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NCAA has not been given sufficient tools to identify poorly performing doctors

EDITOR—The government has announced a new organisation, the National Clinical Assessment Authority (NCAA), which is apparently charged with identifying poorly performing doctors. It is, however, in danger of failing to do its task because it has not been given the tools it needs to achieve this.¹ There are three types of regular review needed by any professionals who are entrusted with the safety of patients.

The first meeting is for individual professionals. They may want a regular meeting with a person they trust and respect, at which they can discuss in confidence all aspects of their professional lives, so that they can give of their best. This meeting should be reflective, not judgmental. It is sometimes called a professional review, mentorship, or appraisal.¹⁻⁴

The second meeting is for the employer to review individual job plans. The organisation has its service goals, and employees have their own professional and developmental needs. The meeting is a negotiation, to bring these different goals together and to agree them. The rules of negotiation should apply, and an agreed job plan is the result.¹

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The third meeting is needed by those held accountable by the public to uphold standards of safety. All professionals who are trained and then licensed to perform a potentially dangerous task on the public must have a regular objective external review of a their performance against defined standards of quality of clinical practice.⁴ This cannot rely on the consultants submitting evidence of their own competence (self assessment), because the system must be robust to lack of insight. Neither can it rely on simple peer assessment because this is not objective. Complaints by patients are only one important source for identifying unsatisfactory practice, necessary but not sufficient to do the job required.

There is nothing pleasant about this task. The public has the right to expect it to be comprehensive, quick, and merciless. A meeting that tries to blend the functions of mentoring, job review, and assessment cannot work: each has a different task and structure.⁴

At the moment we do not have the objective criteria on which standards of clinical practice can and should be regularly assessed. Only when we do can a statutory body undertake the duties the public has every right to expect if they are to have trust in the profession.

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1 Bulstrode C, Hunt V. What is mentorship? *Lancet* 2000;356:1788.

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Revaluation should be part of revalidation

EDITOR—Pringle, in his review of clinical governance in primary care, says that some underperformance is due to local deprivation and health inequities, some to poor systems of care, and some to under-resourcing.¹ Where it is due to an individual, the cause may be a health problem or problems with competency or behaviour.¹

As the bandwagon of clinical governance clatters down Mount Worthiness, may I make a small plea for those who suffer because of the job, and in whose interest, and that of their patients, the best solution would be to fix the job and not the person.² I am currently supporting a primary care group governance lead and three mental health leads (I'll leave out the two psychiatrists)—all highly dedicated, intelligent and caring people who have been off sick with stress for months. Studies consistently show the high levels of stress, anxiety, depression, and burnout that are endemic in many of the ground force, the hapless individuals who have to flesh out the third way or deal with the increasing denizens of the learned helpless and often overmedicalised British population. All the above states of mental ill being are associated with impaired quality of medical care, inappropriate behaviours, and poor performance affecting clinical judgment. As part of revalidation should come revaluation, whereby general practitioners are praised and applauded for surviving yet another year in the NHS (we could call this the "plaudit cycle"). They should also have a full physical and mental health checkup as part of this annual appraisal. Performance links intimately to feelings of control over workload, self worth, sense of value invested by management, and purposefulness.

At a time when we are gleaning new general practitioners from New Zealand and nurses from China and South Africa, perhaps those with any conscience or ability to see beyond the end of their short term political noses could also be encouraged to indulge in some "joined up thinking" to see the worth and value of all that homegrown talent? Unless the NHS starts valuing, and caring for, its employees and those in monopolistic contract to it, the brains will continue to drain. PriMHE has coined the term mental wealth, a national commodity which should be highly valued. The term clinical governance is about as warm and welcoming as a bite from a rottweiler—how about, "Helping you help your patients better"?

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Competing interests: PriMHE is a primary care educational and mental health initiative currently funded by Lundbeck, SmithKline Beecham, Pharmacia, Pfizer, and Priory Healthcare.

1 Pringle M. Participating in clinical governance. *BMJ* 2000;321:737-40. (23 September.)

2 Chambers R, Maxwell R. Helping sick doctors. *BMJ* 1996;312:722-3.

The two tier syndrome behind waiting lists

Article contained numerous inaccuracies

EDITOR—How can the *BMJ* publish an article that is full of statements about the NHS and doctors that it must recognise as untrue?¹

Light suggests that surgeons and anaesthetists are short changing the NHS. However, independent studies show that most consultants work well over their contracted hours.

Light suggests that consultants control the waiting lists to increase private practice, but waiting lists are mainly a resource problem in a state funded system. To get rid of waiting lists the NHS needs more doctors and more infrastructure or an insurance based system.

Light points out that by working one day a week in the private sector surgeons can double their NHS income. This surely reflects the way that successive governments have failed to maintain the consultant salary and have continued to exploit the medical profession. Doctors would be well rewarded in any other walk of life. There are no perks in hospital medicine—no company cars, bonuses, share options, or private health insurance.

Is it right that senior consultant surgeons should get a maximum of £63 000 a year from the NHS (minus £6000 if they do private work) because they work for a state monopoly employer whereas the prime minister's wife, a lawyer, earns over £200 000 a year? Many consultants do private practice because they enjoy it, but many do it to maintain the reasonable standard of living that they feel they have earned and that their peers enjoy. Is it right that many doctors feel they have to do private work?

The BMA calculates that if the present NHS consultant salary was equivalent to that 20 years ago it would be 50% higher than it is now. How do you decide consultants' salary? By seeing what their market value is and looking at the pay of other comparable professional groups. If Alan Milburn wants to modernise the NHS he could start by paying consultants a realistic salary.

The two tier system that Light describes is not ideal but is better than the American system. In the NHS everyone, not only the rich, has access to the best doctors in the country. Currently, few doctors work purely in the private sector. Most are hard working, conscientious, and dedicated to the NHS, and continual criticism is demoralising.

