whether something that has been shown to be effective in general will be effective in his or her particular setting.

To decide whether selective decontamination of the digestive tract should be used you have to consider not only the relative frequency of pneumonia—as Bonten and colleagues seem to suggest—but also the absolute number of patients cared for over a certain period. A 10% frequency has a very different meaning if it applies to 100 patients or to 3000 patients. For this reason the number to be treated is a good measure of the effect of treatment. Bonten and colleagues seem concerned that our estimate—based on the median prevalence of pneumonia in all the studies (29%)—was overinflated by studies with a high baseline incidence of pneumonia. Table III in our paper, however, shows that the estimate of the number to be treated is relatively stable across the whole range of incidence. Even if a baseline as low as 10% is assumed, an average of 16 patients should be treated to prevent an infection and an average of 52 should be treated to prevent one death. Is this information of no value or, as Bonten and colleagues indicate, “potentially misleading”?

Though we recognise the limits of our meta-analysis, it is unfair to say that we ignored the issues of resistance of extra costs resulting from selective decontamination. Rather, we said that these issues have not been evaluated in properly designed studies and that the information available is so sparse and its quality so poor that any conclusion based on the small number of studies that report some information is bound to be potentially misleading.

ALLESANDRO LIBERATI

Istituto Ricerche Farmacologiche “Mario Negri,”
Laboratorio Epidemiologia Clinica,
62-20157 Milan
Italy

1 Bonten MJM, Gaillard CA, van der Geest S. Selective decontamination of the digestive tract. *BMJ* 1993;307:1559-60. (11 December.)

2 Selective Decontamination of the Digestive Tract Trialists' Collaborative Group. Meta-analysis of randomised controlled trials of selective decontamination of the digestive tract. *BMJ* 1993;307:525-32. (28 August.)

Health care in South Africa

EDITOR,—Tony Waterston and Anthony Zwi make some valid comments regarding apartheid's effect on health care in South Africa but deal superficially with several important points.¹ The crucial difference between the National Medical and Dental Association's advocacy of so called selective support (more accurately interpreted as “selective boycott” as there is an element of coercion) and true selective support as advocated by me² seems to have escaped them.

Recent requests by the African National Congress for the removal of sanctions highlights understandable shifts of political strategy. Academic boycott on political grounds is legitimate if so described but illegitimate when assertions that it is moral are not accompanied by justificatory ethical argument. My objections to political strategies being posed under the banner of morality were articulated within a moral position against apartheid more consistent with the professional and academic ethos.²

Criticism of the University of Cape Town's academic support programme on the grounds that it is paternalistic and does not acknowledge the damaging effect of being educated in inferior schools is misguided. The reason for the existence of the programme is recognition of inferior schooling and to provide remedial tuition. When students on this programme were excluded 43% of first year medical students selected on merit for admission to the medical school last year were black.

Wide disparities in health in many developed

countries³ expose the naivety of expectations that legacies of apartheid will be erased overnight. Change is taking place, and the need now is for constructive contributions to the development of sustainable patterns of progress that will diminish inequity. It must be acknowledged that this will be a long, slow process, particularly given the continuing erosion of the South African economy and rapid population growth (about 750 000 people a year).

Interestingly, public health physicians envisage a “poor outlook for equity, comprehensiveness, and equality of access” to health care in the United Kingdom.⁴ Hopefully, Waterston and Zwi are also addressing this and will provide data to improve health care under circumstances in South Africa that are much harder to rectify than those in the United Kingdom.

Finally, Waterston and Zwi's article is an example of colonial and paternalistic thinking. It fails to expose the real roots of disparities in South Africa and elsewhere.⁵ These are perpetuated by, among other things, agencies from Britain and other countries opening recruiting offices in South Africa. Zwi would be a more convincing advocate for change if he returned to South Africa and joined his colleagues in contributing to transition.

S R BENATAR

Department of Medicine,
University of Cape Town,
Cape Town,
South Africa

1 Waterston T, Zwi AA. Health professionals and South Africa: supporting change in the health sector. *BMJ* 1993;307:110-2. (10 July.)

