able, within its limited resources, to respond to the enormous changes in its constituents and their needs over the past five years."

Our mission is, indeed, to use our influence to improve people's health while adapting our work to the major changes that are occurring in our region. We do not, however, believe that we can alter overnight health behaviour that has been shaped over generations. Changes in this can be achieved only through a long term vision, implemented through consistent action. This is the road that the member states in the European region of WHO have chosen in updating their Health for All policy for the 1990s.

Godlee does not reflect this broad vision of health. Why should policy action be contrasted with specific programmes? Why set the short term against the long term? One contradiction in the article illustrates this well: on the one hand, the European office is being called on to move from broad based policy issues to the nitty gritty of health care management and delivery; on the other, with regard to immunisation in eastern Europe the office is reproached for focusing on individual programmes rather than on guiding policy. We believe that all these approaches are steps along a continuum from identifying problems to formulating policy, designing a strategy, and designing methods for practical implementation. Health for All offers a logical and comprehensive framework for doing this since it deals equally with all these aspects.²

Too much is made of the differences between the various organisations and their activities, and the evidence for this seems to be mainly anecdotal. For instance, instead of alluding to discord with the European Union Godlee might have mentioned the 46 areas of cooperation developed between the two bodies.

As for the claim that WHO's work in eastern Europe is consultant based, this is simply not true. Of the 485 staff of WHO's regional office for Europe, some 185 are spread over 26 countries. WHO's liaison offices operate in 24 of the 26 countries of central and eastern Europe and the new independent states. In addition, every one of the 70 or so professional staff in the regional office in Copenhagen spends a substantial part of his or her time "out there," helping countries. Our unique network of consultants is used to supplement this structure, not to serve as a substitute for it.

No country in Europe exploits fully its potential for helping its people choose healthier lifestyles, live in a healthy environment, and enjoy cost effective, quality conscious health services. The WHO regional office in Copenhagen is committed to helping them do this better.

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1 Godlee F. WHO in Europe: does it have a role? *BMJ* 1995;310: 389-93. (11 February.)

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WHO stimulates a commitment to tackling inequalities in health

EDITOR,—In her article on the World Health Organisation in Europe Fiona Godlee fails to appreciate just how large a contribution the European office has made to one of the key issues in health policy today: social inequalities in health.¹ Before the 1980s it was easy for European countries to be complacent about their "fully fledged health infrastructure and high overall levels of health."²

But it is no longer possible for countries to ignore uncomfortable facts about the existence of

inequalities in health, even in the countries with the highest standards of health, such as the Netherlands and Sweden. A major factor in moving the issue up the political agenda has been the work of the European office. Throughout the 1980s it kept up the pressure with a succession of authoritative reports and international meetings on the impact on health of unemployment, migration, recession, and the other major socioeconomic changes that have swept through the region in the past 15 years. It was instrumental in helping researchers in central and eastern Europe to bring into the open the once secret statistics on inequalities in health in their countries, and it continues to document the desperate plight of populations to the east of the region.

More recently, WHO has been at the centre of a concerted effort to shift the focus from documenting the existence of inequalities towards taking action to tackle the problem. Much work has been done on getting interested countries to develop national health strategies that take equity in health into consideration. The fruits of these efforts can be seen, for example, in the Netherlands, which has been committed since 1987 to a national research and development programme on inequalities in health; in Finland, which now has a national centre starting a new phase of collaboration with WHO to develop health policy oriented towards equity; and in Sweden, which is poised to do the same. Even in Britain the WHO's Health for All strategy has helped to stimulate and legitimise a commitment to tackling inequalities in health at the local and regional levels over the many years when there was not even a glimmer of encouragement at the national level.

As socioeconomic conditions across the region continue to worsen I believe that we need more, not less, scrutiny of what is happening to the health and welfare of the most vulnerable sections of the population in Europe. There is a clear and continuing role for WHO in all this.

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Appropriate prescribing in asthma

EDITOR,—It is gratifying to see that our paper on appropriate prescribing in asthma and its related cost in east London¹ stimulated debate and constructive criticism.^{2,3} It is also heartening to read Philip Leech's comment that the NHS Executive supports more prophylaxis against asthma though it may be more expensive.² The progressive view of cost effective prescribing taken by Camden and Islington's pharmaceutical advisers is also good news.³ Nevertheless, the overall emphasis of the indicative prescribing scheme is of downward pressure, which may affect prescribing for asthma in the context of reductions in indicative prescribing amounts.

