acute viral infections may be great enough to suppress allergic symptoms partially or even completely. Needless to say, viral infections which produce upper respiratory tract infection may result in a recrudescence of asthmatic symptoms."[6]

[1] Cornil, A, *et al*, *Acta Endocrinologica*, 1968, **58**, 1.
[2] Ramaekis, L H J, Theunissen, P M, and Went, K, *Archives of Disease in Childhood*, 1975, **50**, 555.
[3] Wexler, B C, *Metabolism*, 1963, **12**, 49.
[4] Cope, C L, and Black, E, *British Medical Journal*, 1958, **1**, 1020.
[5] Melby, J C, *New England Journal of Medicine*, 1971, **295**, 735.
[6] Minor, T E, *et al*, *Journal of the American Medical Association*, 1974, **227**, 292.

The end of excellence?

SIR,—I was interested to read the letter from Mr N D W Weaver (1 January, p 47), in which he thought that the output of articles from teaching or university hospitals "seemed to prove" Dr Terry Davies's point in his open letter to Sir Alec Merrison (4 December, p 1376) concerning "the singular contribution of teaching hospitals as centres of excellence and initiation in research and treatment."

Mr Weaver undertook a "random survey" of the contributions (articles) in the 4 December issues of the *BMJ* and the *Lancet*. In point of fact he surveyed the totality of signed articles and the randomness, if any, lay in the selection of the two issues. One would be interested in the method used to ensure that the two journals were truly randomly selected. This is not the type of statistics one would expect from a "centre of excellence." To me only one fact has been established by this survey—that is, that there was a disproportionately large number of articles and letters from teaching hospitals, university hospitals, and research units in those two issues. The reason for this must still be sought. It may be that it is because they are "centres of excellence"; it may be editorial bias; it may be that other centres are not guided by the imperative "publish or perish"; it may be that other medical units do not have the time, personnel concentration, finances, and equipment to be able to undertake the work necessary to author such articles. The use of the term "centres of excellence" implies that all other centres are "centres of non-excellence," but indeed it is such centres which are required to provide a medical service for the main mass of the population. That is the point which the public appreciates—not the efflux of papers from teaching institutions.

If I may conclude by offering a similar type of "deduction" using the 1 January issue of the *BMJ* I note that that issue contains nine obituaries, not one involving a doctor who had worked at a teaching hospital. May we therefore assume that one of the byproducts of working at a "centre of excellence" is immortality?

F M SHATTOCK

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Liverpool School of Tropical Medicine,
Liverpool

SIR,—I too am an advocate of the retention of teaching hospitals as "centres of excellence," but I cannot allow the letter from Mr N D W Weaver (1 January, p 47) to go unchallenged. It would, indeed, be surprising if the teaching and university hospitals did not produce the bulk of published research—it is there that staff and facilities are concentrated. This proves precisely nothing about their value, in whatever terms this may be assessed, unless one puts a higher worth on knowledge for its own sake than on any other consideration—a position difficult to justify. The country and the world need both doctors who are interested in pushing back the frontiers of knowledge and those whose main or only interest is the welfare of individual patients—just as we need both district general hospitals and "centres of excellence." The problem, to which I do not offer a solution, is to decide on the balance between the two, given that suboptimal levels of both are unavoidable.

P R FLETCHER

Bristol

SIR,—Nearly 20 years ago I heard that in a university hospital in the USA research output was assessed (and charted on a rising graph) by weighing the reprints of publications each year, but I never seriously thought I would see excellence measured by counting publications in the *BMJ* and the *Lancet* by source.

Mr N D W Weaver (1 January, p 47) must remember that just because a teaching hospital writes about a method of treatment (for example, management of Hodgkin's disease) it most certainly does not mean that this treatment is not already being carried out in many non-teaching hospitals.

ROGER HOLE

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The reprint game

SIR,—Especially since the photocopier has become widely available I have been increasingly baffled by receiving postcard requests for reprints from all parts of the world and the United States in particular. Most of these postcards bear every sign of having been filled up by a secretary and many have a printed signature. Recently I was doubly baffled to receive at least 10 requests (four from the UK) for reprints of an article when in fact I had not written an article; there had merely been a short letter from me in a medical journal.

With a photocopier one can be sure of obtaining immediately the desired article. After sending for a reprint there is bound to be a delay, perhaps of many weeks, before it arrives and there is a large chance that it will never arrive, as many requests for reprints go straight into the wastepaper basket. Why do people spurn the certain method of obtaining what they want and instead employ a highly unreliable method which puts authors to trouble and expense?

Can you, sir, explain this remarkable phenomenon? And if you cannot, can any of your readers? Perhaps some of those who instruct their secretaries to send for reprints will answer the points I have made. For I feel sure that I am not unique in wishing for an explanation of this reprint game.

