

offering child health surveillance. There was no significant difference between single handed (10/42 (24%)) and group practices (23/45 (35%)) ($\chi^2=1.59$, $p>0.2$). Only 29 of the 52 practices that had planned in 1990 to introduce child health surveillance had done so two years later. The 23 practices that had said that they would offer child health surveillance but were not doing so were contacted by telephone and asked why. Eleven said that they were too busy to offer the service; five considered that their premises were unsuitable and were renovating them or having new premises built; two said that their premises were inadequate and that their workload was too great; four perceived that there would be too much competition from the local clinic; and one general practitioner expressed a need for support from a health visitor but said that his health visitor was too busy at the local clinic. Nine hoped to start in the future.

Inadequate resources clearly prevented some interested practices from introducing child health surveillance. It is easy to label city practices as bad rather than acknowledge that good practice costs money. Community child health services will need to continue to provide child health surveillance to a large number of children in Liverpool; this also needs to be acknowledged and adequately resourced.

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- 2 Department of Health. *Health service development. Promoting better health: management of general medicine services*. London: DoH, 1989. (HC(89)32.)

Antenatal HIV testing may put pressure on women

EDITOR,—D J Goldberg and F D Johnstone highlight the benefits of testing pregnant women for HIV.¹ Positively Women believes, however, that the guidelines on voluntary named testing antenatally² raise concerns that have not been adequately debated.

Firstly, why should women be tested in antenatal clinics? The editorial points out that women already undergo a range of tests in antenatal clinics, but these tests generally relate to the health of their child. Testing for HIV is different: it tells a woman that *she* has a life threatening condition, which she may pass on to her child. We are concerned that women who are considered to be at low risk may agree to be tested for HIV for the sake of their child without having an opportunity to explore fully the implications of the test.

Two of the benefits stated in the guidelines are that women could consider having a termination or having the child fostered or adopted.² Positively Women is in contact with over 400 HIV positive women, more than half of whom are mothers. We have never heard of a woman putting her child up for fostering and adoption just because she or her child is HIV positive. We also know of HIV positive women who have been put under pressure to have a termination, and we fear that these guidelines may serve as a justification for those health care workers who put pressure on HIV positive women to have terminations or to have their children fostered or adopted.

The editorial states that the programme will be more cost effective if take up of testing is higher in HIV positive women. We fear that this may lead to health care workers putting women whom they consider to be high risk under pressure to have an

HIV test, thus changing the voluntary nature of the testing.

We understand that these guidelines are to be adopted within existing resources. We are concerned that antenatal HIV testing will take resources away from much needed support and care services, particularly services for HIV positive women and children affected by HIV.

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- 2 Department of Health. *Guidelines for offering voluntary named HIV antibody testing to women receiving antenatal care*. London: DoH, 1992.

Reduction in infant mortality probably due to fall in cot deaths

EDITOR,—A headline in the news section states that infant mortality in Britain has fallen by one third in the past 10 years.¹ Going back to 1979 may give a clearer picture (table). From that year to 1983 there was a 21% fall in infant mortality, which was followed by a plateau until 1988; this in turn was followed by the recent 27% fall to the remarkably low rate of 6.6/1000 live births in 1992.

Infant mortality, England and Wales, 1979-92

Year	Rate/1000 live births	Change in rate (%)
1979	12.8	
1980	12.0	
1981	11.1	
1982	10.8	
1983	10.1	-21
1984	9.5	
1985	9.4	
1986	9.6	
1987	9.2	
1988	9.0	-5
1989	8.4	
1990	7.9	
1991	7.4	
1992	6.6	-27

The first fall was related to the increased survival of very premature neonates. The recent one is related to the fall in the number of cot deaths postneonataly, recently announced, which followed so closely on the advice in relation to supine sleeping and not overheating that the advice must have been responsible for the decrease. It is estimated that the rate of cot deaths for 1992 will be only 0.7/1000, which is only a third of that in 1988. In fact, cot death may well disappear before the scientific cause for the death is fully elucidated.

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- 1 Headlines. *BMJ* 1993;306:1288. (15 May.)

Chickenpox in pregnancy

EDITOR,—Prevention is better than cure. Gwendolyn L Gilbert does not give any guidance on whether women who develop chickenpox within a few days before or after delivery should barrier nurse their infant or be recommended not to breast feed.¹ Nor were these questions addressed in another recent editorial on this subject.² Transplacental infection of the fetus in late pregnancy is not inevitable,³ and therefore it is possible that some infants who develop postnatal chickenpox do not acquire the virus transplacentally but become infected by contact with the mother after birth. Chickenpox is highly infectious and can be spread by respiratory droplets or contact with ruptured skin lesions. The mother is contagious from two

days before until five days after the onset of the rash. If the onset of the baby's rash occurs 5-10 days after delivery, mortality is 30%.² Given that the minimum incubation period for a postnatal infection is eight days,³ some of the infants in this high risk group may have acquired the virus postnatally.

