Government secrecy

Baby milk advertising is a case in point

EDITOR,—The government's recent decision not to ban advertising of infant formula milk products emphasises Martin McKee and Tim Lang's concern that public health policies may fall prey to interests of government and industry.¹

Throughout the formation of the two European directives and draft proposals, the British government advocated that such advertising be restricted to professional and scientific journals alone. Last year, the decision to adopt a law allowing baby milks to be advertised in hospital in effect enables expansion of the baby milk market. Such brand name advertising contravenes the World Health Organisation's international code, which clearly states that breast milk substitutes should not be promoted. This code has been supported by the British government since 1981.

During the passage of this law the Ministry of Agriculture, Fisheries, and Food received 210 letters in favour of an advertising ban and 13 against, of which 10 were from baby food companies and advertising agencies. The law came into effect before the issue was debated fully in parliament. In the eventual debate, in April 1995, the main arguments in favour of the government's position came from industry. For example, David Faber, MP for Westbury, speaking on behalf of Cow and Gate, stated, "I should have thought that is exactly what we are here for in the House of Commons—to represent business in our own constituencies and to speak up for them and their interests."

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the BMJ article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.

Failing to ban advertising for infant milk products rests uneasily with the government's expert working party on infant feeding, which states that breastfeeding provides the best infant nutrition.² The working party recommended government health departments to encourage all healthy mothers to breastfeed their babies. Guidance from the Department of Health³ and the British Paediatric Association's standing committee on nutrition identifies the many benefits for mother and child associated with breastfeeding. A randomised trial in the United States showed that removing advertisements for formula milk improved breastfeeding rates more than did intensive efforts to train staff in breastfeeding support.⁴

The Health of the Nation white paper encourages breastfeeding of infants. It has been recommended that departments of public health should set and monitor targets for breastfeeding incidence, prevalence, and duration.⁵ Allowing companies to promote formula milk products in the health care system inevitably undermines breastfeeding rates and associated infant health. McKee and Lang are right to be unsure "that the government acts in the interest of the public rather than those of the corporate backers of the party in power."

NICHOLAS BANATVALA

Senior registrar in public health medicine,

East London and the City Health Authority,
London E3 2AN

PATTI RUNDALL

International coordinator

Baby Milk Action,
Cambridge CB2 3AX

1 McKee M, Lang T. Secret government: the Scott report. *BMJ* 1996;312:455-6. (24 February.)

2 Department of Health and Social Security. *Present day practice in infant feeding: third report*. London: HMSO, 1988. (Report on health and social subjects 32.)

3 Department of Health. *Breastfeeding: good practice guidance to the NHS*. London: DoH, 1995.

4 Frank DA, Wirtz SJ, Sorenson JR, Heeren T. Commercial discharge packs and breast-feeding counseling: effects on infant-feeding practices in a randomized trial. *Pediatrics* 1987;80:845-54.

5 Faculty of Public Health Medicine of the Royal Colleges of Physicians of the United Kingdom. *Promoting breast feeding*. London: RCP, 1995. (Guidelines for health promotion No 41.)

Safety of air travellers is not protected

EDITOR,—The Scott report reveals "Whitehall secrecy and deceit...advancing the interests of major industrial concerns even when they mislead parliament and the public in doing so."¹ Here is another example showing how industrial concerns have misled parliament and contributed to the deaths of 270 people.

In 1985 an Air India jet was lost off Cork through a bomb in an unaccompanied suitcase. By late 1987 ICAO, the international civil aviation organisation, had mandated the "authorisation" of baggage in the hold.

The murder of my daughter and 269 others in December 1988 at Lockerbie was followed by a fatal accident inquiry which Baroness Thatcher refused to attend when cited as a witness. Government ministers prepared "PII certificates" to protect certain documents. The inquiry concluded that hold baggage authorisation was recognised as crucial to preventing such attacks. A Scott-type inquiry has repeatedly been refused.

In 1993 a Department of Transport press release proclaimed "a major advance in aviation baggage security" due for full implementation by April 1996. This was, simply, the authorisation of hold bags, urged on the government in 1987.

Concerning the eight warnings received by government in good time before the attack, the prime minister's private secretary wrote in March 1995 to tell the relatives of the Lockerbie disaster victims that the warnings were not relevant. Some of us have died from stress related disease, some have had their careers destroyed. Grief is the harder to bear in the presence of such deceit, and in the absence of accountability or apology. The memory of the dead is dishonoured.

No doubt reduced security costings help British aviation to be more competitive.²

H SWIRE
Spokesman

UK Families Flight 103,
Caspide House,
Pikes Pool Lane,
Bromsgrove B60 1LH

1 McKee M, Lang T. Secret government: the Scott report. *BMJ* 1996;312:455-6. (24 February.)

2 Wilkinson P. *The lessons of Lockerbie*. London: Research Institute for the Study of Terrorism, 1989:18.

Ombudsman is available when codes of practice fail

EDITOR,—Martin McKee and Tim Lang refer to the "increasing climate of centralisation of power and secrecy that is affecting every government department."¹ Their references did not include the 1995 code of practice on openness in the NHS, the 1994 code of practice on access to government information, or the 1993 white paper *Open Government* (Cm 2290).

