possible that the "brief intervention" was quite similar to, if not identical with, "usual care." In addition, the doctors who provided brief intervention in both experimental groups also provided "usual care" to patients randomised to this condition, greatly increasing the chance of contamination.

The authors also do not provide any description of the procedure used to train doctors in the specific interventions or any description of the method used to determine their competence in performing the interventions. We cannot assume that the doctors actually provided the brief interventions the authors described. Because of these methodological problems, this study cannot be cited as an adequate test of the effectiveness of brief interventions.

Secondly, the authors' finding that the supported brief intervention procedure "significantly increased the success rate" also has to be considered with caution. As the authors note, the self report data which produced the significant differences among groups is tainted by the high failure rate on urinary cotinine testing in smokers who claimed to have stopped smoking. Validation of outcome is further tainted by the low compliance with urine cotinine testing in the supported brief intervention group. Additionally, since the authors did not ask about the use of nicotine gum at follow up, the meaning of a "failed" urine cotinine test is unclear. As the authors themselves conclude, without appropriate validation of self reported smoking status, smoking outcome results are subject to question.

Several previous studies have shown the effectiveness of doctors' counselling efforts,^{1,2} though carefully controlled studies that document the method of physician training and physician compliance with the counselling intervention are also needed. The United States National Cancer Institute is presently supporting a number of such studies. Their results are eagerly awaited.

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Cocktail stick injuries

SIR,—Retained cocktail sticks are found not only in wounds of the extremities (19-26 December, p 1658).

A previously fit 19 year old male student presented with a six week history of abdominal pain relieved by antacids, two weeks of right sided backache with malaise, and loss of appetite and weight. On examination of the abdomen there was slight right upper quadrant discomfort and the tip of the spleen was palpable. He was feverish (40°C) and had three splinter haemorrhages and a soft ejection systolic murmur. The white cell count was $9.7 \times 10^9/l$ (81% neutrophils) and the erythrocyte sedimentation rate 65 mm in the first hour. Blood cultures one and two days after admission yielded *Streptococcus milleri* group C. Echocardiography showed no abnormality. Abdominal ultrasound examination showed no hepatic or renal abnormality but an enlarged spleen, and in the absence of any other obvious focus of infection treatment for endocarditis was started, with 14

days of penicillin and gentamicin. Symptoms and fever resolved although the peripheral white cell count was $13.2 \times 10^9/l$ in the second week of treatment.

He was discharged home well taking oral amoxycillin but within five days was readmitted with increasingly severe right sided abdominal pain; at laparotomy a cocktail stick was found protruding through a hole in the second part of the duodenum into omentum. *Serratia marcescens* was isolated from the small amount of surrounding pus. The patient subsequently admitted that the offending foreign body had been ingested during New Year's Eve revelries some three months earlier—serving to remind us of the importance, in the investigation of febrile gastrointestinal illness, of the question, "And what have you been eating?"

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Embryo research

SIR,—Professor R M Winston is entitled to his opinion (12 December, p 1501) but must it masquerade as fact in a leading article? It is paradoxical that it should occur during a series in the same journal expounding the use of logic.

Firstly, we see yet again an unfounded, unscientific assumption that there is something different about the preimplantation human embryo—something not human, even undifferentiated. To support this argument he, for some reason, mentions the use of abortive, blatant contraceptives, the use of which was foisted on the public long before their real mode of action became known. He goes on to say that many patients would benefit from the detection of genetic defects. His examples—Lesch-Nyhan syndrome, Tay-Sachs disease in Ashkenazi Jews—actually leave one with the opposite impression—that is, that only a tiny minority of pregnant women would benefit and only those who had risk factors beforehand.

Next, Professor Winston justifies embryo experimentation in that it leads to the birth of healthy babies by in vitro fertilisation and, even more incredibly, might help to prevent miscarriages. Two thousand healthy babies by in vitro fertilisation is a drop in the lake of potentially healthy babies aborted, and a drop in the ocean if you add those prevented by contraceptives that prevent implantation. We are left with the idea that a decision banning embryo research imposed by a democratically elected government on unelected research workers, who are at best unrepresentative of the general population of Britain, is unjust. A strange meaning of the word "justice."

If the state banned embryo research it could at least claim to be representing a majority—not, as Professor Winston puts it, "the sincerely held views of a minority."

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AUTHOR'S REPLY—My leading article is, of course, perfectly appropriate as such because it reflects an important body of medical opinion, including that of the BMA.

