Table 1—Results of survey on eating habits of random selection of doctors and patients conducted during beef crisis. Figures are numbers (percentages)

	Had stopped eating beef	Had stopped eating beef products	Allowed children to eat beef	Allowed children to eat beef products	Significance
Doctors (n = 43)	8 (19)	20 (47)	33 (77)	19 (44)	$\chi^2 = 7.0$, $P < 0.01$
Patients (n = 44)	20 (45)	32 (73)	11 (25)	4 (9)	$\chi^2 = 6.2$, $P < 0.05$
Patients by occupational class:					
II, IIIN, IIIM (n = 31)	12 (39)	21 (68)	11 (35)	4 (13)	$\chi^2 = 23.3$, $P < 0.001$
IV, V (n = 13)	6 (46)	10 (77)	0	0	$\chi^2 = 13.7$, $P < 0.001$
Sex:					
Male (n = 48)	5 (10)	21 (44)	31 (65)	18 (38)	
Female (n = 39)	23 (59)	31 (79)	13 (33)	5 (13)	

43 doctors and 44 patients to determine whether their beef eating habits differed during this crisis and what influence, if any, sex and socioeconomic status might have had.

Table 1 shows my findings. Patients were more likely to have stopped eating beef than doctors and to have stopped eating beef products. They were more likely not to allow young children to eat beef (33 (75%)) and beef products (40 (91%)) than were doctors (10 (23%) and 24 (56%) respectively). When patients' responses were analysed by occupational class those in classes IV and V were more likely to have stopped eating beef and beef products than their counterparts in classes II and III. None of those in classes IV or V would allow young children to eat beef or beef products. When both patients and doctors were analysed by sex women were more likely than men to have stopped eating beef and beef products and less likely than men to allow children to eat these products.

It is not surprising that doctors, with their medical knowledge, have been less worried about bovine spongiform encephalopathy and whether to eat beef than have patients. If, however, the public realised that their own doctors were continuing to eat beef then they might be less concerned. My findings show that socioeconomic status influences eating habits; this possibly reflects educational background (and thus the ability to separate facts and risks from the hype) and sources of information (for example, broadsheet rather than tabloid newspapers).

An important issue is the power of the media to influence diet. If people in lower socioeconomic groups continue to eat less red meat, beefburgers, sausages, etc and to prevent their children from eating these then a fall in the incidence of ischaemic heart disease may result—an unexpected benefit of the saga.

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Rehabilitation after brain injury

Author's experience is not unique...

EDITOR,—It is curious: A N Bamji's experience of trying to remedy deficiencies in the provision of rehabilitation for patients with brain injury is being repeated all over Britain.¹ Why is this?

There is no lack of epidemiological evidence of the dire effects of head injury on young men (it

affects mainly males) and their families for up to 50 years.² As Greenwood stated recently³ in a review of a book detailing many models of service providers,⁴ rehabilitation of patients with brain injury is effective. Authoritative statements about the services required have been available for many years—for example, from the British Society of Rehabilitation Medicine (previously the Medical Disability Society).⁵ The Department of Health has set up the brain injury initiative, in which 12 centres will produce data on the effectiveness of their services.

Yet it seems that purchasers and, presumably, their public health consultants fail to see these patients' needs as being of sufficient priority for them to work with providers to provide or enlarge services. Innovation here seems difficult to achieve. The financial risks attached to such new developments cannot be great, since the cost of sending a single untreated patient with a severe injury into the private sector for some two years' treatment is of the order of £100 000. Who holds the key to better things for the majority of brain injured patients?

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...or new

EDITOR,—It may be some comfort for A N Bamji to learn that the struggle to establish rehabilitation services for patients with brain injury in the face of inertia and obfuscation is not a new phenomenon.¹ The reference to war in the title of Bamji's article is particularly pertinent, for during the second world war the foundations for what is required were laid.

Early in the 1940s the Medical Research Council established a committee to advise on the promotion of research into the effects and treatment of war injuries to the brain.² Rehabilitation was emphasised along with the concepts of the team approach, the importance of clinical psychology, and the goal of resettlement in the community. Although the committee was set up in anticipation of the need to treat battlefield casualties, most cases were the result of road traffic accidents and many patients were civilians. Two units of a regional nature existed in

Scotland, and in his annual report of 1945 the medical officer of health for the City of Edinburgh put a strong case for their continuation in peacetime.³ His advice went unheeded, and the rehabilitation services were allowed to wither. The idea was resurrected in the Mair report of 1972.⁴ Ten years later an unusual armistice occurred between clinicians and academics from the rival cities of Edinburgh and Glasgow in an attempt to realise this recommendation. This led to a further decade of constructive, convivial, but fruitless dialogue.

