Secondly, can the outcome of chronic anterior uveitis be predicted from the subtype of juvenile chronic arthritis with which it is associated? In other words, is there any sense in screening the subtypes at different frequencies? There is no doubt that the risk of developing chronic anterior uveitis varies with the subtype of juvenile chronic arthritis. Children with systemic onset juvenile chronic arthritis, rheumatoid factor positive polyarthritis, or spondyloarthritis are unlikely to develop chronic anterior uveitis, and as such probably do not warrant screening. However, there is little evidence to suggest that the outcome of the uveitis is related to the subtype of the arthritis. The risk of chronic anterior uveitis should determine who is enrolled in a screening programme, but the frequency of screening should be independent of the risk of chronic anterior uveitis and be based instead on the natural history of the disease.³

M Rawes's assertion that joint aspiration for septic arthritis is associated with a poorer outcome because it results in late referral to orthopaedic surgeons is debatable.¹ An urgent diagnostic arthrocentesis may not only decompress the joint space but may also allow the initial choice of broad spectrum antibiotics to be modified appropriately in the light of microbiological evidence.⁴ Rawes also implies that arthrotomy and joint washout is the treatment of choice for all forms of septic arthritis in children. There is evidence that some forms of septic arthritis may be successfully treated with a single aspiration of the affected joint and appropriate antibiotic cover, raising the possibility that arthrotomy may be sometimes an unnecessarily invasive surgical procedure.⁵ For further informed debate on this important subject, Wilson and Di Paola's call for a multicentre, controlled, prospective clinical trial of treatment in childhood septic arthritis must be answered.⁶

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- 1 Correspondence. Complications of juvenile chronic arthritis. *BMJ* 1995;311:569. (26 August.)
- 2 Royal College of Ophthalmologists, British Paediatric Association. *Report of a joint working party: ophthalmic services for children*. London: RCO, BPA, 1994.
- 3 Southwood TR, Ryder CAJ. Ophthalmological screening in juvenile arthritis: should the frequency of screening be based on the risk of developing chronic iridocyclitis? *Br J Rheum* 1992;31:633-4.
- 4 Cassidy JT, Petty RE. Arthritis related to infection. In: *Textbook of pediatric rheumatology*. 3rd ed. Philadelphia: W B Saunders, 1995:489-90.
- 5 Bennett OM, Namnyak SS. Acute septic arthritis of the hip joint in infancy and childhood. *Clin Orthop* 1992;281:123-32.
- 6 Wilson NIL, Di Paola M. Acute septic arthritis in infancy and childhood. *J Bone Joint Surg [Br]* 1986;68:584-7.

Rationing: the case for "muddling through elegantly"

EDITOR,—Chris Ham's editorial on health care rationing misrepresents my position on the issue. He suggests that I subscribe to an approach to rationing by muddling through. My actual position is rather more subtle, hence the description "muddling through elegantly." I emphasise "elegantly" because I do not seek to defend the previous closed system, in which resource allocation decisions were often dressed up as clinical ones and hidden from public scrutiny.

I, too, support greater transparency in decision making, but I don't believe discussions about rationing can be tackled effectively or sensibly in a national debate. Muddling through elegantly starts from the premise that rationing will always be a messy affair. The choice confronting policy makers is as follows: does the inevitability of micro level rationing mean a continuation of the kind of

diffuse, largely invisible, kind of rationing that has characterised the NHS, or is there a need to find ways of holding clinicians to account for what they do and insist on greater transparency in their decision making between them and their patients? The first option is an example of muddling through; the second is an example of muddling through elegantly. I subscribe to the second, which has also been described as an approach based on "pragmatic sensibility."²

Wisely, the United Kingdom has not followed other countries' example in producing a national framework to guide rationing decisions within the NHS. Being too explicit about complex, multifaceted decisions is not axiomatically desirable. It may "result in insensitivity to the complexity of clinical care, to the rapidly changing character of medical knowledge, to the uncertainties of the care process, and to the wide range of situations, needs, and preferences of patients."³

Britain already has the most centralised governmental system in Europe. We need less and better government, not more and worse government. A national debate that seeks to explore the complexity of the rationing issue amounts to a contradiction in terms. A national debate, aided by a media whose interest in health care stops at waiting lists and hospital and bed closures, is likely only to trivialise the issue and allow professionals to evade their responsibilities to individuals and groups. Furthermore, an exclusive focus on rationing diverts attention from another difficult policy problem, which is the need to be much more rigorous in the search for cost effective health care.