2 Benatar SR. An alternative to academic boycott. *Nature* 1990;343:505-6.

3 Brooks DD, Smith DR, Anderson RJ. Medical apartheid: an American perspective. *JAMA* 1991;266:2746-9.

4 Pollock AM. The future of health care in the United Kingdom: poor outlook for equity, comprehensiveness and equality of access. *BMJ* 1993;306:1703-4.

5 Ray JL. *Global politics*. 4th ed. Boston: Houghton-Mifflin, 1992.

Immigration status of overseas doctors

EDITOR,—The Home Office's regulations restricting the stay of overseas doctors in Britain to four years was implemented from 1 April 1985.¹ The doctors could work without a work permit for this period for training purposes, and, though there was no provision in the immigration rules to extend the period, the Home Office has used its discretion to allow people to switch their immigration status on the recommendation of the Department of Employment. Work permits have been issued to some doctors in specific jobs provided it had been proved that they were not competing with local candidates or candidates from the European Union. According to the NHS Management Executive's consultation document, from the beginning of this year all training grade jobs in the hospital and community health service will be excluded from the work permit scheme, which implies that doctors must complete their training within the specified period.²

Unlike doctors from the European Union, these doctors have to pass a difficult and expensive test—that set by the Professional and Linguistic Association Board—to prove that they are competent in English and professional knowledge. Passing the test enables them to take employment for training purposes for only four years.

In this era of subspecialised training, most doctors coming to Britain want not only to obtain qualifications such as the MRCP, FRCS, or MRCOG but also to have some training in their chosen specialty and to gain some research experience before returning to their home country in a consultant capacity. Under the current regulations, before a candidate takes part II of these exami-

nations he or she must have at least 18 months (MRCP) to three years (FRCS) of experience. This means that even if the doctors pass all the examinations at their first attempts they will be left with little time for training in a specialty. In fact, most of the doctors only just gain the membership or fellowship of a royal college in this period; on implementation of the rules they have to leave Britain without completing their postgraduate training.

It would therefore be helpful if the training period was extended to at least six years so that the doctors could have two to three years' training in their chosen specialty before returning home. Obviously, being on the “permit free scheme,” they would be unable to claim settled status in Britain and would therefore not be eligible to apply for further jobs. If service requirements no longer justify employing overseas doctors for this length of time then perhaps the entire infrastructure of postgraduate training should be abandoned.

FAYYAZ AHMED

Charing Cross Hospital,
London W6 8RF

1 Department of Health and Social Security. *Employment of overseas doctors and dentists in the United Kingdom*. London: DHSS, 1985. (HC (FP) (85) 14.)

2 Beecham L. Immigration status of overseas doctors will change. *BMJ* 1993;307:1567. (11 December.)

Measles immunisation in developing countries

EDITOR,—Peter Aaby and colleagues raise issues about measles immunisation in developing countries that deserve comment and further evaluation.¹ Measles before the age of 9 months remains an important problem in developing countries that was understated in the paper. In densely populated urban areas of west Africa the incidence may be as high as 30%.²

In a recent unpublished study of measles antibody levels in some 350 infants in Zaria, northern Nigeria, serological susceptibility to measles (defined as a haemagglutination inhibition titre of less than 1/8) rose from about 73% at 4 months to 90% at 6 months and 95% at 9 months. Thus immune protection should be offered to these infants before the age of 9 months. The point of contention is the appropriateness of the standard Schwarz vaccine for this purpose. When this vaccine is given in its modified heat stable form to infants aged 9 months the seroconversion rate is less than 70%, possibly because of poor potency and breaks in the cold chain.³ Thus immunisation with this vaccine before 9 months of age results in poorer seroconversion rates.

The potential beneficial effect of the Schwarz vaccine, unrelated to the prevention of measles attributed to immunising infants before the age of 9 months, deserves further evaluation. Although this effect could be causal, the authors did not compare the immunisation records of the infants vaccinated before and after 9 months. The infants offered measles vaccination early may have been more likely to have completed the course of other immunisations. A single dose of a potent vaccine before the age of 9 months seems most appropriate. It is unfortunate that the high titre vaccines have been withdrawn after reports of high mortality, although causality and the pathogenesis of this association remain unexplained.

