Nursing is underrepresented

EDITOR,—Fiona Godlee's controversial articles on the World Health Organisation expose its strengths and weaknesses but make scant mention of the contribution of nursing to its operations and organisation.¹ This is particularly regrettable given the articles' attention to the medical dominance of the organisation. We can conclude only that the absence of any substantive discussion of nursing reflects the perceived invisibility of nursing within the organisation more generally.

A recent study of nurses in government and non-government organisations across the world chronicled the fluctuating fortunes of the nursing policy base at the WHO since its inception in 1948 and the consequences of nursing's diminished voice in international matters of health.² The contemporary history of the WHO's operations as represented by Godlee suggests the retreat of professionals into enclaves of skill, bureaucratic shelters from the sully of the real world. Yet much of the success of the WHO's programmes has been due to its traditional reliance on nursing and midwifery skill and staff for their implementation in the field. Credit for the successes of programmes such as the expanded immunisation, family health, emergency relief, AIDS, and mental health programmes do not reflect the major contributions of nurses and midwives. Indeed, it is almost a condition that in joining such programmes nurses are expected to shed any overt allegiance to nursing.

How many initiatives of the WHO have failed because they have taken insufficient account of the conditions under which nursing and other front line workers can contribute effectively to health care in the field? How much more could be achieved with appropriate nursing leadership than is at present?

It is worth speculating whether the fate of nursing reflects the declining faith in health professionals as advocates and activists of international health more generally and, in the light of the World Bank's recent initiatives in the health field, a swing of the pendulum towards favouring economists as the technical "fix its" of the future.⁴ Rather than mirroring the status patterns and values of Western capitalism more generally, the WHO could set a moral and economic example by putting its own hierarchical house in order. By taking such positive action it would ensure the greater representation of nursing skills throughout the organisation and the more cost effective deployment of skilled staff.

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A new strategy is needed

EDITOR,—Fiona Godlee is right: the World Health Organisation is in crisis.¹ In the past it came to occupy a position of leadership in major global undertakings such as the eradication of smallpox, the work resulting in the code on breast milk substitutes, the programme on essential drugs, and the primary health care movement. It grasped the importance of these issues, brought its own

resources to bear, and harnessed resources from the outside. It became the instrument by which the global community could agree on common goals and achieve collective action.

But today's challenges are not being met in a similar manner. Health services are breaking down in many countries as a result of insufficient resources. Widespread privatisation programmes are jeopardising access to health care for poor people in developing and industrialised countries alike. The AIDS pandemic threatens to wipe out the progress with regard to health in many parts of the world. The World Bank, in particular through its report *Investing in Health*,² is increasingly taking a leading role in health. Meanwhile, the WHO is occupied by trying to recycle its "health for all" strategy.

The WHO must recapture its normative functions, including not only the obvious ones such as the setting of standards and classification of diseases but also the dissemination of information, advocacy for health, promotion of research, and, above all, its role as the global leader in health and health policy.^{3,4} But it needs also to redefine its role. The most important policy issue that faces it is the very notion of health. In its constitution "health" is the main concept. Yet "disease" has been the focus of action for all the 47 years of the WHO's existence. Medical knowledge has developed, and diagnostic and therapeutic tools have been refined to new technological heights. The WHO has taken as its role the application of this knowledge to specific disease problems.

The time has come to make health and health development the main focus of interest. That would entail focusing more on the aetiology of health and the factors in our environment that are necessary for a healthy life than on pathogenic vectors. It would also mean an end to the medical monopoly on health. Other professionals, such as economists, anthropologists, sociologists, and health planners, would come into the forefront to join with the medical profession in the battle for health.

Doing the right things has to be accompanied by measures to improve internal efficiency. The most urgent reforms in this regard are the strengthening of health policy and analytical functions at country level and the abolition of an obsolete regional structure.

The member states of the WHO must now take the lead. It is up to them to define and implement a new strategy in the battle for world health. If they succeed it will also mean the survival of the WHO.