Light suggests that consultants be made to see NHS patients for a minimum of three days a week. But consultants are already doing this. Most consultants work six or seven fixed sessions (half days), when they see NHS patients, and three or four non-fixed sessions, when they tackle the mountain of non-clinical work expected of them, plus on call commitments. Private practice is performed in addition to this.

I would be happy to show Light what really happens in the NHS. He could then write an article that reflects reality, not anecdote, conspiracy theories, and tabloid sensationalism.

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¹ Light D. The two tier syndrome behind waiting lists. *BMJ* 2000;320:1349. (13 May.)

Market forces have failed to shape development of wage structure in NHS

EDITOR—Although I endorse Pringle's view [above and on *bmj.com*] of Light's Personal view,^{1 2} there are clearly a few "bad apples" known by reputation in most hospitals, and a mechanism to root them out would be of benefit to us all.

The economic "rules" of the NHS are so unnatural that the dedication of most doctors is remarkable. We operate in a system where demand for doctors increasingly exceeds supply, and market forces should dictate that our wages would rise accordingly. Yet we accept employment from a monopoly employer that artificially fixes the wage structure to our detriment. To use Pringle's example, the wage of the prime minister's wife is open to the advantages of the market; ours is not. Were we to provide our services from chambers we would command a more comparable wage and the bad apples would fall by the way.

Market forces have shaped the development of every aspect of the "new" NHS except our wage structure. In that context, there is an Orwellian ring to Light's double speak.

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¹ Light D. The two tier syndrome behind waiting lists. *BMJ* 2000;320:1349. (13 May.)

² Pringle M. Numerous inaccuracies. *bmj.com* 2000;320 (www.bmj.com/cgi/eletters/320/7245/1349#EL11; accessed 5 Feb 2001).

Gatekeeper system is essential

EDITOR—"I'd rather be in Philadelphia" were the words that W C Fields had inscribed on his headstone. Of course, assuming that health care in Philadelphia (where Light works¹) is typical of the American health system, he would have a better than 1 in 10 chance there of not being covered by the state's health insurance.

The NHS currently costs slightly less than half the American system does and provides comprehensive cover. It can do this because of the gatekeeper system, whereby referrals to specialists are vetted by generalists or general practitioners. This system could not work without the agreement of surgeons and anaesthetists, who effectively forego the chance to market themselves direct to the public. If they did this then, as in the United States, health costs would rocket as the provision of services expanded to keep pace with ever increasing demand.

The way to address the problems that Light refers to¹ is by better policing of the few who abuse the present system.

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¹ Light D. The two tier syndrome behind waiting lists. *BMJ* 2000;320:1349. (13 May.)

Problems reflect failure to heed consultants' warnings

EDITOR—It is difficult to believe that the *BMJ* wishes to be taken as a serious medical journal with the publication of Light's personal view.¹ This article is loaded with ex cathedra statements, unsubstantiated claims, and inaccuracies. On Friday 5 May one of our half day operating lists consisted of one patient. One patient was reportedly ill and failed to arrive on the ward, and operations on the remaining two adult patients were cancelled for the third successive time owing to the lack of surgical beds. On Monday 12 June operations on three out of five elective patients were cancelled owing to lack of beds and part of the roof of our twin theatres, constructed in 1930, collapsed, closing that theatre for 48 hours.

Light needs to experience the real world of the NHS hospital service. Waiting lists are lengthening for six reasons:

- The diminished complement of hospital beds over the past five years
- The inability to recruit nursing staff to re-establish ward and theatre teams. In most of the south east of England newly qualified staff cannot afford the cost of living
- The inadequate provision of intensive care unit beds
- The continued occupancy of elective surgical beds by emergency admissions, both surgical and medical, and the inability to discharge patients appropriately to nursing homes, resulting in roughly 8% of acute hospital beds being blocked
- The increased operative and procedure time taken by consultants of all specialties in order to train junior doctors within the Calman training scheme
- The reduced operating sessions available to consultants to permit requirements for formal departmental tutoring and clinical governance meetings.

Our surgical and medical colleagues and their hard pressed secretaries take the responsibility of managing our waiting lists: consultants cannot delegate decisions on whom to operate on, taken on the grounds of clinical necessity, to management.

As doctors we are continually frustrated in our inability not only to undertake non-emergency and non-cancer elective surgery and other procedures requiring inpatient beds but also to teach the next generation of consultants whose training, already foreshortened, is suffering owing to inability to admit elective patients.

The above six reasons have nothing to do with private practice, the maximum part time contract, or shortage of consultants but reflect the inability of successive ministers of

health to heed warnings from hospital consultants on the cumulative effects of bed closures and the Calman training scheme.

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This letter was also signed by 32 members of staff from the Royal Berkshire and Battle Hospitals NHS Trust.

1 Light D. The two tier syndrome behind waiting lists. *BMJ* 2000;320:1349. (13 May.)

Government benefits from current system

EDITOR—Light's article is a perceptive analysis of many things that we British doctors prefer not to think too much about.¹ His argument is that NHS consultants like to have a long waiting list in order to force people into private operations and that the laxity of NHS contracts allows consultants to be absent on private work.

He ignores one glowing fact. Why does he think that for five decades the NHS, under successive governments, has tolerated, even encouraged, such a system? By dangling the carrot of pay at proper international rates in the private sector the government is able to get British consultants to accept an unrealistic low basic NHS salary. When I worked in the United States in obstetrics and gynaecology I was struck that my consultant's indemnity insurance was higher than the entire NHS salary of a British consultant obstetrician.

I note that Light is working in Pennsylvania, and I find it astonishing that he should be unaware of the low pay of British NHS consultants. Why does he suggest that the answer is simply to force consultants to work three days a week when by his own admission they are only paid enough at international and private rates for one day?

It is the government, not doctors, which benefits from this system as lower pay means less of a tax burden, with the private sector subsidising the absurdly low pay of NHS consultants. Consultants would much prefer to be paid adequately by the NHS—then they would not need to do private practice.

