neurites; in neonatal animals they enhance the repair of nerves and reduce the rate of death of nerve cells after peripheral nerve injury.¹³ They have also been reported to slow the progression of a motor neuronopathy in mutant mice. Problems include the administration and bioavailability of these agents,¹⁴ especially in humans, and the possible effects on cells other than motor neurones. Recombinant human growth hormone was not effective in altering the course of the disease,¹⁵ and a trial with recombinant human insulin derived growth factor is in progress. A trial with ciliary neurotrophic factor has now been discontinued.¹⁶ Thyrotropin releasing hormone and analogues have been studied in several clinical trials, because of both neurotransmitter and neurotrophic actions, with no benefit.^{17,18} The proposal that the disease has an immunological basis has resulted in trials of immunosuppressants including cyclosporin, cyclophosphamide, plasmapheresis, intravenous immunoglobulin, and total lymphoid irradiation¹⁹—with no benefit.

Unsurprisingly, many patients and their families are enthusiastic, and impatient, to try any and every possible treatment that might conceivably improve this disease's gloomy outlook. But individual centres in current international trials are recruiting relatively few patients. Frustration may result if participation is impossible owing to lack of available places, exclusion criteria, or geographical distance from a study centre. Although we must try to maintain a positive attitude to managing the disease and recognise that patients' collaboration in further

drug trials is vital, it is important to emphasise that none of these treatments is of proved benefit. Patients not included in a trial are not necessarily disadvantaged or being denied treatment, especially as the studies must include a placebo arm. Publicity about possible new lines of research and "breakthroughs" may raise expectations that cannot be fulfilled. Those conducting trials must therefore exercise control in the claims they make for treatment, especially if these claims are based on preliminary or incomplete data.

Large numbers of compounds with potential therapeutic effects need screening in motor neurone disease, and trial designs need to be further improved to facilitate this.²⁰ The aims are not only to identify potential treatments but also to avoid the use of an ineffective one.

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Drs Orrell and Lane are participating in a current trial of riluzole and Dr Guilloff in a trial of recombinant insulin derived growth factor. The authors have previously participated in trials of branched chain amino acids and thyrotrophin releasing hormone in motor neurone disease.

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The woman on the kerb

Health and the environment are inextricably linked

Picture this. A woman is dragging on the remnants of her cigarette, a pushchair perched on the kerb as she tries to cross the road between the heaving traffic. Her child, his face smeared with sticky orange, is sucking on his lolly and inhaling the dark gases from the bus exhaust in front of his nose. A familiar scene to most city dwellers, it nevertheless fills health care professionals and environmentalists alike with a sense of impotence and frustration.

Most doctors entered their profession because, filled with youthful idealism, they believed that they could help to improve the health of their communities. But reorganisations of health services and power struggles now

loom so large that many are disillusioned and feel that they are failing in a culture of competition and rationing.

Health and the urban environment were brought sharply into focus at a symposium in Manchester last month that ran alongside Global Forum '94, the official follow up to the earth summit in Rio de Janeiro in 1992. The symposium was organised by a partnership between the British Council, the UK Health For All Network, and the Public Health Trust. Despite a wide international representation the British contingent was notably lacking in representatives from medicine or public health.

Two years have passed since governments (including

Britain's) committed themselves to Agenda 21 in Rio.¹ Agenda 21 is a comprehensive blueprint for how to bring about a global shift towards sustainable development. It not only includes an entire chapter on the protection and promotion of human health but is based on the premise that progress towards a healthier life requires powerful input from public health professionals.

In his opening address Dr Greg Goldstein, of the World Health Organisation's healthy cities programme, pointed out that the health sector continues to focus almost exclusively on caring for the sick without seeking to influence the determinants of sickness. Citing the examples of population growth, the environment, pollution, and social behaviour, Dr Goldstein commented that the statutory health sector should be a stronger partner in developing policy in these areas. By the year 2000 more than half the world's population will live in cities (already almost three quarters of people in developed countries live in cities) but, despite commitments to intersectoral collaboration, in only a few countries is there any substantial health input into development policy. Health policies should address not only traditional medical interests such as the organising and financing of health care but also issues such as housing, transport, agriculture, and education.^{2,3} Health advocates need to influence policymaking at all levels of society and in all sectors.

The second key issue to emerge from the conference related to the artificial divide that separates health from the environment. They are now perceived as totally distinct areas and are often interpreted according to their most narrow definitions. But when health is regarded as the state that allows the achievement of maximum human potential and the environment is taken to include its social and cultural dimensions then the distinction blurs. Promoting health for the woman at the city kerbside entails far more than educating her not to smoke; policies that influence air quality, social networks, and transport safety are also needed.

The third key issue concerned how these public health policies could contribute to the process of "governance." Dr Trevor Hancock, a Canadian public health consultant, pointed out that "governance is a process by which we collectively solve our problems and meet our society's needs" as distinct from "government", which is only one of the tools by which governance is achieved. A healthier

future for humanity should be the aim of economic policy and not its byproduct; health policies must address equity in its widest sense.

Common platforms for intersectoral activity are evident in certain areas in Britain—for example, in Glasgow and Liverpool. The symposium heard from Dr Leslie Alexander of Lancaster University and John Rice from the South East Institute of Public Health about their progress in developing and validating health related indicators, as opposed to health (usually disease) indicators. Examples of health related indicators might include specific estimates of air quality or measures as diverse and detailed as the length of cycle tracks, the cost of a food basket, or the availability of locally grown fresh produce.

Two major challenges face the British public health movement in advancing a programme that combines health and the environment. Firstly, the puzzle remains of how to bring together the many relevant disciplines within the statutory, private, and voluntary sectors so that they can develop policy on public health. Secondly, there is the challenge to formulate a method that marries "hard" and "soft" data⁴ and which can establish links between a mixture of environmental factors and people's health. Such a method would need to go far beyond "mere rhetoric"⁵ to provide an objective foundation for what most of us recognise intuitively.

Agenda 21 should result in health having a role in the development of policies affecting all aspects of society. Such a paradigm shift will require many influential advocates for health. As Dr Peter Draper from the Public Health Trust emphasised, recognising the connection between the environment and health requires a degree of lateral thinking. For both public health and medical professionals, making these connections need not detract from the pursuit of excellent and equitable health care but should complement it, thereby strengthening the pursuit of health for current and future generations.

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Please bypass the PORT

Observational studies of effectiveness run a poor second to randomised controlled trials

Struggling to contain health care costs, the United States has devoted considerable attention to health technology assessment, producing clinical guidelines and measures of appropriateness, organising consensus conferences, and carrying out studies of practice variation and "outcomes research." Serious reservations have been expressed about the scientific validity of some of these approaches. Controversy focuses particularly on the use of routine health records to assess the effectiveness of treatments. Such studies conflict with the British tradition of using randomised controlled trials. Last year the New York Academy of Sciences brought together the exponents of

different approaches to evaluating health care. The results have now been published in a book, which also provides edited accounts of the often heated discussion.¹

When Congress created the Agency for Health Care Policy and Research in 1989 it was anxious for quick results, assuming that analysis of databases would provide technical solutions to the United States' health care crisis.² Fifteen patient outcomes research teams (PORTs) with a planned budget of nearly \$200m were established in clinical areas such as ischaemic heart disease, acute myocardial infarction, diabetes mellitus, prostatic disease, and back pain. A team works principally by combining the