Rate of carriage of group A β haemolytic streptococci

EDITOR,—During the publicity last year about necrotising fasciitis the media frequently stated that 10% of the British population carry group A β haemolytic streptococci.¹ Textbooks give a figure of 5–20%.^{2,3}

We tested whether these figures apply to a rural population by taking throat swabs from 310 well people during 12 months. The mean age (37.2 years) and sex distribution (51% were male) approximated to those in the practice population as a whole. During the same period throat swabs were taken from 375 patients with upper respiratory tract infection. The swabs were taken into Allen's transport medium and reached the microbiology laboratory within five hours. With the agreement of the microbiologist a pseudo-diagnosis of an upper respiratory tract infection was given for the swabs from the well people. Group A β haemolytic streptococci were isolated from only two (0.6%) of the well people and from 36 (9.6%) of the patients with an upper respiratory tract infection. The two well people who were positive for group A β haemolytic streptococci were aged 4 and 75.

As we obtained reasonable numbers of organisms from patients with an upper respiratory tract infection our findings are unlikely to be due to faulty swab taking or poor laboratory technique. Either the figures quoted for the rate of carriage of group A β haemolytic streptococci have never applied to rural communities or the rate has decreased since previous studies. Investigation into current rates of carriage in the population of a British city would be interesting.

We thank Dr D Johnston, consultant microbiologist at Scarborough Hospital, for his cooperation.

ROBERT DITCHBURN

General practitioner

JANET DITCHBURN

General practitioner

Dale End Surgery,
Danby,
Whitby,
North Yorkshire YO21 2JE

1 Pennington T. Quoted by Brindle D: Alert to doctors over bug. *Guardian* 1994 28 May.

2 Shanson DC. *Microbiology in clinical practice*. Bristol: John Wright, 1982.

3 Finch RG, Ball P. *Infection*. Oxford: Blackwell Scientific, 1991.

Risk for British travellers of acquiring hepatitis A

EDITOR,—The risk of non-immune British people acquiring hepatitis A during visits to endemic areas has been calculated as 0.047% per visit.¹ Current British guidelines on immunisation against hepatitis A are specific to regions—for example, protection is not considered to be necessary for travellers to Spain, Portugal, or Italy, but tourists visiting all but first class accommodation in Turkey should be protected.²

Cases of hepatitis A are routinely reported to the Public Health Laboratory Service's Communicable Diseases Surveillance Centre by laboratories in England and Wales. Information about whether the infection was acquired in Britain or abroad is provided in, on average, 29% of reports. We summarised the reported travel histories in 1471 cases acquired abroad between 1990 and 1992 by selected region or country of destination. The number of visits made by British travellers each year to each destination was provided by the international passenger survey.³ This longitudinal survey of passengers resident in Britain also provides information specific for each country, about the average duration of visits and reasons for the visits. We adjusted the number of visits by their

Incidence of hepatitis A (cases/100 000 visits/month) and relative risk by destination

Destination	1990	1991	1992	Mean for 1990-2	Risk relative to risk in France and Scandinavia
Region:					
European Union	0.1	0.2	0.1	0.1	3
Other countries in Europe	0.3	0.1	0.2	0.2	4
Eastern Europe	1	1	1	1	20
Australia and New Zealand	2	1	0	1	20
Middle East	2	9	2	4	85
Far East	4	7	4	5	102
North Africa	7	5	4	6	110
Rest of Africa	14	13	9	12	235
South America and Caribbean	9	24	4	12	243
Country:					
Scandinavia	0.1	0.0	0.1	0.0	1
France	0.1	0.1	0.0	0.1	1
Greece	0.2	0.1	0.2	0.2	4
Spain	0.2	0.3	0.2	0.2	5
Turkey	3	2	1	2	42
Mexico	24	53	16	31	612
Indian subcontinent:*					
All travellers	114	87	81	94	1835
Age < 15:					
Visiting friends and relatives	128	119	113	120	2347
Tourists or purpose of visit not known	29	11	5	15	295
Age $\geq$ 15:					
Visiting friends and relatives	64	50	52	55	1083
Tourists or on business or purpose of visit not known	66	52	53	57	1111

*Bangladesh, India, Nepal, Pakistan, Sri Lanka.

average duration (from 10 days for visits to France to 53 days for visits to the Indian subcontinent) and expressed the incidence for each destination as cases/100 000 visits/month.