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August: the killing season

Last week in July is a poor comparison

EDITOR,—Paul Aylin and F Azeem Majeed use an incorrect comparison to prove the hypothesis that the newly qualified house officers who start their posts in the first week of August may be associated with an increase in deaths in hospital—the "killing season."¹ They compare details of all deaths occurring in the first week of August with those occurring in the last week of July; finding no significant difference, they conclude that newly qualified house officers have been falsely accused of increasing the number of deaths in hospital.

Junior medical staff often take annual leave during the last week of July (despite attempts to prevent this), and their places are either taken by locum doctors or remain vacant. It would not be surprising to find that this week was a time of increased mortality, and therefore it is no comfort to know that the first week in August is no different. Perhaps a better comparison would have been a week in the middle of the six months or, even better, the mortality averaged over the whole six months.

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1 Aylin P, Majeed FA. The killing season—fact or fiction? *BMJ* 1994;309:1690. (24-31 December.)

Other measures of quality are needed

EDITOR,—Paul Aylin and F Azeem Majeed point out that they did not have data on admission rates or bed occupancy during the weeks of their study into whether the changeover of house officers in hospitals in August results in an increase in potentially avoidable deaths.¹ They were therefore unable to calculate death rates. Death rates are a crude measure of suboptimal care, and measures of quality such as adverse events or complication rates should also be looked at.² We suggest that the quality of care should be audited regularly throughout the year, so that the adequacy or otherwise of care during the changeover in August is fully assessed.

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Effects of health publicity on prevalence of smoking

EDITOR,—Donald Reid draws attention to the potentially class free effects of health promotion in the electronic media, but he misrepresents the term "health publicity" in our analysis by referring to it as "everything else except price."¹ The model we used to assess different influences on cigarette smoking over the past 20 years included price, income, a specific linear trend, and an error term for random variation.²

Smoking has not declined steadily over this period but, for most of the groups we considered, has oscillated about a downward trend. This cumulative linear effect, not explained by price or income, we interpreted as including the net effects of health publicity and other social trends, including social acceptability and restrictions in the workplace and public places; we denoted this by the term "health publicity." The term would include, but not differentiate, effects of health publicity against smoking in the electronic media. It represents a constant annual decrease in smoking for each group, while the error term includes variation not explained by the three other variables. We conclude that in Britain in the 20 years to 1990 there was no such decreasing trend in cigarette smoking by women in socioeconomic groups IV

and V and no significant decrease by men in socioeconomic group V or women in socioeconomic group III.

Our data do not exclude the future impact of health publicity or, indeed, of a reduction or cessation in advertising on smoking by lower socioeconomic groups, and we think it important that there should be research into and evaluation of health promotion and advertising aimed at these groups.

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Nestlé abides fully to WHO code on baby milk

EDITOR,—Andrew Radford justifies his attack on the British Paediatric Association by giving a reference to a booklet produced by the International Baby Food Action Network, *Breaking the Rules 1994*.^{1,2} He adopts his usual stance of assuming that if his organisation makes an allegation then the rest of the world must believe it to be true, even though many of the accusations are imprecise and unverifiable, have been hoarded for many months, or concern products not covered by the World Health Organisation's marketing code.

Nestlé's investigations indicate that among 455 allegations counted in *Breaking the Rules 1994* and three supporting letters from Baby Milk Action only three charges required corrective action.³ In one case this had been effected before the publication of the booklet. Not only do our investigations show the unreliability of the "monitoring" by International Baby Food Action Network but a number of independent third parties have confirmed the inaccuracy of the accusations. For example, in one case the network's monitor, an adviser on breast feeding, herself declared the accusation regarding her clinic to be "false and unfounded"; in another case the head of a maternal and child health clinic declared the allegations to be "in complete contradiction to what is happening here in the field." Investigations into the unpublished reports from Unicef similarly indicate the inaccuracy of the accusations.

The only conclusion that can be drawn from *Breaking the Rules 1994* is that the British Paediatric Association is fully justified in adopting the position it has done, and not that Nestlé is breaching the code. Nestlé has no wish to intervene in any decision that the British Paediatric Association takes with regard to commercial sponsorship. The association can, however, remain assured that Nestlé abides fully by the WHO's code and all other national agreements.

