One of the ways in which health authorities might find out public opinion about priorities for, and views about, health services is by periodically consulting a standing panel that is more or less representative of the local public. Last March we carried out a survey of all directors of public health in Britain to ascertain how many health panels existed and the number of authorities in which the idea of forming a health panel was being considered. Altogether 136 directors of public health were sent a short questionnaire; 101 questionnaires were fully completed (response rate 74%). Twenty five respondents indicated that a health panel had been established in their authority, and a further 25 indicated that plans existed to create new health panels (in seven authorities these plans had reached an advanced stage).

Our sample may have been biased, but even if all the non-respondents worked in health authorities that did not use panels our results would still indicate that panels are now a widely accepted means of gathering public views about health care. Nevertheless, it is debatable whether the spread of such panels is desirable. No matter how carefully populations are sampled, selective participation may make responses less representative. Arguably, however, the responses would be less selective than responses from groups of patients' or appointed bodies such as community health councils. Attrition of members of the panel may not, however, be random, with the result that a sample will become progressively less representative. Thus panels may not only be more expensive than one off surveys or other means of eliciting public opinion but they may provide less valid answers. Possibly, too, the fact that someone is a member of a health panel may result in his or her views changing: as members become more informed they may become more like professionals in the way that they make decisions. This may be good or bad, depending on whether it results from a true understanding of a problem or from indoctrination into the current way of clinical thinking.

Many of the issues affecting panels—for example, possible systematic changes in expressed opinions with attrition of the members—can be studied through empirical research. As more panels come into existence a study of their characteristics and behaviour becomes more urgent.

T DOWSWELL

Research fellow

R J LILFORD

Professor of obstetrics

Institute of Epidemiology and Health Services Research, University of Leeds, Leeds LS2 9LN

S HARRISON

Senior lecturer in policy studies

K MCHARG

Market research officer

1 Bowling A, Jaboson S, Southgate L. Explorations in consultation of the public and health professionals on priority setting in an inner London health district. *Soc Sci Med* 1993;37:851-7.

2 Harrison S, Hunter D. *Rationing health care*. London: Institute of Public Policy Research, 1994.

3 Hopton JL, Dlugolecka M. Patients' perceptions of need for primary health care services: useful for priority setting? *BMJ* 1995;310:1237-40.

Analgesic effects of sucrose were known to the prophet

EDITOR,—Muslim doctors in Britain will have been interested to read Nora Haouari and colleagues' paper showing the analgesic effects of sucrose.¹ Practising Muslims all over the world rub pieces of chewed dates inside the mouth of newborn babies before circumcision on the grounds that the last Prophet Muhammad did this many times to newborn children.

Copying the prophet in all his actions (Sunnah) and obeying all his sayings (Ahadith) are basic to our belief, and the medical wisdom of giving dates (which are 70-80% sugar in the form of glucose and fructose) before circumcision is clear. I recom-

mend that the authors should investigate the use of sugar from dates in their trials of sugary substances as analgesia.

A MAJID KATME
President

Islamic Medical Association,
London N4 2DA

1 Haouari N, Wood C, Griffiths G, Levene M. The analgesic effect of sucrose on full term infants: a randomised controlled trial. *BMJ* 1995;310:1498-500. (10 June.)

BMJ should review its policy on reprints

EDITOR,—Richard Smith and Tony Delamothe wish to further the dream of their distant predecessors who wrote: "Those whom seas sever and distances divide the *BMJ* now joins in close communion and frequent converse on common... scientific interests."¹ We wonder how they reconcile these sentiments with the BMJ Publishing Group's policy of charging authors for reprints of published articles.

Reprints are vital in parts of the world without photocopiers and in some areas are the only source of scientific information.² The circulation of reprints fosters a spirit of solidarity among scientists² and is an efficient way of obtaining copies of a large number of articles.³ Sadly, European reprints are in terminal decline, and the BMJ Publishing Group seems indifferent to their demise.

Many medical journals, including the *Lancet*, provide authors with up to 100 reprints free of charge, but this is not the case with journals published by the BMJ Publishing Group. Authors are unwilling to fund the cost of reprints and for their own record will often settle for a photocopy. They cannot, however, provide photocopies in lieu of reprints to other people without breaching copyright.⁴ Consequently, those working in less privileged countries are seriously disadvantaged. The BMJ Publishing Group's policy causes greatest hardship to those in greatest need.

