Thus most cancers detected were aggressive, and only a small number of men with prostate specific antigen concentrations >4.0 ng/ml would have a diagnosis of a non-aggressive cancer preceded by a long disease free interval. This was also true for the subset of men who were aged under 70 when the diagnosis was made. Compared with men with antigen concentrations of <1.0 ng/ml, those with concentrations of 2.0 – 3.0 ng/ml had a relative risk of all prostate cancer of 5.5 and a relative risk of aggressive cancer of 6.8 .

It is important to note that this was a once only test, and the potential benefit of repeat screening or the addition of other screening modalities was not available. For men older than 70 watchful waiting may be appropriate management. This new study shows, however, that in this population of American doctors the mean age at diagnosis of prostate cancer was 68.7 years, most of the cancers detected were aggressive, and three quarters of deaths in the cases were directly related to the diagnosis. Thus in younger men screening for prostate specific antigens may be justified, particularly for those in higher risk groups, such as those with a family history of prostate cancer.^{4,5}

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Methods are changing rapidly

EDITOR,—Fritz H Schröder discusses the controversies surrounding the early detection of prostate cancer and some differences in attitude between Europe and North America.¹ It is unfortunate that he emphasises screening rather than treatment. The uncertainty about the ability of treatment to modify the natural course of the disease should be resolved much more urgently than uncertainty about the value of screening, which can be addressed only when certain conditions are met—namely, that the natural course is understood, there is an agreed policy on whom to treat and by which method, and the cost of finding cases is economically balanced in relation to expenditure on medical care.² All these questions have yet to be answered in prostate cancer.

One flaw in screening studies is the rapidity with which methods of detection change. Testing for prostate specific antigen has been used routinely only in the past decade; already, different molecular forms of the antigen discovered recently suggest that newer assays may be more specific.³ In the next five years a multiplicity of tests will probably emerge, with a higher detection rate than the 5 – 8% recently reported in a screening study.⁴ The second problem with screening trials is that they do not specify the type of treatment for cancer provided. It is therefore essential and logical that the efficacy of treatment should be tested before the benefits of screening are assessed. Schröder refers to such studies being carried out in Scandinavia and Britain. These trials are unlikely to provide the answers required. In Scandinavia the randomisation protocol, which excludes high grade tumours, will prevent a clear resolution of the problem. In Britain the Medical Research Council's study,

launched last year, will find it hard to recruit sufficient patients as no provision was made for finding cases, which is the only means of recruiting enough men for randomisation.

A valid and ethically justified study comparing radical surgery with watchful waiting could be conducted only by targeting a population of men who had been fully informed about the consequences of screening and understood that watchful waiting might be offered. Such a trial is currently being organised on a pan-European scale, and it is now the responsibility of governments, the Medical Research Council, and the European Commission to identify priorities and respond to the urgency of providing a definitive answer to the problem by giving adequate support where it is most needed.

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Evaluation of sexual health interventions

EDITOR,—Ann Oakley and colleagues rightly emphasise the need for rigorous evaluation of sexual health interventions.¹ Much early sex is unplanned, and, even though it is encouraging that many more young people now report using condoms,² there is a need to publicise the timing and availability of emergency contraception for those occasions when some form of failure occurs, be it failure to buy a condom, failure to use it, or its failure to remain intact.

Improving knowledge of the availability and appropriate use of emergency contraception has been identified as one of the relatively few opportunities for reducing the high incidence of unplanned pregnancy in Britain, a target in the *Health of the Nation*. Many women, however, while vaguely aware that a postcoital method exists, are unsure of when it can be used and where it is available.³

Last summer we undertook two surveys of publicity for emergency contraception. In one we visited a random sample of 30 general practices in Camden and Islington to see if there was anything in the waiting room to suggest that the service was obtainable there. Only a third of the practices had either specific leaflets or posters about emergency contraception. Their impact, however, varied considerably, from prominently displayed posters to out of date leaflets positioned at the back of a rack. A questionnaire survey of 113 young people's clinics and advice centres was conducted and achieved a response rate of 70% ($n=79$). Although leaflets were available in 70, 24 reported that they were displaying a leaflet published by the Family Planning Association in 1984, which refers to the "morning after pill" and should have long since been replaced.⁴ There were isolated examples of well designed posters and reminders the size of a credit card.