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Nocardia pericarditis

EDITOR,—S J Tabrizi lists the clinical contexts with which nocardial infection has been associated.¹ Malnutrition due to anorexia nervosa should be added to this list. We recently saw a 29 year old Greek man with a long history of anorexia nervosa who had been referred to Britain. He was receiving inpatient psychiatric and dietary treatment in a specialist eating disorders clinic when he complained of a dry cough of 12 days' duration, which became productive with bloodstained sputum. A Heaf test had yielded a positive result when he was a schoolboy. Three years previously he had weighed 92 kg, but after finishing his military service he had started to diet and had rapidly lost weight. There was no history of diarrhoea or self induced vomiting. He was tall (180 cm) and emaciated, weighing only 37 kg. His body mass index was extremely low at 11.4 (normal range 20-24).

Physical examination showed dullness to percussion over the right apical region of the chest anteriorly and oedema of the ankles. Chest radiographs, which had been normal 32 days before, showed a cavitating lesion in the right apex, and the erythrocyte sedimentation rate had risen to 156 mm in the first hour. *Nocardia asteroides* was isolated from a fibreoptic bronchoscopic lavage specimen and subsequently from three separate sputum specimens. No mycobacteria were seen or isolated by culture.

He was initially treated for tuberculosis as the most likely diagnosis and subsequently with sulphadiazine 1 g four times daily for three months. The results of liver function tests, full blood count, and erythrocyte sedimentation rate returned to normal, and the chest radiological appearances resolved. He also slowly gained weight and achieved the mean weight in a matched population.

This is the first report of anorexia nervosa associated with nocardial infection. Malnutrition is recognised as predisposing to infections with various pathogens,² including mycobacteria,³ probably owing to its effects on the function of polymorphonuclear cells,⁴ antioxidant systems,⁵ and humoral immunity. Since anorexia nervosa is fairly common it is interesting that infections such as this are not seen more often.

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Risk factors for breast cancer

EDITOR,—Peter J Lewis comments on the fact that our article on risk factors for breast cancer did not include the role of xeno-oestrogens and progesterone deficiency.¹ The aim of the ABC series is to review the current state of knowledge succinctly. The article did not mention the two factors because

the evidence linking them with breast cancer is conflicting. While some studies have linked pesticides with breast cancer, others have not.² Definitive evidence that pesticides either induce or promote breast cancer has yet to be presented.

The role of progesterone in the breast is unclear. There is a body of opinion that progesterone deficiency, leading to unopposed oestrogen action, is associated with an increased risk of breast cancer.³ Others, however, have failed to show that women either at high risk of, or with, breast cancer have abnormal progesterone concentrations.⁴ Furthermore, there is an opposing view that high progesterone concentrations may be a determinant of risk and that the hazard of a prolonged reproductive life is mediated through cumulative exposure to an excessive number of ovulatory menstrual cycles.⁵ Progesterone also seem to be mitogenic in the normal breast, with increased proliferation being found in the luteal phase compared with the follicular phase of the menstrual cycle.⁶ Proliferation is also increased in women using combined oestrogen-progesterone contraceptive pills.⁶ Against this background, the case for giving progestogens to women at high risk of breast cancer is at best unconvincing and at worst potentially hazardous.

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Trials in palliative care

EDITOR,—In their discussion of the problems and pitfalls of evaluating a palliative care service McWhinney and colleagues mentioned three published trials in palliative care services.¹ Apparently only trials with additional care services were selected, and trials on palliative treatment were excluded. In the field of additional care services we found one other trial.² Many trials in palliative cancer care report problems with patient selection, accrual, attrition, contamination of exposure, and selection of adequate outcome measures. We also conducted a randomised trial on palliative care services, for patients with disseminated colorectal cancer. Our trial compared fluorouracil as single agent by continuous infusion at home versus combination therapy with leucovorin at an outpatient clinic. Main outcome measures were quality of life, use of care services, and satisfaction with care. Quality of life was assessed with a global assessment with a linear analogue scale, the medical outcomes study's 24 item short form, the affect balance scale, the