followed by covert video surveillance is the appropriate means of diagnosis when all the issues are taken into account.

Dispatches showed that in one case the failure to detect abuse under surveillance was not sufficient to prove the innocence of a mother accused of suffocation.

We were hampered in preserving balance by the reluctance of members of North Staffordshire Hospital's paediatrics department to appear in the programme to explain their methods. We attempted to present their known opinions fairly. The executive producer and the producer travelled to Stoke on Trent in October 1993 for a meeting with the hospital's senior staff because we believed that their contribution would have been very important. We kept a place for them in the filming schedule until the last moment possible. The decision was made that the issue was too important to be shelved simply because one of the protagonists would not appear.

We still believe this; we believe the programme was fair, and its conclusions still stand: principally, that a national inquiry into procedures for the diagnosis of Munchausen's syndrome by proxy is needed.

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1 Covert surveillance in Munchausen's syndrome by proxy [letter]. *BMJ* 1994;308:1101. (23 April.)

Drug use in prison

EDITOR,—Michael Ross and colleagues point to the problem of drug use and injecting in English and Welsh prisons and the threat this poses for HIV transmission.¹ Previous studies of injecting drug users have consistently shown that the majority will at some time be imprisoned and that about a third of this group will inject in prison, of whom about three quarters will share needles and syringes.²⁻⁷

Our recent data show no improvement in the situation. From a sample of 507 injecting drug misusers in London interviewed in 1993 in a study funded by the Medical Research Council, 99 were randomly selected to answer questions about their prison experiences. Seventy six had experienced imprisonment. Of these, 45 had received no treatment, advice, or help for their drug problem the last time they were in prison. Injection in prison was reported by 21, and, of these, 14 shared needles and syringes on a mean of 20.2 (range 2-100) occasions.

These findings show no change over previous studies (table) and are complemented by a recent study of drug injecting practices in prison conducted in 1993-4 with recently released prisoners (funded by AVERT).⁸ These ex-prisoners were established drug users who were dependent on opiates or chronic users of other combinations of drugs. All 44 continued to use drugs while in prison. Nearly all (39) experienced withdrawal symptoms in prison. Most considered that using drugs was unavoidable and necessary to alleviate withdrawal symptoms or insomnia. Medication (offered to 22/40) was primarily to aid short term withdrawal; most were given diazepam.

Drug injectors who reported injecting and sharing syringes in prison

Location and date of study	% (No) who injected in custody	% (No) who shared equipment in custody
London 1989 ^a	66 (33/50)	76 (26/33)
Wales 1990 ^a	51 (35/65)	74 (26/35)
England 1989-90 ^a	25 (118/474)	62 (74/119)
England, Wales, Scotland 1988 ^b	23 (32/139)	75 (24/32)
London and Bristol 1990 ^a	27 (30/111)	63 (19/30)
England 1990 ^c	27 (45/168)	71 (32/45)

Seven were prescribed short (less than one week) reducing doses of opiate substitutes. Drug users considered that doctors' judgments were often moral rather than clinical; drug withdrawal was viewed as a self inflicted problem. Sixteen injecting drug users continued to inject. All needles and syringes were reused, and disposal of used injecting equipment was rare. Although nine shared needles and syringes, all made some attempt to clean them. However, appropriate cleaning materials were not available and the conditions of injecting made the possibility of adequate cleaning unlikely. Other paraphernalia shared included spoons, containers for mixing drugs and cleaning equipment, and filters.

The high risk behaviour in prisons reinforces previous data on the situation; the Health Care Service for Prisoners is well aware of this data. The call for improved provision of medical care for drug users in prison¹ needs to be supplemented by decontaminant distribution, improved education about drugs and AIDS, and steps to maximise the opportunity prison provides to help prisoners with drug problems.

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Mental disorders in the developing world

EDITOR,—The issues raised by Melanie Abas and Jeremy Broadhead, particularly the suggestion about the use of local resources in developing intervention programmes, are relevant to mental health care delivery in the developing world.

Many developing countries, however, have other major health problems related to poverty and ignorance, besides those shared with the more developed countries. This makes generalisation of health priority statistics meaningless, and such issues should be left to be determined locally. It is also unlikely that concentrating on minor disorders will improve the image of psychiatric services among either the politicians or the populace, whose felt need is likely to be different, irrespective of beliefs about causation.

Most developing countries are still striving to establish a functional primary health care structure. Hence, observable deficiencies in the mental health component only mirror the state of primary health care in general, rather than a specific inadequacy of mental health training. Attention should be paid to the development of a solid primary care framework, with international support.

Alternative practices also need to be carefully studied and evaluated, and those found harmless and effective should be encouraged, to ease the

burden on meagrely resourced mental health services. Useful collaboration can be established with such practitioners as a way of monitoring their practices.

These measures, along with Abas and Broadhead's suggestions, will go a long way to making essential mental health care not only available but also acceptable, accessible, and affordable in most developing countries.

