pessimism of Mead and Peter C Rubin, who comments on the controversy, be refuted. Moreover, to achieve this it will be necessary to improve the education of all doctors and medical students about the availability of treatments and clinical trials that are suitable for their patients.

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Prophylaxis against malaria

EDITOR,—Santanu Chatterjee expresses concern about the advice given on prophylaxis against malaria, especially to young people travelling for long periods on low budgets.¹ Almost a quarter of 452 foreign travellers studied by Chatterjee in Calcutta were not taking any prophylaxis against malaria. The reasons for this are not reported.

Regulations amending the NHS (General Medical Services) Regulations 1992, which came into effect in England and Wales on 6 February this year, gave general practitioners the power to charge patients for prescribing or providing drugs for prophylaxis against malaria for travel abroad.² This means that private prescription forms will now have to be used to prescribe drugs for prophylaxis against malaria if the drugs cannot be obtained over the counter. The table gives the costs to the patient of a six week course of each of the recommended drug regimens for prophylaxis.

The cost of chemoprophylaxis against malaria for travellers, especially those with low budgets, may be a barrier to their taking any or the most appropriate chemoprophylaxis. For example, the increasing prevalence of strains of *Plasmodium falciparum* resistant to chloroquine and proguanil, the cheaper antimalarials, has resulted in maffloquine, which is much more costly, being recommended as the drug of choice for travel to east and central Africa.³ Of the 3551 cases of malaria reported in the United Kingdom during 1992 and 1993, 1983 were due to *P falciparum*. Fourteen of these 1983 patients died, 12 of whom had contracted the disease in Africa and two in India.⁴ Eight of the 14 patients who died had taken no prophylaxis at all.

If the cost to travellers of chemoprophylaxis against malaria has been a barrier to any or the most appropriate chemoprophylaxis being taken in

the past then the recent changes to regulations may result in an increased number of cases of falciparum malaria being imported into England and Wales, with a resultant increase in the number of deaths from the disease. The short term savings to the NHS resulting from the change in the regulations may be short sighted.

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Profiting from the NHS

EDITOR,—Chris Ham seems gloomy about private finance for NHS trusts for building projects.¹ This could, however, herald a new era, providing modern health service building without the restrictions of the public sector borrowing requirement.

A crisis is developing in the management of acute care through the reduction of trainees' hours of duty, the introduction of higher standards² and new treatments, and, in my specialty, an acute shortage of candidates for consultant posts. It is essential, therefore, to concentrate emergency services on as few sites as practicable; this may mean rebuilding, which would also introduce an opportunity to provide the facilities required for the appropriate level of care.³

In the United States "not for profit hospitals" (analogous to trusts) raise money at interest rates that depend on their credit rating and are based on their history of repayment of loans, the status of the institution, and inspection of the project. NHS institutions have no such history, so that capital for whole hospital projects may either be subject to unsustainable interest rates or be unavailable. Fundholders will certainly, as Ham writes, have to give long term commitments to NHS trusts but cannot cover a pay back period of 20 years or more. Some unquantifiable risk will remain. Perhaps optimum terms could be arranged with a minority contribution of capital (but also repayable) from government funds. This subsidy would make schemes viable, producing a more reasonable residual value in the case of total loss (which must remain a possibility). This may seem impure but be a practical solution.

Ham also seems to be criticising private sector involvement in the control of trusts that borrow. The history of NHS capital expenditure is grim (for example, at the University Hospital of Wales, Cardiff, millions were spent on decaying facades and fire precautions), and there is widespread evidence of great waste in running costs.⁴ There is room for improvement in the management of both

the capital project (which should be completed in time and at the cost stated in the contract) and subsequent recurrent expenditure. More careful scrutiny would therefore be welcome. It is up to purchasers to ensure that their objectives and standards are being met and that short term financial considerations do not receive undue weight. Instead of being looked on as selling off the silver this should be looked on as a golden opportunity for the health service to make rapid progress in updating building for the next century. But it will need the profession's and government action to make it happen.

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Community psychiatric nurses and drug regimens

EDITOR,—Now that Mrs Patricia Cooksley, a nurse who was sacked by Plymouth Hospital NHS Trust in July 1994 because she failed to obtain a doctor's signature on a repeat prescription, has been reinstated, discussion of the issues can take place in a more detached way. The issues surrounding medication are certainly not new, and they have implications for the medical profession.

A study of a community psychiatric nursing service which I carried out for a health authority in the 1980s provides evidence that community psychiatric nurses have long had to face dilemmas over their role in providing drug treatment.

Community psychiatric nurses differed in how far they were prepared to intervene in the oral medication of patients. Half of the 22 nurses in the area studied did modify doses; a further quarter were prepared to increase the dose but by only a single tablet, and they reported to the consultant within a few hours, rather than the more usual 24 hours. There were less overt ways of influencing medication: on occasion, particularly in the case of depot injections, nurses undermined consultants' treatment programmes by emphasising to patients their rights of refusal. Other nurses saw medication as only one of several approaches to mental illness. They viewed medication as the province of doctors and not a remedy which they as nurses would want to use, meddle with, or perpetuate.

Consultants played an important part in determining how some community psychiatric nurses behaved in regard to medication. Nurses whose action was not supported by a changed prescription given after the event would (presumably) not modify dosages again. So, it was not always the nursing profession, or nursing managers in the health authority, or individual nurses who were fixing their own behaviour; rather, it was the medical profession determining standards.

Increasingly, community psychiatric nurses were coming into contact with patients who were looked after solely by general practitioners. Sometimes general practitioners seemed to have less expertise concerning the drugs used in psychiatry than the nurses, and the nurses could find themselves in the anomalous position of advising those who, in fact, carried the responsibility for prescribing.

While variable and ill defined ways of working cannot be satisfactory, for the most part it seemed likely that the involvement of community psychiatric nurses in medication was safe. The practices had clearly evolved among people who had worked together for some time, not because

Cost (£) to patient of six week course of chemoprophylaxis against malaria if obtained over the counter, on NHS prescription, or on private prescription

Drug regimen	Over the counter	NHS prescription	Private prescription*
Chloroquine 300 mg/week	0.76	5.25	7.53
Proguanil 200 mg/day	6.93	5.25	11.9
Chloroquine 300 mg/week and proguanil 200 mg/day	7.69	10.5	19.43
Mefloquine 250 mg/week	Not available	5.25	22.35
Maloprim one tablet/week† and chloroquine 300 mg/week	Maloprim not available	10.5	15.19
			(2 charges by GP) 9.19
			(1 charge by GP)

GP=general practitioner.
*Includes general practitioner's charge to patient of £6 (charge recommended by BMA), cost of drug(s), and pharmacist's dispensing charge.
†Maloprim costs £5.25 on NHS prescription and £7.66 on private prescription.