and in its ultimate aim of abolishing the death penalty.

PAUL MANSOUR

Amnesty International British Section,
Southport,
Merseyside PR9 0LY

- 1 Richards T. The World Medical Association: can hope triumph over experience? *BMJ* 1994;308:262-6. (22 January.)
- 2 BMA Working Party on Torture. *Medicine betrayed—the participation of doctors in human rights abuses*. London: Zed Books, 1992:200-1.
- 3 Amnesty International. *Turkey—possible imminent resumption of executions*. London: AI, 1994. (AI index: EUR 44/01/94.)

Clinical ecology

EDITOR,—We agree with David Pearson that psychological factors can influence health,^{1,2} but we take exception to his statement that “orthodox medicine has already looked fairly at the claims of clinical ecology.” This is simply not true. The Royal College of Physicians’ report was highly selective in its literature citations, which served the clear bias of its authors.² This led us to publish an editorial addressing the potential pitfalls of consensus statements and their influence on medical progress and the quality of patient care.³ We subsequently published a detailed critique of the Royal College of Physicians’ report, highlighting specifically the numerous errors it contained.⁴

We acknowledge that the results of well conducted clinical trials are invaluable in assisting doctors in their decision making, but we take issue with the idea that “unproved” treatments should not be used “except possibly as part of a controlled clinical trial.” This idea has been promulgated in recent years but is directly contrary to the Declarations of Geneva and Helsinki, which emphasise that a physician’s ethical responsibility is to act at all times in his or her patient’s best interest. We cannot support an approach that places scientific investigation as senior to acting, in one’s judgment, in the best interest of a patient; to do so is to violate the most fundamental ethical principle underlying the practice of medicine. This is the level at which the discussion of innovative treatments should be taking place, rather than at the level of the tactics used by Pearson and others.

STEPHEN DAVIES
DAMIEN DOWNING

Journal of Nutritional Medicine,
PO Box 3AP,
London W1A 3AP

- 1 Pearson D. Clinical ecology. *BMJ* 1994;308:202. (15 January.)
- 2 Davies S. The scientific and ethical foundations of nutritional medicine. Part I. Evolution, adaptation and health. *Journal of Nutritional Medicine* 1991;2:227-47.
- 3 Royal College of Physicians Committee on Clinical Immunology and Allergy. *Allergy: conventional and alternative concepts*. London: Royal College of Physicians, 1992.
- 4 Davies S, Downing D. Truth, ethics and consensus—their relation to medical progress and the quality of patient care. *Journal of Nutritional Medicine* 1992;3:91-8.
- 5 Downing D, Davies S. “Allergy: conventional and alternative concepts.” A critique of the Royal College of Physicians of London’s report. *Journal of Nutritional Medicine* 1992;3: 331-49.

Confidentiality, contraception, and young people

EDITOR,—Victoria Gillick implies that sexual behaviour in young people under 16 would be beneficially restricted if doctors either did not prescribe contraception for this age group or did so only with parental consent.¹ Her view is not supported by research. About 28% of boys and 20% of girls have had intercourse by the age of 16, and 55% and 45% of these, respectively, used no contraception on the first occasion. The condom

was chosen by 26-38% and the pill by only 5%.² Clearly the prescription of contraception by doctors was responsible for little if any of this sexual activity.

Young people aged 13-15 place great emphasis on confidentiality when they consult doctors about sexual behaviour and contraception.³ Fear that the consultation will be disclosed to their parents may deter some from obtaining urgently needed help. Many have already risked unplanned pregnancy and sexually transmitted disease before they seek advice. The development of sexual behaviour is part of the process of growing up—of separation from the parents—so teenagers believe that they should take personal responsibility for this private aspect of their lives. Parents have a fundamentally important role in setting standards of behaviour and in providing emotional and practical support, but, in relation to sexual safety, it may be more appropriate and more effective for a teenager to seek help independently from a responsible, informed professional.

The House of Lords’ ruling in the case brought by Gillick established that young people under 16 are entitled to give their own consent to medical treatment, provided that they fully understand its nature and effects. Doctors have a duty to explore with such young people the advantages of involving their parents, but if this is rejected they should remain sympathetic and willing to counsel. Some young women will decide to delay having full intercourse, but others will need contraception. Withholding a prescription is unlikely to prevent intercourse from occurring and could result in considerable harm.

DAVID PAINTIN

Birth Control Trust,
London W1N 7RJ

- 1 Gillick V. Confidentiality, contraception, and young people. *BMJ* 1994;308:342-3. (29 January.)
- 2 Johnson A, Wadsworth J, Wellings K, Field J. *Sexual attitudes and lifestyles*. Oxford: Blackwell Scientific, 1994.
- 3 Allen I. *Family planning and pregnancy counselling projects for young people*. London: Policy Studies Institute, 1991.