Several commentators have drawn attention to the need for better publicity, and, as the Health Education Authority prepares to launch an

initiative on emergency contraception, the opportunity to evaluate the impact should not be lost. The key indicators will be public knowledge of where and when emergency contraception is available, the proportion of women seeking terminations who remain unaware of or unable to access emergency contraception, and the impact on trends at district level in rates of emergency contraception and termination of pregnancy.⁵

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Who uses the Cochrane Pregnancy and Childbirth Database?

EDITOR,—The rationale for the Cochrane Collaboration's publication of systematic reviews electronically is that this medium facilitates updating of reviews in the light of new data and valid criticisms.¹ Dissemination by electronic publication is, however, novel, and the medium is still being developed. In 1993 a survey reported limited uptake of the *Oxford Database of Perinatal Trials* in English obstetric units.² Yet correspondence^{3,4} suggested more widespread use of this database's successor, now produced by the Cochrane Collaboration.⁵ I undertook a postal survey of all British subscribers to the *Cochrane Pregnancy and Childbirth Database* in May 1994.

The questionnaire elicited details about place of work, job, and uses made of the database. Three hundred and eighty seven people were sent the questionnaire, of whom 274 (71%) responded. Most worked in organisations providing care (140), all but 15 of them district general or teaching hospitals. Other sites included academic institutions (58) and purchasing authorities (42). The responses clearly identified 173 separate organisations in which at least one member subscribed to the database.

Three professional backgrounds predominated: midwives (83), doctors (81), and information specialists (56). Other respondents included managers, administrative staff, researchers, audit workers, and members of the National Childbirth Trust. Thirty five respondents were responsible for distributing a copy of the database to 68 further people; and 112 respondents made their copy of the database accessible to others, usually by installing it on a computer in a common area, often a library.

Most (239) of the respondents had viewed the information on the database, and most reported multiple uses. The database was most commonly used to improve personal knowledge and the knowledge of others but also for guiding research, developing clinical guidelines, and informing audit (table).

The most important findings about the *Cochrane*

Use	
To improve personal knowledge	186
To improve others' knowledge by showing them the information in the database	155
To improve others' knowledge by passing information from the database verbally	139
To guide research	102
To help persuade others to use or not use a treatment	94
As the evidence base for a set of clinical guidelines	87
To inform health policy and purchasing decisions	52
To provide standards against which to audit	57
As the evidence base for a patient information leaflet	20
Other	18
Not viewed or no uses	38
One use	29
Multiple uses	207

Pregnancy and Childbirth Database were that (a) at least 239 people nationally were making some use of it; (b) over 200 people reported multiple use; (c) initiatives to make the database accessible to others were common; (d) subscribers were not concentrated in a few organisations; and (e) doctors constituted only one of three main groups of users.

Thus use of the *Cochrane Pregnancy and Childbirth Database* in 1994 was substantially more widespread than use of the *Oxford Database of Perinatal Trials* in 1993.

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Evidence based policymaking

BMA's policy is driven by evidence and research

EDITOR,—Chris Ham and colleagues make a valid point: policy is too often driven by dogma and perceived vested interest. So prevalent is this that governments too often ascribe the same motives to their critics. It has been difficult to convince successive sceptical governments that the BMA's policy is driven by other than narrow sectorial interest. Through its scientific and professional departments the BMA has always been more than the "doctors' trade union," to use the expression that its critics deem belittling; now, with the setting up of its health policy and economic research unit, it can show that its policy is driven by evidence and research and open discussion about potentially controversial topics.

We welcome Ham and colleagues' initiative and endorse the proposal for creating a small group of experienced analysts at the centre of a wider network. I would go further and suggest that the association should participate in such a network through its research departments and would expect other professional bodies in the health service to wish to do likewise.

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- Ham C, Hunter DJ, Robinson R. Evidence based policymaking. *BMJ* 1995;310:71-2. (14 January.)

Policymakers may need to make a break with the past

EDITOR,—It is a shame that there is a need even to make the point that policymaking ought to depend on evidence.¹ Textbooks in policy analysis are clear about the need for evidence to support policy options or to decide among them. But policymaking is not just about learning from the past. We may need to make a break with the past and with past evidence. In this respect choosing policies has little to do with the output of academic policy centres, unread publications, or unused results of extensive and expensive evaluation studies.