Long waiting lists also reduce costs and hence the tax burden. A nine month delay means that people are much more likely not to have the operation: they may not bother to go on the waiting list at all; they may go privately, saving the NHS the cost; they may die or become otherwise too unwell for the operation while waiting; or they may move house, lose their nerve, or learn to live with the problem.

It is astounding that Light should portray this iniquitous system as devised by and run for the benefit of doctors. I am intrigued that he is so full of praise for the government's "heartening change" in attitude to this problem. I note also that his article was quoted in one in the *Sunday Times*, in which many of the same arguments were rehearsed.²

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1 Light D. The two tier syndrome behind waiting lists. *BMJ* 2000;320:1349. (13 May.)

2 Knives out over the NHS reforms. *Sunday Times* 2000 June 4:14-5.

Anecdotes don't constitute sufficient evidence for changing NHS

EDITOR—Light's article will remind most of us who have worked in the NHS of a few doctors who blatantly promote their own interests.¹ It does not seem to recognise the existence of the remaining (large) majority of consultants who work for the NHS at a rate that, by his own reckoning, is 10-20% of private earnings, or less if we consider time on call.

He also implies that all the ills of the NHS are due to the waiting lists. Although this exercises the government and the media, the rest of us know that waiting lists are a symptom of a service cut to the bone by "efficiency savings," so that operations are cancelled for lack of theatre time for emergencies and outpatient departments have too few rooms and too few staff (especially consultants) to see patients any sooner.

It is fatuous to suggest that preventing NHS consultants from practising privately will lead to shorter waiting lists. As consultants choose to earn the same for two days' work as they earn for a week's they will presumably leave the NHS in droves. That they haven't done so already shows the immense commitment to the NHS that most doctors have.

I have no waiting list longer than the clinic next week, and a modest but successful private practice: I have only a two session commitment to the NHS. My full time colleagues in other specialties have no private practice, and yet other constraints of service provision mean there is a continual, although fairly short, waiting list. Waiting lists will disappear only if the NHS pays consultants more, and pays more of them, and, indeed, is generally funded to the level of service we would like to see. If Light carries the day there will be little reduction in waiting lists, although consultants' dissatisfaction with the service will probably fail to match that of bioethicists. I hope I shall be retired before then.

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1 Light D. The two tier syndrome behind waiting lists. *BMJ* 2000;320:1349. (13 May.)

Are consultants undervalued by NHS or profiteering in private practice?

EDITOR—It was interesting to learn from Light that consultants who indulge in private practice can double their NHS salary in a day or even half a day.¹ If this is true, are consultants being financially abused by the NHS if they are being paid a rate one tenth to one fifth of that in private practice, particularly as in the NHS they also have responsibilities for teaching, training, audit, research, and management? Alternatively, are consultants, aided by private health insurance schemes such as BUPA, exploiting

patients' concerns over having to wait and profiteering, or are market forces enabling consultants to be rewarded for skills appropriately in an environment that is not resource limited?

Light does not acknowledge that the KPMG survey showed that both full time NHS consultants and those with a maximum part time "sweetheart contract" work around 60 hours a week.² This is well in excess of the minimum 35 hours required by the contract or expected by the BMA Central Consultants and Specialists Committee, which in 1998 said that it would not be a realistic or defensible position to argue that a group of professionals such as consultants should expect to work only those minimum hours.

Light's conspiracy theory about a two tier syndrome behind waiting lists does not stand up to its surface being scratched. The disruptive impact of medical outliers on surgical services over the recent years because of a poor working partnership between health and social services has been the major factor contributing to lengthening waiting lists. Consultant surgeons are frustrated by physicians preventing them from delivering quality services to their NHS patients. Light has previously indicated that only a minority of consultants exploit their contract.³ If he believes that most are not exploiting their contract and are complying with the duties (both clinical and non-clinical) explicitly outlined in their job plans, how can he realistically claim that government sponsored private practice is one of the main causes of the long waiting lists?

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Surgeons don't work in isolation

EDITOR—The suggestion that waiting lists could be abolished if surgeons were prepared to operate for one additional day a week is appealing, if naive.¹ It assumes that there will be physical theatre space, anaesthetic and nursing staff, recovery room staff, and postoperative beds. In my experience surgery has been limited by all of these but never by lack of an available surgeon. Limited operating time has been a major frustration for most surgeons that I have worked with.

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1 Light D. The two tier syndrome behind waiting lists. *BMJ* 2000;320:1349. (13 May.)

Author's reply

EDITOR—I am sorry to have offended some readers, but these letters actually reinforce my argument. A constellation of long standing government practices and policies

support long waiting times and a second tier of private care. These include fewer consultants and staff per 10 000 and lower funding for salaries, beds, equipment, and sessions than are deemed necessary in good European healthcare systems; pricing practices that minimise the number of sessions purchased; a special government issued contract that provides strong incentives and ample time to build up a private practice from the waiting list; and denial that these practices support (even if unintended) two tier health care.

My argument is structural, not personal. The shortages, incentives, conflicts of interest, and low pay are built in. They need not be intentional to have real consequences. They imply that waiting list initiatives leave untouched the underlying practices and forces that produce long waiting times and support private practice. They do not mean that most consultants will exploit them but rather that the NHS would serve better without perverse structural and financial practices and contracts working against its main goals. Indeed, most consultants dedicate themselves to making the health service work despite its structural shortages. I agree that British consultants and nurses should be paid about 50% more. Nurse specialists should also be developed much more.

Dehn and Mee mention three more recent practices: closing needed beds, reducing hours for junior doctors, and increasing time for training and clinical governance. These reduce resources and time for treating patients, unless compensations are made. But most important is the "nobody's in charge management structure," which accounts for the numerous examples of poor coordination, blocked beds, and bottlenecks and attests to the professional fiefdoms, internal territorial controls, and budgetary barriers that harm quality, responsive care, and efficient use of resources. So there you have my diatribe, which is "obviously untrue and loaded with inaccuracies."

