for vibrant public health leadership and debate,⁴ which are necessary if consumers are to have confidence in official communiqués. When these are absent the media will gladly fill the vacuum.

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En bloc paediatric renal transplantation is not always appropriate

EDITOR,—D Talbot and colleagues suggest that using the en bloc technique to transplant kidneys from young donors would allow the transplantation of organs that are currently not used.¹ If all paediatric kidneys were transplanted en bloc the number of kidney transplant operations would be halved. Possibly more transplant operations would be successful if single paediatric kidneys were used because, despite the worse graft survival, twice as many operations could be performed. Comparable graft survival for single and en bloc paediatric kidney transplants from donors aged 5 years and under have been reported,² but not from donors aged 2 years and younger. Talbot and colleagues state that the kidneys from 36% of potential renal donors in the United Kingdom were not transplanted.¹ Few of these potential donors would have been aged 5 years and under, and therefore the potential of en bloc transplantation to increase the number of recipients of renal transplants is small.

En bloc renal transplantation has been performed in Australia. The Australia and New Zealand Dialysis and Transplantation Registry reports a donation rate of 10 per million population. Altogether 1984 kidneys were offered for transplantation between 1990 and 1994, of which 1895 were transplanted. Sixty six kidneys were from donors aged 5 years and under, and 22 of these were transplanted en bloc as described by Talbot and colleagues.¹ Only four kidneys from a donor aged 5 years and under were retrieved and not transplanted. The registry reports that, for kidneys transplanted from donors aged 5 years and under into adult recipients, the one year graft survival is over 85% for en bloc kidneys compared with 60% for single kidneys.

Clinically, the en bloc technique was first used to transplant the kidneys of an anencephalic baby into a child in 1969.³ En bloc transplantation of paediatric kidneys into adult recipients was first described by Meakins *et al* in 1972.⁴ The advantages of the en bloc technique, originally described by Carrel,⁵ are that the donor aorta and vena cava used in the vascular anastomoses are larger than the corresponding renal vessels, the anastomosis is technically easier, and the incidence of vascular thrombosis is reduced. The transplanted renal mass is doubled and capable of meeting the biochemical demands of an adult recipient. However, two ureters require reimplantation, and the incidence of ureteric complications might therefore be

expected to be higher. The age below which the kidneys from paediatric donors should always be transplanted with the en bloc technique remains controversial, but 2 years remains a conservative estimate.

I thank the Australia and New Zealand Dialysis and Transplantation Registry for the data on en bloc kidney transplants and for its permission to publish them.

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Giving vitamin K at birth

Approach to giving vitamin K should be reconsidered

EDITOR,—Alvin Zipursky concludes that intramuscular administration of vitamin K at birth is not associated with an increased risk of childhood cancer.¹ The recommendation by the British Paediatric Association in 1992 that vitamin K should be given orally rather than intramuscularly was never successfully implemented,² with the result that most maternity units continued to offer an intramuscular injection. The unease about the possible risk that this conferred was resolved by decisions to request informed parental consent. The way in which consent is requested, however, is often unsatisfactory. Parents have to make a difficult choice between two unlikely but disastrous outcomes, and if consent is requested in the labour ward (sometimes between delivery of the baby and the placenta) uptake is often poor.

Now that injections of vitamin K are believed to be safe it seems important to review this policy. Two courses of action seem reasonable. If we are to ask parents to choose between oral and intramuscular vitamin K then the place to do this is in the antenatal clinic. The alternative is to discontinue the practice of parental consultation and reintroduce the routine use of intramuscular vitamin K.

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- 2 Croucher C, Azzopardi D. Compliance with recommendations for giving vitamin K to newborn infants. *BMJ* 1994;308:894-5.

Paediatricians should return to policies of parenteral prophylaxis

EDITOR,—Rüdiger von Kries and colleagues¹ and Pat Ansell and colleagues² provide further evidence against a relation between the administration of parenteral vitamin K in the neonatal period and cancer in later childhood, this relation having been reported by Golding *et al* in 1992.³ As the efficacy of oral prophylaxis has not

been definitely shown, intramuscular vitamin K seems to be the best treatment for preventing haemorrhagic disease of the newborn.

