Finally, Waugh suggests that photography might be added to screening by opticians and be carried out by opticians. This would probably incur an additional fee and is unlikely to be any more cost effective, and is more likely to be less comprehensive, than a system based on the practice register and recall and directly involving the primary care team.

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1 Buxton MJ, Sculpher MJ, Ferguson BA, Humphries JE. Screening for treatable diabetic retinopathy: a comparison of different methods. *Diabetic Med* 1991;8:371-7.

Drug testing has been used in schools for several years

EDITOR,—Owen Dyer reports that Harrow School is to introduce drug testing of its pupils.¹ Drug testing of urine samples has been used at other boarding schools, such as Marlborough College, Sevenoaks School, and Stowe School, for several years. Most boarding schools will probably be prepared for such tests in the near future.

The internal working party at Rugby School, to which Dyer refers, includes a member of the community drugs team, who has worked closely with the school on drugs education for the past five years. We have provided medical advice based on draft guidelines issued by the Medical Officers of Schools Association to all its members last February. The collection of samples will be supervised by a person from outside the school, and—to answer the comment that Dr Richard Nicholson is reported as having made¹—the procedures used will be just as rigorous as those used during drug testing in sport. Neither we nor the school nurses will be involved in the testing or in receiving results.

The most important aspect of the drug testing is that a positive result will lead not to automatic expulsion but to counselling and supervision designed to help the pupil remain at the school. The system has been in use at Sevenoaks School for the past three years and works unobtrusively for the benefit of all the pupils.

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1 Dyer O. Top British school plans drug testing. *BMJ* 1996;312:658-9. (16 March.)

Drug users and people with HIV infection need better care in prison

EDITOR,—A recent incident has shown me the problems that can arise with the medical care of drug users and people with HIV infection in prison. The patient was a long term drug user who had been remanded in custody. He had been seeing me, his general practitioner, for over a year about his drug problem. At the time of his arrest his drug use was still considerable but was reducing, and he was using only prescribed drugs. In the same year his wife had died of AIDS and he had begun to experience illness as a result of his HIV infection.

The medical staff at the prison did not try to contact me to discuss either his drug or his health needs, and he was given a small dose of methadone for a limited time. When I contacted the medical staff to suggest a more appropriate approach my negotiations were unsuccessful.

Forcing this patient to go "cold turkey" could not be seen as curative and would seem to be bad for him and hence bad for the prison. This man had complex medical problems and needed to be treated accordingly.

We know from recent deaths from methadone overdose in prison that the assessments that are done before methadone is prescribed in the community need to be done just as vigorously inside prison.¹ This is possible. A system of titration can be used to avoid overdosing.²

I have been deeply concerned about this patient, but many other cases known to me or reported in the press have highlighted medical care of prisoners that has been less than optimal. Such cases show that policies for the care of drug users and people with HIV infection in prison should be reviewed.

Other points can be drawn from this and other cases. The medical staff working in prisons should use the information that is available to give the optimum care to prisoners. People with drug problems and HIV infection often represent difficult medical cases, with complicated physical and psychological dilemmas, and this needs to be borne in mind in their management. Their management may be complicated by the fact that the prison medical service is outside the rest of the NHS. Harm reduction and methadone maintenance are well established treatments in substance misuse and are recommended in government guidelines³; they need to be applied inside prisons, where one could argue that the need for harm reduction is greater.

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- 1 Blum K. *Handbook of abusable drugs*. New York: Gardner Press, 1984.
- 2 Lowinson J, Berle B, Langrod J. *Clinical aspects of methadone treatment. Handbook on drug abuse*. Maryland: National Institute on Drug Abuse, 1979.
- 3 Advisory Council on the Misuse of Drugs. *AIDS and drugs misuse update*. London: HMSO, 1993.

Providing intensive care

Central bed register would divert attention away from need for adequate resources

EDITOR,—In his statement on intensive care services the secretary of state focused on two main issues—namely, the need to provide more high dependency facilities and the possibility of creating a national register, or "bed bureau," for intensive care.¹ We work in an intensive care unit with a total refusal rate of 29% for appropriate referrals and so are familiar with the problems of identifying vacant beds elsewhere and transferring patients to them. Like others,² we are sceptical of the emphasis on high dependency beds, which, in our situation, would have little impact on the problem, and there would be less need for a bed register if sufficient facilities were available to treat patients in their admitting hospitals.

Furthermore, the proposed register will be costly to set up and run but of little overall benefit. It is our practice, as soon as our last bed is filled, to telephone other units around the region to identify staffed, empty beds so that we have this information before the next patient presents. This is not unduly time consuming and provides the information that we would get from a bed register. When another patient does present we still have to contact the relevant unit again to confirm that the bed is still available. It is not, however, identifying the vacant bed that takes the time. Contacting and discussing the case with the other clinicians involved at both the referring and receiving hospitals can take a considerable time, as can talking to and often pacifying the patient's relatives.

