that refuse to allow free dissemination of their abstracts (even though these are readily available to the CD-ROM services) and, secondly, to ask whether the BMJ Publishing Group could exert some influence on other publishers. Is there no way that publishers could get together, if only in the interests of standardisation of policies? Could not all publishers agree that abstracts should be as free from constraints as reference citations?

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*Although abstracts of scientific articles enjoy the same copyright protection as the articles they summarise (except in the United Kingdom), publishers of scientific periodicals have traditionally made them available to abstracting and indexing services without charge. Over the past few years, however, there has been a huge increase in the number of requests to use abstracts in various electronic products: diskettes, CD-ROMs, and online services. Many medical journals have also introduced structured abstracts. These changes are causing publishers to rethink. They are also worried that with digitisation they may lose control over the use and even integrity of their abstracts. We may thus see more publishers either refusing permission for their abstracts to be used or levying a fee for digital use; but it is very much the policy of the BMJ Publishing Group whenever possible to make all our material available as cheaply as possible, especially to doctors and others working in very poor countries.—EDITOR

Reasons for increased incidence of tuberculosis

EDITOR,—A Hayward and colleagues¹ disagree with our conclusion that the 12% increase in the incidence of tuberculosis in England and Wales between 1988 and 1992 affected the "low risk" white and West Indian communities as well as the "high risk" Indian subcontinent, African, and refugee communities.² They restate our conclusion that the data on incidence by local authority districts in England and Wales are uninformative on this point because the increase was concentrated in poor districts and ethnic group and poverty are highly correlated across districts. Data on incidence over time according to ethnic group are necessary to examine the issue, and such data were available for the London Borough of Hackney.

It was possible to assess changes over time in the size of the ethnic minority communities by using census data for 1981 and 1991 as an unpublished survey by Hackney Borough Council after the census in 1981 showed that the country of birth of the head of household was then an accurate estimate of the ethnic origin of people in Hackney. The data for Hackney showed that the proportionate increase in incidence affected white, West Indian, and Indian subcontinent residents equally. The cases occurring among the relatively large African and refugee communities in Hackney accounted for less than half the increase in cases from 1988 to 1992.

The accuracy of our estimates of the size of these communities is not relevant here; there is no doubt that in most other socioeconomically deprived districts these communities are smaller or non-existent, so there will be even fewer cases than in Hackney. Perhaps the simplest evidence that tuberculosis has increased in white people comes from the Irish data we cited³: the Republic of Ireland has few non-white residents but recorded a greater increase in tuberculosis (16%) than that in England and Wales (12%).

While the recent increase in tuberculosis did occur in white people, the disease remains far more common in certain ethnic minority groups. The data of M J Doherty and colleagues on incidence in London boroughs in 1991 confirm this,³ but they are uninformative on the ethnic mix for the increase between 1988 and 1992.

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Ethical imperative to publish extends to academics too

EDITOR,—I support John Pearn's view that publication of research findings is an ethical imperative.¹ The medical community at large can assess the status of something only if all the relevant information is available.

The pharmaceutical industry is often accused of selective publication of results, and there is some truth in the accusation. There is just as much truth, however, in the charge that academics also fail to publish important items of information. They may not be driven by financial conflicts of interest, but to an academic career other forms of conflict are likely to be just as important, but these tend to be ignored by those drawing up guidelines. The urge to ensure the survival of a point of view with which an academic has become identified is often a stronger driving force leading to bias than is any possible financial gain or loss.

In the context of the pharmaceutical industry I believe that all the research done by a company in both toxicological and clinical areas should be freely published. There are, however, genuine but relatively easily surmountable reasons why this is not a sensible policy for any company that respects, as it must by law, the interests of its shareholders. When a company applies for approval for a new drug in the United Kingdom the law provides that the company's dossier should remain confidential for 10 years. Most other countries have similar laws providing for protection for between six and 10 years. This means that during this period the regulatory authorities cannot use the information in the company's files to license generic copies of the new drug.

