electrocardiographic monitoring.¹⁶ In another study a group of children with hypertrophic cardiomyopathy at high risk of sudden death (history of loss of consciousness, family history of sudden death) who were given amiodarone had a better prognosis than an untreated group at low risk.¹⁷ But the case for amiodarone is not proved, and it has been associated with a higher incidence of sudden death.¹⁸ A high risk group can be identified on electrophysiological¹⁹ and haemodynamic grounds,²⁰ and on the basis of a high risk family history.²¹ There is, however, no evidence that any therapeutic intervention benefits patients with asymptomatic hypertrophic cardiomyopathy, let alone those with only the genetic trait or borderline asymmetric septal hypertrophy. These are the subjects whom screening would detect in larger numbers than real cases.

Screening can have value in reassuring unaffected members of families where the genetic abnormality is known. It can also be used to guide controlled trials of promising treatments in affected members. Only once effective treatments are established, however—and this includes advice to avoid strenuous exercise—should generalised screening be advised. Given the low incidence of the condition, lack of proved treatments, and low sensitivity and specificity of the available screening tests, widespread testing of the general population cannot yet be advised. Screening of athletes would detect only a small proportion of affected individuals, though it may reduce the risks of sudden death on exertion for those few. The major benefit would be in raising awareness of this potentially devastating condition.

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On not listening to patients

Putting patients first must be more than a slogan

Last week a British psychiatrist was convicted of repeatedly sexually assaulting patients over a period of 12 years.¹ One of the most disturbing features of the case was how patients' protestations of abuse were ignored. This may be the extreme consequence of a health service which, although it insists that it puts patients first, often doesn't do so at all.

Most of the patients assaulted by Dr Gordon Maden were young men with severe psychosocial problems—many of them drug addicts with a criminal record. People within the health and social services had been aware for years of the patients' accusations, but nothing was done. One patient who complained was told "to stop being silly."² A colleague of Dr Maden is quoted as saying that nothing was done because "nothing really terrible had happened. . . . The addicts weren't too cut up about it. They had to deal with more degrading things in their lives. And addicts are cunning, devious people. To be honest, I felt they could quite easily manipulate him."³ This is a long way from the central idea of total quality management—that the patient or customer is king. And homeless drug addicts must have as much right to the throne as Hampstead intellectuals.

Last week the House of Commons select committee on the ombudsman heard another story of neglect in the NHS.⁴ The health ombudsman's officer was investigating a case of a terminally ill woman who was moved from her ward in the King Edward VII Hospital in Windsor every weekend for 10 weeks because the ward was closed at weekends to save money. When the ombudsman reported on the case he said: "I cannot recall ever having encountered such a manifest and deplorable lack of regard by management for the welfare of a hospital inpatient." Last week's hearing was to examine why, when the ombudsman's officer was investigating the case, she was repeatedly interrupted by a nurse manager. Once again the NHS ignored the principle of total quality management and instead of learning from its mistakes was desperate to deny them.

These are both extreme examples, but there are probably hundreds of examples every day within the NHS of patients being ignored and treated brusquely. Trisha Greenhalgh describes two such cases on p 464. In one case a woman waited three quarters of an hour with her child screaming with an undressed wound. The doctor eventually arrived and grumbled,

"We should probably see that again; bring it back next week." The "it" was presumably the wound rather than the child, but the woman was upset that she had no time to ask if her child would be all right. In the second case a woman asking questions about her leg ulcer was told, "Look, dear, you go away and make up your mind what you want done, and then we might be able to help you."

When the NHS was founded, people were grateful to have access to free health care and accepted not being treated as equals. But we should be further on in the long march from paternalism. The NHS reforms and the patient's charter are designed to try to make the health service more customer or patient oriented, but structural reforms and exhortations will

never be enough on their own. Deeper, cultural changes are needed, and total quality management—with its insistence that only the patient can define quality—is the way forward. This should be familiar to doctors. The first lesson we learn at medical school is to listen to the patient.

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2 Clouston E. Victim who protested to health staff was told "not to be silly." *Guardian* 1993;February 4:6.

3 Clouston E. Noises were being made at meetings, parents sounding off . . . but the addicts weren't too cut up about it. *Guardian* 1993;February 4:6.

