So much work has now been published on cot death that, in the light of the fate of this major strand of the work in the years before the information explosion and the time needed to document medical papers thoroughly in the midst of that explosion, I suggest that an exhaustive bibliography should be published. This should be arranged chronologically under many headings and extensively cross referenced. Such a publication would almost certainly have to be sponsored, and it would have to be updated every few years.

I thank Professor A S Douglas for helpful comment.

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- 1 Stewart-Brown S. Cot death and sleeping position. *BMJ* 1992;304:1508. (6 June.)
- 2 Abramson H. Accidental mechanical suffocation in infants. *J Pediatr* 1944;25:404-13.
- 3 Werne J, Garrow I. Sudden deaths of infants allegedly due to mechanical suffocation. *Am J Public Health* 1947;37:675-87.
- 4 New York Academy of Medicine. *Annual report*. New York: New York Academy of Medicine, 1945:40.
- 5 Prone or supine? [Editorial.] *BMJ* 1961;ii:1304.

Dispensing doctors

EDITOR,—David Roberts has grossly misinterpreted the statistics from the Prescription Pricing Authority in his letter on dispensing doctors.¹ Closer examination of the detail provided in the authority's annual report for 1990-1 shows that savings could be made if all dispensing was undertaken by pharmacists.

TABLE 1—Average cost (£) of prescriptions dispensed by pharmacists and appliance contractors and dispensing doctors in England, 1990-1

	Pharmacists and appliance contractors	Dispensing doctors
Ingredient cost	5.865	5.411
Discount	-0.556	-0.365
Oncost allowance	0.302	0.568
Fees	1.058	0.893
Container allowance	0.038	0.038
	6.697	6.545
Oxygen treatment	0.035	0.002
Value added tax	0.010	0.775
Average total cost	6.742	7.302

Table I compares average costs of prescriptions dispensed by pharmacists and dispensing doctors in 1990-1. I agree with Roberts that value added tax should be excluded from the comparison, but so also should oxygen as, in proportion, dispensing doctors handle very little cylinder oxygen. On the face of it prescriptions dispensed by pharmacists are 15.2p more expensive, but the cost of ingredients for pharmacists is 45.4p higher. With the exception of generic preparations that are not listed in part VIII of the drug tariff (where the pharmacist selects the product to be dispensed and hence influences the cost of the ingredient), cost is controlled by the prescriber through the selection of the product and the quantity. The difference of 45.4p is reduced by savings on discount and in remuneration—that is, oncost allowance and fees—to 15.2p.

Table II shows the effect of applying pharmacists' costs to dispensing doctors' prescriptions. The cost of the ingredients and container allowance remain the same, fees are higher, but discount and oncost are lower. The revised average cost is £6.264, which is 28.1p less than the equivalent figure for doctors.

Thus if pharmacists had dispensed the 27 014 000 prescriptions dispensed by dispensing doctors in

TABLE II—Effect of applying pharmacists' costs to dispensing doctors' prescriptions

	£
Ingredient cost	5.411
Discount	-0.522 (0.566/5.865 of ingredient year)
Oncost allowance	0.279 (roughly 5% compared with 10.5% of ingredient cost)
Fees	1.058 (higher)
Container allowance	0.038 (same)
	6.264

1990-1 £7.591m would have been saved. I leave it to Roberts to calculate the potential loss had doctors dispensed all prescriptions.

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- 1 Roberts D. Dispensing doctors. *BMJ* 1992;305:187. (18 July.)
- 2 Prescription Pricing Authority. *Annual report 1990/91*. Newcastle upon Tyne: PPA, 1991.

EDITOR,—David Roberts's riposte to Baroness Cumberlege's remarks in the House of Lords concerning dispensing doctors is unconvincing.¹ He argues that because dispensing doctors show lower average costs per prescribed item (less value added tax) than pharmacists, dispensing doctors have saved the government £33m over the six years 1985-91. He does not mention, however, how many items the dispensing doctors prescribed per patient.