If the information in these files is published, however, then the regulatory authorities may decide that there is sufficient information in the public domain for a generic licence to be issued before the expiry of the 10 year confidentiality period. If a product does not have full patent protection then it is in the company's commercial interest not to allow publication before expiry of the 10 year deadline. This is clearly not in the interest of the wider medical community or the public. The situation could easily be corrected. A statement from the European Medicines Evalua-

tion Agency, endorsed by all member countries, could be made to the effect that published material would not influence licensing decisions during the 10 year confidentiality period. This would eliminate a major reason for the non-publication of material by pharmaceutical companies.

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1 Pearn J. Publication: an ethical imperative. *BMJ* 1995;310:1313-5. (20 May.)

100 years of x rays

EDITOR,—I think it pertinent to mention the importance of the discovery of x rays in another area that has affected our medical lives, besides those areas mentioned by Daniel J Nolan.¹ The news took some time to reach South Australia: all communication took six weeks by boat. The discovery was exciting for my grandfather William Bragg, who was professor of physics at Adelaide University, and figure 1 shows an x ray picture of his hand, dated 1 June 1896. The abnormality of the little finger is a result of a childhood injury. That same summer his son, William Laurence Bragg, who was a toddler, broke his left elbow. I believe that the x ray film of his arm, obtained in 1896, was the first film to be used to diagnose a fracture in Australia.

Both Professor Bragg and his eldest son (later my uncle) became increasingly fascinated by x rays, and this led to the birth of x ray crystallography. In 1915 they shared the Nobel prize for their discovery of the structure of salt. From the beginning my uncle, later Sir Laurence Bragg, foresaw the possibility of discovering the structure of biological chemicals, seeing the excitement of working out biological enzymatic reactions from a structural perspective. I remember visiting the Davy Faraday Research Laboratories at the Royal Institution in the 1950s, just as the structure of lysosyme was being discovered.

Sir Laurence went on to supervise the work of Crick and Watson when they discovered the double helix in Cambridge, and this was the crowning of his career in x ray crystallography: his original vision had been fulfilled. It was a joy to him to travel to Stockholm to celebrate the 50th

FIG 1—x Ray picture of Professor William Bragg's hand, obtained in 1896 (reproduced from reference 2 by permission; source—Flinders Medical Centre, Adelaide, Australia)

FIG 2—Postage stamp celebrating 50th anniversary of award of Nobel prize to Professor William Bragg and his son, Sir Laurence Bragg (reproduced from reference 2 by permission)

anniversary of his original prize in 1915, and figure 2 shows a celebratory postage stamp.

Thus Röntgen's original discovery has borne fruit in medical fields far wider than the diagnostic techniques we now use.

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Anti-therapeutic community mental health law

EDITOR,—The defence by K C Calman, the chief medical officer, of the government's Mental Health (Patients in the Community) Bill seems to be based more on hope than on clinical argument.¹ It is also contradicted by the Department of Health's internal review of legal powers on the care of mentally ill people in the community, which preceded the drafting of the bill.² This stated that, although the department believed that wider use of guardianship might help some patients, "we cannot see guardianship offering a ready answer to the problems of the patients with whom we have been concerned." Aftercare under supervision, however, amounts merely to "guardianship, fortified with the power to convey."

Neither I nor Calman can support our expectations of the clinical impact of the bill by reference to clinical trials. This contrasts with the introduction of supervision registers, for which piloting would have been possible and should have been pursued. Calman offers no clinical argument, however, that influence over patients will be enhanced by enforced conveyance to a place "for medical treatment, occupation, education or training" in the absence of the power to treat. Is setting such a weak and confusing clinical boundary likely to enhance patients' compliance with treatment?

Calman rebuts my criticism of the bill—that it fails to offer resources in exchange for further restriction of civil liberties. Clause 1(1)25A(4)(c) of the bill says, "being subject to after-care under supervision is likely to help to secure that [the patient] receives the after-care services to be so provided." I would emphasise that adequate resources are required for this principle to be satisfied. Ordinary guardianship orders are often resisted by local authorities specifically because of their implications for resources, emphasising the frequent inadequacy of community resources. Ironically, some clinicians have suggested that the bill might allow adequate health and social service resources to be obtained by overtly showing unmet need. The doctor would simply record in the case notes, "I would have applied for aftercare under

supervision for this patient, but I was unable to legally do so because the aftercare services were inadequate."