This constellation of government practices and policies compromises quality care in all specialties, but its two tier consequences are highly concentrated in surgery, probably because in a covert pseudo-market, where comparative shopping is nearly impossible, surgeons can charge exclusive rates. Overall, around 1500-2000 consultants submit substantial bills to private insurance companies (and more still to cash-paying customers). This is not "a few." Bad apple theories will not suffice.

More objective data than the results of surveys in which consultants claim to work 60 hours a week for the NHS show that, depending on specialty, surgeons average about one day a week (5-9 hours) operating on NHS patients.¹⁻⁴ Half operate more—a few up to 15 hours a week—but half operate closer to half a day a week. Some theatre sessions run overtime—around a third by half an hour—but another third end just as early.

As most major cases are done during that day, it's no wonder that NHS patients wait much longer for elective surgery than

they would have to if NHS surgeons operated a second day. The BMA's chief negotiator for the private practice committee can mislead the public by saying not one extra patient would be treated if the "maximum part time contract" were abolished,⁵ but he is damning the consultants he represents. Cairns et al say that the bottleneck is lack of sessions, space, staff, and beds. Such arguments take us back to underfunding, "nobody's in charge," and other structural practices that support patients going private. Why have the surgeons, the BMA, and the royal colleges therefore not developed integrated service contracts that could remove these bottlenecks?

In addition to theatre time, surgeons see NHS patients for up to two more days a week (10-14 hours) in NHS clinics, for a total of 2-3 days (15-23 hours). On call duties actually take on average a few hours a month. Research is not a factor for most surgeons. Administrative work and supervision are much more substantial and can take up another 15 hours, for a total of 37 hours. This allows many (but not all) surgeons plenty of time to build up their private practices. The networks, resources, affiliations, and waiting lists of the NHS provide the foundations for private practice. Once surgeons leave the NHS, their private practice "dries up quickly and many have been very disappointed men. GPs soon stop referring patients to surgeons not attached to a good NHS hospital."⁶ The most recent data show that about 60% of all private hospital practice in England takes place in just four regions: North and South Thames, South and West, and Anglia and Oxford.⁷

The current government is the first in a long time to recognise and address the full scope of the problems identified here. Alan Milburn recognised the constellation of government practices and "systemic weaknesses" that plague the NHS and create "the perverse incentives that riddle the NHS and which help sustain long waits for surgery."⁸ This government has stopped the conservative tradition of blaming NHS staff and NHS inefficiencies for inadequate services, admitting instead that funds, staff, and capacity are indeed inadequate and must be substantially increased.

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Maternal age and fetal loss

Missing abortion stratification adds to confusion

EDITOR—The objective of Nybo Andersen et al's study of fetal loss was to measure the age related risk of fetal loss "taking into account a woman's reproductive history."¹ To this end the authors stratified the women according to parity and previous spontaneous abortions but inexplicably omitted stratification by induced abortions. Their only reported use of their complete data on induced abortions was to deduct from the count of fetal loss any miscarriages that occurred before an intended abortion.

The effect of elective abortion on future reproductive health is contentious. Some investigators have found statistical associations between induced abortion and subsequent miscarriages and ectopic pregnancies.² Others have reported that there is no significant association between abortion and either of these events.³ Colleagues of the authors at the Danish Epidemiology Science Centre, using many of the same data, have recently reported a strong association between induced abortion and subsequent preterm and post-term deliveries, a finding that adds to concerns that induced abortion may degrade reproductive health.⁴

Numerous studies have shown that abortion is closely associated with other confounding factors, such as smoking, alcohol, and drug use; promiscuity; and venereal disease (citations to several of these studies are included in my rapid response to Nybo Andersen et al's study on bmj.com).⁵ These behaviours may help women to cope with unresolved anxiety and depression after abortion. Women with a history of abortion are especially likely to persist in using tobacco, alcohol, and illegal drugs during subsequent pregnancies.⁶ This may be because the subsequent wanted pregnancy is a connector to unresolved issues after abortion.

The daunting task of properly sorting out these confounding interactions, incidental associations, and hidden proxy effects has barely begun. Therefore, researchers working with large registry based datasets should always stratify separately for induced abortion. The failure to do so only postpones clarification of important research issues. In Nybo Andersen et al's study the failure to stratify for induced abortion is even more egregious since stratification was done for spontaneous abortion.

Finally, given the political passions associated with induced abortion, researchers should always stratify for it—if only to avoid arousing the suspicion that they are suppressing data for ideological reasons.

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1 Nybo Andersen A-M, Wohlfahrt J, Christens P, Olsen J, Melbye M. Maternal age and fetal loss: population based register linkage study. *BMJ* 2000;320:1708-12. (24 June.)

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Having an induced abortion increases risk in future pregnancies

EDITOR—The latest of three Danish reports about reproductive history informs readers that “fetal loss is high in women in their late 30s or older, irrespective of reproductive history. This should be taken into consideration in pregnancy planning and counselling.”¹

Consider a woman whose first pregnancy occurs at age 30. According to Melbye et al and Zhou et al, if she is pressured to have an induced abortion she should be warned that if she does so she will increase her risk of never having a birth.^{2,3} Will the abortion clinic tell her that her best chance for a full term birth is to carry her current pregnancy to term? No, it will not; no abortion clinic's consent form mentions such a risk. Even if the woman does have a future birth, a previous induced abortion roughly doubles the risk that it will be very preterm (less than 34 weeks' gestation), according to another study of Danish women (relative risk 1.99 (95% confidence interval 1.64 to 2.43)).³ If the woman has two evacuation-type abortions she increases her risk of preterm birth by 1155% (5.14 to 30.64).³ There are at least nine other reports that found an increased risk of prematurity from previous induced abortions^{4,5} (readers can visit www.vcn.bc.ca/~whatsup for references to 10 studies known to me).

By not informing prospective patients of health risks associated with induced abortion, abortion doctors are violating their legal duty to protect health and not needlessly endanger it. Is there any serious health risk for a mother who has a preterm birth? In their study of Danish women Melbye et al inform us that if the gestation of a newborn infant is under 32 weeks the mother has doubled her risk of breast cancer compared with having a full term birth (relative risk 2.08 (1.20 to 3.60) for gestation of 29-31 weeks).²

Let us ensure that women of reproductive age are fully informed about health risks of medical treatments to them and their future children.

