This week in BMJ

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Controlling infection in ICUs may benefit mortality

Infection is regarded as a major cause of mortality in patients receiving intensive care, though estimates of the proportion of deaths caused by infection vary. Since 1984 several randomised trials have looked to see whether prophylaxis using non-absorbable antibiotics with or without a systemic component might prevent infection and reduce mortality. On p 525 the Selective Decontamination of the Digestive Tract Trialists' Collaborative Group presents a meta-analysis of 22 randomised trials containing over 4000 patients that offers new insights into the problem. Patients were evaluated for the effect of prophylactic agents given topically and systemically on respiratory infection and mortality. When all the trials were considered together a substantial reduction was evident in respiratory tract infections (typical odds ratio 0·37), but this was not matched by an effect on mortality. A significant effect on mortality was, however, evident in trials of parenteral and topical prophylaxis combined. The analysis confirms that there is a weak but significant association between infection and mortality and that in heterogeneous populations patients may die even when infection is prevented. The collaborative group continuously includes trials for evaluation and plans an individual patient meta-analysis in an attempt to identify patients who would benefit from selective decontamination of the digestive tract.

Obesity affects the efficacy of antihypertensive drugs

Obese hypertensive patients have a higher cardiac output and lower total peripheral resistance than lean patients at any given blood pressure, and this could affect their response to antihypertensive drugs. On p 537 Schmieder *et al* examined the effect of the β blocker metoprolol and calcium entry blocker isradipine in lean and obese men with mild essential hypertension. After six weeks the decrease in diastolic blood pressure was greater in obese patients who received the β blocker and lean patients given the calcium entry blocker than in lean patients given β blocker and obese patents given the calcium entry blocker. Further studies are needed to determine whether this effect remains with long term treatment.

Lower doses of mifepristone equally effective in inducing complete abortion

In all the countries where the antiprogestin mifepristone has been approved for the termination of early pregnancy the recommended treatment is a single dose of 600 mg mifepristone followed 36-48 hours later by a prostaglandin analogue (such as gemeprost or misoprostol). Because of the limited capacity of the blood to transport mifepristone, however, it has been suggested that lower doses of the antiprogestin would be equally effective in inducing abortion. A task force of the World Health Organisation (p 532) reports the results of a multicentre trial of different single doses of mifepristone (200 mg, 400 mg, and 600 mg) used in conjunction with a vaginal suppository of 1 mg gemeprost. The three doses gave equal rates of complete abortion with no difference in the rates of complications and side effects. The authors conclude that the presently recommended dose of mifepristone for termination of early pregnancy can be reduced without loss of efficacy when used with gemeprost.

Distribution of psychiatric workers in general practice is uneven

Psychiatrists, community psychiatric nurses, clinical psychologists, and other mental health professionals have been moving out of hospitals into general practice over the past 20 years. There is concern that the subsequent deployment of these professionals may not be targeted to the areas of greatest need. On p 544 Kendrick *et al* report a national survey of mental health professionals working on site in general practices. They found a tendency for professionals to cluster within practices, with a preponderance in larger training practices. Further research is needed to determine whether the uneven distribution of mental health professionals in general practices reflects differences in need or inequalities in the provision of health services.

Too many head injured patients arrive in hypovolaemic shock after transfer

Secondary brain damage after head injury is an important cause of death and disability, yet, if poorly done, the transfer of patients with head injuries to neurosurgical units may compromise their condition still further. On p 547 Gentleman *et al* provide guidelines on assessment, resuscitation, and monitoring before and during transfer. The basis of secondary brain damage is inadequate cerebral tissue perfusion and oxygenation, so the priorities are those of advanced trauma life support: to maintain the airway, breathing, and circulation and then assess neurological dysfunction. Once the patient is stable blood pressure, electrocardiogram, oxygen saturation, and urine output are the minimum that must be monitored continuously. Guidelines exist on which patients should be transferred, but patients should not be moved until a neurosurgeon has agreed to receive them and approved the arrangements for transfer. The patient should be accompanied by a doctor and nurse (or paramedic) with experience of managing seriously ill patients and prepared for what can go wrong. The authors point out that too many patients arrive in hypovolaemic shock because of poor management before or during transfer, and that many hospitals do not have adequate portable equipment for transferring patients. They conclude that neurosurgeons have a responsibility to see that junior doctors and nurses in their referring hospitals know how to manage a safe transfer.

BMA NOTICES

Resolutions passed by the annual representative meeting 1993

The BMA's 1991 annual representative meeting resolved that resolutions passed at the annual meeting should be published in the *BMJ*. Some resolutions are published here. The rest will be published in a future issue.

(1) *That in standing order 37* the word "fifteen" in the last line be deleted and the words "twenty-five" be inserted in its place.

