should therefore include true waiting list cases, day cases, and the difficult group described as deferred cases, where admission has been deferred for some reason. Even then one must ask what should happen to those requiring regular admission, for instance for check cystoscopies or repeat oesophageal bouginage. Are these true waiting list cases or deferred cases?

Indeed, changes in the working practices of a unit might also be expected to alter waiting list numbers—for instance, the introduction of flexible endoscopy lists in both gastroenterology and urology may permit greater throughput of patients who would otherwise remain on an audited surgical waiting list.

We endorse the possible association drawn between waiting list statistics and outpatient referrals and suggest that waiting list statistics should be an integral part of a unit or ward audit policy. These types of statistics should be produced as a byproduct of data accruing at unit or ward level as a consequence of the patient management process. This would also facilitate the "detailed local investigation" suggested by Williams *et al.*¹

Closer cooperation and interaction between administrators and clinical staff plus improvements in data processing techniques can only improve this important part of health care audit.

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1 Williams DDR, West RJ, Haggard S, Dias AFS. Waiting list monitoring using information from Hospital Activity Analysis and SBH 203 returns. *Community Medicine* 1983;5:311-6.

Psychiatric abuse

SIR,—Dr Anatoly Koryagin's speech at the last quarterly meeting of the Royal College of Psychiatrists received a well deserved standing ovation (7 November, p 1164). We unreservedly support his and any other struggle against violation of human rights. We greet with enthusiasm every effort on the part of the profession to counteract psychiatric abuse wherever it may occur.

By restricting our condemnation to the incarceration and ill treatment of political dissidents in psychiatric hospitals within the Soviet Union, however, we are overlooking other equally important issues inherent in the concept of torture. Reports from the International Rehabilitation and Research Centre for Torture Victims in Copenhagen state that "Physical methods of torture are administered by physical means, but their main impact is of psychological nature." This is indeed the desired impact of infliction of physical pain. The advancement in behavioural sciences has unfortunately been paralleled by the development of more sophisticated torture techniques. The psychological methods used in torture range from sensory deprivation, "counter effect technique" to inducing "learned helplessness" and "double bind" and "conditioning" techniques. These aim to create "... guilt, fear, loss of self-esteem, and repentance" and ultimately to destroy the personality of the victim.¹ Surely the use of psychological methods in torture and also its psychiatric sequelae fall within the domain of psychiatry.

The practice of torture is widespread throughout the world as outlined in Amnesty International reports. These indicate that over a third (66) of all countries today either practise or condone various forms of torture.² A report by the Commission on

Human Rights of the Economic and Social Council concluded that "no society, whatever its political system or ideological colour is totally immune to torture."³ A BMA working committee on torture found strong evidence about the involvement of doctors in torture in many countries.⁴ It is clear from these reports that neither torture nor the participation of doctors is confined to any specific country. Thus any public statement against psychiatric abuse divorced from this broader perspective and losing sight of the global nature of the problem may fall short of credibility.

We are concerned that, as is evident from Dr Louis Appleby's article, these broader aspects of the problem may have escaped the attention of some of our colleagues.

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- 1 Somnier FE, Genefke IK. Psychotherapy for victims of torture. *Br J Psychiatry* 1986;149:323-9.
- 2 Amnesty International. *Torture in the eighties*. London: Amnesty International Publications, 1984.
- 3 Commission on Human Rights of the Economic and Social Council. *Question of the human rights of all persons subjected to any form of detention or imprisonment: torture and other cruel, inhuman or degrading treatment or punishment*. New York: United Nations, 1987.
- 4 BMA Working Party on Torture. *The torture report*. London: BMA, 1986.

Changing the law on children in cars

SIR,—We support Ms Daphne Gloag's comments on the lack of safety for children travelling in cars (31 October, p 1082). In Leeds there has been an alarming increase in the number of children injured while travelling as passengers in cars last year. During 1986, 150 children were injured compared with 91 in 1985 and 95 in 1984. Police records show that only 26 of the children injured last year were restrained so most of these injuries could clearly have been prevented.

We urge doctors concerned with children to raise the issue with their members of parliament and within their professional organisations.

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Campylobacter pylori in central Africa

SIR,—One of us (GWL) works in a rural mission hospital in Kenya, and we have recently presented similar findings to those of Dr D Rouvroy and others (7 November, p 1174) to the 38th annual meeting of the East African Association of Surgeons held in Nairobi, Kenya, in November 1987.

In summary our major findings were as follows. (1) Eighty per cent of a group of 187 consecutive patients presenting for diagnostic gastroscopy for chronic epigastric pain had active chronic gastritis. (2) In a subgroup of 125 patients with histological diagnosis of active chronic gastritis 107 (85%) had *Campylobacter pylori* identified histologically. (3) *C. pylori* was demonstrable, either histologically or by the rapid urease test (Delta West, Australia), in most cases of gastric ulcer, duodenal ulcer, and gastric carcinoma. (4) In a pilot study using amoxycillin and bismuth treatment, which is known to eradicate *C. pylori*, 13 of 16 patients

with a histological diagnosis of chronic gastritis associated with *C. pylori* showed clinical improvement. *Campylobacter* organisms were cleared in all 13 and the histological picture improved as assessed by scoring the acute and chronic inflammatory infiltrate. (5) In 13 out of 14 completely healthy and asymptomatic volunteers (average age 22) active chronic gastritis associated with *C. pylori* was detected endoscopically and proved histologically.

We have found active chronic gastritis associated with *C. pylori* to be highly prevalent within a rural Kenyan population in both symptomatic and asymptomatic patients. Treatment aimed at eradicating *C. pylori* is required as in our experience less than 10% of patients respond to standard acid reducing therapy with either antacids or H₂ antagonists.

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Clinical experimentation in obstetrics

SIR,—Professor R J Lilford is correct when he says that small trials lack power—the ability to detect a true difference (21 November, p 1298). But it would have been more correct and pertinent to have said that small trials lack the power to detect small differences: the larger the true difference in clinical outcome the smaller is the randomised trial required to demonstrate it. In addition to refuting extravagant claims small randomised trials are invaluable in exposing clinical dogma. A cherished belief in the value of glucose tolerance testing and hospital confinement for all, induction of labour at 42 weeks, and caesarean section for delivery between 24 and 28 weeks should require only small controlled trials to convert the believer (for better or worse) to a more scientific obstetrician who does not know what to believe. The wound need not be great to be enough.

The obstetrician whose certainties have already been poisoned by biting on the forbidden fruit of randomisation may seek to regain paradise through ever larger trials involving numbers of patients such as those shown in Professor Lilford's table. But the bigger they are the harder they fall—see the basic flaw I pointed out in the Dublin trial of fetal heart rate monitoring¹—and even if it were possible to conduct perfect large trials with hundreds of thousands of patients they would probably not be worth the trouble and expense. As well as the limitations outlined by Professor Lilford, remember built in obsolescence, especially when new procedures are being evaluated.

The more positive response of the scientific obstetrician is to accept ignorance and uncertainty in many things and to use these to allow wider management options and more patient choice in clinical practice. So long as we keep conducting small randomised trials, and editors still accept them for publication, we should not stray too far from the unknowable straight and narrow of what is best for our patients.

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1 Mathews DD. Fetal monitoring in labour. *Br Med J* 1986;292:826.