As hepatitis A may be underreported, travel histories may be incomplete, and the number of passengers departing for some destinations is small, we calculated the risk of hepatitis A relative to the risks in France and Scandinavia, which we assumed to be similar to the risk across Britain. We assumed that anomalies in reporting and bias in the collection of the denominator data were consistent across destinations and over time. For the Indian subcontinent we used age specific laboratory data and proxy data on ethnic group⁴ combined with stratified data on reason for travel to estimate the risk by age and by reason of visit.

Our estimates suggest that British travellers to Greece, Spain, and Italy (8 806 068 visits in 1992) have a low risk of infection and do not require protection but that immunisation might be considered to be necessary for the smaller number of travellers to Turkey (329 053 visits in 1992). Children travelling to the Asian subcontinent are at an appreciable risk and therefore need to be protected against infection. The wide variation in incidence of hepatitis A by destination, reason for travel, and age (table) confirms the advantages of targeting advice and prophylaxis. High risk travellers need to be identified in future prospective epidemiological studies to help focus resources¹ and optimise protection.

RON H BEHRENS

Consultant physician in tropical and travel medicine

Hospital for Tropical Diseases,
London NW1 0PE

MARIAN COLLINS

Information assistant

BERANGERE BOTTO

Information assistant

JULIA HEPTONSTALL

Consultant microbiologist

Immunisation Division,
PHLS Communicable Disease Surveillance Centre,
London NW9 5EQ

1 Behrens RH, Roberts JA. Is travel prophylaxis worth while? Economic appraisal of prophylactic measures against malaria, hepatitis A, and typhoid in travellers. *BMJ* 1994;309:918-22.

2 Lea G, Leese J, eds. *Health information for overseas travel*. London: HMSO (in press).

3 Central Statistical Office. *Business monitor; overseas travel and tourism*. London: Government Statistical Service, 1992. (MA6.)

4 Nicoll A, Bassett K, Uliaszek SJ. What's in a name? Accuracy of using surnames and forenames in ascribing Asian ethnic identity in English populations. *J Epidemiol Community Health* 1986;40:364-8.

Cheating in medical school

Cheating continues on through career

EDITOR,—Frank J Leavitt's personal view concerns a first year medical student found cheating at Beer Sheva University.¹ As a general practitioner I would take Leavitt to task over the three examples that cause him concern about dishonesty and his fear for the medical future of this student. "Perhaps he will lie to help a patient friend to take a holiday and call it sick leave"; but all practising doctors have falsified sick notes. What does one write on the certificate when a tired mother of four is in obvious need of a rest for a few days—"washed out," "prevention of child abuse," or some similar phrase? It is far kinder and, I think, correct to write "physical fatigue" or "headache." And what about neglecting to report an infectious disease? I suppose from time to time we all do this, most probably because we do not know the exact diagnosis at the time of the consultation. Often it is only later, sometimes months later, that the diagnosis is confirmed, and I (we?) on occasions forget the official notification.

My biggest criticism of Leavitt is his last example of falsifying death certificates. In Israel, for religious and cultural reasons, postmortem examinations are extremely rare. The shortcomings of the cause of death as written on the death certificates are well known.^{2,3} Sometimes they are pure fabrication. Every doctor makes an educated guess, which he or she hopes is near to the truth when no result of a postmortem examination is available. I suggest Leavitt thinks again.

MELVYN H BROOKS

General practitioner

Tel Shalom,
Karkur,
Israel

1 Leavitt FJ. Cheating at medical school. *BMJ* 1995;310:1014-5. (15 April.)

2 Abramson JH, Sacke MI, Cahana E. Death certificate data as an indication of the presence of certain common diseases at death. *J Chronic Dis* 1971;24:417-31.