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- 1 Nybo Andersen A-M, Wohlfahrt J, Christens P, Olsen J, Melbye M. Maternal age and fetal loss: population based register linkage study. *BMJ* 2000;320:1708-12. (24 June.)
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- 5 Berkowitz GS. An epidemiologic study of preterm delivery. *Am J Epidemiol* 1981;113:81-92.

Data should have been stratified for smoking habit

EDITOR—Danish women have a shorter life expectancy than other Nordic women, and one reason for this is probably that Danish women more often smoke. It would have been interesting to see the data in Nybo Andersen et al's paper stratified for smoking habits, as one would expect this to have a strong influence on fetal loss.¹

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Older women have increased risk of unexplained fetal deaths

EDITOR—Nybo Andersen et al report a comprehensive analysis of the effects of maternal age on the rate of fetal loss.¹ Colleagues and I found that the causes of fetal death (fetuses ≥ 500 g) for women of advanced maternal age have changed significantly over the past 30 years.² In a large dataset in Canada, in a study during 1961-74, we found that women aged ≥ 35 had a 1.5-fold (95% confidence interval 1.2 to 2.2) increased risk of experiencing a fetal death compared with younger women. This was largely due to an increased risk of lethal congenital anomalies (odds ratio 3.2 (1.6 to 6.5)).

In a study during a later period (1978-95) we found that although the absolute rate of fetal deaths had decreased in all women, the risk decreased less for older women (odds ratio 1.8 (1.4 to 2.6)). It seemed that older women were no longer experiencing an increased risk of fetal losses due to lethal anomalies (odds ratio 0.2 (0.03 to 1.5)). Presumably this is because older women were being screened for anomalies in the first and second trimesters and abortions were readily available.

Interestingly, we found that women aged ≥ 35 had an increased risk of unexplained fetal deaths (odds ratio 2.2 (1.3 to 3.8)). These were fetal deaths that occurred in women without any known fetal or maternal risk factors (no maternal history of hypertension, diabetes, abruptio placentae, infection, antepartum bleeding, fetal intrauterine growth retardation, or infection). Like Yudkin et al we found that these fetal deaths occurred late in pregnancy, with two thirds occurring after 35 completed weeks.³ In addition to advanced maternal age, we found that first birth and obesity were significant predictors of this type of loss.⁴

With this information, not only are we better able to counsel our older patients but we can also screen women at risk late in pregnancy in an attempt to reduce these late fetal deaths.

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Risks of having children in later life need to be explained

EDITOR—It is a pity that Stein and Susser confined their editorial on the biological disadvantages of having children in later life to matters obstetric.¹ Their claim that such risks as they and Nybo Andersen et al describe² are outweighed by the possibility that children of a late pregnancy do better at school is debatable; other biological risks should also be considered. One such is the fact that the risk of developing breast cancer increases with a woman's age at first full term pregnancy. There is almost a 2.5-fold difference in the risk of breast cancer between women who have their first child before the age of 20 and those who have their first full term pregnancy after the age of 30.^{3,4}

As possibilities and demands for having children later in life increase, the whole range of risks needs to be explained.

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Obstetric intervention among private and public patients in Australia

Intervention relates more to age than to having private insurance

EDITOR—Roberts et al found that “there are no obvious clinical reasons for intervention rates to be higher in private than in public patients.”¹ There are clinical reasons.

In private practice, women are often older, are career oriented, and have private insurance because they can afford it. Roberts et al's analysis verifies this. In addition to there being more intervention in the older age group the authors also show that privately insured women have fewer children, and therefore intervention relates more to a woman's age than her private insurance status. Interestingly, privately insured women had more episiotomies (perhaps proactively) and fewer third degree tears.

There is an incremental rise in the risk of intervention with increasing maternal age.² As older pregnant women are more likely to be insured, Roberts et al's findings are to be expected. Childbirth in older women may reflect a progressive, age related deterioration in myometrial function,³ and

this needs to be explored further. The link with intervention is therefore with increased age and not private insurance, age being coincidental and not a cause. Roberts et al's age adjusted rates for obstetric intervention per 100 women are pooled results and do not show the effects of age.

Commonly, in all countries the increasing use of caesarean section is accompanied by a decreasing use of instrumental vaginal delivery. As older women become medically aware of the short and long term sequelae of difficult childbirth and their impact on their quality of life, their expectations and demands become greater.³ If, therefore, modern obstetrics can offer women safe, predictable options and a dignified childbirth with minimal perineal trauma they will choose accordingly and are doing so. It is not a question of defending a higher caesarean section rate as King states in his editorial.⁴ There is a considerable morbidity in vaginal childbirth even without intervention,⁵ and women are increasingly recognising this.

It also needs to be recognised that many of the interventions referred to are consumer driven, and women are exercising their choice. To relate the outcome of childbirth to their insurance status may be not only misleading to the uninformed but also misused, as has already happened in the Australian press.⁶

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Women must have full information when choosing private health insurance for pregnancy

EDITOR—Roberts et al's analysis of obstetric intervention in Australia contributes to our understanding of the considerable variation in experiences of privately and publicly insured pregnant women.¹

The findings are consistent with a recent comparison of episiotomy rates in public and private hospitals in New South Wales.² This indicated that in choosing to purchase private health insurance women were twice as likely to experience an instrumental birth (forceps or vacuum). This was in addition to increasing their probability of episiotomy by 60-85% when delivering vaginally in private hospitals in New South Wales.³ This is interesting in the light of suggestions that Australian women perceive that in choosing private health insurance for pregnancy they are purchasing a higher quality outcome

than can be achieved through the public system (Medicare).

