defining ethics, they believe that we have been acting unethically: they describe a typical case in which elective ventilation might be considered—a patient with a clearly diagnosed fatal cerebral injury who undergoes respiratory arrest. They write, “Deliberately prolonging a patient’s dying is unacceptable for any reason.” But such patients die when breathing ceases; elective ventilation does not prolong the act of dying, for one is ventilating a corpse. If that is wrong, let them tell us why, rather than differentiate between dead bodies on the basis of whether a diagnosis was made before or after death, or whether the patient stops breathing in the accident and emergency department rather than a medical ward.

We were taxed by ethical issues when we set up the elective ventilation protocol: ethics may be defined as what is right, and in turn that can be regarded as behaviour that causes no distress, offence, or indignity in the context of current societal values. To act ethically, firstly, we must respect the wishes of the dead and dying; secondly, we must cause no unnecessary distress to relatives; and, lastly, we must cause no emotional crisis for the staff of intensive care units. We know from many surveys of public opinion that over 70% of the public would wish their organs to be used for transplantation after death. In our unit one of the goals of elective ventilation is the respecting of these wishes.

It seemed to us illogical that patients who stop breathing before irreversible brain injury is diagnosed can become organ donors, whereas clinically identical patients who become apnoeic after diagnosis cannot. Such patients often differ only in the time taken to reach hospital, and to claim that they differ in any more fundamental way is pure sophistry. It is hard to see how the denial of a patient’s right to be an organ donor after death is ethical behaviour. The relatives of our electively ventilated organ donors do not feel that we act improperly; rather, they all consider that the process of organ donation allows them to make some sense of an otherwise inexplicable loss.³

It is sad that Park and colleagues have not understood the logical and moral basis of elective ventilation. We welcome this opportunity to restate our position and encourage other units to follow our lead.

ANTHONY NICHOLLS
HANY RIAD

Royal Devon and Exeter Hospital (Wonford),
Exeter EX2 5DW

- 1 Park GR, Gunning KE, Lindop MJ, Roe PG. Organ donation. *BMJ* 1993;306:145. (9 January.)
- 2 Feest TG, Riad HN, Collins CH, Golby MG, Nicholls AJ, Hamad SN. Protocol for increasing organ donation after cerebrovascular deaths in a district general hospital. *Lancet* 1990;335:1133-5.
- 3 Riad HN, Feest TG, Collins CH, Golby M, Nicholls AJ, Hamad SN. Ethical and practical problems of setting up a system of elective ventilation. In: Land W, Dossetor JB, eds. *Organ replacement therapy: ethics, justice and commerce*. Berlin: Springer Verlag, 1991:268-72.

Death rate from asthma

EDITOR,—Our experience supports W T Berrill’s conclusion that the death rate from asthma may be exaggerated.¹ In East and North Hertfordshire (estimated population 480 000) during 1986-91 inclusive, 114 deaths from asthma at all ages were reported by the Office of Population Censuses and Surveys. Even if the contribution of bronchial asthma to cause of death is interpreted generously—for example, part I of the death certificate states death from asthma and part II states chronic obstructive airways disease—only 63 of 100 deaths have so far been found to be attributable to asthma. Fourteen sets of records remain to be examined. The number of deaths in people aged over 65—22 of the 63—reduces the potential for saving lost

years of life. Only 19 of the 63 deaths occurred below the age of 45.

Taking into consideration the circumstances in which many of these deaths occurred, we believe that there will be only a small health gain from reducing mortality. We are therefore shifting some of our attention to exploring the opportunities for reducing morbidity. Meanwhile it would be of great help if the accuracy of death certification could be improved, possibly through audit. Initiatives to improve understanding of the burden of ill health due to asthma would be welcome.

MARGARET JUDD
KATE JOLLY

Department of Public Health,
East and North Hertfordshire Health Authority,
Welwyn Garden City,
Hertfordshire AL8 6RD

- 1 Berrill WT. Is the death rate from asthma exaggerated? Evidence from West Cumbria. *BMJ* 1993;306:193-4. (16 January.)

EDITOR,—W T Berrill implies that death should not be attributed to asthma in older people (over the age of 60) because asthma is “a disease of young people.”¹ Not only is reversible airways disease common in older adults² but, as with most other conditions, older people are probably more likely to die of it than younger people. Thus most people dying of asthma should be expected to be old.

Because of the underappreciation of asthma in elderly people such patients are treated with antibiotics for their respiratory infections but are left to suffer the dyspnoea and hazards of their respiratory obstruction.

J R F GLADMAN

Department of Health Care of the Elderly,
University Hospital,
Nottingham NG7 2UH

- 1 Berrill WT. Is the death rate from asthma exaggerated? Evidence from West Cumbria. *BMJ* 1993;306:193-4. (16 January.)
- 2 Burr ML, Charles TJ, Roy K, Seton A. Asthma in the elderly: an epidemiological survey. *BMJ* 1979;i:1041-4.