Avoidable factors in stroke

EDITOR,—Mr Adiseshiah has pointed out the role of carotid endarterectomy in symptomatic patients with >70% stenosis of the ipsilateral internal carotid artery.¹ The annual incidence of transient ischaemic attacks has been estimated to be 0.4/1000. Of the patients affected, between 5000 and 10000 would be suitable for carotid endarterectomy each year, which would reduce the number of strokes by between 500 and 1000.² The role of carotid endarterectomy in symptomatic patients with moderate stenosis of the carotid artery and in asymptomatic patients with severe stenosis is currently being evaluated by international trials.

Thus the benefit of carotid endarterectomy has been proved in a relatively small subset of patients. Recent research has identified other effective measures to prevent strokes, which may have a greater impact. The Antiplatelet Trialists’ Collaboration showed that low dose aspirin reduces the risk of major stroke and reduces mortality in symptomatic patients.³ Several large trials have shown that treating hypertension in elderly patients reduces the risk of stroke by between 25% and 47% and that treating isolated systolic hypertension is also beneficial.⁴ Finally, primary prevention of stroke by giving anticoagulant treatment to asymptomatic patients with atrial fibrillation reduces the risk by two thirds.⁵

It is not fair to imply that general practitioners alone are at fault for failing to refer the small number of patients who we currently know will benefit from carotid endarterectomy. Effective prevention of stroke requires close cooperation

among general practitioners, general physicians, geriatricians, neurologists, and vascular surgeons. Funding for collaborative research is required to evaluate methods of implementing these research findings so that we can avoid the confusion that has existed about the value of carotid surgery. Is this what health services research is all about?

G E MEAD
P A O’NEILL
C N McCOLLUM

Department of Surgery,
University of Manchester,
University Hospital of South Manchester,
Manchester M20 8LR

- 1 Adiseshiah M. Avoidable factors in stroke. *BMJ* 1994;308:201. (15 January.)
- 2 Brown MM, Humphrey PRD. Carotid endarterectomy: recommendations for the management of transient ischaemic attacks and ischaemic stroke. *BMJ* 1992;305:1071-4.
- 3 Antiplatelet Trialists’ Collaboration. Collaborative overview of randomised trials of antiplatelet therapy. Prevention of death, myocardial infarction, and stroke by prolonged antiplatelet therapy in various categories of patients. *BMJ* 1994;308: 81-106. (8 January.)
- 4 Elder AE, Fox KAA. Where are the guidelines for treating hypertension in elderly patients? *BMJ* 1992;305:845-46.
- 5 Lowe GDO. Antithrombotic treatment and atrial fibrillation. *BMJ* 1992;305:1445-6.

Fluoroquinolones in upper respiratory tract infections

EDITOR,—Roland J Körner and colleagues’ article on the dangers of oral fluoroquinolone in community acquired upper respiratory tract infections raises interesting questions.¹ In the first case reported, a single dose of any antimicrobial drug would have been unlikely to affect the course of the patient’s illness, pneumococcal meningitis. Interestingly, the patient’s treatment in hospital consisted initially of cefotaxime and metronidazole; only after the results of culture were obtained was this changed to intravenous penicillin. The second case report does not stipulate what dose or frequency of oral ofloxacin was prescribed. The underlying haematological malignancy was diagnosed only during the patient’s admission. Again, many other agents considered to be first line drugs in upper respiratory tract infection might not have prevented the sequence of events that led to admission with septic shock. Indeed, despite the results of culture the patient was treated with penicillin in combination with netilmicin.

The authors state that *Streptococcus pneumoniae* is the commonest organism isolated in both upper and lower respiratory tract infections; a series of recent studies has shown that *Haemophilus influenzae* is remarkably common in infections such as sinusitis and infective exacerbations of bronchitis, both acute² and chronic.³ Another Gram negative pathogen, *Moraxella catarrhalis*, is isolated as commonly as the pneumococcus. The quinolones have considerable activity against both of these Gram negative respiratory pathogens.

With ever changing patterns of resistance it is essential to review empirical antimicrobial therapeutic regimens. Use of amoxycillin in cases in which *H influenzae* is likely to be prevalent could be disastrous.⁴ Finally, evidence to suggest that ciprofloxacin is efficacious in both sinusitis and bronchial infections is mounting.⁵ Many of the data are comparative, and rarely is there a pronounced difference between the quinolone and the comparator.

I agree that fluoroquinolones such as ciprofloxacin and ofloxacin are not indicated as first line antibiotics in uncomplicated upper and lower respiratory tract infections in previously fit patients. Both cases reported by Körner and colleagues, however, had complicating features. Indeed, the lesson from these cases is that, despite the use of agents with excellent pharmacokinetics