Nor is it "unscientific." The contention that the preimplantation embryo is different from an implanted fetus is founded on biological facts. Before implantation it is indeed totally undiffer-

entiated with the potential only for becoming a baby. The evidence is that at least 40% (and possibly most) of human preimplantation embryos are lost by the time of the first menstrual period. The "human-ness" of the preimplantation embryo is something we can argue about, but are not sperm and eggs from our species (which are unprotected by law) equally human?

Mr Mallett, unlike most people, opposes blatant contraceptives; perhaps this explains his obviously deeply felt views. Apparently the low dosage pill and the intrauterine contraceptive device were "foisted on the public." Surveys in Hammersmith's family planning clinic confirm that few people worry about the mechanism of action of these contraceptives and that, after thorough explanation of how the device works, not one of our patients has discontinued this contraception for those reasons. Hardly "foisting," Mr Mallett.

There is now no doubt that embryo research will combat severe congenital disease. Of course, Tay-Sachs disease and Lesch-Nyhan syndrome are rare. Since when has affliction with a rare disease meant that that disease is unimportant to patients, their families, or their doctors? But Mr Mallett is typically selective in ignoring the article's discussion of common fatal diseases such as muscular dystrophy and cystic fibrosis—a defective gene carried by one in 20 of the population.

No, Mr Mallett, legislation banning this work would not represent the views of a majority. Most people in Britain support embryo research. In the past two years three independent national opinion polls—and four surveys by responsible television and radio programmes, too—have increasingly confirmed that the majority approve this research. But, more importantly, in a free democracy those suffering the appalling consequences of severe genetic disease and sad effects of infertility or repeated miscarriage should be allowed the benefit of research which they almost unanimously support and which is voluntarily accomplished solely as a result of their own treatment by in vitro fertilisation.

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Light on seasonal affective disorders?

SIR,—Since Drs Melanie Abas and Declan Murphy (12 December, p 1504) admit that the mode of action of light treatment in seasonal affective disorder is unknown and that the extent (if any) of a placebo effect needs establishing one wonders what has been achieved in this subject.

They fail to comment on the possibility of deleterious side effects of intense photic radiations. For example, the work by Lewy *et al* which they quote involved daily two hourly exposures, for possibly 28 days,¹ to a luminance level of about half the threshold intensity producing photoreceptor damage in macaques in a single 12 hour session.² The traditional safety factor of 10 was not considered.

There may be important differences in safe exposures between phakic and aphakic patients because of the protection that the normal crystalline lens may provide for the retina.³ Since the density of the macular pigment appears to be correlated, if only on the basis of a cluster, with the presence of red hair, a further undocumented variable may have been included. Even the possible difference in pupillary diameter—for example, between blue and other eyes—ought to be considered.

As the difficulties of reliably determined retinal illumination (and hence the alleged therapeutic

value of photic radiations) are well known, one wonders why no epidemiological survey of seasonal affective disorder has been undertaken. Presumably congenitally blind people could provide controls worth exploring, other psychological drawbacks notwithstanding. Is the condition more pronounced among the Eskimos, who probably use less artificial light than Swedes? When travelling through Peru I was struck by the paucity of artificial illumination in rural areas. Is anything known about psychiatric conditions there or is life too hard for seasonal affective disorder to flourish? What happens near the equator, where seasonal variations ought to be minimal?

Relevant expert epidemiological studies might provide a short cut to meaningful results, which might elude an apparently more direct approach.

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Trusting patients with case notes

SIR,—We were relieved to note that one of the conclusions of Dr David A Sandler and Professor J R A Mitchell (12 December, p 1523) was that "patients could be trusted." It is perhaps unfortunate that the authors appear to limit this trust to patients as post(wo)men by using patients to deliver their hospital discharge summaries to general practitioners in sealed envelopes.

We have recently completed two parallel randomised controlled trials in Newbury, west Berkshire,¹ and in St Thomas's Hospital, south London.² In these trials pregnant women were given their obstetric case notes to hold throughout their antenatal care (and, in Newbury, until the 10th postnatal day). The effects were compared with those under the more usual practice of giving cooperation cards. As in the Nottingham trial, we found no major negative administrative effects. To the contrary, we found that the new system brought savings in clinical and clerical time and, particularly at St Thomas's, meant that notes were less likely to go astray.

In our studies, however, women not only held their own records but also had full access to their contents. When asked for their views women showed a strong preference for this access. Those allocated to hold their case notes felt more in control of their antenatal care and felt they could talk more easily to the doctors and midwives than women allocated to hold a cooperation card.