Previous studies of reimmunisation with measles vaccine in children, after the first dose early in infancy, suggest that the antibody response is poorly maintained.⁴ If the standard Schwarz vaccine confers protection before the age of 9 months a second dose at 9 months may not alter the morbidity and mortality from measles sufficiently to justify the cost. The cost implications for the

meagre health resources available in developing countries and the importance of ensuring compliance with a two dose immunisation schedule must be carefully considered.

S K OBARO

Department of Immunology,
Chelsea and Westminster Hospital,
London SW10 9NH

- 1 Aaby P, Anderson M, Sodemann M, Jakobsen M, Gomes J, Fernandes M. Reduced childhood mortality after standard measles vaccination at 4-8 months compared with 9-11 months. *BMJ* 1993;307:1308-11. (20 November.)
- 2 Ransome-Kui O. Child health in Nigeria; past, present and future. *Arch Dis Child* 1986;61:198.
- 3 Adu FD, Akinwale OAO, Tomori O, Uche LN. Low seroconversion rates to measles vaccine among children in Nigeria. *Bull WHO* 1992;70:457-60.
- 4 Black FL, Berman LL, Libel M, Reichelt CA, Pinheiro FdeP, Travassos DR, et al. Inadequate immunity to measles in children vaccinated at an early age; effect of revaccination. *Bull WHO* 1984;62:315-9.

Clinical research in trust hospitals

EDITOR,—J S Metters, of the Department of Health, confirms that NHS bodies are not allowed to offer advance indemnity to subjects in research projects and refers to an agreement between the department and the Association of the British Pharmaceutical Industry relating to clinical trials that have been sponsored by the pharmaceutical industry.¹ Metters does not, however, comment on two equally critical issues.

The first issue concerns therapeutic research that is not sponsored, such as comparisons of two or more pharmaceutical regimens or trials of dietary treatment or of new operative techniques or instruments. Such research may or may not be incorporated in the normal investigation and management of a patient provided by the NHS.

The second issue concerns non-therapeutic research carried out on volunteers. This may be purely physiological but may also be a necessary step in the development of new clinical techniques for investigation or treatment. In developing new techniques for clinical measurements of gastrointestinal function and immunity I find it invaluable to pilot methods in volunteers before applying them to patients. This is particularly critical when the technique might be used in children.

At the very least, advice is needed from the Department of Health on what type of insurance academics and clinical investigators carrying out such research should seek and on what is not covered by subscriptions to a medical defence union.

ANNE FERGUSON

Department of Medicine,
University of Edinburgh,
Western General Hospital,
Edinburgh EH4 2XU

- 1 Metters JS. Clinical research in trust hospitals. *BMJ* 1993;307:1499. (4 December.)

Medicine and human rights in Egypt

EDITOR,—Recent concern in the medical literature about the deteriorating human rights situation in Egypt has noted that institutionalised ill treatment of prisoners, including torture, is now widespread and that some prison and forensic doctors are colluding with such practices. Several other Egyptian doctors, including myself, have been documented as victims of torture after arbitrary arrest or of detention without trial amounting to several years. An increasing number of civilians facing charges carrying the death penalty are being

brought to trial in military courts which do not offer internationally recognised standards of justice.^{1,2}

It was in this context that the Egyptian Organisation for Human Rights held its first international conference last month in Cairo. Delegates were drawn from 47 local and foreign organisations, including the medical section of Amnesty International, Physicians for Human Rights from the United States, and treatment centres for torture survivors in Denmark, Britain, France, Greece, and Pakistan. The conference sought to highlight the ethical challenges facing medical staff, particularly in "at risk" areas like the military or prisons, and to debate the role of doctors in human rights issues generally, both as advocates and as clinicians.

The conference recommended the establishment of non-governmental centres for the rehabilitation of victims of torture. There was a formal call for legislation to give the Egyptian medical authorities the right to supervise doctors working in prisons and to visit prisons regularly. Legislation was also sought to mandate independent specialist examination before a death certificate could be issued in the case of a death in detention. The Egyptian Organisation for Human Rights is also pressing for the introduction of courses on human rights to the syllabuses of the faculties of medicine, law, and education and also police academies. Lastly, we are calling on the medical profession to ban any members who continue to perform female circumcision.

MOHAMED MANDOUR

Egyptian Organisation for Human Rights,
PO Box 2516,
Cairo 11361,
Egypt

- 1 Dillner L. Doctors are helping with torture in Egypt. *BMJ* 1993;307:824. (2 October.)
- 2 Hall P. Human rights and doctors in Egypt. *Lancet* 1993;341:1085.