(2) *That this meeting* instructs the joint agenda committee to ensure that motions put up to one conference are not moved to another conference unless they have the permission of the proposer.

(3) *That Alan John Rowe*, OBE, LMSSA, FRCGP, be elected a vice president of the association in recognition of his outstanding services to the association and to the medical profession, particularly in Europe.

(4) *That David Cameron Morrell*, OBE, KSG, FRCP, FRCGP, FFPHM, be elected president of the association for 1994-5.

(5) *That this meeting* views with concern the use of terms such as "overperformance" of hospitals to disguise the chronic underfunding of the hospital service.

(6) *That the association* rejects the continued blanket application of efficiency savings as these are now threatening patient services.

(7) *That this body* strongly condemns the government policy of continued underfunding of the NHS.

(8) (As a reference:) *That this meeting* believes it would be more appropriate to fund the NHS from a hypothecated tax than from general taxation because a change to a hypothecated tax would (*i*) encourage a public debate about investment within the NHS; (*ii*) increase the likelihood of greater funding of the NHS.

(9) *That the level of funding* of the NHS urgently needs to be brought into line with other European countries.

(10) *That increases in resources* for the NHS must be directed towards improving patient care, rather than funding increases in bureaucracy.

(11) *That this meeting* recognises the special problems and needs of London but insists that: (*i*) correcting those difficulties must not be at the expense of primary and secondary care services elsewhere; (*ii*) the proposed reductions in hospital staff in London do not result in a fall in the quality of medical undergraduate and postgraduate education; (*iii*) acceptable arrangements are made for the redeployment of academic staff including, if necessary, redundancy; (*iv*) the data used to assess bed provision be questioned; (*v*) hasty hospital closures be resisted prior to development of adequate primary health care services; and (*vi*) the exceptional needs for hospital care of a high transient and homeless population be assessed before closing hospital services.

(12) *That this meeting* asks that the BMA council should seek to ensure that purchasers of health services seek the advice of all branches of the medical profession, in order to make informed decisions about health care needs.

(13) *That this meeting* believes that LMCs should have statutory recognition in the commissioning process.

(14) *That Her Majesty's government* be condemned for its rapid progress towards privatisation of the National Health Service.

(15) *That this meeting* believes that the purchaser/provider system is not working and needs a radical rethink.

(16) *That this meeting* believes that the medical profession has some responsibility in clinical priority setting, but rationing is the responsibility of the government.

(17) *That the British Medical Association* should be congratulated on its efforts to establish local negotiating committees in view of the real problems experienced by doctors working in trusts.

(18) *That BMA local negotiating committees* must include representatives of all doctors employed by trusts, including training grade and non-consultant career grade doctors.

(19) *That, given the present reality*, this meeting no longer asserts its opposition to GP fundholding.

(20) *That in the light of decisions* taken at the recent conference of representatives of LMCs, this meeting emphasises that: (*i*) the implementation of the fundholding scheme has led to the development of a two tier service; (*ii*) the BMA should continue to campaign for a better more equitable system of commissioning of care that brings equal benefits to all patients; (*iii*) GMSC has the authority to represent and address the problems of all GPs, whether fundholders or non-fundholders.

(21) *That this meeting* believes that a freeze should be imposed on current NHS managerial posts until it can be shown by audit that the increase in their number has brought improvements in terms of the quality of patient care.

(22) *That this body* deplores the government action in interfering with the deliberations of the DDRB and insists that the secretary of state for health fulfils her affirmation and that the government resumes full use of the DDRB mechanism to produce a report in 1994.

(23) *That this meeting* wishes to congratulate the BMA on its efforts and initiative in the realm of international affairs.

(24) (As a reference:) *That this meeting* welcomes the aim of the Commonwealth Medical Association to provide technical advice and assistance to national medical associations in developing Commonwealth countries in order to improve the health and wellbeing of their populations, and wishes this endeavour to expand.

(25) *That this meeting* reaffirms its commitment to the new deal and calls upon the signatories to the Heads of Agreement to reaffirm their commitment to the new deal.

(26) *That this meeting* rejects any attempts to dilute the principles and tenets of *Achieving a Balance* during the implementation of the new deal.

(27) *That this meeting* believes that no health care professional should be allowed to administer chemotherapy unless he/she has completed a formal training programme for this.

(28) *That this meeting* calls on the regional postgraduate deans to use their financial muscle to change the emphasis from service commitments to structured professional training for all junior doctors.

(29) (As a reference:) *That this association* establish a cohort study of one year's graduates for the study of career opportunities and manpower modelling.

(30) *That this meeting* notes the wide variation in the timing and procedures leading to the filling of preregistration house officer posts, and believes that regional postgraduate deans should coordinate this to a national timetable.

(31) *That the medical students group committee* should become a standing committee of the association.