Dr Sandler and Professor Mitchell refer to the importance of communication, but communication means more than the prompt delivery of information from hospital staff to a patient's general practitioner. In addition to communication between different health service professionals there is a need for two way communication between patients and those caring for them. One medium for facilitating that exchange may be written information, whether in the form of the full case notes or merely a discharge summary.

It might be argued that pregnant women are different from other patients as they are not usually ill. But maternal and fetal problems do arise and need to be written in the notes and discussed with

the expectant parent(s). It is reassuring that in neither of these two trials did access to their notes raise the level of anxiety felt by women under these circumstances. Nor has the experience of patient access to records been confined to obstetrics. It has been reported in such diverse specialties as general practice,³ psychiatry,⁴ rehabilitation,⁵ acute admissions,⁶ and child health.⁷

Such access to personal health information is consistent with recent guidelines from the Department of Health and Social Security,⁸ although these are at present limited to computerised data. Nevertheless, they are a step in the right direction of trusting patients to share with health service professionals in the responsibility for their own health care.

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Plastic surgery

SIR,—Plastic surgery trainees will welcome the leading article by Mr D M Davies (12 December, p 1502) and the letter by Mr B N Bailey (9 January, p 134). If the specialty is to continue without plastic and reconstructive operations being more frequently performed by surgeons of other specialties consultant numbers clearly need to be increased. The encroachment of other specialties into reconstructive surgery is likely to make it progressively more difficult for juniors to acquire training in some aspects of plastic surgery, particularly head and neck reconstruction.

The career structure for juniors in plastic surgery is being reorganised in a manner which has anticipated many of the proposals in "Achieving a Balance." There are, however, more registrars at present in training than can be accommodated in the senior registrar grade, before senior registrars begin to be appointed under the new training scheme. Many of these registrars have four or more years of experience in plastic surgery, and several have experience in surgical research.

At a time when the specialty is in urgent need of expansion there is a possibility that the surgical skills needed for expansion will be lost through lack of consultant and senior registrar posts. Mr Davies makes the point that the specialty is failing in its commitment to teaching and research. If this is so the research skills of trainees at present in the registrar grade are an asset that the specialty can ill afford to lose, especially as there is at present no

academic department of plastic surgery in this country.

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Nursing grievances

SIR,—About 30 000 nurses each year leave the NHS. Only 1500 of these join the independent sector and they will have worked for five years for the NHS, on average, before leaving. They continue to nurse British patients, who, as taxpayers, contributed to the costs of their training.

Much greater concern must arise from the 25 000 nurses who apparently abandon their profession to work in offices or shops. We need to identify why nurses leave the profession and find ways of attracting them back.

Of the 2000 nurses joining independent hospitals from all sources in 1985 K J Thomas *et al* showed that 75% had gained some special experience (not qualifications) (report to DHSS, 1987). Not unexpectedly, the largest single group were theatre nurses (11%). The NHS therefore lost about 40 qualified theatre nurses to the independent sector. This compares with 385 who completed approved theatre nursing courses in that year. The problem which the independent sector shares is a general shortage of trained and specialist nurses.

The independent sector already takes part in some basic nurse training courses and conducts some specialist courses. The Independent Hospitals Association intends to contribute further by organising appropriate courses and is conducting a study to determine how this can best be done. We want to increase the capacity for training so that more specialist nurses are produced each year.

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Hospital and community health service costs: England and Scotland compared

SIR,—Drs Alastair C A Glen and John K M Hulbert suggest (12 December, p 1566) that our claim that regional differences in private health care activity have little effect on regional differences in unmet need is not sustained by the finding of Nicholl *et al* that the private sector makes a significant contribution to acute care in England and Wales.¹ In doing so they make the fundamental mistake of equating needs with demands (and by analogy activities with outcomes). Since the NHS is concerned with maximising the impact of resource utilisation on unmet need and hence rationing services in line with greatest needs, consideration ought to be given to the effects of United Kingdom average age specific utilisation in relation to needs in both the NHS and private sectors. The simple deduction of observed private sector utilisation from estimated Resource Allocation Working Party (RAWP) targets is inappropriate, as indicated in the recent RAWP review.²

We are not surprised that Drs Glen and Hulbert take a different stance from ourselves on inter-country resource allocation for health care provision. While our concern is entirely the promotion of equal access to health care for equal needs throughout the United Kingdom, Dr Hulbert admits that, as Scottish National Party health spokesman, his concern is for his "own profession and the people of Scotland."³ Such parochial interests are responsible for the existing levels of health care provision in England and Scotland,