that the Sugar Bureau will not take advantage of this opportunity to gain spurious scientific respectability from the association. It is unwise for the council to become involved with an organisation that clearly has an ulterior motive and cannot be considered to be interested solely in scientific matters.

We hope that our colleagues in the medical profession will note this strange policy of the Medical Research Council and be warned of any further association it may develop in future with a body whose prime purpose is to promote a product known to be harmful to health.

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1 Committee on the Medical Aspects of Food Policy. *Dietary reference values for food energy and nutrients for the United Kingdom*. London: HMSO, 1991. (Report No 41.)

**We sent this letter to the Medical Research Council and received the following reply.

SIR,—The Medical Research Council is well aware of the Sugar Bureau's activities as a pressure group but does not believe that they are a reason to exclude it from objective scientific discussion of a subject in which it has an interest. The aim of the meeting is educational: to ensure that industry is fully informed about the implications of research findings and future plans for dental research so that it can play an active part in reducing caries. The Sugar Bureau's financial contribution to the day will be to meet the limited costs entailed. The council is not conducting any research funded by the Sugar Bureau, nor does it have any plans to do so.

MARY RICE

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Dealing with disasters

SIR,—I support A D Redmond's view that the royal colleges have a part to play in identifying suitable personnel to help with emergencies or disasters overseas.¹

International Health Exchange (formerly the Bureau for Overseas Medical Service) recently established the United Kingdom's first emergency and disaster relief register for health personnel. The register can be used by any agency recruiting for emergencies, including the Overseas Development Administration. The Overseas Development Administration has formally asked the International Health Exchange to be the key provider of health personnel for its disaster response action plan, which was announced by the minister for overseas development in August last year. The

emergency and disaster relief register is based on the International Health Exchange's existing database and 12 years' experience of helping agencies recruit for developing countries.

The register is a list of appropriately qualified health personnel, who are selected according to criteria agreed with agencies experienced in relief work. These include Save the Children Fund, Oxfam, and the United Nations High Commission for Refugees. Personnel required range from those experienced in establishing and organising health interventions through to health practitioners, trainers, and coordinators. Relevant experience of developing countries and emergencies is required along with experience in, for example, public health, feeding, rehydration, mother and child health, or control of communicable diseases.

The International Health Exchange is aware of the existence of surgical and accident and emergency teams with experience in the NHS and overseas and will be inviting them to join the register. It will also be asking the royal colleges to help in identifying suitably experienced doctors from their own memberships. Further dialogue with health authorities will be necessary to facilitate quick release of personnel for emergency work overseas. I look forward to cooperating with these bodies to ensure a quick, effective response when necessary.

ISOBEL MCCONNAN

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1 Redmond AD. Medical response to disasters overseas. *BMJ* 1992;304:653. (14 March.)

SIR,—Reading about the Edinburgh MEDIC 1 team's response to the Kurdish refugee crisis left me with some doubts.¹ Though the authors speak lightly of themselves and their mission, this is, in my opinion, a good example of the wrong kind of help.

Most of the diagnoses presented for the two refugee camps (gastroenteritis, malnutrition, etc) are common in developing countries. These conditions could probably be treated better by Kurdish primary health care staff, who have the advantage of knowing their patients' culture and language. Instead of sending the wrong experts for a short mission (I cannot understand how Western emergency personnel are qualified to work with malnourished children and infectious diseases or to deal with hygiene and sanitation in a developing country) it must be better to help developing countries to become better prepared to deal with disasters themselves.

The cost of this mission is not mentioned and can only be guessed. Most certainly the money could have been used in a better way for the Kurdish people.

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1 Parke TRJ, Haddock G, Steedman DJ, Pollock AJ, Little K. Response to the Kurdish refugee crisis by the Edinburgh MEDIC 1 team. *BMJ* 1992;304:695-7. (14 March.)

Injuries caused by unsecured contents of vehicles

SIR,—M Dudley's report of a front seat passenger in a car who suffered a penetrating injury to the head caused by a garden fork¹ prompts me to report the perineal injuries sustained by the three occupants of a car involved in a head on collision at high velocity, with a combined impact speed of 160 mph.

Although two passengers suffered relatively minor perineal trauma, the worst injury was the complete division of the anus and sphincters in a 24

year old man. The incised wound penetrated to the level of the ischial spines. Primary repair of the sphincter with temporary faecal diversion was followed by a return to normal continence. Shards of plastic from broken audiocassette boxes, one of which was removed by a fireman from the perineum of the patient with the severe injuries, were thought to be the missiles responsible for all the perineal injuries.

Seemingly, unsecured articles of any size, from garden forks to tape cassette boxes, may be injurious during rapid deceleration.

R J REYES

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1 Minerva. *BMJ* 1992;304:326. (1 February.)