Further to the comprehensive picture of intervention that Roberts et al provide is a concerning trend in the variations between private and public hospitals. A longitudinal view of midwives' data for New South Wales between 1993 and 1997 (for 60 hospitals for which data were comparable) shows that over this time episiotomy rates increased in private hospitals while declining in public hospitals.³

Episiotomy rates were 12-15 percentage points higher in private hospitals in New South Wales in 1993-6, with a 16 percentage point difference in 1997. Multiple logistic regression showed that even when clinical factors (such as instrumental birth) were controlled for, up to a 10 percentage point gap remained unexplained by clinical factors relating to episiotomy.³ Despite the observed decline in instrumental birth in private hospitals, from 22.2% to 20.3% between 1996 and 1997, the rate of episiotomy increased from 32.3% to 33.1%.

If women judge the benefits of private health insurance to outweigh the risk of experiencing episiotomy, epidural anaesthesia, induction of labour, caesarean section, or instrumental birth then that is their choice as a consumer. Presumably women purchase private health insurance specifically for pregnancy because they believe that this provides them with benefits. Health insurers and practitioners, however, have a responsibility to ensure that women are aware of the risks and benefits of their options and are indeed making an informed decision. The impact that these choices have on women's experience of pregnancy and birth should not be underestimated.

It is often said that clinical practices should be justified using the best available evidence; I would hope that the practice styles of midwives and obstetricians reflect a commitment to this principle.

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Bupropion for smokers

Bupropion may not be as good as editorial implies

EDITOR—Britton and Jarvis give a surprisingly uncritical welcome to bupropion.¹ Although Jorenby et al did find that 30% of patients who took bupropion were still non-smokers after 12 months (point prevalence data), these volunteers must have been highly motivated as 12-15% of those who took the placebo successfully stopped smok-

ing.² There are no studies showing that bupropion is effective in more averagely motivated patients.

The patients in Jorenby et al's study received intensive counselling, which comprised more than three hours of face to face counselling and 80 minutes of telephone support over the 12 months. It is not realistic for the NHS to provide this level of support. The manufacturers are offering a telephone line for patients to ring for support, but this is not likely to be as effective in motivating and supporting patients. The high success rates reported by Jorenby et al are therefore unlikely to be repeated in day to day practice.

Britton and Jarvis could have pointed out that half of patients who successfully stop smoking with the aid of bupropion will start again within 12 months of coming off the drug. They could also have referred in more detail to the side effect profile and the number of patients for whom the drug will be unsuitable. Bupropion may have a 1 in 1000 risk of inducing seizures (product information from GlaxoWellcome, the manufacturer of the drug). This may be an acceptable risk for drugs to treat disease but is less so for lifestyle drugs.

Bupropion may well prove to be a useful adjunct to smoking cessation, but I would have preferred a more balanced appraisal in a *BMJ* editorial.

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Drug is almost identical in structure to diethylpropion, a controlled drug

EDITOR—Britton and Jarvis's editorial on bupropion does not mention that the drug is an amphetamine derivative.¹ It is almost identical in structure to diethylpropion hydrochloride, which is a controlled (schedule 3) drug because of its supposed potential for misuse. Bupropion has been released in the United Kingdom on the strength of only two American clinical trials financed by the manufacturer. Many patients to whom it will be given will have addictive personalities. Shouldn't the Medicines Control Agency rethink its decision?

When I asked the agency to explain the discrepancy regarding the classifications of the two drugs I was referred to the Home Office, whose advisers said that because bupropion is not a stimulant it need not be classified like diethylpropion. As the drugs are so similar in structure it would be surprising if one was a stimulant and one not. Certainly, dose related stimulation of the central nervous system occurs with bupropion in animals.² Both drugs come in a crushable tablet form, which facilitates parenteral misuse.

Drugs do not have to be stimulants for people to become dependent on them (for example, ethanol and diazepam), and not all stimulants give rise to dependency (only a few people say that caffeine withdrawal is a serious problem). And not all sympathomimetic drugs are stimulants (the appetite suppressant phenylpropanolamine, a sister sympathomimetic to bupropion and diethylpropion, is sold over the counter in the United States).

If bupropion is not a stimulant why does GlaxoWellcome's product monograph list insomnia as its commonest side effect (occurring in just under half of patients)? And if it has none of the anorexic properties of the amphetamines why was the 11th congress on tobacco or health in Chicago on 6-11 August 2000 told that smokers taking bupropion gain less weight than those taking placebo (this information was also contained in the two clinical trials)?

A mass of evidence indicates that diethylpropion is safe and efficacious,³ yet the Medicines Control Agency has made no objections to the European Commission's current attempts to delicense it. Bupropion is being foisted on an unsuspecting British public with little evidence that it works much better than placebo.⁴ The recommended dose of bupropion is much greater than that of diethylpropion. I suspect that a politically correct antismoking drug, however poorly researched and ineffective, will always be given the benefit of the doubt compared with a politically incorrect slimming drug, however safe and effective.

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New products for smoking cessation maintain profile of smoking cessation services

EDITOR—Having established a smoking cessation service last year as part of our health action zone initiative, colleagues and I have been gradually increasing the volume of clients seen in our clinics through self referrals and referrals from general practitioners and hospital consultants.

We have found, as described by Britton and Jarvis, that access to the one week's supply of free nicotine replacement therapy (for those who are eligible) is not always sufficient to set potential quitters on the right track; the bureaucracy can indeed be daunting.¹ Notwithstanding this, we find our clients eager for information on how to stop smoking and ready to use support mechanisms, be they counselling services or pharmaceutical products.

With the launch of bupropion, calls to our freephone information line quadrupled, with most callers wanting access to the new product, which they had seen reported in the media. Our main task currently is directing clients back to their general practitioners for assessment as to their suitability for bupropion while emphasising that the product should be used in conjunction with our support service.

Not surprisingly, general practitioners have differing views as to which interventions they might choose to help patients give up smoking. GlaxoWellcome clearly states that bupropion should be prescribed only to those patients who have already made a clear commitment to giving up smoking. We consistently find, however, that general practitioners want their patients to access our support service as they recognise the importance of taking patients through the process of giving up smoking as well as the use of pharmacological treatment.

