onset.^{3,16} Tests for vero cytotoxin in faecal extracts are often more sensitive than bacteriological culture.^{5,11} Specimens from patients whose clinical condition strongly suggests infection with a strain of *E coli* that produces vero cytotoxin may be referred for specialist investigation using DNA probe techniques.¹²

The management of patients should be supportive, and antimotility agents should be avoided since intestinal stasis may promote absorption of toxin. *E coli* 0157 is sensitive to many antibiotics, including ampicillin, gentamicin, trimethoprim, sulphamethoxazole, and chloramphenicol,²³ but antimicrobial treatment is to be avoided if possible: it does not seem to influence the duration of symptoms¹ or prevent complications⁴ and may even increase the risk of haemorrhagic disease.⁵

J SYMONDS

Consultant Microbiologist,
Russells Hall Hospital,
Dudley,
West Midlands DY1 2HQ

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Griffiths on community care: potentially disastrous

Sir Roy Griffiths proposes radical but potentially effective solutions to the problems of community care in his recently published report (p 945). His emphasis on the creation of an identified and "ring fenced" budget, the clear designation of responsibilities to the local authorities, and the appointment of nominated "care managers" are fundamental to delivering a coordinated service. The principles are right but the practical implementation might well prove disastrous.

Let us look at the advantages. Firstly, responsibility for care for the chronically handicapped in a community is given to those elected by the local population; the electorate should in theory have greater control over the way local services are provided. Secondly, the NHS will focus more on acute hospital care. Chronically sick patients, who lack media appeal and who have never been able to compete successfully for resources within the health service, will have a substantial part of their budgets protected within the proposed community care grant. Thirdly, effective operational planning for individuals will be fostered by the appointment of care managers, who will have more flexibility to be innovative but a clear system of accountability.

There are other advantages, too, in that the new arrangements will give a clear focus for informal carers and relatives. At present relatives have to find their way through a maze of local services. There is also the possibility of a more flexible use of facilities in the statutory, voluntary, and private sectors, including those where competitive tendering may be the right approach. Finally, the present powerful influence of doctors over the lives of the chronically disabled will inevitably wane, and such "demedicalisation" is largely to be welcomed. Medical and nursing skills are only a small

part of the total professional skills required. This new arrangement may provide a better balance of skills and a better opportunity for employing unskilled local people.

Now for the practical disadvantages, the first of which is that health authorities will not like Sir Roy's proposals. An estimated 20% or more of health authority budgets will, presumably, be transferred piecemeal by slow negotiation to local authorities. It is doubtful that an equitable transfer will take place, and local authorities are unlikely to get all the funds from health authorities which they should receive.

A second drawback will be that most local authorities have neither the trained staff nor the organisational structure to manage a community care programme effectively. Recruitment of trained staff is a continuing problem for local authorities and training of non-professional grades of staff is almost non-existent. Another difficulty for local authorities is that they have not developed a culture of objective evaluation. Few use good research methods to evaluate the costs and outcomes of innovative schemes. Dependent individuals are not vociferous consumers and ordinary market forces cannot operate in the same way as might be possible for the acute sector.

Medical education stands to lose from the Griffiths proposals. The split between acute and chronic care will have a substantial adverse effect on medical education, because once relieved of the need to develop services doctors may retreat to their hospitals, and medical students may never need or have the opportunity to learn about the chronic sector. The growing interest in rehabilitation in both physical and mental disorders might be set back dramatically. Specialist medical skills may become less available to the

chronic sick, and medical research into disabling disease may well diminish without the impetus of having chronic patients to care for.

But far and away the most worrying feature of the proposals is whether local authorities have the ability or the will to implement the recommendations. Though most local authorities take as their priority the provision of services to their electorate, an appreciable minority have elected members whose priorities are concerned largely with the advancement of an ideology. Some councils refuse under any circumstances whatever to purchase private services and would rather refuse a disadvantaged person access to care than buy it in privately. Indeed, several local authorities have so mismanaged their own social work departments that they no longer have sufficient staff to fulfil their minimum statutory responsibilities to children at risk and to mentally ill people. The prospect of handing over total responsibility for the care of the most vulnerable people in society to such local authorities is profoundly disquieting. On the other

hand, there are also councils of a different political complexion who know full well that most of their electorate will not make an issue about the care of minority, socially disadvantaged groups.

