# This week in BMJ

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## Tuberculosis is still linked with poverty

The notification rate of tuberculosis in England and Wales is increasing. The observed increase does not seem to be related to an increase in disease related to HIV infection. Tuberculosis has traditionally been a disease of the poor, but little is known of the relation between tuberculosis and poverty in the late 20th century. On page 759 Spence *et al* report the results of an investigation of the association between tuberculosis and poverty in Liverpool. They showed that the relation between tuberculosis and deprivation remains as strong as it always was and suggest that poverty may be a possible explanation for the increase in notification of cases of tuberculosis.

## Urinary tract infections in children are underinvestigated

Good management of urinary tract infections in children is important because of the risk of renal scarring. Jadresic *et al* (p 761) studied the practice and attitudes of doctors in Gloucester health district towards the investigation and management of urinary tract infection in children. They found a more than 10-fold difference between general practices in the rate of referral of urine samples for testing and in the rate of confirmation of urinary tract infection, and only a minority of children aged under 2 with a confirmed infection were referred for renal tract imaging. General practitioners' answers to a questionnaire showed that their views on the need for renal tract imaging differed from recent recommendations. The authors conclude that greater awareness is needed of the importance of the investigation and management of children's urinary tract infections.

## Screening for free β human chorionic gonadotrophin improves detection of Down's syndrome

Biochemical screening for trisomy 21 has developed considerably since the first observation almost a decade ago that a low maternal serum concentration of α fetoprotein was associated with fetal trisomies. Many health authorities and organisations have still not introduced screening programmes, and debate still continues over the best test combination to use. On page 764 Spencer and Carpenter report the results of the first prospective study with the two markers free β human chorionic gonadotrophin and α fetoprotein. The results, indicating a detection rate of 69% with a 5·2% false positive rate, confirm the performance found in retrospective studies. In addition to trisomy 21, the group found that the test combination also highlighted other anomalies such as Turner's syndrome. The success of this screening programme should provide support to health authorities planning to introduce screening for Down's syndrome in the near future.

## Senna-fibre combination is more effective than lactulose in long stay elderly patients with chronic constipation

Constipation is a common complaint in elderly people in long stay hospital or nursing home care. It may be difficult to treat and is associated with considerable morbidity. There is a need for treatment with laxatives that are safe and cost effective. Several laxative preparations are available, but there are few good comparative clinical studies of commonly used laxatives in elderly patients. On p 769 Passmore *et al* report the results of a randomised controlled trial comparing lactulose with a senna-fibre combination. For all measures of efficacy, the senna-fibre combination was more effective than lactulose, with no difference in adverse effects between the treatments. The effects were seen with a lower dose than recommended for the senna-fibre combination, compared with a higher dose than recommended for lactulose, and the senna-fibre combination was more cost effective.

## Risk of childhood leukaemia reduced by early attendance at creches

The contribution of viruses in the aetiology of childhood leukaemia is biologically and epidemiologically plausible. To examine this association Petridou *et al* (p 774) studied 136 children with leukaemia and 187 controls in two areas of Greece. Children who had ever attended a creche (where crowding ensures transmission of infections) had a reduced risk of developing leukaemia, and the risk was further reduced when early attendance at a creche (during the first two years of life) was examined (relative risk 0·28 (95% confidence interval 0·09 to 0·88)). The authors conclude that the study supports their hypothesis that childhood leukaemia may be a rare manifestation of an infection that is more likely to remain subclinical at an earlier age of infection.

## Surgery based investigations are more expensive

New diagnostic technology is increasingly available in general practice but has not been properly evaluated. On p 775 Rink *et al* evaluated two bacteriological tests using dipsticks and kits and four biochemical tests using desktop analysers in 12 practices. The equipment was used most often for testing for presence of urinary tract infection and for measuring cholesterol and γ-glutamyltransferase concentrations. The costs of these near patient tests in the surgery were higher than equivalent laboratory based tests except for those for urinary tract infection. The impact on the process of care was minimal. Cholesterol testing in the surgery was used mainly for screening and the only significant improvement was in recording of risk factors in patients' records.

