regimens, and treatment centres are not likely to be an affordable option for the resource-poor countries with the bulk of multidrug-resistant tuberculosis in the foreseeable future. Owing to the lack of laboratory infrastructure in Uzbekistan, and central Asia as a whole, Médecins Sans Frontières had to fly out all sputum samples to a laboratory in Germany just to gauge the extent of the problem in this region. The difficulties and costs involved in doing such a survey might well mask the extent of the drug-resistance problem globally.

In response to the high level of multidrug-resistant tuberculosis in Uzbekistan, Médecins Sans Frontières is now implementing a pilot DOTS-Plus programme under the auspices of WHO’s Green Light Committee. This pilot programme aims to demonstrate the feasibility of DOTS-Plus in this setting, given adequate resources and technical support. The pilot programme will treat an initial cohort of 100 patients over 3 years. The pilot programme includes the establishment of a specialist laboratory capable of drug susceptibility testing and a large investment in training of local staff.

However, the DOTS-Plus pilot programme will cover only about 100 patients of the 800 who would be diagnosed with multidrug-resistant tuberculosis every year if drug susceptibility testing was available for all presenting tuberculosis patients. Pilot programmes are therefore just a start. The scale of the problem in the rest of Uzbekistan, and the rest of the former Soviet Union, can only be imagined.

In such settings, in which the presence of multidrug-resistant tuberculosis is a major barrier to tuberculosis control, and in which local resources do not permit the provision of essential services such as adequate laboratory and treatment facilities, international resources must be mobilised to offer these patients a treatment option where a treatment option exists.

Normative role for medical humanities

Sir—Several recent papers, including a Commentary in this journal,1 have attempted to set out a vision of the aims of medical humanities in medical education. Leaders in this fledgling specialty have been cautioned against becoming elitist and exclusionary.2 In this debate, however, one important theoretical contribution seems to have been overlooked.

Medical humanities remain to be thoroughly assessed as a normative tool—ie, a mechanism of critical reflection on the fundamental human virtues and principles of conduct that underpin regulatory systems. So conceived, medical humanities can represent a tangible manifestation of the idealistic norm-creating process that John Rawls in his Theory of Justice terms “reflective equilibrium”.3 Ronald Dworkin calls a similar jurisprudential method “law as interpretation”4 because it involves the judiciary’s attempting to discern and render coherent the mass of normative principles on which their community has reached apparent consensus.

The criticisms by legal positivists of such normative techniques seem to have dimmed somewhat with the passage of legislation such as the Human Rights Act 1998 (UK) and the New Zealand Bill of Rights Act 1990 (NZ), as well as the recently announced Human Rights Act of the Australian Capital Territory. Such acts encourage the relevant judiciary and legislatures to engage in international normative consensus on a grand scale.

The project to expose the theoretical foundations of medical humanities to jurisprudential, philosophical, and regulation-theory analysis could see it emerge as an important strategy for awakening and supporting the sense of conscience that the foundational ethical codes and central instruments of human rights place at the heart of professional rule development and obedience.5

Questions that the Centre for Medical Humanities and Human Rights at the Australian National University plans to research include how best to depict or discern and render coherent the mass of principles of medical ethics, health law, and human rights. The normative role of conscience, via professional destruction to ensure effective use of principles of medical ethics, health law, and human rights.

Likewise scrutinised will be medical humanities’ involvement in the rigorous assessment of how best to ensure that modern doctors are prepared, encouraged, and supported to challenge injustice, inhumanity, and human rights violations.

Medical humanities, then, might yet find that among its central roles in medical education is the nurturing of an active professional conscience in graduates. One method of doing this might involve the arousal and encouragement to practical expression of the foundational virtues (eg, justice, fairness, empathy, compassion, and loyalty to the relief of patients’ suffering) that normatively generate and support the use of principles of medical ethics, health law, and human rights. The normative role of conscience, via medical humanities in professional regulation, should become a valued area of interdisciplinary research.

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1 Bolton G. Medicine, the arts, and the humanities Lancet 2003; 362: 93–94.

Prevalence of iodine deficiency worldwide

Sir—Vitti and colleagues1 have reported on iodine deficiency in Europe, and Koutras and colleagues2 have described the situation in Greece. We present a report on the situation of this deficiency worldwide.