The proposals also ignore the importance of appropriate facilities being available for the actual transfers. If critically ill patients are to be moved safely they must be accompanied by a suitably trained and experienced team as well as the necessary monitoring and other equipment.

Access to a central register of available intensive care beds will save little time in these situations. It diverts attention away from the need for adequate resources to transfer patients safely on the rare occasions when this would be necessary if sufficient beds were available. Now more than ever, with increasing political and financial pressure on acute hospital services, we need to ensure that a safety net exists that is big enough and strong enough to catch patients who slip through the system and become critically ill; that safety net is intensive care.

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

For neurosciences, proposals are "too little too late"

EDITOR,—There has been much media interest in the apparent shortfall of neurosurgical intensive care beds in the south east of England that has resulted in the transfer of critically ill patients out of their region. The situation seems to be deteriorating, and Professor B A Bell recently said that his neurosurgical unit at Arkinson Morley's Hospital in south west London turns away one emergency case each day owing to a lack of beds.¹ In 1993 the Society of British Neurological Surgeons suggested that a minimum of four designated neurosurgical intensive care beds should be provided per million population served.² In South Thames this would require 24 such beds, yet only nine are presently available.¹

The National Hospital for Neurology and Neurosurgery in central London is a national neuroscience centre that receives tertiary referrals from around Britain. We have always, however, provided a "regional" neuroscience service, including emergency provision, to our local referral area. A recent audit carried out at the hospital provides fresh evidence for a shortfall in the provision of neurointensive care. During the four months November 1994 to February 1995 we accepted 14 emergency admissions to our neurosurgical intensive care unit from outside our normal referral area. In comparison, during the same four month period recently ended, such emergency admissions had risen to 52 while local referrals remained static. Forty two patients had been transferred from hospitals to the south and west of London, having been refused admission to their local neuroscience centre. Many patients had been referred to several units before being accepted at the National Hospital, and in all cases the reason for refusal was the lack of availability of an intensive care bed.

This almost fourfold increase in emergency admissions from outside our normal referral area has put great strain on the services provided at the National Hospital. Our neurosurgical intensive therapy unit functions as both a high dependency and an intensive care unit, with nurses being allocated according to the relative

proportion of patients requiring high dependency and intensive care. To accommodate the additional emergency caseload we have returned about one third of elective cases, scheduled for high dependency care on the unit, direct to the ward. This has put additional strain on the ward staff. Cancellations of elective surgery requiring postoperative intensive care have unavoidably increased.

Our experience highlights the underprovision of intensive care beds in the south east of England. We welcome the recent announcement by the secretary of state for health of increased provision of intensive care services,³ but in the neurosciences we think that it may be too little too late.

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1 Halle M. Finding fails to find bed search. *Hospital Doctor* 1996 Mar 21:32-3.

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Severe problems with interhospital transfer of critically ill children will continue

EDITOR,—Like many others involved with interhospital transfer of critically ill children, we find that it is extremely difficult. We have much sympathy with the predicament of Dr Ruth Jameson and her team during the transfer of Nicholas Geldard on the night of 2 December 1995.¹ It has been suggested that, once Nicholas was found to be dead at Hope Hospital (although formal tests to confirm brain stem death had not been done), a bed should have been found for him nearby. It is further suggested that the transfer to Leeds should have been cancelled. This is the nub of the criticism of Dr Jameson's team in the report on the case by North West Regional Health Authority.²

Our unit was the nearest paediatric intensive care unit and was full on the night that Nicholas died. We do not provide ventilatory support on wards other than the intensive care unit. This practice was instituted many years ago after an audit of ventilatory support on general wards at our hospital showed that the results were bad. We have also prospectively audited critical incidents among patients coming into our unit, of which there are a depressingly high number.³

It is extremely difficult to effect a major change in the direction of treatment during interhospital transfer. The report does not explain how Dr Jameson was expected to effect this when a local paediatric intensive care bed was not available, although paragraph 143 of the report is critical that this was not done—a criticism that we regard as unjustified. The people who criticise should try transferring a few sick children before they speak again. Those who have experience of interhospital transfer are well aware of the difficulties that can arise.

The counsel of perfection is to have a paediatric emergency transfer service and sufficient intensive care cots. Until that time, doctors transferring patients can expect to encounter severe problems during transfer and unjustified criticism after it.

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1 Carnall D. UK reviews intensive care and emergency services. *BMJ* 1996;312:655. (16 March.)

2 North West Regional Health Authority. *Inquiry into the care and treatment of Nicholas Geldard*. Liverpool: NWRHA, 1996.