3 Slater PE, Halfon S-T, Ever-Hadani P. Death certificates in Jerusalem: sources of information about cause of death. *J R Coll Gen Pract* 1984;34:619-20.

Poor teaching may be responsible

EDITOR,—I am saddened by the tale of cheating in medical school—not by the fact of Jack's cheating but by Frank J Leavitt's reaction.¹ Why did Jack cheat? His teachers seem not to have considered

the possibility that his cheating was a silent revolt against the inadequacy of the course or of his teachers. The wise lecturer always notes if his or her audience is sleeping—it is a sure sign of a bad, boring, or useless lecture. Was Jack's cheating another version of the sleeping student?

G T WATTS
Retired consultant surgeon

Birmingham B13 8LD

1 Leavitt FJ. Cheating at medical school. *BMJ* 1995;310:1014-5. (15 April.)

Lying statement reinforces in appropriate cultural stereotype

EDITOR,—This year we celebrate the 50th anniversary of the defeat of the racially inspired policies of Nazi Germany. It is therefore particularly surprising and disappointing to find an article from Israel, of all places, which contains the statement that "people of some Middle Eastern cultures see little wrong with lying." The author, Frank J Leavitt, should make it clear to readers which groups he is referring to (Israeli, Palestinian, Jordanian, etc) and the scientific evidence on which his statement is based. The editor of the *BMJ* should also make clear whether, on reflection, it is appropriate for such racist comments to be published in the journal.

JOHN A THOMPSON
Reader in medicine

Department of Medicine, University of Glasgow,
Royal Infirmary,
Glasgow G3 7ER

1 Leavitt FJ. Cheating at medical school. *BMJ* 1995;310:1014-5. (15 April.)

Medical students cheated in the past too

EDITOR,—Frank J Leavitt describes his soul searching when deciding to mark down a medical student guilty of plagiarism.¹ The comforting thought had arisen that the student had wanted to have some means of escape from medicine, which may indeed have been so. An entry dated 27 October 1883 in the minutes of the medical college, in the archives of St Bartholomew's Hospital, suggests that is not always the case:

A letter as to Mr Matthew Souvielle from Dr William Osler of Montreal was read and a letter from Mr Matthew Souvielle in reply was also read. As Mr Souvielle admitted what Dr Osler asserted amongst other matters, that he had endeavoured to obtain a degree at the University of Erlangen by a fraudulent thesis it was resolved that Mr M Souvielle be not permitted to enter to the practice of this Hospital and that as his term of admission to the dissection room has expired, he be not permitted to enter the school.

This student's fraud had concealed a desire not to leave the profession but to continue in it. Discovery in one place had involved further deception abroad. What later scientific or medical frauds might have resulted had Osler not intervened—and had the authorities at St Bartholomew's not taken it on themselves to maintain academic standards—can only be speculated on. Leavitt can take comfort from the fact that Osler—and all others who take active steps to combat medical or academic fraud—would support his decision.

RUTH RICHARDSON
Wellcome research fellow in the history of medicine

Department of Anatomy and Developmental Biology,
University College,
London WC1E 6BT

1 Leavitt FJ. Cheating in medical school. *BMJ* 1995;310:1014-5. (15 April.)

Author's reply

EDITOR,—I was particularly distressed by John A Thomson's failure to read my words carefully and to see that I was praising the student's Middle

Eastern culture, in contrast to that of some northern Europeans, like the followers of the German philosopher Kant, who might be sticklers for fine points of "absolute truth" while failing in kindness, forgiveness, and caring for the lives of their fellow humans. As I made clear in what I wrote, I seriously considered overlooking the student's cheating for this reason, but I rejected the idea for reasons of medical ethics. The student is a Jewish Israeli, as am I. We both fully belong to the same non-Western culture. Only a lack of familiarity with our culture can have led Thomson to call my remarks "racist."

For clarity I should add that Judaism can be quite lenient with respect to a well intentioned lie—to spare someone's feelings, for example. And a number of authorities in Jewish medical ethics will approve of a doctor lying to a patient with a terminal illness to spare the patient mental distress. But these matters are different from fraudulent deception, which cannot be accepted.

