mobility. A reduction in dependence is a notable feature to aim for to decrease the level of disability. Even though patients who are able to walk after amputation may become wheelchair dependent within five years, they have a good quality of life for up to five years and may maintain this from a wheelchair.

The suggestion that it is best to forgo prosthetic rehabilitation and issue a wheelchair to elderly patients who have had a lower limb amputated is incorrect. Minerva is right, however, to say that the home environment needs to be adapted for wheelchair independence.

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Scientific and letter fraud in the Victorian era

EDITOR,—The issues of scientific and letter fraud^{1,2} were closely linked in the Victorian era, as is exemplified by the actions of Sir Edwin Chadwick and Sir John Simon. These two men dominated public health and were known for their unusual approaches.

Chadwick was influential in government circles. He packed committees with people sharing his views and altered the results of investigations.³ Simon, the chief medical officer and an opponent of Chadwick, refrained from airing his differences with the government in public.⁴ Nevertheless, he believed strongly that the political issues needed to be debated openly. By sending anonymous letters to the *Times* he ensured a balanced public debate of crucial issues, such as the registration of medical practitioners, without undue bias from the influence of his position.⁵

Whereas Chadwick might be chastised for scientific fraud, Simon should not be associated with letter fraud. Unsigned contributions still have a place in peer reviewed professional journals, whether as letters to the editor, viewpoints, or editorials.

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A living will is not euthanasia

EDITOR,—We were concerned to read Ian Robertson's description of living wills.¹ He states that they are "quasilegal," but this is untrue. In the landmark Canadian case of *Malette v Shulman* Dr Shulman was found liable in battery for ignoring Mrs Shulman's advance refusal of treatment.² In the more recent English case of *Airedale NHS Trust v Bland* three judges in the House of Lords confirmed the legal effect of advance statements.³

Robertson states that "the whole concept of the living will is...based on the very naive notion of the basis of motivation, emotion, and intent in the human mind." In fact, the basis of the living

will is the principle that any adult has the right to refuse medical treatment for reasons that may be "rational, irrational or for no reason"⁴ and that "the same principle applies where the patient's refusal has been expressed at an earlier date."⁵ If this is what Robertson means by "motivation, emotion, and intent" then we would take issue with his description that such factors are "very naive."

Robertson confuses living wills with euthanasia. Euthanasia is illegal in Britain, and a living will cannot demand an illegal act. An adult of sound mind can, however, legally refuse any medical treatment, including nutritional support and hydration. A living will that refuses life supporting treatment under certain circumstances does no more than allow a mentally competent person to extend his or her present rights to a future period when he or she no longer has the mental capacity to make decisions.

To argue that injury to the brain changes one person into another is to strike at the heart of individual autonomy. It leaves the fate of the mentally incapacitated adult entirely in the hands of his or her doctor, whose judgment about treatment might be far from what the person would have desired.

No adult is obliged to complete a living will. But it is surely right that a legal mechanism exists to allow mentally competent adults to make advance refusals about medical care that will be respected if they later lose the capacity to make those decisions themselves.

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Accident and emergency doctors lack proper training in trauma

EDITOR,—Since the Royal College of Surgeons reported on 1000 deaths from trauma in 1988¹ the upgrading of trauma care in Britain has been widely debated. Training in advanced trauma life support (ATLS) is seen by many people as a vital part of this upgrading process.^{2,3} Skinner, writing on behalf of the Royal College of Surgeons in 1993, stated that "all doctors involved in the initial resuscitation and subsequent management of patients with major injuries should possess a current ATLS provider certificate from the RCS."⁴ Senior house officers form the majority of the workforce staffing accident and emergency departments. They should be trained in advanced trauma life support in accordance with the college's guidelines.

Thirteen major accident and emergency departments provide trauma care for the several million people who live in the Southwest region. An audit was conducted in June 1994 to establish the proportion of senior house officers working in accident and emergency in the region who had a certificate in advanced trauma life support. The audit was repeated 12 months later. It was found that only 11 (16%) of the 68 senior house officers working in the 13 departments in 1994 and only nine (11%) of the 70 working there in 1995 had a certificate in advanced trauma life support.

There are several possible reasons for this lack of certification. The Royal College of Surgeons' data on the career stage at which doctors received their

training in advanced trauma life support suggested that only 0.25% were trained before full registration. Most senior house officers work in accident and emergency in their first or second post-registration job and hence have not had access to a course when they start their job. The problem is exacerbated because having passed a part 1 examination of a recognised college is a prerequisite for being allowed on to many courses. Many senior house officers are on the waiting list for courses while doing their accident and emergency attachments, but waiting times can be up to a year, and in a lot of cases trainees have moved on from accident and emergency before they receive their training. This is despite the expansion in the number of courses available.

The principles of advanced trauma life support help relatively inexperienced doctors to deal with complicated clinical situations in a controlled and structured way.⁵ They thus improve the overall standard of patient care. Senior house officers working in accident and emergency should be trained in advanced trauma life support; a gold standard would be certification as a prerequisite for applications to work as a senior house officer in accident and emergency posts, or official training in advanced trauma life support could be built in to induction courses in accident and emergency. To achieve this, access to the courses needs to be improved. This has major implications in terms of resources.

We are conducting a national audit to record the numbers of senior house officers in Britain who have been trained in advanced trauma life support. It will be interesting to see if the figures from the south west reflect a more widespread problem.

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Review of prescribed treatment for children with asthma

Weaknesses in methods and analysis limit conclusions

EDITOR,—Analysis of a computerised prescribing database showed that 9362 children were prescribed some form of preventive treatment for asthma. Of these, 1358 received sufficient repeat prescriptions to suggest that they were consistently receiving prophylactic treatment.¹ Several weaknesses in this analysis limit the interpretation and conclusions reported.

Firstly, the author assumes that all children remained on the practice list for a whole year. Morton-Jones and Pringle estimated that 30.6% of people on a practice list registered or de-registered within one year.²

Secondly, there is an implicit assumption that asthmatic patients require preventive drugs continuously, and this may indeed be stated in guidelines. Some, however, will be newly diagnosed during the year, while for others the problem will no longer be active and treatment will be stopped. The increased proportion of patients using inhaled steroids and the decreased proportion using inhaled sodium cromoglycate identified during this study emphasises the dynamic nature of patient management. In addition, there will be