# Fate of motions referred to 1993 BMA craft conferences

The 1986 representative meeting of the BMA resolved:

"That when a motion is properly submitted for the annual representative meeting agenda but is then deferred to a craft committee conference the relevant minutes of that conference or the fate of that motion, if not debated, should be published in the *BMJ*."

The fate of the motions submitted to the BMA's annual meeting but referred to craft conferences is published here.

Any motions not reached are referred back to the sponsoring constituencies, which are invited to submit a written memorandum requesting that the motion be considered by the appropriate committee.

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| LMC | = LMC conference | C | = Carried |
| S | = Senior staffs conference | CB | = Bracketed with motion carried |
| J | = Junior staffs conference | L | = Lost |
| PH | = Public health conference | W | = Withdrawn |
| CO | = COMAR (conference of academic representatives) | NR | = Not reached |

BATH DISTRICT

*That the NHS Management Executive* should press all NHS trusts to introduce equivalent clauses for paragraph 190 and 330 of the terms and conditions of service for medical staff, and provide an independent appeal procedure against dismissal of consultants and confirm the rights of consultants to speak out publicly on matters affecting patient care. C (S), NR (PH)

BLACKBURN

*That this meeting* believes that the terms and conditions of the staff grade should be changed to allow on call duties. NR (S)

BRADFORD AND AIREDALE

*That this meeting* calls upon the BMA to negotiate with the NHS Management Executive to allow newly appointed consultants in trusts the right of appeal against dismissal to the secretary of state. NR (S), NR (PH)

BRIGHTON

*That this meeting* is certain that the new deal on junior doctors' hours will fail unless underfunding and manpower restraints are corrected. NR (J)

*That this meeting* considers that the BMA should negotiate a central removal expenses agreement for junior doctors. NR (J)

CAMBRIDGE, HUNTINGDON AND ELY

*That juniors* should not be expected to work in contravention of the NHS terms and conditions of service. C (J)

DERBY

*That this meeting* urges the association to press for terms of remuneration appropriate to their seniority for staff grade doctors carrying out on call duties. NR (S)

DEWSBURY

**For the new deal** to be effective much more attention has to be devoted to removing tasks of no educational value from doctors in training by the recruitment and training of other grades of staff. NR (S), C (J)

*That a satisfactory service* to patients in the hospital sector can only be maintained by a substantial increase in consultant numbers in the light of the increasing pressures due to rising expectations, charter standards, formal commitment to teaching and audit, involvement in management, new legislation, and reduced junior doctors' hours. NR (J)

DUNBARTONSHIRE

*That this meeting* is concerned that moves being taken to reduce junior doctors' hours of work would appear to be significantly reducing their training experience and seriously affecting the career structures envisaged by the document *Achieving a Balance*. L (J)

EAST BERKSHIRE

*That this meeting* does not believe that the workload of junior hospital doctors has been effectively reduced by the promulgation of shorter working hours. BMA council is requested to pursue a vigorous policy to achieve a true reduction in their workload in a manner which recognises the educational needs of junior hospital doctors as well as their service commitment. CB (J)

EAST KENT

*That consultants* over 55 years of age should not be expected to work an onerous on call rota. NR (S)

FORTH VALLEY

*That this meeting* insists that work for waiting list initiatives within NHS hospitals be classified as overtime and remunerated as such. NR (S)

GLOUCESTERSHIRE

*That consultants* in acute specialties lacking middle grade staff should not be compelled to work beyond 72 hours a week on call. NR (S)

GREAT YARMOUTH AND WAVENEY

*That this association* should encourage purchasers to make the implementation of the new deal for junior doctors implicit in their contractual arrangements with provider units and seek guarantees of such implementation in the form of penalty clauses. CB (J)

HAMPSTEAD

*That this meeting* deplores the lack of medical manpower planning which does not balance the need for adequate training with the need for service provision and proposes that more senior doctors are required if both these needs are to be satisfied. NR (J)