Seat belts in pregnancy

SIR,—We fully support Malcolm Pearce's and Malcolm Griffiths' and colleagues' advice that seat belts should always be worn in pregnancy and agree that the belt should be worn above and below the bump.^{1,2} The authors have obviously never been pregnant or they would know that it is extremely difficult to keep the lap belt over your thighs: it tends to ride over the symphysis, and this can be uncomfortable.

From personal experience of pregnancy we suggest placing a small cushion under the belt. This in no way distorts the belt's position but makes it much more comfortable. Women will also find it reassuring when driving a car to have some protection, albeit psychological, between the bump and the steering wheel. The cushion is also useful between the lower abdomen and seat belt after a caesarean section and, indeed, any lower abdominal surgery with consequent scar.

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1 Pearce M. Seat belts in pregnancy. *BMJ* 1992;304:586-7. (7 March.)

2 Griffiths M, Usherwood M McD, Reginald PW. Antinatal teaching of the use of seat belts in pregnancy. *BMJ* 1992;304:614. (7 March.)

Cycling and health

SIR,—In reviewing the BMA's report *Cycling: Towards Health and Safety* Fiona Godlee correctly mentions that its recommendations are far from new.^{1,2} The unique relevance of cycling to the promotion of health, however, has been poorly recognised by the medical profession, probably because of an understandable concern about the consequences of encouraging cycling in the current hostile traffic conditions.

As the author commissioned to write the report, may I point out that, in addition to assembling much existing evidence on the wide ranging issues surrounding cycling (particularly the medical and health aspects), the report does break new ground. It includes an analysis aimed at relating the loss of life years through deaths of cyclists to the gain of life years through increased longevity from the improved fitness resulting from regular cycling. The analysis shows that the gains far outweigh the losses at present and could do so even more as the environment for cyclists is made user friendly.

This has implications for health and transport policies and, indeed, for policies on the environment and energy conservation. Far from it being irresponsible, owing to the risk of injury, to encourage the general population to transfer from motorised transport to the bicycle whenever

feasible, it could be judged irresponsible not to do so owing to the risk to health of not getting regular exercise. Given proper provision for it, for the great majority of the population cycling as part of the routine of daily travel has the potential for improving fitness in a way that cannot be matched by any other comparable exercise regime—for instance, the report shows that there is only one public swimming bath for every 45 000 people in Britain.

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- 1 Godlee F. On your bikes. *BMJ* 1992;304:588-9. (7 March.)
- 2 BMA. *Cycling towards health and safety*. Oxford: Oxford University Press, 1992.

Unrestricted visiting hours

SIR,—D N W Griffith suggests that extended visiting hours should be the norm in all hospital wards.¹ The premise that extended visiting hours are beneficial is unproved, and the question must be asked, "Beneficial to whom?" Any change in practice must be for the patient's good, but none of the studies quoted by Griffith paid great attention to patients' opinions.

Garton stated that patients benefit from open visiting but did not offer any data to support this view.² Irvine and Smith conducted a questionnaire survey in geriatric wards and reported that extended visiting was "undoubtedly welcomed by patients" but added that "geriatric patients are not good at completing questionnaires." They did not offer any analysis of patients' responses.³

Flexible visiting should not be confused with unrestricted visiting, and this point was recognised by a committee of the Central Health Services Council.⁴ We are concerned that in encouraging open visiting we may be promoting uncontrolled visiting and that the wishes and best interests of the most important person, the patient, are being neglected. We believe that the case for unrestricted visiting hours remains unproved and that, though unrestricted hours may be more convenient for visitors, there is no good evidence of benefit to patients.

R A COOPER
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- 1 Griffith DNW. Geriatric visiting hours: lessons for the general wards? *BMJ* 1992;304:292. (1 February.)
- 2 Garton EJ. In praise of open visiting. *Nursing Times* 1979;75:1747.
- 3 Irvine RE, Smith BJ. Patterns of visiting. Some experiences of free visiting in a general hospital geriatric unit. *Lancet* 1963;i:597-600.
- 4 Department of Health and Social Security and Welsh Office. The organisation of the in-patient's day. Report of a committee of the Central Health Services Council. London: HMSO, 1976.

Completed consultant episodes increase but hospital discharges decrease

SIR,—We are writing to corroborate the Radical Statistics Health Group's analysis of recent trends in hospital activity.¹ We purchase health care for our residents from several inner London teaching hospitals. At one of the hospitals there was a projected increase in activity for 1991-2 substantially above the planned contract "template" activity for 1990. The teaching hospital was asking for an increase in funding for 1992-3 because of the projected increase (roughly £2000 per episode for an extra 500 episodes, or £1m).

