pattern of pain is of no value in localising the site of the lesion.[2]

We advocate consultation with a senior doctor and consideration of early computed tomography for patients with a good history of neck rotation at the time of impact. This increases the chance of bony injury,[2] particularly between the occiput and C2, which is often poorly visualised in plain films. Computed tomography should also be considered in those with a fixed abnormal neck position, particularly if pain does not seem to be the restricting factor, and those with definite neurological signs and symptoms, even if their presentation is delayed.

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2 Macnab I. The whiplash syndrome. *Orth Clin North Am* 1971;2: 389-403.
3 Janes JM. Severe extension-flexion injuries of the cervical spine. *Mayo Clin Proc* 1965;40:353-61.
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Infantile colic and parental stress

EDITOR,—Päivi Rautava and colleagues suggest an interesting association between infantile colic and parental stress.[1] In their study, however, colicky symptoms were assessed by the parents themselves. It would not be surprising if stressed parents perceived their baby's crying as worse than did those under less pressure. Thus the authors' screening procedure is likely to have picked up infants with genuine colic and those whose parents had an exaggerated awareness of their child's screaming. The only way to avoid conflating these two groups is for continuing tape recordings to be made of the infant. Otherwise, results such as this may led to the premature conclusion that all instances of excessive, paroxysmal screaming of uncertain organic aetiology are a consequence of parental tension.

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1 Rautava P, Helenius H, Lehtonen L. Psychosocial predisposing factors for infantile colic. *BMJ* 1993;307:600-4. (4 September.)

Description of ME revised in disability handbook

EDITOR,—Anthony David's contribution to Medicine and the Media contains several factual errors concerning myalgic encephalomyelitis.[1] Firstly, the all party lobby of nearly 100 members of parliament, which is working with patients' organisations on problems with state benefits and other matters of concern, has been concentrating on the disability living allowance, not invalidity benefit as stated. As a result of this joint action the Disability Living Allowance Advisory Board has agreed to important changes to the clinical description of myalgic encephalomyelitis in its "disability handbook." The next revision of this will make it clear that myalgic encephalomyelitis is a separate clinical entity from the chronic fatigue syndrome (although they have several features in common), is not hysterical in origin, and can result in severe and permanent disablement. In common with the tenth revision of the *International Classification of Diseases* the handbook will also refer to myalgic encephalomyelitis as a neurological disorder.

Secondly, there is no evidence to support David's view that myalgic encephalomyelitis has become "a no go area" in the quality press. During August and September both the *Times* and the *Independent on Sunday* devoted a total of three pages to the subject, with four separate views being expressed.[2,3]

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1 David A. Camera, lights, action for ME. *BMJ* 1993;307:688. (11 September.)
2 Marcovitch H, Stuttaford T, Wessely S. What exactly is the chronic fatigue syndrome called ME? *Times* 1993 Sept 14:16.
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Discharging patients into the community

EDITOR,—Jane Yeo reports the problem she experienced earlier this year with a patient newly discharged from an old fashioned institution to the community.[1] This problem, however, should be considered in the context of the relocation of 240 patients with learning difficulties from a hospital condemned as unsuitable for their care into many small and friendly homes across the district, West Berkshire. This relocation, which was completed in March, has produced, on one hand, two complaints (of which Yeo's was one) and, on the other, a dramatic improvement in the quality of life for most of the patients.

Meanwhile the process of change continues and two full time consultants in learning difficulties were recently appointed to lead the community team. This trust is committed to designing the best possible service for these patients and, despite hiccups in the transitional phase, wishes to work closely with general practitioners towards this aim.

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1 Yeo J. Neuroleptics in learning disability. *BMJ* 1993;307:620-1. (4 September.)

Provision of highly specialised services

EDITOR,—The current purchaser-provider arrangements are designed to ensure, as far as possible, that the health care needs of local people are met by local services. Luisa Dillner's report on the initial findings of the Clinical Standards Advisory Group[1] and Nick Kitson's letter[2] highlight the difficulties that patients with highly specialised needs face in getting access to appropriate services. But in addition to the threat to the provision of services there is a more insidious threat.

By bringing together professionals with highly specialised skills, many highly specialised services provide both services and training. Training offered in such units ensures the continuity of services and allows services to develop new methods of treatment. It is by this means that the supra-regional deaf mental health services have established a unique outpatient child psychiatric service for deaf children and their families and pioneered family therapy for deaf people in Britain.

Thus the possible demise of highly specialised services threatens not only the immediate provision of services but also the gathering together of skilled professionals that ensures that their skills are further developed and disseminated. Because these professionals' patients are often widely spread across Britain, however, they do not represent a large enough constituency in any single district health authority to register effective protest against threats to services.

Some district health authorities have developed consultative processes between the users and providers of services to ensure that local health needs are adequately met. Such arrangements are of no use to patients with highly specialised needs, such as those described by the Clinical Standards Advisory Group and Kitson. The advisory group offers important professional advice to the Department of Health with regard to a small group of such patients. But there is a growing need for monitoring bodies that can represent users and providers of services and the Department of Health and can ensure that district health authorities and general practitioner fundholders make adequate provision for people who require highly specialised services.

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1 Dillner L. NHS reforms deny patients specialist services. *BMJ* 1993;307:151. (17 July.)
2 Kitson N. Availability of specialist services. *BMJ* 1993;307:567. (28 August.)

Prioritising resources

EDITOR,—The question of the prioritisation of resources in health care is clearly of utmost importance.[1] One of the main factors that should be taken into account in prioritisation is the evidence that interventions do more good than harm—that is, effectiveness. One of the few instruments available to purchasers that provides objective evidence on effectiveness is the series of bulletins *Effective Health Care*. Thus we were disappointed by Chris Ham's dismissal[1] of some of the topics that we have chosen to study—namely, the treatment of persistent glue ear and screening for osteoporosis to prevent fractures. When Ham questions the relevance of these topics he surely misses the point: it is the impact of changes in decision making at the margin that is the most important consideration,[2] not simply the total volume of activity or the prevalence of the condition.

Topics assessed in *Effective Health Care* are selected on the basis of their implications on resources, uncertainty about their effectiveness, and their likely impact on health status. The selection process entails considerable market research and discussion by a steering group comprising senior health service managers, directors of public health, and academics.

Glue ear is the commonest reason for elective surgery in children, yet large geographical variations in treatment rates exist and doubts remain about the appropriateness of surgery in many cases. These doubts are strengthened by the finding in a recent randomised controlled trial, in which surgery was undertaken on the basis of clinically determined need, that around a third of children were operated on unnecessarily.[3] Similarly, doubts exist about the likely impact of population screening programmes for osteoporosis. Estimates suggest that such screening is unlikely to prevent more than 5% of fractures in elderly women. The two *Effective Health Care* bulletins on these subjects have aided commissioning authorities in allocating resources towards proved therapeutic activities. There is considerable evidence that this information has been used around Britain in setting standards and changing decisions on commissioning.[4]

Commissioning in the health service is (and will probably always be) an uncertain science in which some of the most important decisions are taken around the margins of activity. Information based on evidence raises the level of debate in com-