The health services indicator dataset for 1989-90 shows that dispensing doctors prescribe more items than their non-dispensing colleagues (8.51 items per patient compared with 7.87). Thus the net ingredient cost per patient (excluding value added tax) for patients of dispensing doctors was £42.58, compared with £42.11 for patients of non-dispensing doctors. This small but higher amount means that, rather than saving the government £5.8m in 1989-90, dispensing doctors actually cost the government £1.41m. Furthermore, this figure ignores additional costs such as fees and container allowances. This may help to explain Baroness Cumberlege's concern.

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- 1 Roberts D. Dispensing doctors. *BMJ* 1992;305:187. (18 July.)

Victims of Creutzfeldt-Jakob disease

EDITOR,—Of course the 1900 or so families in the United Kingdom whose children received cadaveric pituitary derived human growth hormone that was contaminated with the agent of Creutzfeldt-Jakob dementia between 1959 and 1985 should have been informed seven years ago. Apart from the ethical considerations, the recipients should have been warned at the earliest opportunity never to be blood or tissue donors.

Many of the anxious families whose children were treated with human growth hormone before 1985 would have their anxieties alleviated if it were to be shown that they are constitutionally not susceptible to the agent of Creutzfeldt-Jakob dementia. As Clare Dyer stated, there is no way of knowing how many recipients will eventually develop the disease.¹ There is good evidence for believing, however, that only certain people—those of an unusual genotype—are likely to be

susceptible to the disease after infection. The government is currently monitoring all the cases of Creutzfeldt-Jakob disease that occur in the United Kingdom as part of its surveillance of the effects, if any, of the outbreak of bovine spongiform encephalopathy on the human population. It would therefore be possible to establish which genotype is susceptible to the ailment, and those recipients of the contaminated human growth hormone who are of other genotypes could then be reassured. Even the susceptible individuals are not necessarily doomed: whether they develop the disease or not would also depend on the dose of the agent which they had received. This relatively simple matter is surely the least the government should be doing in these gloomy circumstances.

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- 1 Dyer C. Families of victims of Creutzfeldt-Jakob disease sue government. *BMJ* 1992;305:73-4. (11 July.)

Emergency treatment against a patient's wishes

EDITOR,—The issue of the right to refuse life-saving treatment has been highlighted by two recent court cases: a 16 year old girl with anorexia nervosa was overruled in her decision to refuse being fed¹ and the Court of Appeal decided that blood transfusions should be given to a 20 year old victim of an accident against her wishes.^{2,3} The delivery of emergency treatment against the apparent wishes of the patient may also pose a major dilemma for a doctor treating a casualty.

In a recent personal experience I was called, as medical registrar, to the casualty department to see a middle aged man who had attempted suicide by drug overdose one to two hours before. The patient suffered from ischaemic heart disease; there was no known psychiatric history, and the circumstances that had provoked him to take the overdose were unclear. It was thought that he had taken about 100 tablets, including atenolol, isosorbide, diltiazem, and temazepam. His blood pressure was 90/50 mm Hg, he had a slight bradycardia, and he was rather confused.

We decided that further deterioration could be averted only by gastric lavage. The patient refused and indicated forcefully that he wanted to die. There were no features of psychosis, and no section in the Mental Health Act applied.⁴ Such a situation faces a doctor with the dilemma of either acquiescing in the patient's demands or treating against his or her wishes. Because of this patient's deteriorating physical condition an immediate decision was necessary. We undertook gastric lavage and removed a large proportion of the ingested tablets. The patient subsequently developed severe bradycardia and heart block and required cardiac pacing. Although he remained aggressive, no undue force was required. His mental state deteriorated, and he became semicoherent.

The treatment was not covered by the Mental Health Act, and the attending medical staff were protected only by the common law duty of care owed by a doctor to his or her patients and by the doctrine of necessity.^{5,6} Guidelines issued by the Department of Health state that "a patient has a fundamental right to grant or withhold consent prior to examination or treatment."⁶ The guidelines also, however, give examples of treatment that have raised concern and, in relation to maternity services, state that "decision may have to be taken swiftly at a time when the woman's ability to give consent is impaired, for example, as a result of medication including analgesia. If the safety of the woman or child is at stake, the obstetrician or midwife should take any reasonable action that is