(32) *That this meeting* believes that the divisional system of the association is central to the democratic process for its members, and should be strengthened as a result of any constitutional review.

(33) *That we urge* the association to reconsider helping general practitioners with locum payments in order for them to attend as representatives at such meetings as this.

(34) *That the standard* rate of subscription be increased by 1·3% (according to the subscription ranges stated below) with effect from 1 October 1993:

	Recommended rate (£)	Reduction (%)
Standard rate	£225.60 (Current rate £222.72)	Nil
1st year after qualification	£56.40 (Current rate £55.68)	75
2nd, 3rd, and 4th years after qualification	£112.80 (Current rate £111.36)	50
5th, 6th, and 7th years after qualification	£169.20 (Current rate (£167.04)	25
Members in the armed forces, except those within seven years of qualification	£197.40 (Current rate £194.88)	12·5
Channel Islands and Isle of Man, except those within seven years of qualification	£197.40 (Current rate £194.88)	12·5
Overseas	£141.00 (Current rate £139.20)	37·5
Dental surgeons, except those within four years of qualification	£141.00 (Current rate £139.20)	37·5
Preclinical teachers and non-clinical research workers	£112.80 (Current rate £111.36)	50
Retired from practice before 1 October 1993	£84.60 (Current rate £83.52)	62·5
Spouses of members	£84.60 (Current rate £83.52)	62·5
Medical student members	£20.40 (Current rate £20.16)	91

Notes
(1) A salary link can be claimed by any member whose annual salary or professional income does not exceed the standard salary of a senior house officer at the second incremental point. This will be fixed at half of the standard rate of subscription.
(2) Members who are principals in general practice will pay the standard rate irrespective of the year of qualification.
(3) A temporary retirement concessionary rate, equal to the retired rate shown in the above table, may be claimed where a member's annual gross earnings from medical practice are expected to be less than the annual salary of a clinical assistant appointed under paragraphs 94 or 107 of the terms and conditions of service and working for an average of two notional half days per week.
(4) A member who claims the spouse reduction shall not receive as a benefit of membership a free copy of either the journal or *BMA News Review* unless he or she so requests in writing.

(35) *That, considering increasing professional stress*, all doctors should have the opportunity to retire at 55 years of age, if they so wish, without loss of pension rights.

(36) (As a reference:) *That this meeting* is in favour of full pension rights being based upon an expected working life of thirty five years after registration.

(37) *That this meeting* believes that the arrangements for widowers' pensions be amended so that they are based on contributions of women doctors since entry into the service, rather than from 1 April 1988 as they are at present.

(38) *That this meeting* deplores the recent amendment to the Trade Union Reform and Employment Rights Bill which would permit employers to deny pay rises or other benefits to employees who refuse to sign personal contracts.

(39) *That in the absence* of a regional tier of administration in Northern Ireland the DHSS (NI) take on a leading role in the rationalisation of health services in Northern Ireland.

(40) *That this meeting* deplores the continued failure of the government to implement an effective consultant led occupational health service within the NHS.

(41) *That this representative body* feels that health care professionals should be strongly advised to ensure that they have been immunised against hepatitis B.

(42) *That this meeting* categorically rejects the legalisation of euthanasia.

(43) *That the representative body* endorses the BMA guidelines on the treatment of patients in persistent vegetative state.

(44) *That this meeting* insists that, in the matter of advance directives, no doctor should be obliged by patients, relatives, or hospital administrative staff to act contrary to his or her conscience.

(45) *That this meeting* is gravely concerned at the threat to patient confidentiality from the current development of NHS information management systems, and calls upon the secretary of state to produce a patient confidentiality charter.

(46) *That the representative body* endorses the following policies in relation to sex selection of embryos: that (*i*) there is no ethical objection to sex selection for medical reasons; (*ii*) it remains unethical to terminate a pregnancy on the grounds of fetal sex alone except in cases of sex related disease; (*iii*) it is unethical to use ineffective techniques for sex selection or to imply directly or indirectly that any method has a success rate beyond that proved in scientifically valid clinical trials.

(47) *That this meeting* notes the failure of implementation of the GMC's 1980 recommendations on basic medical education and believes its forthcoming recommendations are also doomed to fail unless: (*i*) wholesale reform of curricula rather than piecemeal change is demanded; (*ii*) central funding of medical schools is made conditional upon satisfactory progress in curriculum reform; (*iii*) more attention is given to standards of teaching in the allocation of SIFTR/ACTR/STAR; (*iv*) additional funding is made available to allow curriculum reform to take place; (*v*) medical students are kept fully involved at all stages of curriculum reform.

(48) *That this meeting* recognises the present inadequacies of postgraduate medical training and welcomes the major review of its structure and looks forward to the full implementation of its recommendations with the necessary resources.