and in its ultimate aim of abolishing the death penalty.

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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.

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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.

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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?

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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

and good activity against many of the expected pathogens, underlying conditions may dictate the clinical course of events. Unfortunately, the perfect, immutable antimicrobial does not yet exist.

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Tobacco advertising near schools

EDITOR,—Richard Smith has presented the case for a ban on tobacco advertising.¹ Advertising and promotion of tobacco are currently regulated by a voluntary agreement between the government and the tobacco industry,² and this has been used as a reason not to introduce such a ban. The voluntary agreement relies on the commitment of the tobacco industry to be effective, but the industry has frequently circumvented it—for example, by using sports sponsorship to gain access to television.³

Despite this the public has to trust the industry not to target advertising and promotion at young people or encourage them to start smoking. Assessing whether or not the content of an advert "exploits those who are specially vulnerable . . . on account of their youth or immaturity"² is difficult and open to wide interpretation. Compliance with other sections of the voluntary agreement is easier to measure and can indirectly test the commitment of the tobacco industry to the code as whole.

In relation to advertising near schools, the voluntary agreement states that poster advertising may not be placed if "clearly visible and identifiable from within buildings or boundaries of schools . . . nor adjacent to entrances and exits or the pavements forming the boundaries to such schools."² A survey was carried out to measure compliance with this section of the voluntary agreement.

Altogether 192 primary and secondary schools in four inner London boroughs, identified from borough listings in the telephone directory, were surveyed. Twenty two had poster sites positioned as defined above. These schools were then visited monthly for six months (December 1992-May 1993), and all tobacco advertisements were identified and photographed. By the end of the survey tobacco advertisements had been placed in vio-

Tobacco advertising outside 22 London schools where advertising in violation of voluntary agreement was possible during six month study

Month	No of schools with tobacco advertisements	Cumulative No of schools with tobacco advertisements
1	4	4
2	2	4
3	8	9
4	5	12
5	8	14
6	4	14

lation of the voluntary agreement near two thirds of the 22 schools (table).

Reducing teenage smoking is one of the targets identified in the *Health of the Nation*, but progress towards the target so far has been marginal.⁴ Although tobacco advertising is only one influence on teenage smoking,⁵ it is amenable to a relatively simple measure: it can be banned completely. This would be an effective way to reduce the prevalence of smoking in Britain.¹

These results question the tobacco industry's commitment even to the relatively weak provisions of the voluntary agreement. If the government is serious about reducing smoking it should ban tobacco advertising.

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Home visits by general practitioners

A different experience

EDITOR,—I was surprised to read Michael J Noble's letter and to see his figures on home visits in general practice.¹ The age distribution of patients receiving out of hours home visits in his practice differs from that in mine, although I also practise in a semirural area. I take part in an on call rota with my four partners and two other, smaller practices; the total population at risk at nights and weekends is some 17 000 patients.

I undertook a retrospective audit of my own out of hours calls for the past six months. Of 228 out of hours consultations, only 47 (21%) were with patients over 65. Eighty four (37%) were with adults between 16 and 65 and 97 (43%) with children under 16. Most of the patients in the younger two age groups had conditions that would not have prevented them being transported to a central location—as indeed several were, either to meet me in the surgery or to come to my home.

So far as out of hours visiting is concerned, my experience is different from that of Noble; it is out of hours calls that are presently under consideration and for which emergency centres have been suggested. The situation with regard to daytime visiting is, however, different, with visits to elderly people predominating. Noble is not specific about the timing of the visits he mentions, and I wonder if he is confusing the issue.

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Local problems need local solutions

EDITOR,—Michael J Noble states that the overwhelming majority of home visits are made to patients over 65.¹ This may be true in his practice but is not in mine. In my urban practice of 14 900 patients, in an area where a pit was recently closed, patients over 65 received 47% of all home visits

(4374 out of 9224) during the past 12 months. If only late night visits (that is, those made between 10 pm and 8 am) are considered, however, patients over 65 were responsible for only 22% (152 out of 684 in the same period) whereas children aged under 14 were responsible for 30% (203). Thus for some practices it may be feasible to expect patients to attend an emergency centre.

The problem is the diversity of general practice. I do not believe that one solution will fit all practices; local solutions are needed for local problems.

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New techniques in assisted conception

Consultation document incomprehensible

EDITOR,—The Human Fertilisation and Embryology Authority has recently published a public consultation document, *Donated Ovarian Tissue in Embryo Research and Assisted Conception*.^{1,2} This document discusses the "issues surrounding the use in research and treatment of ovarian tissue obtained from mature women, from girls or women who have died or from aborted fetuses" (para 1). Comments on these issues are invited from "members of the public, interested bodies and organisations" (para 42).

To respond to the document the public must first be able to understand its contents. We have assessed this formally using a readability formula. This provides an estimate of the proportion of the population likely to understand a piece of text, based on the lengths of sentences and words.³ This formula classifies the document as difficult and academic. We estimate that 11-31% of the British population are able to understand the document (given the formative data available), so most of the public are effectively excluded from commenting on it. Any report based on the responses it elicits must take into account which members of the public have been able to respond to it.

Involving the public in the debate about the uses of new technologies is to be applauded. Writing simpler consultation documents would ensure that the views of a wider selection of the public could be elicited.

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Parents and their children happy with assisted conception

EDITOR,—Luisa Dillner reports on the current controversy over developments in assisted reproduction technologies whereby children might be conceived by use of ovarian tissue from aborted fetuses or female corpses.¹ The Human Fertilisation and Embryology Authority has published a consultation document on these issues, which are also being considered by the ethics committee of the BMA. We wish to report the findings of the