Eventually, in 1991, £500 000 was set aside over three years to provide for the entire population of Scotland. Three small units were approved for the rehabilitation of patients with brain injury; they had no direct funding but depended on the vagaries of the medical market. The unit at Astley Ainslie Hospital is fortunate in having the support of Lothian Health and other purchasers, but demand outstrips resources and many patients do not get adequate medical rehabilitation, especially those living at a distance; access for families and carers is integral to successful resettlement. It is salutary to reflect that the one time there was the prospect of substantial development money was in anticipation of casualties in the Gulf war. Fortunately, that conflict did not result in many such casualties. The casualties on our roads create more disabled people than many a war, but despite lip service being paid to rehabilitation no priority is given to it. So it is a case of both war and jaw.

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Laboratory tests for *Helicobacter pylori* should be more widely available

EDITOR,—The presence of *Helicobacter pylori* is an increasingly important consideration in the management of patients with dyspepsia. Recent strategies for managing dyspepsia in primary care^{1 2} and for the use of gastroscopy services³ have incorporated the patient's *H pylori* status as a specific decision point.

For general practitioners to be able to implement these new management strategies effectively they require access to diagnostic tests for *H pylori*, both to identify those patients who are infected and to confirm the success of eradication treatment. The commonly available non-invasive tests are carbon-13 and carbon-14 urea breath tests and laboratory based microtitre serum antibody assays.

The Primary Care Society for Gastroenterology conducted a postal questionnaire survey of all general pathology laboratory services in Britain in July 1995, seeking details of the availability of non-invasive tests and whom they were offered to. Pathology services in paediatric, maternity, and other specialist hospitals were excluded from the study. A total of 133 laboratories were identified, of which 103 (77%) responded (table 1). Sixty seven of the laboratories provided serum antibody tests. Twenty one provided urea breath tests, although five others stated that the gastroenterology department in their hospital did these. Only 65 laboratories offered a non-invasive test to general practitioners. Twenty eight laboratories offered no tests at

Table 1—Number of laboratories (n = 103) making tests for *H pylori* available to gastroenterologists, other hospital doctors, and general practitioners (GPs)

Test	Gastroenterologists	Other hospital doctors	GPs
Urea breath test only (¹³ C or ¹⁴ C, or both)	7	4	4
Urea breath test and serum assay	14	4	1
Serum assay only	53	57	59*
Near patient test only	1	1	1
Total offering service	75	66	65
No service offered	28	37	38

*Two further laboratories offered serum tests to fundholding GPs only.

all. Fourteen planned to introduce a non-invasive test within the next 12 months, though six would be restricting this service to hospital doctors.

Many of the guidelines on managing dyspepsia that emanate from secondary care advise that the success of eradication treatment should be confirmed by a laboratory test. However, the urea breath test, which is most suitable for this, was provided to gastroenterologists by only 20% of the laboratories and to general practitioners by only 8%. Some gastroenterology units have their own facilities for urea breath tests and make these available to general practitioners on an ad hoc basis. Near patient testing kits can also be bought by general practitioners. These alternative sources are unlikely to have an appreciable impact on the overall availability to general practitioners of tests for *H pylori*.

The restricted availability of non-invasive tests for *H pylori* limits both the effective use of gastroscopy services and the implementation of management guidelines for peptic ulcer disease. These tests, particularly urea breath tests, should be more widely available, and they should be as accessible to general practitioners, who manage 90% of peptic ulcer disease, as they are to gastroenterologists.

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Epidemiology of aortic aneurysm and peripheral vascular disease may show ethnic differences

EDITOR,—David Coggon and colleagues report the contrasting epidemiology of aortic aneurysm and peripheral vascular disease in England and Wales.¹ They conclude that, during the period studied, death rates from aneurysm were highest in the south and east of England and Wales whereas peripheral vascular disease was most common in the north and west, with an inverse relation with social class, and that there are other causes for aortic aneurysm besides the well established risk factors for atherosclerosis.