Although the launch of bupropion has given us a few headaches in coping with the demand for our services, it is an opportunity we have embraced willingly. New products and methods for smoking cessation maintain the profile of our service, and others like it, in terms of media coverage and, more importantly, health service priorities. We welcome any opportunity to work more closely with primary care colleagues in tackling smoking and reducing smoking related diseases.

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Where are practices supposed to find money for bupropion?

EDITOR—With the arrival of a new oral treatment for smokers, Britton and Jarvis rightly state that the challenge is now to provide widespread accessibility to nicotine replacement and bupropion.¹ The first reaction of the practice where I work, however, was not pleasure at a great step forward; instead we hoped that our primary care group would find a way of helping us limit its prescription. I am sure that we are not alone in this attitude.

Despite our best efforts our practice is already spending more than our allotted prescribing budget. If we were to provide bupropion to a tenth of our practice population (not unlikely in view of the number of patients already making appointments to ask for it), at £86 a course it would cost our practice £106 250. We have no doubt that for society at large this would be money well spent, with enormous health gains. Unfortunately, the NHS does not work like that.

Until new money is regularly pumped into prescribing budgets we now have to ask ourselves what we are going to stop prescribing, or how we are going to limit

prescribing, every time a new, and probably more expensive, drug is introduced. This behaviour, which has been forced on primary care doctors, is just one example of why we languish in the second division of healthcare systems.²

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Authors' reply

EDITOR—We agree with Harrison that bupropion used in conjunction with less intensive counselling support, or in less motivated subjects, than in the original clinical trials^{1,2} is likely to yield lower cessation rates. Parallel experience with nicotine replacement therapy, however, indicates that while the highest cessation rates are achieved in conjunction with intensive counselling support, the addition of nicotine treatment to less intensive interventions generally roughly doubles the cessation rate achieved.³ Something similar will most probably apply to bupropion.

It is clearly desirable that bupropion is used in conjunction with the highest level of counselling support achievable, but some compromises have to be made. At a population level a reduction in overall efficacy with a less intensive support package will be more than offset by more extensive population coverage. Harrison is right that bupropion treatment carries a 1 in 1000 risk of seizures, but all effective drugs have adverse effects. This one needs to be balanced against the 1 in 2 chance of premature death associated with continued smoking.

Experimentation with smoking may be a lifestyle choice, but, for most smokers, nicotine addiction and continued smoking are not.⁴ As an effective agent to help smokers give up smoking bupropion is no more a lifestyle drug than, for example, drugs used to treat diabetes or hypertension in people who are overweight or statins used in the primary prevention of heart disease.

Concerns raised by Kinnell over potential dependency on bupropion also need to be weighed against the risk to health of continued smoking. But clinical trial data, and postmarketing surveillance of bupropion in the United States (where it has been used since 1988, first as an antidepressant and latterly for smoking cessation), suggest that dependence is not a problem. The fact that bupropion prevents some of the weight gain associated with smoking cessation is probably to patients' advantage.

We argued that the arrival of bupropion might provoke a major change in the demand for smoking cessation services, and Richardson is clearly rising to the challenge. Financing new pharmaceutical developments is always difficult in an environment of finite resources, and we can only imagine

the problems that Vautrey faces. New drugs that are effective usually end up being funded somehow, and Vautrey might take some solace from the fact that bupropion, like all smoking cessation interventions, is probably more cost effective than most other prescribing in primary care. He may even be able to finance bupropion or nicotine replacement therapy entirely from savings from his statin budget.

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Competing interests: JB has been reimbursed by GlaxoWellcome for attending international conferences in respiratory medicine and is participating in a clinical trial of transdermal nicotine funded by Pharmacia and Upjohn. MJ has received honorariums from GlaxoWellcome for speaking and attending meetings of advisory panels.

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Early neonatal mortality and timing of low risk births

Several factors predisposing to increased mortality at night were not excluded

EDITOR—Heller et al's unstated premise that the incidence of perinatal death due to intrapartum asphyxia in low risk pregnancies may serve as a sensitive measure of the quality of peripartum care delivered is appealing.^{1,2} But their proposition that the observed higher nocturnal perinatal mortality in their selected population arose because of substandard care was not justified.

Firstly, the authors did not do a comprehensive interrogation of index case records. The Confidential Enquiry into Stillbirths and Deaths in Infancy adopts the gold standard method of a multidisciplinary scrutiny of records to ensure accurate diagnosis and quantify substandard care.

Secondly, imprecise selection criteria meant that the sample population was heterogeneous in terms of pregnancy risk and method of delivery. Further bias arose because Heller et al's early neonatal death rate (0.15/1000 births selected) represented only a small fraction of the unstated overall early neonatal death rate (3.1/1000 live births found in a similar population by the Confidential Enquiry into Stillbirths and Deaths in Infancy³).

Thirdly, criteria required before perinatal asphyxia is diagnosed were not adopted.⁴ Deaths classified as asphyxia related that

occurred as a result of hypoxia during labour do not necessarily mean that the hypoxia was preventable.

Better information would have been derived if the crude early neonatal death rate had been reclassified in a pathophysiological cause specific manner (for example, with the amended Wigglesworth classification⁵) and incorporated birth weight and gestation specific mortality. Such cause specific mortality relations better identify the exact contribution of antepartum and intrapartum risk factors to infant mortality and whether any diurnal variation in their incidence occurs. Case-control analysis of matched cases with similar obstetric and neonatal factors and delivery centres but different delivery times could further show the contribution of delivery time to perinatal death and whether this relation is cause specific.

Pregnancies without substandard care or obstetric risk that incur higher nocturnal perinatal mortality pose a serious concern; they are perhaps a manifestation of the fetomaternal physiology specific to this time that is currently unknown. Antepartum unexplained fetal death might enter into this subgroup. Standards of healthcare delivery are always under inspection (for example, by clinical governance and the media). Comprehensive evaluation, with consideration given to other possible causes, is essential before such "human" issues are drawn into the causality equation for adverse outcome.