4 Brindle D. Ombudsman's "worst case" riles MPs. *Guardian* 1993;February 4:6.

Antibiotic prophylaxis of neonatal group B streptococcal infections

Rapid testing of women at risk may be worth while

The group B streptococcus is the commonest cause of non-inatrogenic bacterial sepsis in the first weeks of life in many centres in Britain, continental Europe, Australia, and northern America.^{1,2} About two thirds of infections occur in the first five days and more than half of these are apparent at birth. These early onset infections are characterised by pneumonia and septicaemia, accompanied in 30% of cases by meningitis,³ and have a mortality of about 20%. The only practicable way of preventing group B streptococcal sepsis is chemoprophylaxis, though immunoprophylaxis may well be an alternative within a decade.⁵ The options available are simple: withhold all chemoprophylaxis, offer it to everyone, or target a risk group. There are difficulties with all three approaches.

A prerequisite for early onset group B streptococcal infection is maternal genital carriage during pregnancy. Reports of genital carriage vary widely, but 20% to 25% of women are probably carriers in most countries. Despite this, the incidence of the infection seems to vary widely. In the United States about 1% of infants born to colonised mothers develop group B streptococcal infection; in northern Europe, including Britain,² the incidence seems to be about 10 times lower. Some European countries do have higher rates—for example, the incidence of group B streptococcal infection in Norway may be as high as 1.8 per 1000 live births.⁶ In England, however, the low infection rate seems to have remained stable over the past decade as the number of cases reported each week to the Communicable Disease Surveillance Centre has not varied greatly.

The heaviness of carriage and the risk of neonatal septicaemia are directly related: infants who are heavily colonised have an increased risk of infection of at least 10-fold.⁷⁻⁹ The risk of neonatal group B streptococcal sepsis is also significantly increased in combination with perinatal risk factors.^{10,11} In a prospective study in Chicago 61 out of 32 384 newborn infants had group B streptococcal septicaemia (1.9 per 1000 live births). When one or more of premature labour, membranes ruptured longer than 18 hours, or intrapartum fever were present the attack rate rose to 7.6 per 1000, while in the absence of risk factors it fell to 0.6 per 1000. Fifteen of the 16 cases with a fatal outcome had one or more of these risk factors.¹⁰

Giving antimicrobial agents to all pregnant women would reduce the incidence of neonatal sepsis due to group B streptococcus but would represent an unjustified overprescription of antibiotics. Indeed, identifying all carriers of

group B streptococcus during pregnancy by culture and giving prophylaxis during labour also represents a level of antibiotic administration which is hard to justify.¹² Some American centres identify carriers and then give prophylaxis during labour to those at increased risk.¹³ This approach is based on the finding that intrapartum ampicillin significantly reduced neonatal group B streptococcal infections when given to carriers who had one or more additional risk factors.¹³ Another reason for adopting this approach is that infants born to mothers who have no perinatal risk factors suffer from less severe infections and respond better to treatment.¹¹ Unfortunately genital carriage of group B streptococcus is unstable, so a swab taken during pregnancy does not necessarily predict carriage at delivery. Combining vaginal and rectal swabs, together with the use of a selective culture medium, improves the predictive value (positive predictive value of 67% and a negative predictive value of 92%¹⁴) but only to a level which makes mass screening viable in areas with high rates of infection. In areas of lower incidence the cost-benefit ratio of this approach does not justify such large scale screening, and the risk of adverse effects outweighs the benefits.¹⁵ The fact that group B streptococcal infections are rare in many British hospitals also means that clinicians have little incentive to initiate preventive measures.

An alternative approach to targeting that is particularly suited to low risk areas is offered by rapid tests: first identify the risk during labour and then test for carriage. This avoids mass screening and means that fewer than 5% of women will receive intrapartum chemoprophylaxis.¹³ Several new kits based on latex particle agglutination or enzyme immunoassay technology can yield results within 20 minutes, and these tests may be performed by the bedside. None are as good as conventional culture, and though their specificity is good the sensitivity is relatively poor (up to 60% in total but up to 90% in heavy carriage).^{16,17} Nevertheless, they seem to be sensitive enough to detect most heavy carriers.¹⁸⁻²⁰ In a retrospective analysis a latex agglutination test gave positive results in all mothers who delivered infants with group B streptococcal infections, and no neonatal deaths due to group B streptococcal infection occurred in the group testing negative.²¹ The sensitivity of such kits may also improve.

The choice in Britain is therefore between withholding all chemoprophylaxis and using a rapid screening test. Both decisions involve compromise, but we believe the latter approach should now be taken as it targets a sufficiently small