This student, as I said, "was one of the sharpest and most enthusiastic participants in class discussion." So I do not think that this particular case was a case of "silent revolt against the inadequacy of the course or of his teachers," as G T Watts suggests. But Watts is right to suggest this possibility, which had not occurred to me. Just as a poor grade means that we failed at getting the material across, so cheating may indicate a serious flaw in our teaching. I will have to re-examine my teaching. And I must thank Watts for this.

Ruth Richardson's historical comment is interesting, but I wonder whether printing the student's name was not a violation of his privacy.

FRANK J LEAVITT
Research fellow

Jakobovits Centre for Jewish Medical Ethics,
Faculty of Health Sciences,
Ben Gurion University of the Negev,
Beer Sheva,
Israel

Careers advice for medical undergraduates

EDITOR,—The provision of careers advice to medical undergraduates seems an obvious necessity. This will become even more important with the new changes to the curriculum (of "core plus options") because students will not get as broad an exposure to specialties.

We are medical students in our final year at the University of Leeds and have for a long time been concerned at the lack of guidance on careers available in medicine. Until recently, there was no careers advice at all. Students and junior doctors with sufficient nous would perhaps approach a senior in a specialty in which they were interested. Such advice, however, would obviously be biased. For many doctors, choice of career seems anecdotally to have been based on chance or hearsay or on their drifting through specialties at senior house officer level.

We believe that objective, formalised careers advice should be available to undergraduates and junior doctors, parallel to that provided for non-medical undergraduates by the university careers services. This should be as broad as possible, covering the various medical specialties, including management, pharmaceutical industry, journalism, and so on, as well as the more conventional areas. We have suggested that a resource room should be made available, and information from the royal colleges, the BMA, and the careers section of the *Student BMJ*, along with details of relevant postgraduate courses worldwide, would form a useful beginning. Perhaps it would also be helpful to have brief statements from a variety of consultants and professors on how they got where they are and what was useful and not in the course of their careers.

An interesting precedent has already been set in

Leeds. Historically, the law department used to deal with careers itself. Now the careers service caters for law undergraduates, and advice given even includes advice on legal specialisation. Perhaps the same could happen with medicine. Proposals along these lines were regarded favourably by the dean and postgraduate dean at Leeds, and recently a regular careers fair has been introduced. We would be interested to hear what other hospitals and medical schools have available for their staff.

SIMON WILSON
Final year medical student
ASHLEY REECE
Final year medical student

Leeds LS6 2HQ

Australia needs an organisation for victims of medical accidents

EDITOR,—It is interesting to see how the improvement in patients' ability to obtain compensation for medical negligence in Australia is triggering the same initial response as was provoked in Britain when work by Action for Victims of Medical Accidents started to have an appreciable effect.¹ In Britain, too, doctors talked of the dice being loaded against the doctor when the opposite was—and, sadly, still is—true. The difficulty in financing an action and finding a competent lawyer and sympathetic medical experts and, finally, the enormous hurdle of the Bolam test ensures that patients have a small chance of succeeding in a medical negligence action. (In the case of *Bolam v Friern Hospital Management Committee* negligence was defined as failure to come up to the accepted standard of medicine as evidenced by a responsible body of medical opinion.^{2,3}) For example, while over four fifths of ordinary actions for personal injury are successful, less than half of actions for medical negligence succeed. In addition, doctors accused patients of damaging the health service by claiming compensation, when the blame lay with the accidents resulting from unacceptable practice and the reluctance of the health carers to address that issue.

Fortunately, the emphasis now seems to have been altered in Britain. We hear less of the complaints and more of the need to address the real problem through initiatives, such as the management of risk, audit, and evidence based medicine; these initiatives should improve standards and thereby reduce accidents and, incidentally, litigation. Perhaps Australia needs an organisation such as Action for Victims of Medical Accidents to concentrate minds.

ARNOLD SIMANOWITZ
Chief executive

Action for Victims of Medical Accidents,
London SE23 3TP

1 Chapman S. "The first thing we do, let's kill the lawyers." *BMJ* 1995;310:1090. (29 April.)

2 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

3 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

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.