As the parliamentary and health service ombudsman I eschew party political comment. I try to operate with fairness, especially when dealing with complaints where requests for information under the codes have been refused by government departments and agencies or by NHS bodies. I have already published four reports to parliament on the government code and will be making my first report on the NHS code in the summer. In the cases I have investigated wherever I have recommended that the information requested should be disclosed, it has been.

WILLIAM REID
Health Service Commissioner (Ombudsman)

Church House,
Great Smith Street,
London SW1P 3BW

1 McKee M, Lang T. Secret government: the Scott report. *BMJ* 1996;312:455-6. (24 February.)

Vaccines and Guillain-Barré syndrome

EDITOR,—Three cases of Guillain-Barré syndrome were reported to the Committee on Safety of Medicines in Britain during a recent programme which immunised just under 8 million children with measles/rubella vaccine (DM Salisbury, Department of Health, personal communication). This low figure might be due to underreporting but is reassuringly less than the background risk of developing the syndrome (which would have been expected to be about

7.6 cases in the month after immunisation in the United Kingdom, based on the typical reported annual incidence of 1/100 000).¹

We questioned 103 patients with Guillain-Barré or Miller Fisher syndrome, 98 household controls, and 93 hospital controls in south east England in 1992-4 (before the measles/rubella immunisation programme).² Thirteen patients, and nine household and five hospital controls reported being immunised within 12 weeks before onset of neuropathy in the index case. The immunisations were for influenza in 10 patients and eight household and three hospital controls, typhoid/cholera in one patient and one household control, typhoid alone in one patient, tetanus toxoid booster in one patient, diphtheria/tetanus/pertussis in one hospital control, and human immune globulin in one hospital control. The median intervals between immunisation and neuropathy onset in the index case were 44 (range 3-64) days in patients, 44 (7-64) days in household controls, and 36 (14-62) days in hospital controls. The differences in proportions immunised between the patients and either of the control groups are not significant but the confidence intervals for the odds ratios are wide. A matched analysis shows that the odds ratio of cases having been immunised was 4.0 (95% confidence interval 0.4 to 197) in comparison to household controls and 2.2 (0.7 to 8.1) in comparison to hospital controls. A similar study in 1983-4 also failed to show an increase in risk since 6/100 patients and 5/100 hospital controls had been immunised in the previous 12 weeks.³ The odds ratio for the two series combined was 1.8 (0.7 to 4.4).

Our case-control studies and the literature do not suggest any increased risk of Guillain-Barré syndrome after vaccines currently used in the United Kingdom. However, obtaining the number of individuals required to detect or exclude a small increase in absolute risk would require an active surveillance programme or classification of Guillain-Barré syndrome as a notifiable disease. At present we rely on diligent reporting to the Committee on Safety of Medicines of cases of the syndrome after vaccination.

RICHARD HUGHES
Professor of neurology
JEREMY REES
MRC clinical research fellow

Department of Neurology,
United Medical and Dental Schools,
Guy's Hospital,
London SE1 9RT

NIGEL SMEETON
Lecturer in medical statistics

Department of Public Health Medicine,
Guy's Hospital

JOHN WINER
Consultant neurologist

Queen Elizabeth Hospital,
Birmingham B29 6JD

- 1 Hughes RAC. *Guillain-Barré syndrome*. Heidelberg: Springer-Verlag, 1990.
- 2 Rees JH, Soudain SE, Gregson NA, Hughes RAC. A prospective case control study to investigate the relationship between *Campylobacter jejuni* infection and Guillain-Barré syndrome. *N Engl J Med* 1995;333:1374-9.
- 3 Winer JB, Hughes RAC, Anderson MJ, Jones DM, Kangro H, Watkins RFP. A prospective study of acute idiopathic neuropathy. II. Antecedent events. *J Neurol Neurosurg Psychiatry* 1988;51:613-8.

Providing intensive care

Cases of trauma can be managed in general intensive therapy units

EDITOR,—D W Ryan points out that increasing resources is one solution to the current crisis in the provision of intensive care services.¹ The editorial fails, however, to address the problem of the inefficient use and staffing of some units.

About 210 cases of major trauma occur in adults each year in Birmingham. About one third

of the patients are admitted to the major injuries unit at University Hospital (formerly sited at the Birmingham Accident Hospital). Most of the rest are managed at the two other main district general hospitals. There are 24 general beds in intensive therapy units on the three sites, five of which are allocated to the major injuries unit. The major injuries unit is separately staffed by four consultant anaesthetists and junior anaesthetic staff on rotation and, in addition, has eight consultant and 18 junior orthopaedic staff sharing the on call rota as well as its own complement of nursing staff. The general intensive therapy unit at University Hospital, with six beds, is separately staffed by its own anaesthetists and nursing staff. The two other district general hospitals manage their major trauma workload within existing resources and have no intensive therapy unit beds designated for cases of trauma.

