Assessment of the SF-36 version 2 in the United Kingdom

Emily D. Sainsbury, D. Butterworth, E. B. et al.

LETTERS TO THE EDITOR

Editor,—I read with interest the recent article on the SF-36. The authors present data regarding the psychometric properties and epidemiological characteristics of the SF-36 version 2. The authors present the results from a large sample of people aged 18–64. The analysis reveals that the questionnaire has good internal consistency and construct validity. The layout of the new questionnaire is certainly improved and in this respect I think that participants will find it easier to complete. However, I believe that many of the problems that were inherent in the original version have not been resolved. The validity and reliability of the questionnaire relies in part upon people completing it accurately. Any change in the questionnaire’s format should be designed to improve the accuracy of users responses, which will in turn improve the psychometric qualities of the questionnaire.

The authors concede that the present data are only based upon people of working age and so it remains unclear how suitable this measure is for older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I believe that many of the problems that were inherent in the original version have not been resolved. The validity and reliability of the questionnaire relies in part upon people completing it accurately. Any change in the questionnaire’s format should be designed to improve the accuracy of users responses, which will in turn improve the psychometric qualities of the questionnaire. The authors concede that the present data are only based upon people of working age and so it remains unclear how suitable this measure is for older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I believe that many of the problems that were inherent in the original version have not been resolved. The validity and reliability of the questionnaire relies in part upon people completing it accurately. Any change in the questionnaire’s format should be designed to improve the accuracy of users responses, which will in turn improve the psychometric qualities of the questionnaire. The authors concede that the present data are only based upon people of working age and so it remains unclear how suitable this measure is for older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.

In my personal experience I would suggest that the SF-36 is not a suitable measure to use with older age groups. The main shortcoming with the questionnaire is not the layout but rather the language of the questionnaire. I would be grateful for an opportunity to draw your attention to my experiences.
offered such criticisms of the SF-36 but have produced scarcely scientific proof to support their claims. Claims that the measure is inappropriate for the elderly are more often than not based upon little more than anecdotes, rather than rigorously conducted qualitative studies. Secondly, Dr Lloyd suggests that there will be errors in the answers provided by older respondents to the questions on the SF-36. This is not particularly surprising and is to be expected with all age groups. All questionnaire items consist of true measurement plus an error term. The trick is to reduce the error term as much as is possible. This is why health status measurement has been the most part adopted multi-item scales. If we take mortality as the underlying attribute then the summed score of all the items will be more reliable than a single question. This is because all true measurement from each item will be summed while error terms on all the items will be random and, effectively, non-additive (the logic here is that for every person who scores a little high on a given item there will be someone who scores a little low, and so on). This, of course, assumes that items have been selected carefully and are neither unrelated or too closely related; an assumption that is implicitly built into the SF-36.

Recent data report on the successful use of the SF-36 in older patients in a large scale survey. Normative data are available. This evidence would seem to suggest the SF-36 is useful in this patient group, but specific research would have to be undertaken to establish a world that now embraces evidence based medicine it might be wise to adopt a similarly rigorous approach to questionnaire selection and application.

CRISPIN JENKINSON

Health Services Research Unit, University of Oxford, Institute of Health Sciences, Oxford OX2 7LP

8 Greenland S, Morgenstern H. Ecologic, bronchitis and emphysema, and ischaemic heart disease. Three diseases that are strongly related to smoking, and other smoking related diseases accounted for two thirds of the excess mortality, and other smoking related cancers accounted for a further sixth of the excess. Diseases reflecting other harmful effects (strokes of the liver, AIDS), or differences in medical care, accounted for little of the total excess mortality, while two important aetiological factors in circulatory diseases, serum cholesterol and blood pressure, show little difference between deprived and affluent districts (see references 37–39 in our paper).

Blakely has three concerns about our smoking related death analysis. We do not think that the “ecological fallacy” of Greenland and colleagues (which may produce a bias in either direction) is a material problem in this context, particularly as we are not inferring relationships at the individual level, but rather of relations between smoking and diseases through confounding is unlikely. Asbestos and other occupational exposures that cause lung cancer may be more common in smokers, but these exposures cause relatively few lung cancer cases in relatively low districts. Associations between smoking and other heart disease risk factors tend to be weak, and as stated above, blood pressure and serum cholesterol show little variation between affluent and deprived districts. Blakely suggests that relative risk estimates from the British Doctors Study are not generalisable. The results of the British Doctors Study in relation to smoking have in general been supported quantitatively by other large cohort studies, and we confirmed this for ischaemic heart disease. Moreover one would expect estimates of relative risk to be generalisable. The proportion of excess mortality in smokers should be the same in populations where smoking is relatively common or uncommon or where, for reasons other than smoking, the disease is relatively common or uncommon.