3 Sharples A, O'Neill M, Dearlove O. Impact of specialised paediatric retrieval teams. *BMJ* 1996;312:120-1. (13 January.)

Surgeons will not want jobs in hospitals that do not do emergency surgery

EDITOR,—Proposals to rationalise the delivery of accident and emergency, trauma, and emergency surgery have a good clinical basis and are a response to the pressures of junior staffing, hours of work, and cost effective care. Many advantages accrue to patients, staff, and the delivery of services when a hospital's routine does not have to accommodate emergency surgery. Patients sleep better, and theatre lists can be planned with confidence.

When these proposals become a reality, there are several unexpected byproducts. The loss of acute trauma and emergency surgery from a hospital changes its character. Minor accident and emergency services and elective surgery become the norm, and the physicians may be reluctant to admit medical emergencies without surgical cover. The Royal College of Surgeons withdraws the hospital's recognition for training junior staff. Surgeons deprived of emergency surgery, if still chasing the "bubble reputation," decamp to hospitals that satisfy their aspirations. Their replacement is the problem. Surgical posts that exclusively provide elective surgery are unlikely to attract accredited senior registrars who aspire to practise the full range of the discipline. Consultants in the later stages of their career, surgeons from overseas, or some of the numerous surgeons based in Britain who have been unsuccessful in achieving a substantive consultant appointment are likely to apply. The main problem facing the trusts is the attitude of the college assessor, who may stick rigidly to the view of "no accreditation, no job." This then places the trust in the position of making an appointment that may conflict with the assessor's recommendation—an unsatisfactory but necessary decision so that surgical services can be provided for the population.

Those planning the centralisation and rationalisation of services need to consider how surgical services can continue to be provided in those hospitals deprived of emergency surgery. It is also necessary to be aware of the political consequences that result when a local population and politicians are convinced that rationalisation is about cutting services to which they are accustomed.

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Television and radio should be used to disseminate important information

EDITOR,—Since the Committee on Safety of Medicines' statement about the safety of third generation oral contraceptives¹ concerns have been expressed about how information was disseminated during the "pill scare." Sally Hope is concerned about how similar messages might be handled in future.²

The National Coordinating Unit for Clinical Audit in Family Planning has looked at the recent dissemination of information warning of the risks associated with oral contraceptives. In initial reports, family planning professionals complained that they received information from the media before seeing the official statement from the Committee on Safety of Medicines, which caused some confusion, anxiety, and misinformation. In

Table 1—Initial and subsequent sources of information about recent pill scare reported by 234 family planning professionals

	Initial	Subsequent
Public media:		
Television, radio	111	156
Newspapers, magazines	9	160
Orally from colleague	49	127
Committee on Safety of Medicines' letter	21	181
Orally from patient	18	71
Letter from Faculty of Family Planning and Family Planning Association	4	187
Pharmaceutical company	4	170
Email	1	19
World Health Organisation's statement	0	39
Other	17	23

December 1995 the unit circulated a questionnaire to regional advisers of the Faculty of Family Planning and delegates who attended the national audit conference. Of the 242 respondents who returned their questionnaire by 18 January, 103 were general practitioners, 60 family planning doctors, 59 family planning nurses, 12 practice nurses, and 7 "other."

The Committee on Safety of Medicines' statement preceded other sources of information in only 9% of cases (table 1). Over half of the respondents obtained their initial information from the media, a fifth received it orally from a colleague, and 8% heard the information first from their patients. The number of official sources from which the respondents had heard differed, with 34 respondents receiving only the committee's letter, 40 only the letter from the Faculty of Family Planning and Family Planning Association, and 147 both letters; 21 were still waiting for either.

With any urgent statement concerning medical practice it is important that experts act as the primary sources of information to clinicians so that patients can receive correct information. Acting as the primary distributor is difficult: family planning is provided by a wide range of specialists, including general practitioners, community nurses, family planning doctors and nurses, gynaecologists, and midwives. There is the added challenge of contacting other medical colleagues for whom contraceptive problems may not be a major focus of clinical services. Thus a variety of methods for disseminating information will probably be necessary. If the public media of television and radio result in the most rapid dissemination of information, as our survey indicates, then they should be consciously used to disseminate official statements, with rapid follow up of written information sent by more than one route.

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1 Committee on Safety of Medicines. *Combined oral contraceptives and thromboembolism*. London: CSM, 1995.

2 Hope S. Third generation oral contraceptives. *BMJ* 1996;312:576. (2 March.)

Gynaecological problems should continue to be treated in primary care initially

EDITOR,—S K Smith's provocative editorial argues that a more medical approach is needed in gynaecology.¹ We are general practitioners in a