Although prescribing costs in City and East London are lower than national averages despite high morbidity and mortality, general practitioners still face the possibility of reductions in prescribing budgets. While the Prescription Pricing Authority has pointed out that the extra costs of steroid inhalers in asthma may be justified, the overriding message that doctors receive from prescribing analysis and cost (PACT) data and their indicative prescribing budget statements is that prescribing costs should be contained. The low cost of prescribing for asthma in east London suggests that general practitioners may be extending this message to asthma.

We acknowledge the drawbacks inherent in using as an indicator of effectiveness a crude process measure such as the ratio of prophylactic treatment to bronchodilators prescribed.^{4,5} Methods that link process to patient outcomes are needed before we can really talk about effectiveness.

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Measuring cardiolipin antibodies

EDITOR,—Cardiolipin antibodies have been variously cited as a risk factor for cerebral thrombosis^{1,2} or splanchic venous thrombosis,³ or as an epiphenomenon loosely associated with vascular disease.⁴

Cardiolipin antibodies seem to represent a family of low affinity antibodies which share a limited ability to bind to bovine cardiolipin. This rather artificial assay system, dependent on the binding of a low affinity human autoantibody to a non-primate, cross reacting substrate of unproved relevance, can lead to some rather bizarre comparisons. Cardiolipin antibodies are probably identical to the chronic biological false positive Wasserman reaction described more than two decades ago in relation to systemic lupus erythematosus and related disorders, the same bovine cardiolipin being used in the modern enzyme linked immunosorbent (ELISA) assays for cardiolipin antibodies and in the classic Wasserman reaction. Cardiolipin antibodies are related to, but are distinct from, lupus anticoagulant, which represents a further feature of the more general grouping of phospholipid antibodies.

Experience in distributing both single patient materials and pooled materials in the United Kingdom national external quality assessment scheme for anticardiolipin antibody has revealed several inconsistencies. Individual patient materials characterised as containing cardiolipin antibodies of defined levels with one commercial kit do not always give similar results with another kit from an equally reputable source. That the various commercial kits have a similar, if not identical, standardisation can be shown by their parallel responses when tested with pooled human serum materials or with the reference material 90/656.

Of concern, however, is the tendency for users of the assay results to accept the numbers as hard data and decide patient stratification or treatment on the basis of those numbers. Distributions within assessment scheme show a between laboratory coefficient of variation of 25-30% for any one sample. Similar levels of imprecision have been shown between assays, and on occasion between lots, for individual commercial kits by the Medical Devices Agency kit evaluation ("blue cover") reports.

A further concern has arisen from recent studies within the assessment scheme. Four serum samples were made by diluting a single patient

material and distributed on two separate occasions during an eight week period. The 108 participating laboratories were asked to interpret their results on a scale from negative through low titre, medium titre, to high titre positive. The table shows the interpretative result plotted against the mean cardiolipin antibodies titre expressed as the all laboratory trimmed mean. With all 16 cells of the matrix occupied there is clearly room for improvement not only in the means of analysis of this family of autoantibodies but also in their interpretation. Even the highest dilution of this series, with a mean of 28 GPLU (IgG phospholipid units) would be considered as a moderate titre positive result by the criteria of Greaves,⁵ yet eight laboratories (9%) considered it to be negative. Also, 9% and 5% of laboratories considered samples with 57 and 76 GPLU to be negative or at best only weakly positive.

Matrix of interpretative comment and all laboratory trimmed mean of cardiolipin antibodies

	Positive			
	Negative	Low	Medium	High
76 GPLU/ml	2	2	19	65
57 GPLU/ml	5	3	36	44
41 GPLU/ml	3	7	57	22
28 GPLU/ml	8	15	57	9

GPLU=IgG phospholipid units

On the basis of the evidence there seems little room for confidence in the concordance of numeric values for cardiolipin antibodies, and only slightly more confidence in their semiquantitative interpretation.

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Herbal medicines should be in child resistant containers

EDITOR,—The recent accidental ingestion of a diuretic herbal medicine by a two year old, requiring admission and electrolyte monitoring, prompted me to examine the wider implications of this case.