M R LAW

Department of Environmental and Preventive Medicine, Willesie Institute of Preventive Medicine, University of Medicine, Chancellors Square, London E14 2BQ

1 Law MK, Morris J. Why is mortality higher in poorer areas and in more northern areas of England and Wales? J Epidemiol Community Health 1998;52:444–45.
6 Gordon SM, Morgenstern H. Ecologic, bronchitis and emphysema, and ischaemic heart disease. Three diseases that are strongly related to smoking, and other smoking related diseases accounted for two thirds of the excess mortality, and other smoking related cancers accounted for a further sixth of the excess. Diseases reflecting other harmful effects (strokes of the liver, AIDS), or differences in medical care, accounted for little of the total excess mortality, while two important aetiological factors in circulatory diseases, serum cholesterol and blood pressure, show little difference between deprived and affluent districts (see references 37–39 in our paper).

Blakely has three concerns about our smoking related death analysis. We do not think that the “ecological fallacy” of Greenland and colleagues (which may produce a bias in either direction) is a material problem in this context, particularly as we are not inferring relationships at the individual level, but rather of relations between smoking and diseases through confounding is unlikely. Asbestos and other occupational exposures that cause lung cancer may be more common in smokers, but these exposures cause relatively few lung cancer cases in relatively low districts. Associations between smoking and other heart disease risk factors tend to be weak, and as stated above, blood pressure and serum cholesterol show little variation between affluent and deprived districts. Blakely suggests that relative risk estimates from the British Doctors Study are not generalisable. The results of the British Doctors Study in relation to smoking have in general been supported quantitatively by other large cohort studies, and we confirmed this for ischaemic heart disease. Moreover one would expect estimates of relative risk to be generalisable. The proportion of excess mortality in smokers should be the same in populations where smoking is relatively common or uncommon or where, for reasons other than smoking, the disease is relatively common or uncommon.

M R LAW

Department of Environmental and Preventive Medicine, Willesie Institute of Preventive Medicine, University of Medicine, Chancellors Square, London E14 2BQ

1 Law MK, Morris J. Why is mortality higher in poorer areas and in more northern areas of England and Wales? J Epidemiol Community Health 1998;52:444–45.
Bracken fern consumption and human bladder cancer

Editor—In a recently published paper, Wilson et al reviewed four studies that explored the relation between bracken and human health: a case-control study of gastric cancer in North Wales; a cohort study of oesophageal cancer in Japan; an ecological study in North Wales that compared standardised mortality and incidence rates for gastric and oesophageal cancer in 34 districts with survey maps of bracken areas; and an ecological study in Costa Rica that compared age specific incidence rates for gastric, oesophageal, and cervical cancer among people from bracken free compared with bracken infested areas. Although some weak associations were noted in these studies, Wilson et al argued that statistical analyses were limited and that little evidence exists for a carcinogenic hazard from bracken.

We would like to call attention to the results of our case-control study that assessed the risk of bladder cancer from bracken fern consumption. Bracken has been shown to be carcinogenic in experimental and observational animal studies, producing bladder tumours in guinea pigs and cattle.1 Our study was conducted in northern New England to determine reasons for the high bladder cancer mortality rates in this area.

The study included all white residents of Vermont and New Hampshire who died during 1975-79 from bladder cancer. Two randomly selected controls per case, matched on state, gender, race, age (52 years) and year of death, were randomly selected from all other resident deaths (excluding suicides). A questionnaire sought information on demographic characteristics, lifestyle occupational and residential histories, history of tobacco and beverage use, medical history including bladder infection, and consumption of selected dietary items including bracken fern (fiddlehead greens). Interviews were conducted with the next of kin of 325 cases and 673 controls. Odds ratios (OR) were calculated with the next of kin of 325 cases and 673 controls. Odds ratios (OR) were calculated by fitting logistic regression to the data.

Our reply to Wilson et al.

Letters

We would like to add some caveats, without which the argument is not strictly correct. These caveats are unconventional in Bayesian theory but are supported by Lindley and, presumably, Burton et al. We hope that it will be helpful if we make them explicit.