Is the breast feeding mother more likely to pass on infection if there are chickenpox lesions close to the nipples, or can the virus be transmitted in milk (as can human immunodeficiency virus,³ herpes virus, hepatitis B virus, and cytomegalovirus)? Alternatively, do the anti-infective properties of breast milk outweigh the risk of infection from the mother? Some reference books recommend isolation of the infant from the mother until she is no longer infectious⁵ but others provide no guidance on this subject.³ Insisting that a mother barrier nurses her newborn baby and expresses milk until any breast lesions have crusted would be justifiable if it was known whether this had any impact on the course of neonatal chickenpox, a condition with a high mortality. On the other hand, these preventive measures may be very upsetting to the parents as their newborn infant will seem to them to be perfectly robust and without a rash. The practice should be discontinued if it is based on myth rather than evidence.

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- 1 Gilbert GL. Chickenpox during pregnancy. *BMJ* 1993;306:1079-80. (24 April.)
- 2 McIntosh D, Isaacs D. Varicella zoster virus infection in pregnancy. *Arch Dis Child* 1993;68:1-2.
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Updating FHSA registers

EDITOR,—Graham Bickler and Stephen Sutton suggest using electoral registers to check family health services authorities' general practice address lists.¹ We have reported the result of using the electoral register for this purpose in a research study: we estimated that about 21% of 18000 patients were not resident at the address listed.² But we are less enthusiastic about recommending this method for routine use in screening programmes.

In our experience, checking a family health services authority's list against the electoral register by hand is not simple. The electoral register is arranged by fairly small districts; long streets may be covered by several districts. In addition, one general practice may be covered by more than one electoral register. We found the exercise of locating addresses to be time consuming.

The task could be made less onerous by buying the electoral register on computer disk (cost £18 per 1000 names for our study area). However, one can only eliminate names from family health services authorities' lists, and this elimination will be incorrect in 13% of cases, according to Bickler and Sutton. New addresses for patients cannot be identified from the register because of insufficient data to achieve an exact match (date of birth is not recorded). Though excluding patients with incorrect addresses permits a more accurate and comparable estimate of uptake of screening, it does not mean that any more patients are screened. We have some anxiety that the use of uptake rates

corrected for wrong addresses will improve the apparent efficiency of screening while failing to locate those who are being missed.

Other methods of improving lists of patients' addresses that we have used in our research studies include periodic mailings to patients, recording an alternative contact address, using Post Office returns (which identified 40% of inaccurate addresses in one mailing in our experience), examining general practices' manual and computerised records, and using local telephone books. The relative cost effectiveness of these methods depends on the extent of automation that can be achieved. Direct linkage of computerised records of practices and family health services authorities, with a formal protocol for checking and updating a practice's address records at each contact with a patient, probably holds out the best hope of achieving a register with minimal errors in addresses to optimise uptake of screening. The technology to achieve this has already been adopted in other European countries.¹

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- 1 Bicker G, Sutton S. Inaccuracy of FHSAs registers: help from electoral registers. *BMJ* 1993;306:1167. (1 May.)
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Do we need more hospices?

EDITOR,—In 1987 a prospective survey asked patients with advanced cancer for their preferred place of death, and 15% chose a hospice.¹ A recently published survey by the Association for Palliative Medicine estimates that, in 1990, 14% of cancer patients in the United Kingdom were dying in a hospice²—suggesting there are enough hospice beds, at least for cancer patients. So why have 47 inpatient hospices opened since 1990 and why are a further 15 units being planned?

Local charities continue to be obsessed with establishing inpatient hospices even though there are now nearly 200 in the United Kingdom. However, financial pressure is restricting unit size to 10 beds or less, despite running costs that are 50% higher than larger units.³ There is a long delay in finding capital funding and, although some patients may be well served, such units cannot adequately fund education, community support, joint service ventures, and clinical development, so their influence is small. In contrast, charities supporting community or hospital palliative care teams see their services start early, help more patients, and develop an influential partnership with existing services.

The continued planning and building of small, expensive "corner" hospices is becoming a scandalous waste of scarce resources. However, from next year any government financial support will come solely from contracting,⁴ and while it is clear that contracts will demand evidence of the effective use of resources, it is not clear if all hospices will satisfy these demands. Some charitable hospices will choose to function in isolation but they can expect the same demands from the public, NHS services, or perhaps the charity commissioners. Hospices will also need to review whether they are primarily a service or a resource. A resource or "catalyst" hospice is a quality led partner to other agencies and requires a quality service, but not necessarily inpatient beds. For example, given the choice and effective support, 67% of patients

would prefer to die at home and 16% in hospital¹—consequently hospices may choose to divert resources away from expensive beds to community and hospital support. It is also wasteful to see adjacent charities providing similar or identical services. Pleas for cooperation between charities have gone largely unheeded, but public accountability and the increasing number of agencies developing palliative care mean that this will have to change.