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- 1 Ham C. Health care rationing. *BMJ* 1995;310:1483-4. (10 June.)
- 2 Smith I. Ethics and health care rationing—new challenges for the new public sector manager. *Journal of Management in Medicine* 1992;6:54-61.
- 3 Mechanic D. Professional judgement and the rationing of medical care. *University of Pennsylvania Law Review* 1992;140:1713-54.

Setting priorities for surgical waiting lists

EDITOR,—The House of Commons health committee's report *Priority Setting in the NHS: Purchasing* recommends the refinement of targets for waiting times.¹ Now that the worst excesses of waiting have been removed in most areas the time has come to think more deeply about measures of need for surgery.

Waiting lists have been discussed by Culyer and Cullis.² We have ordered waiting lists in Salisbury by using the following variables: progress of disease, pain or distress, disability or dependence on others, interference of disease with normal occupation, and time spent waiting on list. The first four variables must be improvable by surgery. Each variable is scored 0-4. Patients are assessed in outpatient clinics, and default scores typical for the condition are applied, though these may be adjusted for the individual patient. An overall score (using weighting factors derived from a study of priority among 75 patients assessed by both general practitioners and consultants) is generated.

Purchasers can now be much more sophisticated about their requirements for waiting lists; they can state that they do not, for example, want any patients waiting on a list if they have pain uncontrolled by strong analgesics, are dependent on others, or are out of work (in addition to the usual time factor), or they can declare a maximum aggregate score (weighted sums of squares).

We have incorporated this scoring system into software for a system that manages waiting lists (Delian Medical Systems, Princes Risborough)

and that also monitors the resources required to treat patients on the lists. This data base now contributes to the setting of priorities and targets to ensure that patients with the greatest need are treated first and that purchasers and providers are informed about the resource implications of treating patients on waiting lists. Both purchasers and providers can now inspect their lists and discuss, with full facts at their disposal, who should be offered treatment first.

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- 1 House of Commons Health Committee. *Priority setting in the NHS: purchasing*. London: HMSO, 1995.
- 2 Culyer AJ, Cullis JG. Some economics of hospital waiting lists in the NHS. *Journal of Social Policy* 1976;5:239-64.

Homoeopaths and chiropractors are sceptical about immunisation

EDITOR,—Richard J Roberts and colleagues point to several reasons for disappointingly poor response to immunisation campaigns.¹ A further, not well recognised cause is the attitude of some complementary practitioners. One British survey noted that the commonest reason for refusal to immunise was homoeopathy.² Interesting new data come from Austria, where the practice of homoeopathy by non-medically qualified people is illegal. A recent survey shows that only 23% of Austrian homoeopaths believe that immunisation is important.³ The problem also extends to other complementary practices. One third of American chiropractors believe that there is no scientific proof that immunisation prevents disease and that it causes more illness than it prevents.⁴

These cumulative data imply that some complementary practitioners (doctors and non-doctors) put their patients at risk through their attitude towards immunisation. This issue needs to be considered when the safety of complementary medicine and its practitioners is discussed.

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- 1 Roberts RJ, Sandifer QD, Evans MR, Nolan-Farrell MZ, Davis PM. Reasons for non-uptake of measles, mumps, and rubella catch up immunisation in a measles epidemic and side effects of the vaccine. *BMJ* 1995;310:1629-32. (24 June.)
- 2 Simpson N, Lenton S, Randall R. Potential refusal to have children immunised: extent and reasons. *BMJ* 1995;310:227. (28 January.)
- 3 Rasky E, Freidl W, Haidvogel M, Strongegger WJ. Arbeits- und Lebensweise von homöopathisch tätigen Ärztinnen und Ärzten in Österreich. *Wien Med Wochenschr* 1994;144:419-24.
- 4 Colley F, Haas M. Attitudes on immunization: a survey of American chiropractors. *J Manipulative Physiol Ther* 1994;17:584-90.

Reflex sympathetic dystrophy

May be accompanied by involuntary movements

EDITOR,—In the review of reflex sympathetic dystrophy we were particularly interested in figure 3, showing reflex sympathetic dystrophy of the left foot.¹ The affected foot has a curious, intuned dystonic posture; readers are not told whether this was a constant feature. Involuntary movements, including tremor, spasms, and