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In response

This letter raises two important issues concerning the assessment of pain in people with communication impairments.

The first questions the validity of judging the presence and severity of pain from observed behaviours in a communication-impaired population. For some of these individuals there is no other option but to assess pain by proxy and we would entirely agree that the generic behavioural pain scales that have been developed for this purpose are neither reliable nor sensitive enough to provide more than a suggestion of the presence of pain or discomfort. Further detective work on the part of the clinical team is essential before decisions can be made about intervention.

The second concerns a patient's ability to comprehend the concept of pain sensation, as opposed to pain affect or other distress, and to use a pain tool to indicate its presence and severity. We see no reason why dysphasic patients, many of whom are already disenfranchised from engaging in discussion about their care, should not be given the opportunity to convey information about their pain, or any other subjective state, with the assistance of enhanced tools presented by trained staff, for example speech and language therapists. Many of these patients have difficulty using traditional rating scales[1] and we have found that creating a 'communication ramp' by using the scale of pain intensity (SPIN) alongside pictures and gestures can enable some to communicate successfully about pain,[2] which is empowering for both staff and patients.

Caution is, however, always needed when interpreting information about pain, whether through self-report or by proxy, and we would agree with others[3] that a comprehensive pain assessment should consider both these sources as offering complementary perspectives on what is often a complex clinical picture.

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Tuberculosis: where are we going?

Thwaites' excellent editorial detailing the latest advances in research into new drugs, vaccines and diagnostics for tuberculosis (TB) finished on an upbeat note with a call for 'unsurpassed cooperation between scientists, clinicians and politicians' (*Clin Med* November/December 2006 pp 523–5). One word seemed to be missing: money.

Current funding for all research into TB is estimated to be under $500,000,000, approximately half of that required to fund a single drug in development from discovery to clinical use. Yet this amount has to be spread across all drug, vaccine, diagnostic and operational research. A recent report shows that the World Bank funding into TB in Africa is wholly inadaquate.[1] In contrast funding for the World Health Organization's other priorities, HIV/Aids and malaria, is reasonable. As the editorial points out, TB is increasing at 1% a year across the globe and 5% in areas of high HIV prevalence. In the UK the increase over the last year has been 11%.[2]

In 2004 the Chief Medical Officer's report on TB resulted in a flurry of committee activity and well-intentioned recommendations. In 2006 the National Institute for Health and Clinical Excellence published its guidelines on the management of TB.[3] Despite these initiatives, evidence is accumulating that we are not even maintaining previous levels of service as funding is being reduced at a local level.

Unless the world in general and the UK government in particular wake up to the fact that we cannot bring TB under control without adequate resources the situation is going to deteriorate badly.

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Self-harm in the general hospital

Editor – I was interested to read Kapur's article (*Clin Med* November/December 2006 pp 529–32). I would just like to take issue with the perspective which looks largely at the impact of family and society on the behaviour and outcome of the patient, but little in the opposite direction. In particular, I am interested in the impact that a parent's suicide attempt may have on their children, and more alarmingly the strong association between mothers who harm themselves and physically abuse or neglect their children.[1,2] I think it is of paramount importance that when a parent of young children attempts suicide, the welfare and safety of the children is taken into account. This would entail taking a complete family history, and viewing parental self-harm as a child protection crisis. It might involve, with the patient's consent, informing general practitioners, health visitors, school nurses or paediatricians. I would certainly recommend that in