Epidural analgesia in labour

EDITOR,—An item by Minerva may mislead readers.¹ It states that epidural analgesia with bupivacaine is associated with factors that adversely affect the infant, such as lower maternal self esteem, prolonged labour, use of oxytocin, and forceps delivery. No randomised study has ever shown that these negative aspects of childbirth are a result of epidural analgesia.

The study to which Minerva refers, by Sepkoski *et al*, compared women who received epidural analgesia, without randomisation, with poorly matched controls who had no pain relief; matching was based on criteria expected to affect the placental transfer of the local anaesthetic bupivacaine.² An attempt to match for the duration of the first and second stages of labour, the use of oxytocin, and the mode of delivery failed. The authors assume that these are a direct result of epidural analgesia and refer to work in which, again, randomisation was not done. It is not surprising that the women who had epidural analgesia had significantly longer labours, a greater requirement for oxytocin, and a higher rate of instrumental delivery as such factors increase the need for epidural analgesia and therefore cannot be assumed to result from it. Moreover, they may themselves affect neonatal behaviour and interaction between the mother and her infant. Non-randomised comparisons of epidural analgesia with no analgesia or other forms of pain relief are likely to be biased since those women experiencing long, difficult labours are more likely to request epidural analgesia.

Sepkoski *et al* used 0.5% bupivacaine in their study. This high concentration is unnecessary and

not standard practice in Britain as it results in an appreciable motor block, which impairs maternal satisfaction.³

There are studies in which neonatal assessment has been made after attempts at randomisation of analgesia during labour. In one, no adverse effects on neonatal outcome were found.⁴ Other studies that were not randomised failed to show adverse effects on the baby. Indeed, in many studies epidural analgesia has been shown to be beneficial. Kangas-Saarela *et al* found that babies whose mothers had received epidural analgesia with bupivacaine had higher neurobehavioural scores than those whose mothers had not received such analgesia.⁵ Two other studies showed no adverse effects of epidural bupivacaine in labour on neonatal neurobehavioural scores.^{6,7}

Minerva should take the scientific methods used in papers into consideration. This would prevent questionable findings influencing a much wider readership.

ROBIN RUSSELL
JAMES BROADWAY
FELICITY REYNOLDS

Anaesthetic Department,
St Thomas’s Hospital,
London SE1 7EH

- 1 Minerva. *BMJ* 1992;305:1514. (12 December.)
- 2 Sepkoski CM, Lester BM, Ostheimer GW, Brazelton TB. The effects of maternal epidural anaesthesia on neonatal behavior during the first month. *Dev Med Child Neurol* 1992;34:1072-80.
- 3 Murphy JD, Henderson K, Bowden MI, Lewis M, Cooper GM. Bupivacaine versus bupivacaine plus fentanyl for epidural analgesia: effect on maternal satisfaction. *BMJ* 1991;302:564-7.
- 4 Thalme B, Belfrage P, Raabe N. Lumbar epidural analgesia in labour. I. Acid-base balance and clinical condition of mother, fetus and newborn child. *Acta Obstet Gynecol Scand* 1974;53:27-35.
- 5 Kangas-Saarela T, Jouppila R, Jouppila P, Hollman A, Puukka M, Juuriari K. The effect of segmental epidural analgesia on the neurobehavioural responses of newborn infants. *Acta Anaesthesiol Scand* 1987;31:347-51.
- 6 Scanlon JW, Ostheimer GW, Lurie AO, Brown WU, Weiss JB, Alper MH. Neurobehavioural responses and drug concentrations in newborns after maternal epidural analgesia with bupivacaine. *Anesthesiology* 1976;45:400-5.
- 7 Aboud TK, Khoo SS, Miller F, Doan T, Henriksen EH. Maternal, fetal and neonatal responses after epidural analgesia with bupivacaine, 2-chloroprocaine, or lidocaine. *Anesth Analg* 1982;61:638-44.

Thromboembolic complications of laparoscopic cholecystectomy

EDITOR,—The incidence of deep venous thrombosis and pulmonary embolism in diagnostic laparoscopy is low. It was reported as 0.2 cases/1000 procedures in a confidential inquiry into 50 427 gynaecological laparoscopies.¹ In a single report of 100 laparoscopic salpingectomies deep venous thrombosis occurred in one patient.² Concern has been raised, however, about the increased potential for thromboembolism in patients undergoing laparoscopic cholecystectomy.³ The true incidence of thromboembolism in this procedure is not known.

