to save life or prevent a deterioration in the patient's health without formal consent. Medical and not legal considerations are of greater importance in life-threatening situations and the courts are most unlikely to censure a practitioner for proceeding to provide essential treatment in an emergency. . . . The guiding principle is to act in good faith and in the immediate best interests of the patient's health and safety. If there is any doubt there should be no hesitation in seeking the advice and opinion of one or more colleagues.

The legal arguments used in the recent court cases to which Peckham refers do not seem to be directly relevant to the emergency treatment of life threatening drug overdoses.^{3,4} In the current legal climate, it is suggested that the risk of treating such patients and being charged with assault is less than the risk of facing charges of medical negligence from the patient's family if treatment is withheld and the patient dies.

As a psychiatric registrar, I have been contacted on several occasions by medical staff who are uncertain of the circumstances in which common law and the Mental Health Act can be applied. The first aim must be to avoid using such powers by persuading patients to accept treatment voluntarily. If the patient continues to refuse treatment, however, common law allows the practitioner all necessary powers to detain and treat patients in life threatening medical emergencies.

The Mental Health Act is for the treatment of mental disorders⁵ and cannot be extended to the treatment of medical emergencies even if they arise as a direct consequence of a mental disorder. If a patient is mentally ill and takes a life threatening drug overdose the first priority is for the medical emergency to be treated, if necessary under common law. The need for psychiatric treatment can be assessed after medical treatment has been completed.

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Eradication of poliomyelitis

EDITOR,—Andrew J Hall's editorial points to three elements in the eradication of poliomyelitis—namely, immunisation days, mopping up operations, and high quality surveillance—and rightly recommends the availability of laboratory support.¹

For global eradication of poliomyelitis two tier laboratory support would be essential to carry out, at least in industrialised countries, investigations like the in situ polymerase chain reaction² or in situ transcription³ to identify and characterise poliovirus genomes both in clinical specimens and in postmortem material from suspected cases. The developing countries where poliomyelitis is hyper-endemic would require simplified, one or two step test procedures that did not depend on tissue cultures to measure poliovirus antibody levels and screen for polioviruses in clinical specimens. That should not be an insurmountable technological issue if rapid diagnostic techniques like liposome immunoassays were to be adapted to polioviruses. Liposome immunoassays, which use antibodies conjugated to liposomes (artificial phospholipids) containing a dye (rhodamine sulphate), are available for detecting antigens in clinical specimens. They do not require a solid phase for the antibody-conjugate to generate a signal since the signal is

generated by release of rhodamine sulphate dye during the antigen-antibody reaction.⁴

No apparent source of poliovirus infection was established in three of the cases reported by Rachel Joce and colleagues.⁵ Any possibility, albeit rare, of reactivation of poliovirus in the host nervous system after its acquisition decades earlier merits exclusion. A study of the intrathecal immune response of 36 patients with the postpolio syndrome reported oligoclonal IgM bands in 31 patients, significantly raised cerebrospinal fluid levels of IL-2 and s-IL-2R, and a correlation between intrathecal synthesis of IgM antibody synthesis and the cerebrospinal fluid IL-2 and s-IL-2R levels.⁶ Post-mortem tissue from the 41 year old man reported on by Joce and colleagues could be subjected to an in situ polymerase chain reaction with poliovirus specific primers.⁷

The acquisition of poliomyelitis by a 62 year old previously healthy man during a holiday in a beach resort in Morocco⁸ is similar to a case in a 65 year old man with type 1 poliovirus in Morocco itself.⁸ Indeed, both these cases are a grim reminder of the continuing rise in the number of tritypic antibody negative people among those aged 50 and over in industrialised countries. As polio vaccine was not available before the 1950s people now aged over 50 would not have been routinely vaccinated.⁹ A simplified test procedure to screen such people for antibodies to poliovirus would be invaluable. Regular screening of travellers to endemic areas would ensure that otherwise healthy people in this age group were adequately vaccinated against polio before departure. Furthermore, such screening would also ensure that there were not any tritypic antibody negative people and that the possibility of an outbreak of polio was minimal.

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Nurses' access to subjects for research

EDITOR,—I would like, through your column, to raise a serious concern in relation to nurses' access to patients for their inclusion in nursing research. It has often been drawn to my attention that nurses have been required by local ethics committees to seek access to patients through their medical colleagues even though the studies related directly to nursing matters. Occasionally such access has been refused even when ethical approval has been given.

This raises several questions. Firstly, it would seem that it is the patients themselves who should be offered the opportunity to decide whether or not they wish to participate in nursing research, provided that they are fully informed of the nature

of the study. It has been the custom to admit patients to hospital under the care of a named medical consultant, or to access community care through a general practitioners' register, but this does not imply that patients should be denied the right to make personal decisions about their involvement in research. Protecting them by denying them such choice does not seem to be in line with an acknowledgment of their right to choose.

Secondly, there is an important question about whether one professional group has the right to gatekeep research activities initiated by colleagues working in a complementary but different profession. While multidisciplinary work will always have a vital role to play there is also an urgent need for each profession to deepen its own understanding of practice. Without the opportunity to explore nursing matters through rigorous, well controlled research our understanding of the contribution that nurses and nursing can make to health care would be severely hampered. It is both worrying and sad that nurses could be restricted in this activity by colleagues who are not always familiar with either the areas of work which they would like to explore or the methods which they may employ.

I would be interested to hear how widespread this practice is and the rationale for such action.

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Congenital toxoplasmosis

EDITOR,—Susan Hall's review article stated that those in favour of screening for toxoplasmosis "have held the limelight."¹ This is odd as her article, a recent editorial,² and a report from a multidisciplinary working group set up by the Royal College of Obstetricians and Gynaecologists³ have all been against screening. Unfortunately, the thinking in these publications is inconclusive: there is not enough information, so we do nothing. Our approach is that if there is not enough information, this information should be obtained.⁴ We first made this suggestion in January 1990. A problem has been identified and an obvious solution is available,⁴ yet we wait.

We have reviewed published epidemiological information, including our study over 10 years in which 16 000 women were prospectively screened.⁴ We have dealt with false positive results and their reduction at least a hundredfold, and emphasised the importance of counselling.⁴ Our position is that studies such as ours cannot yield more information. An acceptable study should be dealing with 50 000 pregnancies a year, so a multicentre trial may be more appropriate than smallscale studies. The review article may have been unable to prove the case for a national screening programme, but it clearly shows the need for a government funded, pilot screening programme.⁴ Our position is therefore that there is not enough information for national screening, but a pilot programme should be instigated now.

The difference between actively seeking information as opposed to analysing available data is seen in the British Paediatric Surveillance Study.¹ Fourteen cases a year may be substantially less than the expected number but is more than twice the incidence previously calculated by Susan Hall in 1983.⁵ Her previous figure was from analysis of laboratory reports, and the current figure is also from clinicians dealing with the problem.

As professionals deliberate and multidisciplinary bodies produce reports, life goes on. Many women are now demanding to be tested, and one medical defence organisation has advised members that they may face litigation if they refuse to screen such women.⁴ Patients are now expected to be seen