There are well established ethnic differences in the manifestation of atherosclerotic vascular disease—for example, the incidence of coronary artery disease is increased among Indo-Asians, while that of vascular complications related to hypertension, such as stroke, is higher in black or

Afro-Caribbean patients.² Data on ethnic differences in the prevalence of aortic aneurysm and peripheral vascular disease in Britain are, however, limited. We therefore examined the computerised hospital admission diagnoses for patients admitted with aortic aneurysm and peripheral vascular disease to our city centre district general hospital, which serves a multiethnic population of 300 000, between 1976 and 1986.

Of the 66 patients admitted with aortic aneurysm, 56 (84.8%) were white, one (1.5%) was black, and five (7.6%) were Asian; of the 1466 patients admitted with peripheral vascular disease, 1282 (87.4%) were white, 52 (3.5%) black, and 46 (3.1%) Asian. The proportions of white, black, and Asian adults in the population served by this hospital during the period surveyed, however, were 83%, 10%, and 7% respectively.³ When this was taken into account a significant excess of white patients was seen among those who presented with peripheral vascular disease ($\chi^2 = 13.14$, df = 2, $P < 0.001$) and there were no trends for this to change over the years. There was no significant ethnic difference, however, among the patients who presented with aortic aneurysm ($\chi^2 = 4.26$, df = 2, $P = 0.19$).

We suggest that in addition to the contrasting epidemiology of aortic aneurysm and peripheral vascular disease in England and Wales¹ there may well be ethnic differences in the presentation of these manifestations of atherosclerotic vascular disease, which need to be considered in any detailed analysis. Further insight into the epidemiology of vascular disease in different ethnic groups is required.

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Drop out rate in medical schools seems reasonable

EDITOR,—James Parkhouse claims that the drop out rate from medical schools in the United Kingdom ranges "from 11.7% to 14.1%."¹ If true, this suggests serious problems. His figures, however, disagree with other estimates by a factor of two.

In a recent follow up of 2732 of the cohort of entrants to medical school in 1991, 133 (4.9%) had left during the preclinical (basic medical sciences) stage²; comparable figures for preclinical drop outs in the 1981 and 1986 cohorts were 35/502 (7.0%) and 60/876 (6.8%)

respectively.^{3 4} These figures are similar to the estimate of preclinical wastage in the survey of medical education by the General Medical Council for the five years to 1990 (1350/20 000 (6.8%)), with a small additional clinical wastage of 299/20 000 (1.5%) giving an overall wastage of 8.2%.⁵ Parkhouse's indirect estimate of 11.7% to 14.1% is from 41% to 70% higher than the General Medical Council's estimate.

Parkhouse calculates drop out as the difference between input and output figures derived from two different sources. For the cohorts qualifying in 1989 to 1994 he compares two estimates of the average number of qualifiers (3648 (from the University Statistical Record) and 3576 (from the Higher Education Funding Council for England)) with the funding council's estimate of the number of entrants five years earlier of 4145, giving drop out rates of 12.0% and 13.7% respectively. Although the estimates of qualifiers agree with average provisional registrations with the General Medical Council of 3649, the estimate of entrants is much higher than that given by the Universities and Colleges Admission Service, which averages 3837. The source of the discrepancy is not clear, but double counting of students at Oxford and Cambridge Universities is possible; certainly the admission service's figures are likely to be more accurate since they are based on named individual students rather than aggregated statistics. When the admission service's and the General Medical Council's figures are used the drop out rate is 6.8%, which is compatible with the General Medical Council's rate of 8.2%⁵ and almost half the rates based on Parkhouse's figures of 12.0% and 13.7%.

Both my colleagues and I² and the General Medical Council⁷ found that about half of the students who drop out do so for non-academic reasons (probably most realise that medicine is an inappropriate career). Given this and that a non-zero drop out rate is presumably necessary to maintain academic standards, then an attrition rate of about 3.5% due to academic failure does not seem either unreasonable or unexpected.

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Correction

Neuroleptic prescribing in residents of nursing homes

Owing to an editorial error, only one author is given for the fifth letter in this cluster (29 June, pp 1667-9); there were in fact four authors. The complete list of authors should have read: Heather J Cameron (senior registrar in geriatric medicine), Garnavel General Hospital, Glasgow G12 0YN; William Reid (consultant physician in geriatric medicine), Southern General Hospital, Glasgow G51 2TF; Carol Fisher (audit facilitator), Belvidere Hospital, Glasgow G31 4PG; and David J Stott (David Cargill professor of geriatric medicine), university department of geriatric medicine, Glasgow Royal Infirmary, Glasgow G4 0SF.