JOHN W TODD

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**The making of a photocopy of a published article for *personal* use does not infringe the copyright laws and most medical libraries, including the BMA library, will supply such photocopies on payment of a small fee. Many authors now make it their practice to ignore all requests for reprints other than those from personal friends, libraries, and individuals in remote areas whose access to journals and photocopying services is likely to be restricted. —ED, *BMJ*.

Thrombosis statistics

SIR,—Dr S E Browne (11 December, p 1452) has made an important point concerning the reliability of statistics on the thromboembolic complications of oral contraceptives. There is little doubt about the under-reporting of such complications to the Committee on the Safety of Medicines.

At the Radcliffe Infirmary, Oxford, during 1972-4 72 women aged 15-45 years were seen with clinically suspected deep vein thrombosis (DVT) of the lower limb. Ascending venography was carried out on all patients. The results were as shown in the table.

Result of venography for DVT	Oral contraception	
	Yes	No
Positive	14 (28%)	6 (26%)
Negative	35	17
Total	49	23

Without venography the number of DVTs that might have been regarded as associated with oral contraception would have been exaggerated almost four-fold. It may be that a DVT is more likely to be diagnosed clinically in a woman with leg symptoms if she is also taking oral contraceptives.[1]

The under-reporting of DVTs secondary to oral contraceptives therefore may be balanced partly by a number of unsubstantiated but reported clinical diagnoses.

DAVID A TIBBUTT

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[1] Tibbutt, D A, Williams, E W, and Faulkner, T, *British Medical Journal*, 1973, **4**, 737.

BUPA and the long-stay patient

SIR,—The very thoughtful letter addressed to you by Dr R G Cooper and Mrs L A M Ford (18 December, p 1505) calls for some comments for which I hope you will find space.

Ably put as it is, their argument is nevertheless based on a false premise. The benefits paid by all the UK provident associations are, and always have been, related to acute medical or surgical illness calling for specialist intervention and usually requiring a short term as an inpatient. History establishes this. When BUPA was first formed the maximum period of accommodation benefit was six weeks in a subscription year. As time went on this was extended to 10, 13, and then 26 weeks. When, a few years ago, it was decided to provide cover for 52 weeks this was intended to apply to the comparatively rare cases, such as severe road accidents, in which active treatment is indeed required for a very long time. It was certainly not in order to provide permanent residential accommodation for elderly people needing custodial care, some nursing, and medication. For this to be made available it would be

necessary to raise subscription rates to astronomical levels.

The figures quoted by Dr Cooper and Mrs Ford in this particular case are most confusing, and my respectful advice to them is that they would do the patient a kindness, not an injury, by completing the questionnaire and so enabling her position to be properly investigated. I have never heard of a "half-amenity bed," but the cost of an ordinary amenity bed is £3 per day, which amounts to £1095 pa. If she is really being charged £4146 pa something is wrong. If from BUPA she receives only £240 pa it is apparent that she must be a subscriber to the old Standard Scheme and has ignored the advice given to her year after year that she should transfer to the Unit Scheme. Under the former, which was closed to new subscribers many years ago, benefit is payable only for 13 weeks in the subscription year; which both explains why her total benefit has been so limited and confirms that she could not have been justified in believing that she was covered, as your correspondents suggest, against "all eventualities."

D V DAMERELL
Chief Executive,
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London WC2

"Nurse consultants"

SIR,—May I again use your columns to reassure Miss J Kelly (1 January, p 49) that I am neither a Rip Van Winkle nor am I God-like? I am well aware that people outside hospital do call themselves "consultants" and rightly so, but Miss Kelly must agree with me tacitly, for in her last sentence she refers to nurses "continuing to aid and abet the consultant." She must mean the medical consultant, but if nurses can call themselves consultants as well, would the old and frightened patients she mentions know to whom she refers?

D EYRE-WALKER

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SIR,—When I read the letter by Dr D W Eyre-Walker (4 December, p 1386), I thought a reply was not called for, as this may be one isolated view. However, I was most surprised at the apparent hysteria which appeared in your letter pages (25 December, pp 1558, 1559, and 1565).

Can Dr D M Bowers be serious when he states that it is a bigger crime to be disliked by a nurse than it is to kill a patient? And his remark concerning nurses "reporting on medical staff" is certainly new to my knowledge, as surely in any dispute between a doctor and nurse it is the truth that should be sought. Perhaps Dr Bowers resents the passing of the "doctor must always be right" philosophy.