L W DUNN, Hong Kong; T O ADEBOWALE, Aro, Nigeria; C UMATHY, Bangalore, India; I B CHAUDRY, Karachi, Pakistan; S D YANGYE, Kaduna, Nigeria; Y A RAHIMI, Afghanistan; R OMOIGU, Benin, Nigeria; D DIGHI-DEO, India; M N SIDDIGI, Pakistan; P U IKWUAGWU, Jos, Nigeria; G FESTUMBERHAN, Eritrea; J A NGOWI, Tanzania; O OLAYINKA, Ibadan, Nigeria; D H PEPPE, Portharcourt, Nigeria; F M IBITOYE, Ilorin, Nigeria; O OBIKOYA, Ibadan Nigeria; participants at overseas doctors' course held at the department of psychiatry, University of Manchester, in April.

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1 Abas M, Broadhead J. Mental disorders in the developing world. *BMJ* 1994;308:1052-3. (23 April.)

Cancer of the upper gastrointestinal tract

EDITOR,—In their letter J G Weil and S J Munday provide further evidence of surgeons' experience as a prognostic factor and in their subsequent editorial S O'Reilly and A Forastiere draw attention to the potential value of multimodality in the management of oesophageal cancer. We wish to emphasise the worldwide paucity of randomised trials in this disease; this could well be delaying improvements in treatment. To help rectify this situation, in 1990 the Medical Research Council's Cancer Therapy Committee set up a working party to conduct a programme of multicentre randomised trials on treatment. This programme is progressing well.

Firstly, 204 of a planned intake of 1000 patients have to date been entered into an international trial of simple design, started in 1992, comparing surgical resection with or without two cycles of preoperative chemotherapy (OE02 trial). This complements the similar intergroup trial in the United States mentioned by O'Reilly and Forastiere; indeed, we are discussing the possibility of a joint analysis.

Secondly, we are processing updated individual patient data from four of the five randomised trials (two of them cited by O'Reilly and Forastiere) that have investigated surgical resection with or without preoperative radiotherapy for a meta-analysis, and expect to receive data from the fifth trial soon. This will give us the best currently available assessment of the role of preoperative radiotherapy.

Thirdly, we are piloting a regimen of intended "curative" radical radiotherapy plus chemotherapy in patients with locally limited disease unsuitable for surgical resection. If this regimen proves acceptable, we plan to undertake a large multicentre randomised trial comparing radical radiotherapy with or without chemotherapy (OE03 trial) with survival and the control of dysphagia as the main end points. The previous randomised trials addressing this question were small and collectively were inconclusive; O'Reilly and Forastiere did not mention a trial that showed significant advantage over radiotherapy alone.¹

Finally, in patients with advanced cancer, we are piloting a policy of intraluminal treatment—using, for example, laser, brachytherapy, or alcohol injection—plus a simple regimen of two fraction or single dose palliative external beam radiotherapy. If this policy looks promising, we again aim to

follow the pilot study with a randomised trial comparing intraluminal treatment with or without external beam radiotherapy (OE04 trial). The aim is to improve the quality and duration of palliation with minimal disruption to patients' lives. The OE03 and OE04 trials have already been agreed to in principle by the MRC's Cancer Therapy Committee, pending the results of the respective pilot studies.

We urge clinicians who treat oesophageal cancer to collaborate in large randomised trials. Such trials offer the most reliable method of assessing and comparing treatment policies and so of improving the results of treatment. Copies of the protocols and further information can be obtained from the MRC's Cancer Trials Office. We are now particularly eager to recruit more centres into the OE02 trial.

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1 Weil JG, Munday SJ. Management of oesophageal cancer. *BMJ* 1994;308:1103. (23 April.)

2 O'Reilly S, Forastiere A. New approaches to treating oesophageal cancer. *BMJ* 1994;308:1249-50. (14 May.)

3 Hatlevoll R, Hagen S, Hansen HS, Hultborn R, Jakobsen A, Mantyla M, et al. Bleomycin/cisplatin as neoadjuvant chemotherapy before radical radiotherapy in localised, inoperable carcinoma of the esophagus. *Radiother Oncol* 1992;24:114-6.

Equity in the NHS

EDITOR,—Margaret Whitehead's picture of health services before the establishment of the NHS reminds us of the dangers of market forces operating in health care.¹ She indicates clearly that we are now well along the road to requiring certain sections of the population to pay directly for the consequences of ill health. What causes the greatest concern, though, is that the main financial burden is falling on the most disadvantaged in society.

The continuing care of older people has in effect been taken out of the public sector and privatised. As this has been accomplished without any public debate most of the population are unaware of the profound effect it will have on financial arrangements for old age. It has been allowed to occur despite repeated statements from the Department of Health and ministerial pronouncements that long term care in the NHS, free to patients, still has a place.^{2,3} Despite the protest by the Social Security Committee in 1991,⁴ the view held by the National Association of Health Authorities and Trusts—that the provision of long term nursing care of older people is no longer a function of the health service—seems to have prevailed. More recently, Sir Duncan Nichol, when chief executive of the NHS Management Executive, confirmed that when medical assessment deems that long stay care is required on the grounds of ill health it should be provided free by the NHS.⁵ Thus the onus is on consultants who must make such assessments, but the financial consequences are likely to influence the outcome in favour of social care and discharge from hospital.

