from antidepressants. Commonly, patients with moderate or severe depressive disorder suffer prominent low mood in the morning, with their mood lifting towards evening. Thus the observation that deliberate self poisoning peaks in the early evening is unlikely to be due primarily to depressive disorder. The patients studied are likely to vary in motive and psychopathology, but these were apparently not assessed.

The half lives of different antidepressants and their active metabolites vary widely, as do their absorption and elimination in different subjects. These factors make the prediction of the time of peak plasma concentrations difficult. In addition, there is little evidence that mood and suicidal behaviour are correlated with diurnal variations in serum antidepressant concentrations. Much more important are the detection and effective treatment of the depressive disorder if one is present. Recent studies in primary care have shown poor skills in detecting depressive disorder and in treating such disorder effectively—that is, giving sufficient dose of an antidepressant for sufficient time—and poor compliance.^{2,4}

Finally, the extrapolation of the results of observational studies on deliberate self harm to different countries is problematic. A recent comparison of the characteristics of people who harmed themselves in Oxford and Utrecht showed significant differences in age, incidence of socioeconomic problems, and incidence of psychiatric and personality disorders.⁵ The implication is that the threshold for and nature of self harm may vary among nations, making conclusions regarding prevention drawn from observational studies specific to the population studied.

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Managing sharps injuries

EDITOR,—Ruth R White and Elisabeth J Ridgway show considerable variation in the management of sharps injuries both between and within hospital departments and emphasise the importance of clear and consistent advice and appropriate intervention and follow up.¹ Although they allude to the need to reduce the number of sharps injuries, they do not specifically comment on some of the enduring problems of preventing and managing them—namely, poor uptake of hepatitis B immunisation and failure to report sharps injury, particularly among doctors.

A survey of all doctors employed by South Glamorgan Health Authority between August 1990 and February 1991 indicated that only 27% of respondents were fully immunised against hepatitis B.² The main reason for non-immunisation was a low perception of risk; the main reasons for incomplete immunisation were forgetfulness and job movement.

A further survey of this cohort found that as few as 5% of needlestick injuries were reported.³ Doctors who were not fully immunised against hepatitis B were no more likely to report incidents than those who were fully immunised. The reasons for non-reporting included a low perception of risk

or of the importance of the incident, insufficient time, and unfamiliarity with reporting procedures.

Proper management of sharps injuries depends on good reporting. Without it prophylaxis after exposure, counselling, and follow up are likely to be inadequate. The requirement that health care workers involved in procedures that are prone to result in exposure must be able to show immunity against hepatitis B means that many more doctors are probably immunised than hitherto, but doctors' complacent attitudes to the health and safety hazards of sharps injuries are still a cause for concern. Doctors' perceptions of low risk patients have been shown to be inaccurate.⁴ Doctors clearly need to be better educated about the importance and desirability of prompt reporting of all sharps injuries.

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Matching inhalers and spacer devices

EDITOR,—Concern has been generated by the pharmaceutical industry about inhalation treatment and large volume spacer devices in advertisements in the *Pharmaceutical Journal*.^{1,2} General practitioners and pharmacists are being informed that generic bronchodilator metered dose inhalers should not be used with a large volume spacer since this could lead to decreased efficacy. We believe that clinicians and pharmacists should know that some metered dose inhalers may be more efficient than others in terms of depositing drugs in the lung airways and, therefore, that the same amount of drug will not necessarily enter the lungs when different metered dose inhalers are used with the same spacer system. In our opinion these differences are unlikely to be of significant clinical relevance with regard to bronchodilator treatment.

There are differences between the pulmonary depositions achieved by different inhalation devices, and this is particularly important with dry powder inhalers. There can be considerable differences between the pulmonary depositions achieved by different dry powder inhalers, metered dose inhalers, and a metered dose inhaler with a large volume spacer. It is, therefore, important for clinicians and pharmacists to be aware of this and that a change of steroid inhaler could lead to a clinically significant increase or decrease in pulmonary deposition and in clinical efficacy. Whenever an inhaled steroid device is changed close clinical monitoring is necessary so that treatment can be stepped up or down as appropriate. However, we do not believe this to be as important with inhalation devices containing bronchodilators.

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- 1 Advertisement. *Pharmaceutical Journal* 1994;252:between pages 876 and 877.
- 2 Advertisement. *Pharmaceutical Journal* 1994;253:between pages 8 and 9.

n of 1 trials

EDITOR,—I am not at all sure where you are trying to lead us. In the "editor's choice" in the issue of 22 October you say: "One sort of study that most doctors could undertake is an n of 1 trial in which treatments are allocated randomly and in double blind fashion to a single patient. . . . If you have a patient for whom you are not sure whether one drug will be better than another then maybe you have an ethical commitment to embark on such a trial."