Intensive care for children

EDITOR,—We support the call for improved national paediatric intensive care services¹ and the principles outlined in the British Paediatric Association's document²; however, the method of achieving this should not be oversimplified. As Shann observes, a substantial number of children receive no intensive care,³ emphasising the failure of many to appreciate the benefits of early referral to intensive care units. Increasing the number of paediatric intensive care beds will not resolve this issue unless an increase is linked to improved postgraduate training. Tertiary centres can contribute to this process only if suitably experienced consultants are recruited in sufficient numbers. Without these, opening a paediatric intensive care unit will not, in itself, guarantee the appropriate quality of care. There is a need for more paediatric intensive care beds, but many children admitted to intensive care units do not require services unique to teaching hospitals. Where high standard facilities already exist, it makes little sense to move patients elsewhere.

We agree that a fully comprehensive paediatric intensive care service cannot be organised at a district level, but we believe that high quality paediatric intensive care can be provided within a district hospital. In our district, the intensive care nursing team is led by a sister who has both ENB 100 and RSCN qualifications. Sixty per cent of our nurses hold an intensive care diploma; of these, 30% have received training in paediatric intensive care. Single cubicles are used preferentially, and parental participation is encouraged. Treatment is supervised by full time intensivists with specific training in paediatric intensive care. Our training posts attract high calibre medical staff with

experience in paediatrics, anaesthesia, medicine, or surgery. The Regional Paediatric Advanced Life Support course, based here, has considerable input from our intensive care team, and together with our local university we have established one of Britain's few "Principles of paediatric intensive care nursing" ENB 920 courses. As it is important to recognise limitations as well as capabilities, we have also developed a sophisticated transport system which allows us to transfer any patient who requires treatment or investigation that cannot be provided locally.

We hope that paediatric intensive care services will be rationalised but in our view, it will still be necessary for larger general intensive care units to continue to care for children, using criteria which define when transfer is appropriate. It is clear from our own experience that critically ill children can receive high quality care in district if it is provided by appropriately trained attendants who offer the necessary commitment.

J PALMER

B L TAYLOR

G B SMITH

Department of Intensive Care Medicine,
Queen Alexandra Hospital,
Portsmouth PO6 3LY

P FULBROOK

University of Portsmouth,
Portsmouth

- 1 Dillner L. Children's intensive care is poor, says report. *BMJ* 1993;307:1444. (4 December.)
- 2 British Paediatric Association. *The care of critically ill children*. London: BPA, 1993.
- 3 Shann F. Australian view of paediatric intensive care in Britain. *Lancet* 1993;342:68.

Medical accidents

EDITOR,—Leonard Evans advocates "more precise terminology" and considers that using a more appropriate term would help doctors (and others) to reduce harm.¹ This is timely in the light of the *Health of the Nation* key area of "accidents."

Evans advocates use of the word "crash" as a more accurate term to describe traffic "incidents." Though "crash" moves away from the notion of fate and chance typically associated with a traffic accident, it is still problematic. Many pedestrian injuries and deaths cannot accurately be described or explained as the outcome of a crash.

"Accident prevention" is a well established activity involving the work of many safety professionals. The word "accident" is so embedded in our everyday language, and because it is used to account for most unintentional injuries it is difficult to avoid its use. The phrase "accident prevention," however, is paradoxical and misleading. How can measures that are developed to enhance safety prevent an occurrence that is seen as the outcome of fate, chance, or bad luck?

We encourage the wider acceptance of the perspective centred on "injury control and prevention." Sophisticated models have been developed within this perspective for the scientific analysis and understanding of the complex factors involved in sustaining and preventing injury. Such an approach entails focusing on both intentional and unintentional injury and has major implications for public health policy.

Our work in West Yorkshire has stimulated the local adoption of an injury control perspective in the development of policies for enhancing safety. Recently completed research,² together with an ongoing study into the risk behaviour of older children, has drawn attention to the limitations of the essentially individualistic and behaviour change approaches that are characteristic of many epidemiological studies of injury control. Our work suggests that an understanding of broader social and societal factors affecting the risk of injury is important.