Any new arrangements must ensure that no council can ignore its responsibilities. No mechanism now exists which comes close to providing comfort on this critical issue, and the strength of Griffiths's ring fence would need most careful testing. Broad brush central monitoring of budgets and of performance indicators would need supplementing by rigorous monitoring of the standards of care. Furthermore, powerful sanctions will be essential if these proposals are to be supported by health professionals working in the community.

ELAINE MURPHY

Professor of Psychogeriatrics,
United Medical Schools of Guy's
and St Thomas's Hospitals,
Guy's Hospital,
London SE1 9RT

Plastic insulin syringes: reuse or waste £8m a year

Plastic insulin syringes have been used for many years and after a long campaign by the British Diabetic Association became available on general practitioner prescriptions in September 1987. Unfortunately this has not been the benefit it should have been because the Department of Health and Security has insisted that syringes should be used once only. The National Pharmaceutical Association follows the DHSS in its advice to pharmacists, yet this is contrary to current practice. Patients have for years preferred to reuse their syringes, and reuse is the established advice of diabetologists. Confusion has therefore arisen: some patients are refused syringes if they say that they will reuse them, while others are being issued with far too many—one 40 year old patient of ours has been given enough syringes to last her until she is 89. This policy not only wastes about £8m a year but also reduces the credibility that health professionals (and the DHSS) need to sustain the confidence and compliance of patients. Another anomaly is that only syringe-needle combinations have been made prescribable and not needles for other syringes or the popular Novopen injector needles.

Plastic syringes were originally designed for hospital inpatients, and to prevent their being used for more than one patient it was specified that they should be used only once. Patients soon realised that the plastic syringes were much more convenient and comfortable than the National Health Service alternative of reusable glass syringes and steel hubbed needles. They therefore became available for purchase or were obtained from hospital clinics. Many ecologically and economically minded patients began to reuse the plastic syringes. Extensive studies of this practice were thus performed, particularly to consider the risk of infection, and they showed reuse to be remarkably safe.¹⁻⁹ Infected injection sites are extremely rare. The number of organisms on the skin is far below that needed to cause infection after an injection with a 25-27 gauge needle.¹⁰ Furthermore, insulin preparations contain a preservative so that even if many bacteria are injected into the bottle of insulin it reesterilises itself within 24 hours.¹¹

In the 10 years before syringes became available on prescription neither the DHSS nor the manufacturers reported any adverse effects or warned against reuse. Only recently did one manufacturer issue a card stating that "reuse is not so much an infection problem, but it does represent a serious health risk"; "major dangers" are said to include needles clogging, breaking, or bending, lack of lubrication, and illegibility of the scale. (We understand that this card is no longer being issued.) These hazards have not been supported by published reports, but a personal communication to us has described 92 incidents in over five years' experience—48 clogged needles, 21 blurred scale markings, and 13 blunt, eight bent, and two broken needles. These hazards are of minor importance because when a plastic syringe becomes blocked or blunt or when the markings become blurred the patient simply throws it away. Broken needles that cannot be removed are extremely rare, are best left in situ, and seldom cause trouble; furthermore, they used to occur with the old NHS steel needles.

In Britain at least 50 million injections have been given through reused plastic syringes, yet no hazards have been reported in medical journals or at scientific meetings. Thus both experience and formal evaluation have proved reuse to be safe. The medical advisory committee and the executive council of the British Diabetic Association have therefore consistently advised that plastic syringes may be reused up to five times. The association and most diabetologists will continue to give this advice, although we tell patients that if they wish to use their syringes only once they are free to do so.

We have pointed out to the DHSS that reuse of syringes would reduce the annual costs from £10m to £2m, and we find it extraordinary that in these days of enforced efficiencies the government is wasting £8m of taxpayers' money to prevent a non-existent problem. It is absurd to insist on rituals that evidence has proved to be unnecessary.

We urge the DHSS and all others concerned to agree our policy on reuse on grounds of both economy and common