Since forced conveyance is likely to be perceived as anti-therapeutic, and sometimes even as dangerous, aftercare under supervision will be reduced to a mechanism for encouraging proper case reviews. It must not be perceived as a means by which patients in the community can be directly controlled. There is a deep divide between legislating for care in hospital and in the community.⁴

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Telephony remains useful in medical informatics

EDITOR,—Enrico Coiera¹ and Paul McLaren and C J Ball² point out that even in the midst of recent technological advances the telephone remains a valuable tool for doctors. We have recently shown that, in north London at least, the telephone's potential for improving communication between consultants and general practitioners has not been realised.

We sent a questionnaire to 100 local general practitioners to determine the number of telephone calls from a consultant that each general practitioner had received in the preceding month and whether he or she would like to receive more such calls. We also determined how easy it was to contact general practitioners by studying the telephone calls that we made to general practitioners over nine months.

There was a 93% response rate to our questionnaire. Fifty eight general practitioners had received no telephone calls from a consultant in the previous month, and only 12 had received more than one such telephone call. Eighty three respondents wished to receive more calls, with 78 specifically stating that they did not mind being interrupted in a busy surgery about an important matter. General practitioners were generally easy to contact by telephone. Contact was made within five minutes in 49 of the 75 calls we made and within 24 hours in 63 calls.

We found that general practitioners appreciate telephone discussions with consultants when important or pressing matters about one of their patients arise. Although the general practitioners were usually easy to contact by telephone, they received few calls from consultants. We look forward to joining the Internet when the British Paediatric Association gets its home page. Nevertheless, we are confident that even when the Internet is established in medical practice the telephone will remain a powerful way for general practitioners and consultants to communicate with each other.

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Should older women be offered in vitro fertilisation?

Authors' premise is faulty

EDITOR,—In concluding that "it is not right to withhold fertility treatment on the grounds of the interests of the potential child" on the premise that existing will always be preferable to non-existing, Tony Hope and colleagues are guilty of false logic.¹ They wonder whether it is better never to have existed than to be born and have one's mother die while young. Their error is in attributing interests to a being that does not exist and then weighing these interests against the interests of a being—that is, the potential mother—who does exist.

If their argument holds, then all parents of whatever age are under a moral obligation to have as many children as possible by whatever means medical science can provide and to turn thousands of hypothetical babies into real babies on the grounds that it is better to be real than hypothetical. This conclusion is logical given their premise, but their premise is faulty. Anyone who saw a television documentary on the "dying rooms" in China's orphanages (*Secret Asia*, "The Dying Rooms," C4, 14 June 1995) might consider that humanity might have been served better if those wretched and unwanted babies had been left as hypothetical ones.

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Counselling may be a better use of resources

EDITOR,—The ethical debate on in vitro fertilisation for older women and the interests of the potential child¹ attracted considerable attention in the media, although the media failed to report that age cut offs have primarily been instituted on the basis of effectiveness. We agree that if the take home baby rate after in vitro fertilisation among older women were to improve then there would be a case for re-evaluating guidelines. We accept that if the interests of the child are important then the age of the father and comorbidity affecting the parents' life expectancy or ability to care for the child should also be considered. Age cut offs may become less of an issue as the current cohort of infertile couples requesting in vitro fertilisation either receives treatment or gives up the attempt to have children. In the future, the backlog of couples requesting treatment will have been cleared and referral will mainly be for incident cases of infertility, although some older women in second marriages may request treatment.

Tony Hope and colleagues point out that criteria for adoption are strict, although they argue that the case for in vitro fertilisation is different from that for adoption since the infertile couple are the only potential parents for the as yet unconceived child. We see no reason why strict though rational criteria should not be in place for in vitro fertilisation. If health authorities allocate resources to assist in the birth of a finite number of children then couples have to compete for one of these limited courses of treatment. Couples need to justify why they should have assistance to conceive their potential child in preference to other couples. Effectiveness and ability to care for the child in its formative years may be among the factors to be considered. The suggestion that we might "choose between 'competing' couples, on the basis of seeking to maximise the number of happy children made per pound spent," is actually an argument for investment