I do not have any patients who take drugs and do not fall into the above category. The decisions that I make (salbutamol or ipratropium bromide? Azathioprine or cyclophosphamide? Bendrofluazide or co-amlofruse?) are invariably not made on a double blind basis but are based on some reasonable (to me) therapeutic hypothesis and partly on the results of trials that pertain to a relevant group of patients (but not necessarily to the patient in question); observations both clinical and investigative of the apparent effects in that particular patient; cost; and, not least, what the patient tells me of any apparent symptomatic effect, good or bad.

Suppose I select just one patient for an n of 1 trial out of the 12-16 whom I see in an outpatient clinic. Suppose all my colleagues do the same. We then go to the pharmacy and ask it to make up double blinded packs of the two drugs, as Lyn March and colleagues did for their comparison of paracetamol and diclofenac, which were "identically presented." This week I shall need nifedipine versus amlodipine, next week amoxycillin versus erythromycin. It is not, even remotely, practicable.

March and colleagues did not do a series of n of 1 trials with different pairs of drugs. They did a series of n of 1 trials in a defined group of patients with the same pair of drugs. In short, they did a standard double blind randomised trial in a group of patients in the standard way and then looked at individual responses within the group. Our pharmacy would respond on that basis, but what's new?

Could it be that editorially you have somewhat exaggerated the point?

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- 1 March L, Irwig L, Schwarz J, Simpson J, Chock C, Brooks P. n of 1 trials comparing a non-steroidal anti-inflammatory drug with paracetamol in osteoarthritis. *BMJ* 1994;309:1041-6. (22 October.)

Postnatal sexual health

EDITOR,—The author of the personal view who believed that she could not be the only woman to have felt "physically and mentally broken by the experience of childbirth and its aftermath"¹ strongly echoed findings from our survey of sex after childbirth undertaken for the National Childbirth Trust earlier this year (G Barrett and C Victor, British Sociological Association's medical sociology conference, York, 1994). Altogether 1010 women replied to a questionnaire placed in the winter edition of the trust's magazine (circulation roughly 10 000). They gave details of their background, most recent delivery, and subsequent sex life. The characteristics of respondents broadly reflected the profile of the membership of the National Childbirth Trust (91% were married, 76% were aged 30 or over), and, as would be expected of members of the trust, a high proportion (97%) breast fed. Rates of intrapartum procedures (caesarean section (12%), forceps and ventouse delivery (14%), and episiotomy (28%)) were similar to rates found in the wider population.³

Our survey showed a high level of morbidity among the respondents. Half (513) believed that their sex life was "less good" than it had been before the birth of their child. Pain was the most quoted reason for this (116 women) and had often persisted a long time after the birth. The respondents thought that doctors either dismissed or failed to recognise their problems, and comments about untreated morbidity were common (for example, "penetration now makes me feel like I'm about to inadvertently pass a stool" and "a major episiotomy made sex impossible for over a year"). Loss of libido and vaginal dryness associated with breast feeding were also common problems, about which the women believed that they (and their doctors) had little knowledge.

The women were largely unprepared for the sexual problems and physical changes they had experienced—an interesting finding, given that the respondents were largely middle class and educated and had attended additional antenatal classes run by the National Childbirth Trust. Only a small minority of the respondents had been given information about postnatal sexual health by health professionals before the birth of their baby, and after the birth discussion about resuming their sex life revolved mainly around contraception.

We agree with the author of the personal view that there are many times in the postnatal period when women come into contact with health services and could be helped with postnatal sexual difficulties. Our concern, however, is that maternal and child health services focus more on the child than the mother and that health professionals do not always have the awareness, knowledge, and skills to deal with problems with postnatal sexual health.

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1 New baby? How wonderful. *BMJ* 1994;309:815-6. (24 September.)

2 Welch A, Chapple J, Beard R. *North West Thames regional annual maternity figures 1992: St Mary's maternity information system*. London: North West Thames Regional Health Authority, 1992.

Payment for blood donations

EDITOR,—John D Cash is worried about the German policy regarding payment for blood donations.¹ I join him in his concern. The Council of Europe defines voluntary unpaid donations as follows: "Donation is considered voluntary and non-remunerated if the person gives blood, plasma or cellular components of his/her own free will and receives no payment for it, either in the form of cash, or in kind which could be considered a substitute for money. This would include time off work other than that reasonably needed for the donation and travel. Small tokens, refreshments and reimbursements of direct travel costs are compatible with voluntary, non-remunerated donation."² Some European Union documents use the same definition,³ which is generally accepted by international organisations.

Last October, at a meeting of the committee of experts on blood transfusion and immunohaematology of the Council of Europe, the German delegate indicated that the German minister of health had accepted this definition, but the interpretation was such that "small tokens" and "reimbursement of direct travel costs" allowed payment of a lump sum of up to DM50 (£20) per donation. Moreover, he was prepared to accept the report of the committee only on the condition

that the German interpretation was approved and accepted by the rest of the committee.

We are on a slippery road if such playing with words is generally accepted. The paid plasma donors in the United States receive less than £20, hence they are unpaid according to the German interpretation. Who would then be a paid donor? We must be vigilant that the European Union keeps unpaid donors unpaid in the spirit of the directive 89/381/EEC.