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Data suggest that difficulties in fetal monitoring are magnified at night

EDITOR—The report by Heller et al suggests that the rate of asphyxia related deaths in low risk pregnancies is higher in births that occur at night.¹ A key question is what percentage of these deaths were potentially preventable.

We have reviewed the timing of delivery in a recent consecutive case series of 22 infants with early onset moderate to severe neonatal encephalopathy plus cord blood acidosis.² We have previously reported that half of the cases were associated with unpreventable catastrophic events or antenatal

hypoxia. These cases were equally distributed between delivery during the day and during the night. In the remaining 11 cases questionable fetal heart rate traces were either not recognised or not acted on in a timely manner by the primary care giver. Twice as many of these cases were delivered during the night as during the day.

These data suggest that the inherent difficulties of fetal monitoring in clinical practice are magnified at night by fatigue and a reluctance to consult more experienced staff. Varma et al are right (above and on bmj.com³) to point out the selective nature of the population studied. But Heller et al's results provide an important indication of where practical efforts to improve fetal monitoring should be focused.

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Authors' reply

EDITOR—These authors and others who have written rapid responses to our short report (at www.bmj.com/cgi/eletters/321/7256/274) have raised several important points, but we cannot address them all here in the word limit given. We are therefore replying only to some selected topics, hoping that readers will refer to our more comprehensive reply at www.bmj.com/cgi/eletters/321/7256/274#EL9.

We agree with Varma et al that the data of the Confidential Enquiry into Stillbirths and Deaths in Infancy as well as the Wigglesworth classification have advantages over our data. Nevertheless, our data indicate an excess early neonatal mortality at night that we believe was worth reporting.

Our selection criteria are much more precise than those in the British studies that we referred to.^{1,2} Our death rate is so low because our analysis was restricted to low risk births. We gave the rationale for this: "babies born during the day are more likely to be preterm or high risk babies who have had induced births." It is easy to show that this is the case, which implies that our selection criteria are more likely to avoid bias than to produce it.

Several other authors pointed out that explanatory factors besides decreased medical care at night might be responsible for the observed mortality gradient.³⁻⁵ Further considerations referring to preventable mortality or morbidity fractions at night also refer to this issue.

When submitting our short report we did not think that the *BMJ* would be sufficiently interested in German data confirming

previous British analyses for us to submit a full paper. We said that we would be willing to provide additional information and tried to do so in the revisions of our short report, but we were advised not to exceed the word limit. A report with a maximum of 600 words is bound to leave open questions. Since performing our study we have extended our database, performed additional detailed analyses taking alternative risk factors into account, and written a new article.

No evidence in the strict meaning of the word can be expected from an observational study. As randomised clinical trials exploring this issue would be unethical, however, we believe it is justified to consider "better designed shifts, resulting in shorter working hours or decreased workload with greater supervision by experienced staff at night."

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Patients with primary herpes should be screened for syphilis

EDITOR—In their excellent clinical review on caring for patients with genital herpes, Drake and colleagues rightly mentioned the need to consider screening patients with genital herpes for other sexually transmitted infections.¹ However, we feel that they should have been more specific and recommended screening for treponemal antibodies. Since the first report of an increase in the number of cases of infectious syphilis in Manchester last year,² the number of new cases has continued to rise (A Sukthankar, P Chandiok, personal communication). A small number of patients with syphilis have presented with symptoms and signs of "typical" primary herpes infection. Tests for treponemal antibodies should be ordered routinely for all patients presenting with genital ulcer disease, particularly those from high risk groups, such as men who have sex with men and immigrants from the former Soviet Union.³

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Explosions may occur if dry ice is placed in airtight transport containers

EDITOR—Since January 1999 all infectious pathology specimens sent by post have had to be packaged according to United Nations approved packing instruction 602.^{1,2} This states that the primary specimen receptacle must be placed in an airtight secondary container (figure (top)), which in turn must be placed in an outer, labelled shipping package. The postal service does not require packing instruction 602 to be applied to specimens considered non-infectious, but many laboratories apply it to all specimens sent by post, and some to specimens sent by non-postal courier.

Pathology specimens transported from one laboratory to another often need to be kept frozen during transit. One method of achieving this is to pack them in dry ice (solid carbon dioxide). We report on four cases in which explosions occurred after dry ice was placed in containers that complied with packing instruction 602.

The first explosion occurred when a laboratory assistant attempted to unscrew the cap of a container into which she had placed dry ice a few moments earlier. She developed massive bruising of her thigh (figure (bottom)). The second explosion, which happened on a busy section of motorway, ripped apart a motorcycle pannier, with loss of the specimen. The other two explosions occurred after pathology staff received a transport container that was visibly misshapen. One of these explosions blew a hole in the laboratory ceiling and scattered debris over 30 m².

Dry ice explosions have received surprisingly little attention in the medical literature.³ When warmed to 20°C solid carbon dioxide exerts a huge vapour pressure (28.7 Pa),⁴ yet the safety data sheet of at least one manufacturer⁴ and the Health and Safety Executive's website (www.open.gov.uk/hse/hsehome.htm) contain no reference to the explosion hazard. When we contacted product specialists from several companies that market transport containers none was aware of the risk.

We recommend the following:

- All manufacturers of dry ice should refer to the explosion hazard on their safety data sheets
- All airtight transport containers should display a hazard warning
- The Health and Safety Executive should provide advice as to what action laboratory staff should take if they receive airtight containers that might contain dry ice.

We also recommend that laboratory staff receive instruction about the safe dispatch of

Top: Specimen transport containers that comply with packing instruction 602. Bottom: Haematoma caused by exploding transport container

pathology specimens. Unfortunately, given the shortage of biomedical scientists and the fact that NHS ancillary workers are frequently asked to perform duties for which they have not been adequately trained,⁵ dry ice is likely to continue to pose a serious threat to the safe transportation of pathology specimens.

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