In the first place, the result of a standard analysis cannot be interpreted as a Bayesian result if the analysis has incorporated any of the following elements:

1. Rejection of corrections or other adjustments to error levels.
2. Analyses that are mathematically multimodal even though there is a unimodal underlying cause—measured for example, standard methods for analysing clinical trials with interim analyses
3. Analyses that ignore sources of variance—for example, common methods of evaluating survey data that take into account sampling variation but not measurement error
4. Conditional designs that violate the likelihood principle by adjusting the results of any part of an analysis on the grounds that another analysis was either planned or carried out—for example, clinical trials again
5. Test statistics chosen for their frequentist properties—for example, unbiased statistics used in preference to more natural or more powerful biased statistics.

It can be seen from this list that the design of Bayesian studies can be markedly different from the more common frequentist designs. A major benefit of Bayesian theory to the practising epidemiologist is the fact that Bayesian designs can be more natural in their design. For example, in a Bayesian design conservatively planning results to be modelled and not to model the design and not have to be adjusted according to the number of analyses.2

In summary, there are many cases in which Bayesian theory can be used to provide a useful alternative interpretation to a standard calculation, as Burton et al suggest; but there are other cases in which a Bayesian analysis yields not only a different conclusion but also a different design and different numbers.

JASON GROSSMAN

Department of History and Philosophy of Science, University of Melbourne, Parkville, Victoria 3010, Australia

MAHESH K B PARMAR

Cancer Division, International Agency for Research on Cancer, IARC, Place de la Bordée, 69372 Lyon, France


Reply

We thank Dr Grossman and Dr Parmar for their positive comments. Their letter provides a valuable addendum to our original paper1 and, as they assumed, we concur completely with what they have written.

The conclusion of Wilson et al of no serious health threat to exposed populations.

LINDA MORRIS BROWN

SHEILA HOAR ZAHM

ROBERT S HOOVER

Division of Cancer Epidemiology and Genetics, National Cancer Institute, Bethesda, MD 20892, USA


Human rights—a public health issue?

The year 1998 was important as it helped us to make a clear connection between two key global issues—human rights and public health. The two anniversaries, the 50th anniversary of the enactment in the UK of the first ever national Public Health Act in 1848, and the 50th anniversary of the Universal Declaration of Human Rights proclaimed by the General Assembly of the United Nations on 10 December 1948, added further momentum to the implicit connection. An added bonus was the UK government’s decision to incorporate the European Convention of Human Rights into the UK law, thereby increasing the utility of the Convention for UK citizens. In the United Kingdom the Medical Foundation, whose patrons include Sir Richard Doll, has given the connection between human rights and public health a new vigour through its advocacy and pastoral work in the field.

The chains linking public health and human rights are the Covenant on Civil and Political Rights and the Covenant on Economic, Social and Cultural Rights. These covenants lay the main foundations of the Universal Declaration.

The first covenant details the basic civil and political rights of individuals and nations. This covenant provides for the following rights for nations:

- the right to self determination
- the right to own, trade and dispose of their property freely and not deprived of their means of subsistence.
- the right to freedom of movement
- the right to privacy and right to protection of that privacy by law
- the right to liberty and freedom of movement
- the right to legal recourse when their rights have been violated, even if the violator was acting in an official capacity
- the right to presumption of innocence until proven guilty
- the right to appeal a conviction

The covenant forbids torture and inhuman and degrading treatment, slavery or involuntary servitude, arbitrary arrest and detention. It further forbids propaganda, advocating either war or hatred based on race, religion, national origin or language.

The second covenant describes the basic economic, social and cultural rights of individuals and nations, including the right to:

- self determination
- paid or otherwise compensated maternity leave
- free primary education and accessible education at all levels
- copyright, patent and trademark protection for intellectual property
- self determination of family size
- free medical care
- free secondary and tertiary education
- right to social security
- right to subsistence
- right to rest and leisure
- the right to freedom of thought, conscience and religion
- the right of national self determination
- the right to work
- the right to form trade unions
- equal pay for equal work
- paid or otherwise compensated maternity leave
- the right to establish and own property
- the right to freedom of association and to form trade unions
- the right to freedom of thought, conscience and religion
- the right to freedom of opinion and expression
- the right of peaceful assembly
- the right to freedom of association
- the right to freedom of association
- the right to the presumption of innocence until proven guilty
- the right to appeal a conviction

The covenant also provides for the right of people to choose freely whom they will marry and with whom they will find a family, and requires that duties and obligations of marriage and family be equally shared between partners. It also guarantees the rights of children and prohibits discrimination based on race, sex, colour, national origin or language.