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1 Cash JD. Payment proposed for blood donations in Germany. *BMJ* 1994;309:1160. (29 October.)

2 Council of Europe. *Guide to the preparation, use and quality assurance of blood components*. Strasbourg: Council of Europe Press, 1992.

3 Van Aken WG. *The collection and use of human blood and plasma in the European Community in 1991*. Brussels: European Commission, 1994.

Nestlé's donation

EDITOR,—The letter from the Honorary Secretary of the British Paediatric Association states that the Nestlé donation was accepted under the policy of taking money from companies "whose products are not harmful and whose marketing practices obey the ethical standards set by the codes of the countries in which they operate." Recent monitoring of Nestlé's activities shows that the British Paediatric Association has contravened its own policy.

A new report, *Breaking the Rules 1994*,² compares the activities of 74 manufacturers of breast milk substitutes with the requirements of a World Health Organisation marketing code.³ Every country in the world has voted to support this code, and many have adopted all or part of it as national legislation. Information from 62 countries shows that all companies violate the code and indicates that Nestlé violates it more than twice as often as its closest competitor. On the issue of giving free or subsidised supplies of baby milk to hospitals—now generally recognised as the most detrimental practice inducing mothers away from breastfeeding—a sample survey found Nestlé free supplies in 13 countries where they have been banned by governments. Unicef field officers reported free or low cost supplies by Nestlé in a further seven countries where governments have acted to end the practice (unpublished data).

The British Paediatric Association appears to have simply taken Nestlé's word that it abides by the WHO code. The association's council should look into the matter more carefully and reject donations from manufacturers of breast milk substitutes.

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1 Dodd KL. Nestlé's donation. *BMJ* 1994;309:414. (6 August.)

2 International Baby Food Action Network. *Breaking the rules 1994. A worldwide report on violations of the WHO/Unicef international code of marketing of breast milk substitutes*. Cambridge: Baby Milk Action, 1994.

3 World Health Organisation/Unicef. *International code of marketing of breast milk substitutes*. Geneva: WHO, 1981.

Reform of GMSC needed

All GPs should have right to vote

EDITOR,—At the British Medical Association's annual representative meeting this year a motion proposing reform of the General Medical Services Committee was put down for debate. As it was placed too low in the order, debate was not possible despite an appeal to suspend standing orders. The

motion, proposed by Mid Surrey, Kingston and Esher division and Leicester division, read: "That this meeting believes that members of the General Medical Services Committee should be elected by a direct vote of all general practitioner principals arranged into large constituencies rather than by [local medical committee] members."

Not all members of the BMA are aware that members of the GMSC are indirectly elected and that ordinary general practitioners have no part in their election. An analogy would be parish councillors electing members of parliament. There is a strong feeling throughout Britain that now is the time for reform. The morale of general practitioners is low, recruitment is minimal, and early retirements are increasing. All these are examples of the failure of the present system and leadership. Under the proposed system general practitioners would be enfranchised for the first time, there would be a larger choice of general practitioners (rather than the present "time servers") for places on the GMSC, and the GMSC would take greater note of what general practitioners said.

The GMSC has agreed that this is an important issue but has refused to sponsor a referendum of all general practitioners through the Electoral Reform Society, preferring that the motion should be proposed for possible discussion at next year's annual representative meeting or the conference of local medical committees. The annual representative meeting declined to take the matter seriously this year, and debating it at the conference of local medical committees would be akin to asking a condemned man to debate whether he wished to be hanged. The only alternative, unless the GMSC reverses its decision, is for the many hundreds of supporters of reform to call extraordinary general meetings of the BMA until the GMSC permits such a referendum.

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BMA's reply

EDITOR,—The tone of David Roberts's letter makes it seem that there has been some systematic attempt by the BMA to deny him the opportunity to raise this important question. This is not the case. The order of business for the annual representative meeting is decided by the agenda committee, and it is wrong to suggest that there was any deliberate attempt to place Roberts's motion "too low" in the order. In addition, it is open to any member to seek the support of his or her colleagues to get a motion not previously accorded priority placed in the position of a "chosen motion." This Roberts failed to do. He furthermore failed to move the annual representative meeting to suspend standing orders to get his motion debated.

Since the annual representative meeting Roberts has been in correspondence with the council's secretariat, and as a member of the council he raised the matter at the meeting on 11 October, when the subject was extensively debated. At that point Roberts did not seek to put a motion seeking a referendum or bring forward any list of signatures calling for an extraordinary general meeting. He was, however, assured by the chairman of council that, although this year's annual representative meeting had not found it possible to discuss the motion, the matter would be discussed at next year's meeting. He was also reassured by the chairman of the General Medical Services Committee that the matter would be debated at the conference of local medical committees next summer. Roberts has subsequently written to me again on the issue; and further time will be devoted to it by the council at its meeting on 14 December.

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