Finally, the authors report that their practice is to perform a laser cone biopsy when cytological abnormality persists or worsens after a normal colposcopic biopsy. We share their concern that women with abnormal cervical cytology should be rigorously followed up after a negative punch biopsy. As our paper questioned the effectiveness of colposcopically directed punch biopsy in excluding disease, however, we believe that further information on the diagnostic yield of laser cone biopsy in these circumstances would be extremely valuable.

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Strict product liability arrives

SIR,—Ms Clare Dyer's article (27 February, p 635) on product liability raises many important points for the medical profession at large, but particularly, as she points out, for "doctors who introduce additives into intravenous infusions, which is common practice in operating theatres and intensive care units." It is vitally important that guidelines for such uses are established and accepted by both clinicians and the pharmaceutical industry at an early stage if the interests of anaesthetists and intensivists (and consequently their patients) are not to be compromised.

As supplied some drugs are unsuitable for direct administration to the patient and must be mixed with a diluent before use. Examples would be antibiotics, using a small volume of diluent, and inotropes, using a larger volume. In these cases the manufacturer usually states the diluent and dilution required, and provided these instructions are adhered to it is difficult to envisage any responsibility devolving on to the clinician. Such agents are, however, often diluted differently by individuals or units, who should confirm the suitability of their practice directly with the manufacturer. Other drugs—for example, some muscle relaxants—are supplied ready to use. It may be desirable to administer these by infusion, which can be achieved with the undiluted drug only when a suitable syringe driver is available. As this is not always the case, further dilution may be required. In these instances it would be necessary for the manufacturer to state on the datasheet suitable methods of dilution. Such practice would probably be considered a normal mode of administration rather than the constitution of a new product. The use of a simple diluent such as 0.9% sodium chloride or water for injections, and limiting such mixtures to single drugs, would minimise the likelihood of drug interactions or inactivation *in vitro*.

On the other hand, the Consumer Protection Act probably means that there is no longer any place for the ad hoc mixture of drugs in one container. Uncertainty about the resulting

pharmacological constitution, physicochemical characteristics, and stability of such mixtures will almost certainly result in their being considered new products and the clinician a producer. While this practice is unnecessary in many instances, it is widespread among anaesthetists—for example, in the use of atropine and neostigmine for reversing muscle relaxation. Some such mixtures are becoming commercially available, although they have the possible disadvantage that dosage ratios are fixed.

More generally, the widespread use of generic prescribing and dispensing, whether in hospital or general practice, inevitably makes it more difficult to keep a record of the source and batch number of a particular drug used in any patient. Anaesthetists are generally exacting in their records, yet these consist mostly of approved names, not trade names; indeed it is difficult to see how any of the proposed additional information could be recorded in practice, unless by the use of some automated system such as a barcode reader.

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Dietary management of gastroenteritis

SIR,—We are surprised that the leading article by Dr B A Wharton and others on the dietary management of gastroenteritis (13 February, p 450) dismisses the use of a low lactose special formula without mentioning the use of a milk based low lactose formula, which has been shown to speed recovery from gastroenteritis.¹ We have not seen such a dramatic reduction in lactose intolerance after gastroenteritis as the author of an editorial in the *Lancet*.²

Until three months ago our policy on the management of gastroenteritis in bottle fed infants was similar to that recommended by Dr Wharton and colleagues. We then changed our management to give 5% dextrose feeds for 12 hours followed by a full strength low lactose milk based formula (HN25, Milupa Ltd, Denham, Middlesex). This is continued for 10-14 days and then normal formula feeds are reintroduced.

In the three months since the new policy was introduced we have treated 37 infants with mild gastroenteritis not requiring intravenous therapy. The formula was well tolerated without vomiting in all but one infant. Diarrhoea ceased within 12 hours and only one infant relapsed when the special formula was stopped by the general practitioner and normal formula feeds reintroduced after only four days.

During the same period one year ago 67 infants were treated for mild gastroenteritis. In 14 infants diarrhoea returned immediately feeds were reintroduced and these were given soya based lactose free formulas. A further four infants relapsed after discharge home and required readmission to hospital. There was no difference in the average length of hospital stay of the two groups.

Our preliminary conclusion is that the use of a low lactose milk based special formula is beneficial in the treatment of mild gastroenteritis and reduces the risk of relapse of diarrhoea.

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Refusing to treat the indigent

SIR,—Minerva's suggestion that a patient in the USA would be asked about his hospital insurance before being given tissue plasminogen activator for acute myocardial infarction is a misunderstanding of the quotation. Usually statistical data—name, address, phone number, next of kin, social security number, insurance carrier, etc.—are asked for before treatment. In an emergency such as an acute myocardial infarction, however, the need for treatment pre-empts such information gathering.

The hospital cost of treatment with tissue plasminogen activator for acute myocardial infarction is \$2300, not the \$10 000 to \$15 000 quoted, and it is already available in an overwhelming majority of local United States hospitals.

To withhold medical care in an emergency on the grounds of inability to pay is unacceptable in American medicine. To do so would be to invite multi-million dollar malpractice suits, with the expectation of large punitive damages, and it would bring down the wrath of the local peer review organisation. The doctors concerned could be banned from treating any patient paid for by federal funds—over 40% of hospital patients—and could be reported to the state health department, which might cancel the doctor's licences to practise. Federally mandated peer review organisations examine the records of every patient who dies in hospital, along with those of all patients injured in hospital accidents, including those affected by allergic reactions to drugs and bedsores, patients readmitted within 30 days of discharge, those who make an unscheduled return for surgery, etc, along with a random sample of other patients. Sanctions are applied if the care is substandard. If a pattern of refusal to care for indigent patients were discovered the matter would be referred to the state health department, which would then impose sanctions ranging from a fine to removal of the hospital's operating certificate and closure of the hospital.

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Genetic counselling

SIR,—The two personal view articles by Professor Michael Drummond and the pseudonymous Louise Knight (20 February, p 566 and p 567) are a graphic illustration of the problems of obtaining informed consent for procedures in which the outcomes have not only low probabilities but a wide range of utilities. Your correspondents report one 38 year old woman who was not offered amniocentesis for Down's syndrome and was later worried that she might have accepted it if it had been. Another woman aged 35 was offered amniocentesis in an apparently neutral way and accepted it. She later concluded that this was the wrong decision for her since she probably values the accidental abortion of a normal child as much worse than the birth of a child with Down's syndrome. The situation was complicated in the second case because the woman became aware of a further possible risk from amniocentesis which preyed on her mind. Both women went on to deliver normal healthy babies yet were dissatisfied with the care they received. What can the obstetrician do?

Genetic counsellors do not usually know the patient's utilities before describing the possible outcomes and probabilities of a course of action. Without detailed counselling patients will often make wrong decisions because of faulty information. Counselling, however, may influence patients to make decisions not in accord with their