The prediction by Colin Douglas that hospices will wither and die⁵ is proving pessimistic. The NHS that he believed no longer needed hospices is now contracting with those hospices for services and is also recognising their role in clinical development. But, in the future, hospice planners must understand that as centralisation is replaced with sensitivity to local needs, complacency with quality, and professional isolation with partnership, any new inpatient hospices will be superfluous.

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- 1 Townsend J, Frank AO, Fermont D, Dyer S, Karran O, Walgrove A, et al. Terminal cancer care and patient's preference for place of death: a prospective study. *BMJ* 1990;301:415-7.
- 2 Association for Palliative Medicine. Facilities and activity in period January-December 1990. *Association for Palliative Medicine Newsletter* 1993;January.
- 3 Hill F, Oliver C. Hospice—an update on the cost of patient care. *Health Trends* 1988;20:83-5.
- 4 NHS Management Executive. *Hospice funding*. Leeds: Department of Health, 1993. (EL(93)14.)
- 5 Douglas C. For all the saints. *BMJ* 1992;304:579.

Infection control in dentistry

EDITOR,—The importance of control of transmission of infection in clinical practice has been highlighted by the growing awareness of blood-borne viruses, particularly hepatitis B, C, and D viruses and HIV. Guidelines on infection control measures are widely available from many sources.¹ Thus far, though, few healthcare workers worldwide have been nosocomially infected with HIV, and the only transmission of HIV to patients from an infected health care worker seems to have been in a dental practice.²

The past decade has seen dramatic improvements in the awareness of the need for infection control in dentistry and the publication of various guidelines. Few studies, however, have scrutinised the implementation of recommended procedures, though in 1991 we examined the activities in one hospital clinic, found them wanting, and reinforced the need for infection control.³

It was clearly important to re-examine this area after the need for infection control had been re-emphasised. Therefore in 1992 we scrutinised 12 dentists examining and 14 treating emergency patients. The dentists were hospital staff from house officer to consultant grades. Each was scrutinised for one procedure and was unaware of the true reason for the presence of the observer.

The results, shown in the table, were encouraging in one respect, in that all those undertaking

Safeguards used during examination or treatment of emergency dental patients. Values are numbers (percentages) of patients

Infection control procedure	Dental procedure		
	Examination only (n=12)	Examination and treatment (n=14)	Total (n=26)
Handwashing at start	5 (42)	5 (36)	10 (39)
Protective gloves worn	9 (75)	14* (100)	23* (88)
Handwashing after procedure	5 (42)	5 (36)	10 (39)
Face mask worn	4 (33)	8 (57)	12 (46)
Protective eyewear worn	7 (58)	10 (71)	17 (65)
No obvious contamination of pen, notes, or non-operatory surfaces	3 (25)	1 (7)	4 (15)

*In two instances gloves were not changed before use on next patient.

dental treatment wore protective gloves. However, there were clear deficiencies in terms of protection for the patient or the operator, or both, in all 26 instances, and though we found no overall consistent pattern in the deficiencies, we know that dentists tended to be consistent in their deficiencies in infection control,³ and it would seem from the present results it is almost impossible to achieve perfection.

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- 1 Bird AG, Gore SM. Revised guidelines for HIV infected health care workers. *BMJ* 1993;306:1013. (17 April.)
- 2 Risk of transmission of HIV during dental treatment [editorial]. *Lancet* 1992;340:1259-60.
- 3 Scully C, Porter SR, Epstein J. Compliance with infection control procedures in a dental hospital clinic. *Br Dent J* 1992;173:20-3.

Department without daylight

EDITOR,—In their editorial Sam Basir Warner and J H Baron emphasised concern for the patient's environment and, in particular, the value of restorative gardens.¹ A J Carter mourns the passing of balconies as a feature of hospital design as it has limited patients' access to fresh air and sunlight.² My requirements are more simple.

I write from my windowless office in a modern accident and emergency department. The department consists of waiting areas for patients, dressing and receiving areas, a resuscitation room, a general practitioner admission unit, seven offices for senior medical and nursing staff, a seminar room, a reception area, an office for secretaries, and a coffee room. Only the last three have windows, and the coffee room has mirrored security glass. Our paediatric casualty department is entirely without windows.

A garden would be lovely, but isn't it time we saw the light?

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- 1 Warner SB, Baron JH. Restorative gardens. *BMJ* 1993;306:1080-1. (24 April.)
- 2 Carter AJ. Patients need fresh air. *BMJ* 1993;306:1481. (29 May.)

Coroners' role in children's deaths

EDITOR,—In the scramble to allocate blame after the Beverley Allitt trial,¹ attention is focused on the roles of hospital management, ward nursing staff, and consultant paediatricians. Already managers have been relocated, the ward closed, and the consultants sacked. Yet the one person who remains untouched by this whole sad affair is the