In a survey that I carried out last year on behalf of the British Geriatrics Society members were asked their opinions on issues relating to long term care. Of the 489 respondents, 196 agreed with the statement that all forms of such care should be means tested while 377 thought that some long stay beds should be retained in the NHS. This suggests that a substantial proportion of doctors who care for older people continue to favour the traditional

role of the NHS in the provision of long stay care at no financial cost.

Inequity in the NHS has now reached the point that adequate funding of acute care is possible only because of the transfer of resources from the long term care of older people. This amounts to blatant discrimination against those who are both old and chronically ill or disabled.

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1 Whitehead M. Who cares about equity in the NHS? *BMJ* 1994;308:1284-7. (14 May.)

2 Department of Social Security. *Financing of private and voluntary residential care*. London: HMSO, 1992.

3 Mawhinney B. *Caring for people: speech to IHSM/ADSS conference*. London: HMSO, 1992.

4 Social Security Committee. *Fourth report. The financing of private residential and nursing home fees*. London: HMSO, 1991.

5 Warden J. The lottery of long term care. *BMJ* 1994;308:742. (19 March.)

World Medical Association

EDITOR,—George Giri asks which organisation represents Spanish doctors in the World Medical Association (WMA), because as far as he can ascertain there is no equivalent of the British Medical Association (BMA) in Spain. He asks also whether the Spanish doctors' dues are paid by the government.

Spanish doctors are represented in the WMA by the Consejo General de Colegios Médicos de España, which like the BMA is both a founder of the WMA and a current member of the Standing Committee of Doctors of the European Union. Its membership, and its funding, is drawn from physicians of all specialties throughout Spain and it is not subsidised by the government.

Exact equivalence to the BMA is not a prerequisite for membership of the WMA, because many of the representative organisations from other countries differ from each other in certain respects—even those which may seem at first glance to be identical. To belong to the WMA an organisation must have a "membership broadly representative of physicians in that country" and it "must not be subject to, or controlled by, any office or agency of the government."

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1 Giri G. World Medical Association. *BMJ* 1994;308:921. (2 April.)

Waiting times and the patient's charter

EDITOR,—Surely no one feels that seeing 90% of outpatients within 30 minutes of their appointment time is an unreasonable objective. However, to impose this particular standard in the patient's charter now will almost certainly lead to consequences which are against patients' interests in the short and intermediate term at this hospital.

In 1989, when norms were set, we were already trying to cope with a patient population close to double that recommended for the number of consultants in post. To increase our throughput would have been unsustainable. We have already had to accede to the divisive requirements of a two tier system engendered by fundholding and non-fundholding practices, which is inevitable (and undeniable) in a situation where demand outstrips the provision of services.

Now we face a challenge which is likely to prove insurmountable and has a financial penalty that

will exacerbate the problem. We will respond seriously to the challenge, but to have any hope of seeing patients within 30 minutes of their appointment time it is more likely that we will see considerably fewer routine patients (except for those of fundholders); be refractory to requests for seeing urgent and expedited patients whom we traditionally have squeezed in; decline requests from medical students for special attachments; discourage postgraduate activities such as teaching and accommodation of medical and paramedical visitors; and be inclined to send away and rebook those patients who will not be seen "in time" because of unexpected absences, such as staff sickness.

Many of our patients, new and old, require several detailed assessments by professional support staff before seeing a member of the medical staff. Many depend on ambulances, making appointment planning optimistic. We urge the rulemakers to reconsider the simplistic requirement that patients be seen within 30 minutes of their appointment to see a doctor. If the requirement were to relate to appointments with any staff member this would help us to develop and improve the running of our paramedical support services.

If money did follow the patient, as was promised, an already highly cost effective hospital like ours could afford to deliver the exemplary, innovative, and often complex management that is properly expected of us, while fulfilling our training and research commitments.

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Elderly people who get stuck in the bath

EDITOR,—As a medical nonagenarian with bilateral hip replacements, I agree that it is often difficult and sometimes impossible to get out of a bath unaided.¹ If I lie in a normal sized bath I am unable to get out unaided. Fortunately, however, my own bath, which is old, is slightly broader than usual baths, and this allows me to roll over on to my front, from which position I can rise to my knees and then stand erect and step out of the bath.

What I cannot understand is why anyone should get seriously burnt or scalded in the bath. Surely it is dangerous to leave the hot tap running when you are in the bath. It is common sense to test the heat of the water before getting into it; a thermometer is not required.

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1 Cadier MA, Shakespeare PJ. Elderly people who get stuck in the bath. *BMJ* 1994;308:1240. (7 May.)

Correction

New public health

A typesetting error occurred in this letter by Nigel Bruce and others (11 June, p 1568). The sentence in the middle of the penultimate paragraph should read, "These processes—central to Health for All theory and increasingly important in national health policy"—require commitment, resources, and experience."