse, doctor, or pharmacist) had placed an embargo on it? What would happen if I placed an embargo on all the treatments Beevers uses and she vetoed all those I use? Would we each agree to use nothing at all? If nurses and pharmacists are to have autonomy why not physiotherapists and dietitians? What about occupational therapists, appliance officers, chiropodists, and blood gas technicians?

Hospital patients have to be looked after by a team, and the team leader, normally the consultant, should be willing to listen to advice. It will be a sad day for patients, however, if anybody in the hospital can give advice and the consultant has no option but to take it.

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- 1 Beevers M. For and against Eusol. *BMJ* 1992;304:1442-3. (30 May.)

EDITOR, — M Beevers's controlled experiment with Eusol is an unhelpful contribution to the debate about the product.¹ It merely shows a contact dermatitis in undamaged skin, common to a wide range of topically applied antiseptics and antibiotics.² Perhaps we should all persuade our local pharmacy departments to erase povidone iodine and cetrimide from their formularies on similar tenuous grounds.

Few would dispute that full strength Eusol can be irritant, and for this reason it should never be placed on clean, granulating wounds. It is, however, an invaluable, cost effective ally along with the knife in treating dirty, necrotic wounds. Conclusions drawn from in vitro studies of damaged fibroblasts cannot be applied to the microenvironment within a mature decubitus ulcer.

The wound dressing industry is now worth millions of pounds, and much of the problem lies here. Every drug company is jumping on the bandwagon. Unfortunately, the nursing profession is being taken for a ride on it too. Effective marketing with colourful posters and sponsored, authoritative looking leaflets have helped to entrench the position of the new generation of products for wound care.

Most reconstructive surgeons in the United Kingdom remain strongly in favour of using hypochlorite solutions in managing difficult wounds, while accepting the need for formal trials. An infamous cartoon depicts a nurse pouring a bottle marked Eusol down the lavatory. The caption reads, "Sister, I'm just going to clean the toilet." If you have a wound like a toilet it requires a toilet cleaner.

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- 1 Beevers M. For and against Eusol. *BMJ* 1992;304:1442-3. (30 May.)
- 2 Bajaj AK, Gupta SC. Contact hypersensitivity to topical antibacterial agents. *Int J Dermatol* 1986;25:103-5.

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.