Last year, Kale reported on a conference held at BMA House, entitled "Getting information from the developed to the developing world." He highlighted the paucity of relevant health information in developing countries and in eastern Europe, discussed the inefficiency of various methods of distribution, and included a plea that systems for transferring information that "allow people [in such areas] to select the material themselves." Reprints were not mentioned.

It is to be hoped that global development of electronic means of publishing and distribution will reduce inequalities in access to medical and scientific information. In the meantime, the BMJ Publishing Group could show that it recognises the importance of reprints by reviewing its policy of charging for them.

DAVID CUMMINS
Consultant haematologist
RICHARD M OSBORN
Library manager

Harefield Hospital,
Middlesex UB9 6JH

1 Smith R, Delamothe T. The BMJ family. *BMJ* 1995;310:1550-1. (17 June.)

2 Liberski PP. Reprint solidarity. *Nature* 1990;343:586.

3 Martin-Iverson MT. Why reprints are necessary. *Nature* 1989; 337:594.

4 Dworkin G, Taylor RD. *Blackstone's guide to the Copyright, Designs and Patents Act, 1988: the law of copyright and related rights*. London: Blackstone, 1989.

5 Kale R. Health information for the developing world. *BMJ* 1994;309:939-42.

**The BMJ Publishing Group does not provide free reprints to its authors because printing reprints is expensive, and we think that the costs outweigh the benefits. We would rather spend the money on providing free subscriptions to some centres in the developing world. As copyright

holders we have no objection to authors sending photocopies of their articles to individuals in the developing world who could not otherwise easily obtain them.—EDITOR

Concern about "lookback" exercise for hepatitis C

EDITOR,—Nigel Higson expresses concern about the national "lookback" exercise being undertaken to detect recipients of blood donations originating from donors subsequently found to be positive for hepatitis C virus. Those of us in the transfusion service who are supervising the lookback exercise share several of Higson's concerns. Specifically, the counselling of patients who have been exposed to hepatitis C through blood transfusion requires knowledge about the disease and experience of notification, pretest counselling, and support after the test. On the other hand, no new resources have been made available for this exercise. In many cases, general practitioners have indicated that they are inadequately equipped to deal with the task, and the burden has then fallen on the clinical staff at transfusion centres, who have the necessary skill and experience but no additional resources. Furthermore, the concentration of the workload on the transfusion centre can lead to disadvantages for the patient, who may have to travel long distances to meet an unknown clinician, who will be transmitting information that is bound to lead to anxiety and worry. In many circumstances this would best be done by a person who has knowledge of the patient and his or her medical history and personal circumstances.

A further concern is that many of the recipients who have been identified through the exercise are elderly. Not only are they unlikely to suffer any important consequences of hepatitis C infection, given the long time that symptoms take to develop, but they are the patients least likely to benefit from being transported to a site distant from their home to be interviewed by a person they have not met before and will never see again. There is no easy answer to this problem. In my experience of supervising a lookback exercise in two transfusion centres and involving close on 2000 blood components that must be traced through to recipients, discussion between the general practitioner and the clinician at the transfusion centre can often lead to a reasonable compromise that puts the patient's interests first.

The transfusion service has never advised that people who have received a transfusion and are not contacted through the exercise can be reassured. It has always been accepted that the exercise will be incomplete since hepatitis C is likely to have existed in the donor population throughout the 1980s, when tests were not available. Higson's solution, of offering testing for all recipients, would not produce complete results either. A considerable proportion of recipients are unaware that they have received a blood transfusion. These are usually patients who received the transfusion during surgery or emergency treatment. Furthermore, the fact that blood has been transfused is not necessarily noted in the hospital discharge letter. We have always advised general practitioners and concerned recipients that those who know that they have had a blood transfusion and are concerned about the possibility of hepatitis C can be fully reassured only by having a blood test. We should not pretend, however, that this will identify many more infected recipients than the targeted lookback programme currently in progress.

PATRICIA HEWITT
Acting medical director

North London Blood Transfusion Centre,
London NW9 5BG

1 Higson N. Concerns about "lookback" exercise for hepatitis C. *BMJ* 1995;311:953. (7 October.)