It seems to me that there is a tension between the needs of those people who believe that health policy ought to be scientific and ought to reflect what we know and those who see policymaking as a creative and developmental activity that leads thinking. I agree with Chris Ham and colleagues that politics is driven more by values than by facts and that it is important for policy to be informed by evidence of what works and does not work.¹ Unlike practical medicine, however, policymaking is experimental, involving new insights which may fly in the face of what seems to be "evidence."

I am concerned about the suggestion that a "small group of experienced analysts" should be set up. It is true that policymaking and policy analysis are often separate endeavours, with the policy analysts separated from the official policymaking processes. But to assume that a small group of experienced analysts could perform functions different from those performed by the extensive network that undertakes policy analysis now is mistaken and probably undesirable. Such centrist thinking always assumes the need for coherence and rationality of policymaking; it is similarly uncomfortable with the pluralistic and diverse interchanges that occur when policy analysis and policymaking derive their nourishment more widely and perhaps less scientifically.

This particular suggestion is old fashioned in a world that is moving toward a more experimental and encouragingly daring approach to health policy. Safe solutions may be sought by traditional policy analysts. Those of us who think of policy as something more, as something creative, as something daring, will look elsewhere.

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Academic experts don't have a monopoly on wisdom

EDITOR,—Evidence based policymaking, discussed by Chris Ham and colleagues,¹ is not a novelty. Since the establishment of the Brookings Institution in 1916 and the Hoover Institution in 1919 public policy research institutes have proliferated worldwide. Robert C Wood is currently John E Andrus professor of government at Wesleyan University; served in various capacities in the cabinet during the Truman, Eisenhower, Kennedy, and Johnson administrations; and later advised Nixon, Carter, and Bush. He has written an excellent account of the role of academic experts in the formulation of American presidential policy from 1960 to 1988.² Think tanks exist in Britain too: Ham and colleagues cite the work of the King's Fund and similar organisations in providing research data on the impact of the "marketisation" of the NHS. So there is no basis for their call for such research institutes to be established.

What they are actually asking for is entirely different: they would like the findings of the research conducted at these institutions to form the basis of all public policymaking. In other words,

they are demanding a role for academicians in the formulation of public policy. They demand that both the government and the opposition should be "[required] to base their policies on evidence." They also want to see a situation in which every statement of new policies "[is] accompanied by a statement of the evidence that was consulted in their preparation."

It is well known that public policy is driven by a combination of rhetoric, ideology, and knowledge and that the character of government depends on which predominates. As Wood sees it, "It is better that [presidents] be possessed of what knowledge we have, however incomplete, than to act on beliefs and convictions that simply cannot come to pass."² The same is easily said for prime ministers. Nevertheless, the belief that academic experts have a monopoly on wisdom is arrogant (no one has yet come forward with an explanation of stagflation) and the demand that their research findings must be cited in all policymaking even more so. Heads of governments should certainly listen to academic experts; but ultimately they have to exercise their own political instincts and judgment.

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Pharmaceutical donations to eastern Europe

EDITOR,—Express Aid International would support the formation of a British medicines advisory group to coordinate pharmaceutical donations to eastern Europe by British charities, as suggested by Christopher J Derrett and colleagues.¹ Such a group might serve to resolve the conflicting advice that charities receive from the World Health Organisation and eastern European and British sources. I suggest, however, that such a group should widen its remit to incorporate a database of available donated pharmaceuticals so that specific requests for aid could be managed through a single point of contact. The example of Americares is worth emulation.

I am concerned, however, that the authors seem to suggest that current British health care practices must serve as the sole criterion for pharmaceutical donations to eastern Europe and Romania in particular. I believe that charities must operate within the constraints of the recipient health care system and that it is unwise to use British criteria as a basis for meeting requests for pharmaceutical aid from eastern European countries. Such action might be interpreted as an attempt to impose British health care standards on eastern European practice.

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Correction

Treating mental health problems in health care workers

Owing to an editorial error Sheila C Macpherson's letter was published under the title "Treating mental health problems in health care workers" (15 April, p 1010). The letter was in response to an article about a doctor's experience of testicular cancer and should have had the title "Miracle cure."