According to Barton *et al*, in 1993 almost three fifths of babies born in the United Kingdom received oral vitamin K without there being any consensus about dose or frequency of administration⁴; thus infants were exposed to an increased risk of haemorrhage.⁵ This shift towards a policy of oral prophylaxis can be observed worldwide.

Late onset bleeding is potentially life threatening but preventable and rare, and doubts concerning the safety and efficacy of oral vitamin K remain. Now that a risk of cancer associated with parenteral vitamin K has been ruled out, all paediatricians should return to policies of parenteral prophylaxis until this question has been definitely solved. Next time, before we change our practice we should be confident that the new treatment works as well as the old one.

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Alternative theories about AIDS should not be dismissed out of hand

EDITOR,—Stuart W G Derbyshire's review of Peter Duesberg's book *Infectious AIDS: Have We Been Misled?* is tendentious.¹ He says that all Duesberg's supporters contend that Duesberg's ideas "were wilfully suppressed by AIDS investigators for reasons associated with ideology and personal gain." Branding all supporters in this manner misses the point that many thoughtful scientists agree with Duesberg on many points while disagreeing on others. I wrote the preface to this book because I support openness in science and because I agree that "integrity" or rigour in AIDS science is wanting, beginning with the tautological definition of AIDS given by the United States Centers for Disease Control (no HIV = no AIDS). I, and many other supporters of Duesberg, should be identified with specific issues instead of being swept into a general category. For examples of specific support one can consult the jacket of this book, where Nobel prize winner Kary Mullis is quoted as saying, "We have not been able to discover any good reasons for why most people ... believe that AIDS is a disease caused by a virus."

Neither is a conscious conspiracy among scientists necessary for this lack of integrity and shutting out of minority opinion to take place. The pressures brought on basic scientists to follow consensus thinking, especially in times of scarce research funds, are much discussed, and it is clear that integrity and openness in science are doomed when consensus take over.

Derbyshire insists that "overwhelming evidence" exists for HIV as the cause of AIDS and cites

haemophilia data that cannot establish correlation or cause. Duesberg has argued against these data and against mistaking correlation for causality,^{2,3} but this review fails to mention these arguments and makes no effort to convey the breadth and depth of the reviews collected in the book.

Finally, I agree with Derbyshire: Duesberg has been mistreated. What Peter Duesberg has been arguing for—more research on substances known or suspected to be immunosuppressive—should not be controversial, it should be welcomed. If true, then Duesberg should be taken seriously and not, as Derbyshire suggests, placed “peripheral to the mainstream AIDS debate ... as a maverick rather than as a heretic.” That debate would be impoverished or non-existent were it not for Duesberg’s persistent scientific criticisms over 10 years. Derbyshire cannot have it both ways where a serious critic with something constructive to offer is also marginalised and mistreated by our AIDS leadership.

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Objective tests exist to aid diagnosis of hand-arm vibration syndrome

EDITOR,—We were pleased that the hand-arm vibration syndrome is included in the ABC of Work Related Disorders but would like to point out some of the more recent developments in the diagnosis of this syndrome.¹ C M Jones rightly states that there is no single diagnostic test. The role of laboratory diagnostics such as cold provocation testing, measurement of vibrotactile and thermal thresholds, and aesthesiometry was extensively reviewed in a workshop held in Stockholm in 1994.²

Jones refers to attempts at inducing vasospasm by cooling the hand. A report by a working party of the Faculty of Occupational Medicine stated that simple cold provocation by immersion of the hands in cold water in an uncontrolled fashion followed by visual inspection of skin colour is of negligible value: it gives a high number of false negative results and should be abandoned.³ For acceptable cold provocation testing, minimum criteria for standard acclimatisation and standard challenge conditions should be fulfilled, an end point defined, and the sensitivity and specificity reported. Measurement of finger skin temperature with thermistors, thermocouples, or thermal imaging was considered to be a satisfactory technique, along with measurement of finger systolic blood pressure. Temperatures of $\leq 10^{\circ}\text{C}$ can lead to vasodilatation, making it difficult to interpret the results.

There is also evidence that multiple objective tests of the sensorineural component of the syndrome can improve accuracy when the condition is being staged according to the Stockholm scale.⁴ The Health and Safety Executive and subcommittees of the International Standard Organisation are currently attempting to standardise tests for both the vascular and sensorineural components of the syndrome.