*That this meeting* proposes that all consultants need ongoing medical education and should have guaranteed paid study leave with full expenses. CB (S)

LEICESTERSHIRE AND RUTLAND

*That this body* deplores the strict adherence given to limiting junior doctors' hours which is proving counterproductive as it produces a less well trained workforce with loss of continuity of care. L (J)

MID SURREY, KINGSTON AND ESHER

*That this meeting* considers that consultants in communicable disease control should be the medical officers concerned with enacting section 47 of the National Assistance Act 1948. NR (PH)

*That this meeting* considers that regional consultants committees should be instructed not to hold meetings at such times and in such places as to preclude the attendance of the majority of their members. W (S)

NORWICH

*That this meeting* deplores politically motivated decisions to increase consultant numbers when there are insufficient adequately trained junior staff in some specialties to make up these posts. NR (J)

ORMSKIRK AND SKELMERSDALE

*That the BMA* should reconsider its support for shorter working hours for all junior doctors. If applicable to all junior hospital doctors it would jeopardise the training in some specialties. L (J)

*That hospital employees* should have free car parking. If feasible, this should be in a safe and secure staff car park. Priority should be given to staff on emergency call from their homes. C (S)

ST HELENS AND KNOWSLEY

*That performance related pay* for general practitioners is not compatible with a pool system of remuneration. CB (LMC)

*That this representative body* is concerned about the implications for consultants' workload in the light of the proposed reduction in juniors' hours of work and junior doctor numbers. CB (S)

SEFTON

*That this meeting* supports the view that appointments to consultant posts should continue to be based on merit alone, and time spent in training should not be the sole criterion for satisfactory completion of training. CB (S), NR (J), NR (PH)

SHEFFIELD

*That this meeting* does not consider the staff grade to be a consultant equivalent and urges the CCSC to seek: (*a*) the protection of the original, defining, terms and conditions of the staff grade; (*b*) adherence to the quota for staff grade posts of 10% of consultant numbers. NR (S)

SHROPSHIRE

*That the GMSC* should compose and maintain a register of non-fundholding general practitioner commissioning groups in order to support their activities. NR (LMC)

SOMERSET

*That with the increasing* involvement of consultants in management there is a need for recognition of properly organised and funded courses of training in this field. NR (S)

SOUTH BEDFORDSHIRE

*That this meeting* deplores the concept of a two tier consultant grade as proposed by NAHAT. CB (S)

*That this meeting* views the increasing implementation of short term consultant contracts with grave concern, because of the detrimental effect on the continuity of patient care, and the detrimental effect on recruitment and the development of the consultant's career structure. NR (S)

SOUTH MIDDLESEX

*That the BMA* insist that health authorities and trusts provide realistic part time and job share facilities for consultant members who need such for family or other reasons. CB (S)

SOUTH TYNESIDE

*That this meeting* considers it unacceptable that when consultants are providing emergency cover they should be required to be resident on call. CB (S)

*That this meeting* considers there to be an urgent need to increase the number of consultant posts and that the number of doctors in training should be appropriate to the number of consultant posts available. NR (J)

STOCKPORT

*That this meeting* proposes that adequate central funding should be made available for additional paramedical support required for the successful implementation of the new deal. C (J)

WARRINGTON

*That the British Medical Association* ought to make it clear to the government that properly trained and increased medical staffing is fundamental to meeting the demands of the National Health Service. NR (J)

WIRRAL

*That this meeting* insists that a system of sufficient monitoring must be in place, with adequate regard to the time taken for the collection of data, in order to assess accurately the implementation of the new deal on junior doctors' hours of responsibility. NR (J)

*That this meeting* deplores the high level of wastage in training grades and insists that this should be more closely controlled. NR (J)

WORCESTERSHIRE

*That this meeting* insists that the Department of Health increases the remuneration of young doctors engaged in higher professional training and clinical research in order to match the salaries of their hospital based contemporaries. NR (J), NR (COMAR)