as Jenkins and Wingate commented on. Twelve of the children were concerned by change in the affected parent's mental state or personality; nine expressed uncertainties and fears about the future and fears of getting the disease themselves; eight complained of a limited social life and limited communication in the family; six complained of constant nagging and trivial talk; six said that they could not turn to their affected parent for advice or decisions; and four complained that the affected parent had no idea of their feelings.

Our results highlight how even minor or subtle disabilities in a parent can cause children considerable anxiety. While the impact of disability on partners or adult carers is well recognised, the impact on different generations is neglected¹ and worthy of further discussion.

The complexities of meeting the varied needs of those suffering from multiple sclerosis is being increasingly recognised,⁴ although the needs of children and young people still fail to be addressed. Meeting the practical needs is straightforward through care attendant schemes.⁵ We still have great difficulties in meeting emotional needs. We wish to emphasise the emotional impact of a disabled parent on his or her children. This is particularly important with regard to cognitive impairments or if the parent is deteriorating (however subtly) from emotional, intellectual, or physical impairments.

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Prescribing antibiotics in general practice

EDITOR,—Conrad M Harris and David C E F Lloyd have tried to address an important issue for general practitioners considering their antibiotic prescribing behaviour.¹ Their work, however, is descriptive, and no firm conclusions should be drawn from it on the optimum treatment of infections (often respiratory) in general practice.

I was intrigued to read that a five day course of phenoxymethylpenicillin was more common than a seven day course. Can anyone tell me why? I have tried to trace the evolution of prescriptions for five days of phenoxymethylpenicillin and have found references to intramuscular treatment during an epidemic of infection with group A β haemolytic streptococci in American servicemen,² and the subsequent use of oral penicillin for 10 days,³ for which recommendations persist in the United States.⁴ The reason for the final transition from 10 to five days eludes me.

The authors' comments that five days' treatment could save money have received attention in some general practice magazines.⁵ But the authors make no reference to the effectiveness of the treatments they describe. To conclude that the most commonly prescribed treatment is the most appropriate treatment is based on a false premise—that the majority knows what it is doing.

I have spent the past 12 months trying to contribute to the question of efficacy by asking general practitioners in Avon to take part in a randomised controlled trial comparing antibiotic with placebo for the treatment of sore throats. Interestingly, we have used a five day course of phenoxymethylpenicillin. I hope to report whether this is effective later this year.

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Guidelines

EDITOR,—J D Swales¹ has misconstrued Gene Feder's message² about the importance of ensuring that the way in which guidelines are developed is clear to potential users. Guidelines can change medical practice and lead to improved outcomes for patients.³ To achieve this, however, people who use guidelines (including clinicians, purchasers, and providers) need to identify those that are scientifically valid⁴ and disseminate and implement them appropriately.⁵ Guidelines are more likely to be scientifically valid if systematic reviews or meta-analyses are used to identify and synthesise evidence; they are developed by a nationally based multidisciplinary group that includes representatives of all key disciplines; and explicit links are made between their recommendations and the strength of evidence.⁶ The development of guidelines, however, is subject to many potential biases that reduce their validity. It is important that people who develop guidelines provide adequate documentation to allow potential users to appraise the guidelines validity and to make an informed judgment about whether to adopt them in their clinical practice. The lack of documentation about the methods of development provided with most published guidelines means that potential users are unable to do this.

Feder observed differences in the evidence used to develop two guidelines on hypertension and in the recommendations made. Swales suggests that the differences are probably due to the different value judgments of the people who develop guidelines. An alternative explanation, however, is that the development of one or both of the guidelines was flawed and that the observed differences reflect differences in the validity of the guidelines. Without further documentation about the methods used in their development it is impossible for potential users to judge why the guidelines differ.

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Notifications of measles

EDITOR,—David W G Brown and colleagues¹ finding that only 17% of sporadic cases of measles were confirmed serologically is not surprising.¹ From February to July 1993 we carried out a survey to determine whether notifications of measles in Tameside Metropolitan Borough were based on reasonable clinical suspicion. We defined a notification as reasonable if the patient had had fever; a rash over the face and body lasting at least three days; and one of cough, coryza, and sore eyes.² For notified cases we interviewed the parents and asked about symptoms and signs; vaccination history; history of measles; and whether, before becoming ill, the patient had been in contact with someone known to have measles. Vaccination history was also checked against child health computer records.

The parents in 35 of 42 cases were available for interview. None gave a history of contact with someone with measles. Only 10 patients fulfilled the criteria, of whom two were under 1 year old and four had been immunised against measles. Of the remaining four patients, three were young men aged between 20 and 22. Ten patients had not had a fever, and 18 had not had a rash of appropriate distribution or duration. Nine were under 1 year old, the youngest being 6 weeks old.

The criteria used in this study were fairly non-specific and would have resulted in the notification of many illnesses other than measles. This makes the notification system impracticable for detecting outbreaks or monitoring vaccination programmes. In addition, many parents in this study expressed anxiety at the diagnosis of measles, particularly in young babies, so care should be taken to ensure that the diagnosis is correct.

Measles is now relatively rare in Britain, and some general practitioners seem to be uncertain of the clinical signs and symptoms. We look forward to the widespread availability of salivary testing and to the day when laboratory confirmation of the diagnosis before notification becomes routine.

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Human rights in Turkey

EDITOR,—As a member of both the Turkish Medical Association and an ethnic minority group from the Balkans, I feel compelled to reply to Paul Mansour's letter about the presence of doctors during executions in Turkey and his comments concerning the Kurdish problem.¹ I have never experienced or witnessed institutionalised racial discrimination against any ethnic minority in Turkey. Since 1980 increasing terrorist attacks by Kurdish separatists have led to a warlike situation in south east Turkey, through which innocent locals have suffered. Terrorism also caused delay in further democratic reforms.

Turkey has a democratically elected parliament in which all ethnic minority groups, including Kurds, are represented. This parliament holds