Iodine deficiency is the main preventable cause of brain damage in children and therefore constitutes a public-health concern worldwide. Assessment of the magnitude of iodine deficiency disorders (IDD) and monitoring of the progress made towards its elimination represent the cornerstone of the strategy for IDD control. Over the past few years, WHO has developed a database on IDD, in which data on urinary iodine and goitre from all countries of the world are compiled. On the basis of urinary iodine data collected during

WHO regions* | Population‡ with urinary iodine <100 μg/L
---|---
| General population | School-age children |
Africa | 280,325,000 (42.6%) | 49,465,000 (42.3%) |
Americas | 75,083,000 (9.8%) | 9,955,000 (10.1%) |
Eastern Mediterranean | 228,451,000 (54.1%) | 40,224,000 (55.4%) |
Europe | 435,452,000 (56.9%) | 42,215,000 (59.9%) |
Southeast Asia | 624,013,000 (39.8%) | 95,628,000 (39.9%) |
Western Pacific | 365,352,000 (24.0%) | 47,056,000 (25.7%) |
Total | 1,988,654,000 (35.2%) | 284,543,000 (36.4%) |

1993–2003, the current national, regional, and worldwide prevalence of iodine deficiency has been estimated. The estimates presented focus on urinary iodine, since it is a more reliable indicator of recent iodine status than clinical goitre. However, clinical goitre prevalence was used to compare the 2003 results with those of the previous decade, for which figures for urinary iodine were not available.

For each country, the most representative estimate of iodine deficiency was selected by use of two criteria: the administrative level for which the sample is representative (eg, national, regional, or local) and the population groups surveyed (eg, school-age children, pregnant women, adults). The database and results of the epidemiological analysis are available at: http://www3.who.int/whosis/ (accessed Oct 14, 2003).

The results show that data for urinary iodine have been collected for 92% of the world’s population. Globally, more than 1·9 billion individuals have inadequate iodine nutrition (defined as urinary iodine excretion <100 μg/L), of whom 285 million are school-aged children (table). The world prevalence of school-aged children with inadequate iodine nutrition is 36·4%. The lowest prevalence is found in the Americas (10·1%) and the Western Pacific (25·7%), whereas the highest prevalence is found in Europe (59·9%).

These findings show that iodine deficiency is still a public-health problem in some regions of the world. Salt iodisation is the recommended strategy for IDD control, since it has been shown to be an effective way of reducing the prevalence of IDD. The lowest prevalence of iodine deficiency is found in the American Region, where the proportion of households consuming iodised salt is the highest in the world (90%), and the highest prevalence of iodine deficiency is in the European Region, where the proportion of households consuming iodised salt is the lowest (27%).

The correct

We hope that this information system will be maintained in order to monitor the IDD situation and track progress towards the goal of global IDD elimination adopted by the World Health Assembly in 1990. *Bruno de Benoist, Maria Andersson, Bahl Takkoouche, Ines Egli
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What’s major about adverse cardiac events?

Sir—The major finding of Joachim Schofer and colleagues’ E-SIRIUS study (Oct 4, p 1093) is that, although more than 40% of control patients had angiographic restenosis, only 5% had serious clinical events. The so-called major adverse cardiac events that drive the difference between the two study groups include the soft endpoint “need for target lesion revascularisation”. The study confirms that, in 2003, you can’t stop an interventional cardiologist. To quote Abraham Kaplan: “Give a small boy a hammer and he will find that everything he encounters needs pounding.”

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A conspiracy against the professions

Sir—As an old man, like those who twittered like grasshoppers on the walls of Troy as the battle raged below, I have a privileged spectator’s view of what is going on while still being concerned about my duty to the past and future of our (or, in my case) profession. One of my own mentors—the otherwise liberal and left-wing-leaning child psychiatrist, Donald Winnicott—warned me when I first qualified that the establishment of a centralised health service would lead inexorably to the loss of professional independence and the bureaucratisation of our practice, as has now happened in the UK under the successive onslaughts of Thatcherism and Blairism.

Now the chief executives reign supreme, like the generals in 1914–18, with no personal experience of service, while those delivering the sophisticated and humane care that the public is told it has a right to expect struggle like Laocoön in coils of red tape and regulations before even getting to grips with the real enemy—ie, human suffering caused by disease. It is a great sadness to learn from one’s best pupils that, in the prime of their life, what they look forward to is either retirement or a move sideways into one of those semi-administrative positions that confer more status, pay, and prestige than bedside medicine and clinical research. One is tempted, with regard to politicians and journalists in their relationship with the professions, to borrow the Kleinian concept of envious destruction.

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Zaidi FH, Weir R, Fielder AR. Reporting on the eye and other surgical organ systems. Lancet 2003; 362: 1915–16—In this Correspondence letter (May 31), R Weir’s address should be “Institute of Ophthalmology, University College London, London, UK” and A R Fielder’s address “Department of Ophthalmology, Imperial College London, London, UK.” The correct e-mail address for correspondence is “fzai2@hotmail.com”.