I accept that there may be a case against the development of clinical nurse consultants/specialists, and I must agree with Dr D J Pearce regarding the nonsensical verbiage of the job description that he illustrates. There is, however, an equally strong case for the development of clinical nurse specialists. The concept of the clinical nurse specialist is that of an expert practitioner in nursing with considerable knowledge, a high degree of skill, and extensive experience in the care of patients in the specialty concerned. Care is always essential even if effective treatment and cure cannot always be achieved. This differs from the primary task of the doctor, who is concerned mainly with treatment and cure. The nurse participates in therapy by carrying out the medically prescribed treatment and reporting on its effect, but in the area of care the nurse herself is the prescriber. In order to fulfil this unique role nursing knowledge needs to be developed in depth and the skills of the experienced nurse need to be utilised to the full.[1]

The nursing profession has weathered two major changes in less than a decade, the introduction of the Salmon management structure and the reorganisation of the NHS. Each of these changes has been administrative in character and it might well be argued that we have suffered as a basically clinical profession from managerial mediocrity. Many of us in the nursing profession now want changes which will affect the practice of nursing at a clinical level and provide opportunities for the nurse to develop her career without leaving the clinical scene. By so doing we should be able to improve the standards of care delivered to our patients.

At this hospital we have clinical nurse specialists in stoma care, intravenous therapy, infection control, and our breast unit. None of these positions has weakened the traditional role of the ward sister or interfered in the relationship which exists between the patient and his medical practitioner. Rather it has helped to promote a caring environment in which the patient, doctor, nurse, and paramedical staff participate as a therapeutic team.

ROBERT TIFFANY
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[1] Royal College of Nursing, *New Horizons in Clinical Nursing*. London, RCN, 1975.

**This correspondence is now closed.—ED, *BMJ*.

Safety of children in cars

SIR,—There appears to be a real danger of setting the standards of child restraint in cars (leading article, 1 January, p 2) so high that few people will use any method at all.

My experience is that the British Standard seat belts for children with the conventional four-point restraint will allow only two seat belts to be fitted to the back seat of an ordinary saloon car (I am not referring to methods for infants but for children aged 4-12). If there are more than two children to be carried some suppliers will refuse to fit restraints as the British Standard will not be correctly observed.

I feel sure that any reasonable restraint is better than none and also that provision needs to be made for varying numbers and sizes of children being carried. A restraining system that will cope with this cannot be based on fixed belts with four-point anchorage, because of the amount of space they take up.

I suggest a strap anchored about 15 cm (6 in) above the level of the back seat, parallel to it, and a detachable harness consisting of a waistband and a crotch strap which could be attached by a buckle in such a way as to exclude sideways movement. With this system four children could be easily accommodated and possibly five or six if the attaching straps were varied in length to allow some to sit forward and some to sit back. An advantage of the waist anchorage is that it would reduce "whiplash" injuries to the neck, transferring the force to the lumbar spine, which is better able to cope with it.

Although the system would prevent sudden forward motion to a great degree, it would only reduce and not prevent lateral and vertical motion in an accident. Thus injury might be caused by contact with the side of the vehicle. But at least restraint could be provided for up to six children and I have not seen any other way of doing this.

Sooner or later the law and the insurance companies will require that children in cars be fitted with restraints and we must ascertain that the kind of restraints provided take into account that some families have more than 2·4 children and that some people take other children as well as their own to school, parties, camps, and other outings.

J HARDIMAN

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SIR,—With reference to this question (leading article, 1 January, p 2), as a two-car family with frequent changes of car we find it almost impossible to maintain an adequate restraint system in each vehicle for our children. Each fitting involves lengthy dismantling of part of the car, boring holes in the bodywork (which is not exactly an advantage when reselling), not to mention the actual fitting of bolts, screws, etc, if you are lucky enough to have the correct ones. Finally the seat or harness cannot easily be removed when adults are travelling in the back.

If all manufacturers provided standard anchor points all these problems would be solved and many more children would use restraints.

PRUNELLA E NEWTON

Sale, Cheshire

Danger of instant adhesives

SIR,—With reference to Mr C P de Fonseka's letter (11 December, p 1447) concerning a child who bit into a tube of cyanoacrylate adhesive, no one denies that such a hazard exists and there is clear warning on these rather expensive adhesives: "Keep away from children." Biting into any type of tube containing any glue is potently hazardous.

However, cyanoacrylates polymerise immediately on contact with water, are non-toxic, and easily peelable, and all residues are biodegradable within a relatively short period. I would refer to a previous letter (10 July 1976, p 109) in which I quoted the US Consumer Product Safety Commission investigation report on these materials. They found no "*unreasonable* risk of injury from the fast bonding characteristics of cyanoacrylate adhesives" (my italics).

Loctite (UK) Ltd, in an effort to inform medical practitioners of the first aid and casualty treatment of human skin adhesion by cyanoacrylates, had a special leaflet on the correct procedures to be adopted printed and distributed some weeks later as an insert in the *BMJ*. Further copies may be obtained through Loctite (UK) Ltd, Welwyn Garden City, Herts AL7 1JB, on request.

D J O'SULLIVAN
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Loctite (Ireland) Ltd

Dublin