A recent report on the major injuries unit found no significant difference in outcome between patients admitted from the accident and emergency unit and those admitted direct to the major injuries unit.² There seems to be no rationale for allocating a fifth of the total complement of intensive therapy unit beds at the three sites to a dedicated trauma intensive therapy unit, particularly when no improvement in outcome can be shown.

While intensive therapy unit services in Birmingham are undoubtedly underresourced, the resources that are currently available are clearly not being used to their maximum efficiency. The amalgamation of the major injuries unit with the existing on site intensive therapy unit would eliminate duplication of staff and services and lead to savings, which could be used to increase the overall number of beds.

D F BOWDEN
Consultant in accident and emergency

D P BURKE
Senior registrar, West Midlands regional rotation

Manor Hospital,
Walsall WS2 9PS

- 1 Ryan DW. Providing intensive care. *BMJ* 1996;312:654. (16 March.)
- 2 Janjua JK. Major trauma at the South Birmingham Trauma Unit: its evaluation and outcome. Birmingham: University of Birmingham, 1995. (MMedSci dissertation.)

Service can't cope with troughs in demand, let alone peaks

EDITOR,—David Ryan correctly points out that "moving critically ill patients between hospitals has become a far from ideal way of life."¹ Politicians have only recently taken note of this, but in fact this situation has existed for as long as I have been a consultant (11 years) working in an intensive care unit in a large teaching hospital.

Recent deaths of critically ill patients who were being moved between hospitals and the media publicity that followed stimulated the health secretary into a typical knee jerk reaction.² The fact that more use will be made of high dependency beds and that a national database of intensive care unit beds will be set up are two such announcements that Stephen Dorrell has made in the House of Commons. Either Mr Dorrell has been misinformed or, as a typical politician, he chooses to ignore the glaring facts that (a) the high dependency unit beds that he is talking about do not exist (only 15% of hospitals in Britain have such beds), (b) high dependency unit beds are not a substitute for intensive care unit beds, and (c) setting up high dependency unit beds will require resources.

The database of intensive care unit beds is flaunted as the "cure all" for the lack of intensive care unit beds in Britain. We have had such a scheme in the north west for the past six years or so (it was previously simply called the bed bureau and is now named the intensive care bed

information service). This was set up to save time for clinicians trying to find a bed. It did not (and was not meant to) solve the problems with intensive care unit beds that existed then, as they do now. I recently heard a chief executive of a health authority in the north west say that there were troughs and peaks in demand and that it was not possible to plan for all contingencies. He was absolutely correct. The trouble is that, throughout my working life as a senior registrar and as a consultant, we have barely been able to cope with the troughs.

ROOP KISHEN
Consultant in intensive care medicine and
anaesthesia Intensive Care Unit

Hope Hospital,
Salford M6 8HD

- 1 Ryan DW. Providing intensive care. *BMJ* 1996;312:654. (16 March.)
- 2 Carnall D. UK reviews intensive care and emergency services. *BMJ* 1996;312:655. (16 March.)

Centralised paediatric intensive care beds are blocked

EDITOR,—While I echo DW Ryan's call for more resources for intensive care, I take issue with Ryan's choice of words when referring to paediatric intensive care.¹ The inability of major paediatric centres to accept all referrals for intensive care may undermine but in no way negates the British Paediatric Association's recommendation that sick children be provided with specialist nursing and medical care.² The recommendation is sound.

Centralisation of paediatric intensive care is the way forward, as Shann³ and others have urged. But there are other reasons, apart from a lack of resources, for the shortage of acute paediatric intensive care beds. More children are surviving previously fatal illnesses but remain dependent on a ventilator. At present there is no facility for caring for these long stay patients who no longer need the full resources available in intensive care units. Altogether 42% of our acute paediatric intensive care beds are currently blocked by such patients, and these unavailable beds were an important factor in our having to refuse 276 patients referred to our paediatric intensive care unit last year. These patients are ready for discharge, but the health authorities from which they came are unable to arrange the provision of services for them locally.

This is likely to be an increasing problem and needs to be addressed by those people charged with planning intensive care and high dependency services across Britain.

IAN JAMES
Director of intensive care

Great Ormond Street Hospital for Children NHS Trust,
London WC1N 3JH

- 1 Ryan DW. Providing intensive care. *BMJ* 1996;312:654. (16 March.)
- 2 British Paediatric Association. *Report of a working party on paediatric intensive care*. London: BPA, 1987.
- 3 Shann F. Paediatric intensive care. *Lancet* 1993;342:1240.

Disodium pamidronate has beneficial effect in Paget's disease of bone

EDITOR,—We are surprised that the authors of the review on diagnosing and managing Paget's disease of bone did not comment on the efficacy of a single infusion of disodium pamidronate in active Paget's disease.¹ Several studies have shown the beneficial effect of this treatment, with a substantial number of patients remaining in remission for up to 18 months to two years.^{2,3} Our study showed the beneficial effect of even a moderate dose (60 mg) given as a single infusion