It is true that there is still no gold standard, but the move to objectivity combined with a good

occupational history should replace total reliance on the history, which may vary on different occasions.

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Living wills do have legal effect provided certain criteria are met

EDITOR,—I disagree with Tom Arie when he states that “in the United Kingdom ‘living wills’ have no legal force.”¹ Although it is true that there is no legislation governing the use of living wills (also known as advance directives), recent case law suggests that at common law, in England and Wales, an advance refusal of treatment will have legal effect provided it meets the elements necessary for validity as set out in *Re T*.² These elements are that (a) the person was an adult and mentally competent when he or she made the advance refusal, (b) the person knew the nature and consequences of the refusal at the time that he or she made it, (c) the person intended the refusal to apply in the circumstances that have subsequently arisen, (d) the person was not acting under undue influence when he or she made the decision, (e) the refusal has not been revoked, and (f) the person is now mentally incapable of making the decision.

In the more recent case of *Airedale Trust v Bland* three judges confirmed the legal effect of an advance refusal of treatment,³ and in *Re C* the High Court issued an injunction supporting an advance refusal of treatment.⁴

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GPs' responsibility for midwives' actions

GPs are not responsible if midwives are employed by a trust or are self employed

EDITOR,—Early this year I signed a joint statement with the Royal College of General Practitioners, which clearly states that midwives are at all times responsible and accountable for their actions. Thus I was dismayed to read P D Thomas’s letter, which is based on the mistaken assumption that doctors carry vicarious liability for acts and omissions of midwives.¹ This is not the case. If a general practitioner personally employs a midwife, a nurse, or anybody else then he or she is responsible, as the employer, for the acts and omissions of that

employee. Midwives who are employed by the health authority or are self employed are responsible and accountable for their own actions.

Thomas’s second mistaken assumption is that obstetric problems are more adequately dealt with by general practitioners than by paramedics. Paramedics are called specifically for their resuscitation skills and not for obstetric skills. When midwives need obstetric skills they will transfer the woman to hospital to a specialist obstetrician; they are unlikely to call a general practitioner. The days of doing forceps deliveries in the home have long gone, and modern roads and vehicles allow women to be transferred within an hour.

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- 1 Thomas PD. GMS’s advice on intrapartum care. *BMJ* 1996;313:305. (3 August.)

Author’s reply

EDITOR,—In reply to Caroline Flint’s comments, I would refer her to the NHS General Medical Services Regulations. Paragraph 20(2)(b) of schedule 2 confirms that the doctor with whom the patient is registered is responsible for the acts and omissions of all people acting on his or her behalf unless those people are doctors on any NHS medical list and themselves responsible for their own acts and omissions. I do not believe that the joint statement can negate this statute—as I have discovered to my cost—but Flint’s letter clearly highlights the recipe for conflict that can exist when both independent general practitioners and midwives employed by trusts offer intrapartum care.

At a midwife led home delivery an ambulance will usually be called for any intrapartum problem. The joint statement supposes that obstetric emergencies should more properly be managed by hospital obstetricians or neonatologists, but with the demise of obstetric flying squads it is quite possible that specialist intervention will be provided too late to be effective. Few hospital trusts have medical staff free to attend domiciliary emergencies. Indeed, my local hospital is now obliged to employ its consultants as locum obstetric registrars.

Most ambulance services can indeed effect transfer within an hour, but it can take far less than an hour for both a mother and her baby to die of an unexpected intrapartum catastrophe. While I do not believe that any general practitioner would attempt a domiciliary forceps delivery for simple delay in the second stage of labour, this manoeuvre and many other medical interventions can be life saving if there is extreme fetal distress or if other serious problems occur, such as massive postpartum haemorrhage. This is why I attend all confinements and try to keep my obstetric and resuscitation skills finely honed.

My local ambulance service grants ambulance staff a paramedic certificate after they have successfully completed a five week course. The certificate entitles the staff to use parenteral prescription only medicines on their own recognition only if a doctor is not available. It is not a superior qualification to that held by any registered medical practitioner.¹ If nine years of vocational training no longer equips doctors to manage obstetric emergencies more adequately than any midwife or paramedic then something is very wrong.²

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- 1 *The medicines (products other than veterinary drugs) (prescription only) amendment No 2 order 1992.* London: HMSO, 1992. (SI 1992 No 2937.)
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