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 arouse “conscience” and to map its relation to professional virtue, ethical principle, law, and human rights. Similarly subject to scrutiny will be how and whether we should encourage medical students to accept potential roles as conscience-motivated “whistle-blowers” who risk personal and professional destruction to ensure greater individual safety for patients as well as more transparent and enforceable norms of clinical governance. 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 efficient 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.

**Prevalence of iodine deficiency worldwide**

Sir—Vitri 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

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

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