By examining the change in the number of completed consultant episodes per discharge of an inpatient from hospital for all acute specialties we

showed that the overall number of inpatients treated had actually fallen. Completed consultant episodes had risen by 9.0% but hospital discharges had fallen by 2.2% in the same period (table).

Change in number of completed consultant episodes per discharge from 1990-1 to 1991-2

	Inpatient episodes	Discharges of inpatients	Episodes per discharge
1990-1	4520	4179	1.08
1991-2*	4928	4088	1.21

*Projected figures.

Examination of particular specialties suggested that most medical specialties are more accurately recording transfers, particularly endocrinology, nephrology, and rheumatology as well as general medicine itself (completed consultant episodes per discharge rising from 1.0 to 1.6, 1.0 to 1.8, 1.0 to 2.0, and 1.0 to 1.4 respectively). The figures show that a small increase in the accuracy of recording of completed consultant episodes per discharge can result in a substantial increase in apparent activity. Other purchasing authorities might like to be aware of this. The mechanism of recording, of course, also offers a perverse incentive for encouraging the transfer of patients from one consultant to another and possibly from ward to ward.

Though a change in ratio might be acceptable this year as data gathering improves, a further increase in the number of completed consultant episodes per discharge in 1992-3 should be viewed with suspicion.

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- 1 Radical Statistics Health Group. *NHS reforms: the first six months—proof of progress or a statistical smokescreen?* *BMJ* 1992;304:705-9. (14 March.)

Placing children in adult psychiatric wards

SIR,—The Children's Society condemned the recent decision that the admission of a 12 year old girl to an adult psychiatric ward was not unlawful,¹ but where else are such children to go? Provisions for inpatient care of children (and their families) are so limited that psychiatrists are often unable to find an appropriate bed. Alternatives are to prevail on colleagues who have beds in adult wards or to come to some arrangement with social services institutions or, failing these, to think of private facilities.

After closing one children's inpatient unit a region looked at the need for adolescent beds, after a report that another region was successfully running a service for children and adolescents without any need for beds. On further inquiry it was understood that the psychiatrist managed this financially attractive service by refusing any need for admission and stating that all such cases were only "social problems."

Social Services have closed children's homes so the possibilities for managing a child within those institutions have gone. It is certainly inappropriate to place behaviourally disturbed children in a paediatric ward, where very ill children and their necessary equipment would be at serious risk from unreasoned or malignant behaviour.

Inpatient units for children and adolescents work carefully in a planned way over quite long periods so it is difficult for them to respond quickly to "emergency" admissions. To keep beds empty for the occasional, but certainly inevitable, serious crisis would be disastrous in these budget conscious

times. A properly staffed unit for seriously disturbed young people always looks excessively costly to budget holders. I regret that more units for young people will probably close.

"Difficult to place" children will always be a minority, but there must be specialist units for them. Financial arguments must extend beyond short term and recognise that long term costs arise in later years if care remains inadequate. Alongside financial arguments there are important humanitarian arguments which have their own urgency.

Appropriate inpatient provisions would allow revisions of the Mental Health Act to be easier to formulate for both lawyers and psychiatrists. This would enhance all work "in the best interests of the child" and lessen the accusations of misuse of the current powers when the infrequent but "common practice" of admitting young people to adult psychiatric units occurs only when there has to be safety during dangerous circumstances.

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- 1 Dyer C. Placing children in adult psychiatric wards. *BMJ* 1992;304:462. (22 February.)

Access to records for epidemiological research

SIR,—Had I not already been a "situation ethicist," chairing the interprofessional working group on confidentiality of health records would surely have made me one. This is a subject in which autonomy and beneficence clash head on, and E G Knox in no way exaggerates the threat to epidemiology, a science from which so many and such great benefits have flowed.²

Not once but many times I learnt that absolute autonomy, as advocated by the self appointed proxies for patients, is a veritable boomerang, though it is a perverse one in that it damages not the proxies but present and future patients. With wearisome repetition I instanced the practical difficulties of obtaining explicit consent from the subjects of death certificates. Our final compromise proposal, from which some dissented, was that access to records for epidemiological research could be ethically legitimised, should the patient's consent not be obtainable for practical reasons, by both the agreement of the custodian of the record and the approval of the research protocol by an ethics committee—not a Platonic universe of ethics committees.

DOUGLAS BLACK

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Reading RG8 7EN

- 1 Black D. Iconoclastic ethics. *J Med Ethics* 1984;10:179-82.
- 2 Knox EG. Confidential medical records and epidemiological research. *BMJ* 1992;304:727-8. (21 March.)

Correction

The cholesterol controversy

An error resulted in A I Polanska being given as the sole author of this letter (14 March, p 712). In fact, the letter was written by Dr Polanska and Dr B A Malik, of South Tyneside Health Authority, South Shields NE33 3BN.

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.