As well as restricting the death penalty to the most serious of crimes, the covenant also guarantees condemned people the right to appeal for commutation to a lesser penalty and forbids the death penalty entirely for people under 18 years of age.

The covenant permits governments to temporarily suspend some of these rights in cases of civil emergency only, but also lists those rights that cannot be suspended for any reason.

The second covenant describes the basic economic, social and cultural rights of individuals and nations, including the right to:

- freedom of opinion and expression
- the right to the right to information
- the right to freedom of association
- the right to freedom of thought, conscience and religion
- the right to freedom of opinion and expression
- the right to freedom of assembly
- the right to freedom of association
- the right to the presumption of innocence until proven guilty
- the right to appeal a conviction

The second covenant also describes the basic economic, social and cultural rights of individuals and nations, including the right to:

- freedom of thought, conscience and religion
- the right to freedom of opinion and expression
- the right to freedom of assembly and association
- the right to freedom of association
- the right to freedom of thought, conscience and religion
- the right to freedom of opinion and expression
- the right to freedom of assembly
- the right to freedom of association
- the right to the presumption of innocence until proven guilty
- the right to appeal a conviction

The second covenant also describes the basic economic, social and cultural rights of individuals and nations, including the right to:

- freedom of expression
- the right to freedom of association
- the right to freedom of thought, conscience and religion
- the right to freedom of opinion and expression
- the right to freedom of assembly
- the right to freedom of association
- the right to freedom of thought, conscience and religion
- the right to freedom of opinion and expression
- the right to freedom of association
- the right to the presumption of innocence until proven guilty
- the right to appeal a conviction

In addition, this covenant forbids exploitation of children and requires all nations to cooperate to end world hunger. Each nation that has ratified this convention is required to submit annual reports on its progress in providing these rights to the Secretary General of the United Nations. Each country that is a party to the Covenant on Economic, Social and Cultural Rights of the Universal Declaration of Human Rights is required to submit annual reports on its progress in providing these rights to the Secretary General of the United Nations.

The two covenants implicitly recognize and reinforce the World Health Organization’s Charter on health. Human health at a global level can only be effectively sustained if individuals within nations have certain enshrined rights that enable them to shape the outcomes of the key decisions that affect resource use and allocation within and between nation states.

The Universal Declaration of Human Rights needs champions within nations, both to keep the Declaration in the public eye and to assist individuals whose rights as defined by the Declaration have been breached or violated. There are many such organizations based in a number of countries. The Medical Foundation is one such body, and is prominent in the UK. The main focus of the Foundation’s work is campaigning on behalf of victims of torture. The Foundation also meets the immediate care needs of victims of torture.

The Medical Foundation is one such body, and is prominent in the UK. The main focus of the Foundation’s work is campaigning on behalf of victims of torture. The Foundation also meets the immediate care needs of victims of torture.

The Foundation’s work is likely to acquire an added significance now that there is widespread support for the setting up of an International Criminal Court. A majority of the countries that call for the Court to be a permanent tribunal with universal jurisdiction over individuals responsible for systematic violations of human rights. It is argued with force that the creation of a judicial institution is crucial to the struggle against the culture of impunity that is prevalent throughout the world. By designating massive and systematic violations of human rights as crimes and effectively prosecuting the violators, the international community would show its resolve to uphold justice and the rule of law as the foundation of peace and security. So far 74 states have signed the Rome Statute Signature and Ratification Chart, however it needs 60 states to ratify the Statute for the Court to be set. So far only one state, Senegal, has ratified the Statute. It is vital that internationally the public health movement persuades more nations to ratify the statute to enable the Court to become operational.

Public health practitioners have a vested interest in supporting the work of bodies such as the Medical Foundation, as they help to remind us that the twin goals of health and human rights for all are attainable, the obstacle being us collectively. The human rights agenda is vital for public health practitioners. It is too important for us to ignore it.
Assessment of the SF-36 version 2 in the United Kingdom.

A Lloyd

J Epidemiol Community Health 1999 53: 651-652
doi: 10.1136/jech.53.10.651

Updated information and services can be found at:
http://jech.bmj.com/content/53/10/651.citation

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/