errors (SEs), from which one can calculate confidence intervals
to reach the conclusions we made – that the social gradient in
non-fatal accidents appears not to be increasing and the total
rates are falling in men.

The data published in the Health Survey for England (HSE)
2001 refer to social class of the head of the household, as is now
customary in the HSE, while the rates presented in our paper
were based on the respondent’s social class, which was used in
the 1995–1996 survey. The sample sizes are provided in the
Table for readers’ interest.

Yours faithfully,
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Sirs,

We read with interest the article by Taylor and Cheng1 which
describes the significant social class gradient in breast cancer
types and the outcome of potentially unnecessary mastectomies.
These important findings demand a healthcare response
although the multi-factorial aetiology of breast cancer will
inevitably mean that changes to service delivery will be challeng-
ing to implement. This population-based cross-sectional study
made good use of postcode data and Townsend scoring to assess
levels of deprivation.

We note that no adjustment was made for ethnicity or smok-
ing history and these are both plausible confounding factors, for
example, ethnicity might explain the general oestrogen receptor
status gradient through the social classes. It would also be inter-
esting to have a further breakdown of the data for the broad
range of breast cancers which could potentially be contained
within the ‘other’ category in order to know whether or not
tumours of all histopathological types are associated with social
class gradients.

The finding that there was no significant difference in time of
presentation between women who were identified via the breast
cancer screening programme and those who entered the system
via other pathways was of particular interest and it raises
questions about the effectiveness of the NHS Breast Cancer
Screening Programme.

The authors correctly acknowledge the large amounts of
missing data may bias the results. As a general point we are
concerned that 19 per cent of patient notes were unobtainable as
we think that this may have important implications for con-
tinuity of clinical care within the NHS.

References
1 Taylor A, Cheng KK. Social deprivation and breast cancer. J Publ Hlth

Yours faithfully,
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Situational awareness in public health

Sirs,

In his editorial1 Edmund Jessop uses the example of a crash
between two 747s on the runway at Tenerife Airport to remind
us of the importance of using the contribution of everyone
present at a meeting when reaching conclusions or decisions.

The pilot of the aircraft that started to take off in poor
visibility while another aircraft was still on the runway was a
very senior training captain. He was held in some awe by more
junior crew members, who were likely to be uneasy about
challenging his decisions.2 This ‘management by domination’,
imPLICIT OR explicit, has become a feature of the NHS over the
last decade, and I cannot be the only person who has heard it
said that ‘if you fall out with x that is the end of your career’.

Airlines have learned the hard way that this management style
does not work in the longer term, and have introduced ‘crew
resource management’ to overcome it. Perhaps the NHS needs
to consider something similar.

Another useful lesson from this disaster is that the same
word can mean different things. In the 1970s the use of ‘clear’ in
aviation might mean unobstructed (‘is the runway clear?’),
vacated (‘have you cleared the runway?’), audible (‘reading you
loud and clear’), or an authorization (‘you are clear to take
off on runway 25’). Since Tenerife the use of words has been
codified more strictly, and ‘clear’ may only be used by an air
traffic controller to authorize manoeuvres such as take-off,
landing, routing, etc. Perhaps public health practitioners should
remember that words and expressions such as ‘primary care
drinking’, and others that trip off our tongues daily, may not
mean the same to the general public as they do to us.
In addition, three doses do not automatically guarantee a sufficient protective titre. It is well known that the percentage of IDUs who do develop a protective titre after vaccination is lower than in the general population: 95–99 per cent of young adults in the overall population who receive a series of three doses develop a protective serum titres, and 77 per cent in our study. Often, additional doses are required for seroconversion.

Although the concentration of antibodies to HBV depends on the time between the second and the third dose, institutions other than centres for drug users could administer quicker vaccination protocols than the classic 0–1–6 (0–1–2 or quicker), with higher doses of the vaccine, if needed (40 μg or more), since many patients are HCV positive and high alcohol consumers, both factors contributing to a negative antibody response.

Given the high risk of hepatitis B infection among heroin users, we suggest that voluntary hepatitis B vaccination for heroin users become a standard public health practice in drug treatment service centres; this clearly requires staff training since the patients are known to be difficult to treat.

References


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