In 1976 the introduction of child resistant containers in the United Kingdom resulted in a reduction in the accidental ingestion of paracetamol and aspirin by children.¹ These containers are, however, compulsory only for solid prescribed medication, and poisoning with other drugs such as herbal and veterinary preparations should not be ignored. The use of childproof containers for liquid medication still remains an important topic for discussion, and as yet an acceptable design has not been finalised.²

The degree of control demanded of prescribable drugs does not extend to those of herbal type. In view of the increasing use of such medicines, there is likely to be an increased risk of accidental ingestion.

Some herbal medicines have been adulterated

with heavy metals, leading to potential toxicity in overdose, the signs and symptoms of which are often recognised late.³ Childproof containers should be a legal requirement for herbal medicines. This would facilitate the implementation of the government recommendations with respect to the reduction in childhood accidents.⁴ Meanwhile, parents should be cautioned to store such medicines out of the reach of children.

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Priority setting processes for health care

EDITOR,—My review of *Priority Setting Processes for Health Care* made two criticisms.¹ Firstly, the authors failed to discuss the policy and political contexts in which priority setting is taking place. For example, the Oregon system, with which they open the book, was about redistributive justice—that is, politicians recognising the need to extend health care to large sections of the community which formerly had little or no access to care. In contrast, priority setting in the remaining health care systems is concerned not with extension but with decreasing the availability of health care to some groups in society.

Johann Calltorp and colleagues seem impervious to the effects of the market both as a resource allocator and in priority setting at district and subdistrict level.² To neglect how markets can impinge on local priority setting processes is to assume that health care decisions operate in a vacuum at local level. Redmayne and Klein have shown that in Britain health authorities are muddling through³; others, including myself, suggest that the vacuum in planning which has resulted from the fragmentation of the market and the loss of a population focus is leading to greater irrationality and new inequities in decision making.⁴ As the Select Committee on Health reported, "support for priority setting must go beyond the dissemination of good practice . . . at a minimum the NHS Executive should ensure that epidemiological profiles including variances from national averages, analyses of need, and details of current provision are open and accessible to public scrutiny."⁵

My second criticism related to the lamentable failure of the authors to subject the priority setting exercises to critical evaluation. The book makes a virtue of the pseudoscience of the priority setting industry. Given the vogue for effectiveness and efficiency, what is the public to make of the thousands of pounds that are spent on priority setting exercises instead of patient care—especially when those exercises provide no useful results?

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Fees for postgraduate medical education lectures

EDITOR,—In the current wave of popularity for postgraduate education we are daily made aware of an increasing number of commercial conference organisers who make a profit from the time contributed by the lecturers. Recently I found myself agreeing to participate, assuming that a fee or at least some recognition would be forthcoming. I did not even receive a letter of thanks until I wrote to the company, who then said it had been a successful evening, providing me with a copy of the delegates' assessment. I was informed that their events "provide the opportunity for consultants to gain quality exposure to a relatively high number of GPs." I am not sure what benefit is supposed to come from this—more outpatients to see?

I write this letter to warn others and to pose the question as to whether a blacklist of firms profiting from our giving up free time should be established?

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Training doctors

EDITOR,—Isobel Allen's report on doctors and their careers¹ should stimulate a serious assessment of how we train doctors in Britain. As a female surgeon I can only despair at my own specialty, orthopaedics, where women represent less than 2% of consultants and around 3% of trainees. This is probably the worst record among the major specialties for the recruitment and training of women in hospital medicine.

My own experiences as a trainee would hardly encourage other members of my sex. The worst episode occurred in 1991 when I was a career registrar in Scotland expecting my first child, and my professor informed me that I would not be regarded as a "doctor in training" for the purposes of maternity employment rights. I received my P45 in the post. After a lengthy appeal I was reinstated and completed my registrar rotation. When I returned to work I was not made welcome and no apology was forthcoming.

Subsequently I was very fortunate and obtained a part time senior registrar post in England, 200 miles away from my home and family. Although the travelling was difficult, I did manage to complete my training and obtain a consultant post.

I would not ask a sane person of either sex to repeat my experience of surgical training. I love my job but I hate the system that made it so difficult for me to become a surgeon. Radical change is required in both regimes and attitudes if we want to give our young doctors the careers they deserve.

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Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.