

We feel we have produced a thought-provoking study of some aspects of intensive care, including the importance of medical/surgical status. We highlighted the difficulties of measuring and adjusting for appropriateness, disease severity, and casemix, which could provide a useful starting point for further studies. Fielden and colleagues suggest that the answer is obvious to the question of whether, for appropriately referred patients, mortality in those refused intensive care is significantly greater than that of those admitted. Our work shows that the answer is not obvious, but without randomised controlled trials among specific groups of patients, the question may never be properly answered.

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Tackling obesity

SIR—*Lancet* readers may like to know what is planned by the International Obesity Task Force (IOTF) following Per Björntorp's summary (Aug 9, p 423)¹ of its report, compiled by Tim Gill and Vicki Lakin at our WHO Collaborating Centre with input from about 90 international experts around the globe.

In June, 1997, after the WHO consultation,² the IOTF Council (of which Björntorp is a member) accepted WHO's revision and extension of its report to take account of third world concerns, and it agreed on a new 2-year programme. The IOTF has now become a subgroup of the International Association for the Study of Obesity (IASO). It has set up four new working subgroups on childhood obesity, the economic impact of excess weight gain, new approaches to obesity prevention, and health-care systems for obesity management. The childhood obesity group, chaired by Bill Dietz of Boston and involving WHO and other experts, has developed a new set of working definitions of overweight and obesity throughout childhood. These definitions will shortly be published.

IOTF plans to support national obesity associations in drawing attention to new knowledge on obesity because there is so much ignorance and, indeed, prejudice among doctors, health-care managers, and policy makers. Rosenbaum and colleagues' review³ highlights important features of the metabolic resetting of energy regulation and weight stability in the obese. This resetting is not recognised even by some experts, so it is little

wonder that doctors and the public ascribe the obese patient's failure to return to normal weight as a problem of self-discipline. A communication group, led by Stephan Rössner (Stockholm) has begun the process of helping to change perceptions and management practices.

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- 1 Björntorp P. Obesity. *Lancet* 1997; **350**: 423–26.
- 2 Prevention and management of the global epidemic of obesity: report of the WHO consultation on obesity (Geneva, June 3–5, 1997). Geneva: WHO (in press).
- 3 Rosenbaum M, Leibel RL, Hirsch J, Obesity. *N Engl J Med* 1997; **337**: 396–407.

Resistance to methicillin

SIR—D C E Speller and colleagues' report (Aug 2, p 323)¹ might lead us to believe that England and Wales are awash with methicillin-resistant *Staphylococcus aureus* (MRSA) and therefore that invasive staphylococcal infections—ie, septicaemia and meningitis—are best treated with vancomycin. These workers clearly showed that in the thousands of staphylococci tested in hospital laboratories, methicillin resistance has risen from 1.6% in 1989 to 13.2% in 1995. But they did not state how many of their strains were isolated from patients with staphylococcal infections acquired in the community. I suspect it was only a small proportion of strains, and that the incidence of methicillin resistance in staphylococci causing community infections is less than 1%.

Most isolates of invasive staphylococci are obtained from hospital patients, patients who have been on the receiving end of advanced surgical or medical treatment. It is not England and Wales that are awash with MRSA but the hospitals therein. The reasons related to antibiotic use, nursing and medical care failures in hygienic procedures, lack of containment isolation facilities, overcrowding, intensive turnover of beds, transfer of patients from ward to ward, and lapses in controlling the spread of antibiotic-resistant bacteria in hospital. This is compounded by the current trend in competitive hospitals to reduce services that are difficult to justify in terms of income raised. This trend has led to losses of clinical microbiologists, who are the main human resource for controlling the rise in hospital-acquired infection. Control of infection is a time-consuming occupation and requires a visible day-to-day presence where the problems arise. Decreasing staff numbers and

increasing workloads are responsible for this state of affairs, which can only worsen as executives try to balance the accounts.

Some hospitals are getting to be too dangerous for sick patients. I wonder whether Speller and colleagues have the figures on the mortality of patients with MRSA septicaemia?

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- 1 Speller DCE, Johnson AP, James D, Marples RR, Charlett A, George RC. Resistance to methicillin and other antibiotics in isolates of *Staphylococcus aureus* from blood and cerebrospinal fluid, England and Wales, 1989–95. *Lancet* 1997; **350**: 323–25.

Twins behaving badly

SIR—Peter McGuffin and Anita Thaper (Aug 9, p 411)¹ used the Cardiff Twin Register to explore the genetic basis of bad behaviour in adolescents. They found 43 monozygotic (MZ) and 38 dizygotic (DZ) adolescent twins willing to complete self-report questionnaires; but 40% refused. Their definition of bad behaviour included everything from arriving at school late to getting into fights. They tried their results (numbers of naughty MZ and DZ twins are not given) against one simple genetic model and one environmental model. Neither fitted but on the grounds of parsimony they assumed there was a major genetic effect. One might think that a 40% refusal rate would be grounds enough to invalidate this study.

The lack of information on the relative rates of bad behaviour in twins and singletons undermines its applicability to singletons. Twins among your readers may suspect that tests that mostly concern behaviour in school would give strange results in twins. For the benefit of singletons I should point out that when your twin is in the same class, the same playground, and the same year group the chances are that all your little transgressions will be reported back to your parents, and you therefore suffer double jeopardy. This engenders either good behaviour or enhanced sneakiness. Could this effect account for the low levels of bad behaviour reported—only 15% got into fights and only 41% ever arrived late—as well as for the high refusal rate?

With apologies to Janet.

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- 1 McGuffin P, Thaper A. Genetic basis of bad behaviour in adolescents. *Lancet* 1997; **350**: 411–12.