We have performed laparoscopic cholecystectomy on 438 patients, and thromboembolism has occurred in three: one deep venous thrombosis, one non-fatal pulmonary embolism, and one fatal pulmonary embolism. All three cases were confirmed by phlebography or ventilation-perfusion scanning or after death. Interestingly, two of the cases were diagnosed within four days of surgery, and both patients had been mobile up to the day of surgery. All three patients received prophylaxis with subcutaneous heparin and compression stockings. The patient with the deep venous thrombosis also had intraoperative stimulation of the calf. We believe that thrombosis of leg veins or pelvic veins occurred intraoperatively, accounting for the early presentation in two of the patients.

In the laboratory we have shown hypertension in the common femoral vein in a pig undergoing laparoscopic Nissen fundoplication. When pneumoperitoneum was established, the femoral venous pressure rose from 4 mm Hg to 9 mm Hg. With duplex Doppler scanning of the common femoral vein in humans we have shown a considerable reduction in peak blood flow velocity and shortening of the flow cycle during the respiratory phase on two occasions, with a return to normal venous blood flow characteristics on removal of the intraperitoneal gas.

These cases highlight the potential for thromboembolism with laparoscopic cholecystectomy. Our early experimental work suggests that the aetiology may be increased venous stasis caused by the raised intra-abdominal pressure associated with pneumoperitoneum. Also, these procedures, in contrast to gynaecological laparoscopy, are performed in the reverse Trendelenberg position, which would compound any venous stasis already present.

Further work must be performed to document the incidence and aetiology of deep venous thrombosis and effective prophylaxis during prolonged therapeutic laparoscopy. Until these issues have been resolved all patients undergoing laparoscopic cholecystectomy should be regarded as at risk of deep venous thrombosis and pulmonary embolism. They should have some intraoperative measure to reduce venous stasis of the lower limbs as well as routine preoperative and postoperative prophylaxis against deep venous thrombosis.

J O JORGENSEN	K HANEL
N J LALAK	D R HUNT
L NORTH	D L MORRIS

Departments of Surgery and Radiology,
St George Hospital,
Kogarah,
Sydney,
NSW 2217,
Australia

- 1 Chamberlain G, Brown JC. *Gynaecological laparoscopy. The report of a working party in a confidential enquiry of gynaecological laparoscopy*. London: Royal College of Obstetricians and Gynaecologists, 1978.
- 2 Dubuisson JB, Aubriot FX, Cardone V. Laparoscopic salpingectomy for tubal pregnancy. *Fertil Steril* 1987;47:225-8.
- 3 Deyo GA. Complications of laparoscopic cholecystectomy. *Surgical Laparoscopy and Endoscopy* 1992;2:41-8.

Consent for surgery for psychiatric patients

EDITOR,—On three occasions in the past two years the duty surgical team have contacted me while on call as duty psychiatrist with a view to giving consent to a surgical procedure on behalf of a patient. The patients were all detained under the Mental Health Act, required urgent surgery or invasive investigation, and were, in the opinion of the surgical team, unable to give informed consent.

On each occasion I felt that insufficient effort had been made by the surgical teams to decide on the capacity to give informed consent, and I was dismayed at the immediate assumption of incapacity because the patient had been sectioned. I must emphasise that I was not asked to determine the capacity to give consent, but simply to complete the paperwork.

My understanding of the law is that an adult patient who is capable of doing so must give consent to any medical treatment if that treatment is to be lawful. At the time of the decision the patient needs a capacity commensurate with the gravity of that decision. If the patient lacks the requisite capacity, then the doctors must act in what they perceive to be his or her best interests, with information garnered from previous knowledge of the patient, discussion with family and friends, and taking into account any relevant directive previously made by the patient. What the

legal force and effect of any such directive might be is uncertain; it is unclear whether health care staff are required to carry out the terms of the directive or whether those who act in good faith with the terms of the directive are immune from civil or criminal prosecution. There is, apparently, no case law on this point.

I was unable to find any legal basis under current English law whereby a psychiatrist might give consent (or otherwise) for a patient to have an invasive surgical procedure. Speaking to colleagues informally, I find that this situation is not uncommon. I would remind the surgeons involved in such instances that they, and not the duty psychiatrist, are in the best position to know if an operation is in the best interests of the patient.

NICK KOSKY

Nelson Hospital,
London SW20 8BD

Shetland oil spill

EDITOR,—The study that has been mounted consequent on the grounding of the tanker *Braer* on 5 January 1993 has been inaccurately reported.¹ The study's aim, as approved by the Shetland Health Board Ethical Committee, is "to determine the human health effects of the Shetland oil spillage" on the people resident within 5 km of the spill.

The project was designed in epidemiological terms, not as "health checks" on the population. A health check, in my opinion, involves a clinical examination and intervention, where appropriate, based on the findings. This is the province of an individual's general medical or occupational health practitioner, not of an epidemiologist. When this study was mounted participants were advised in writing that all findings would be reported to their medical practitioner, whom they should consult for their individual results.

Many laboratories have cooperated at short notice and are analysing large numbers of samples. Over 1200 biochemistry and haematology specimens were examined and reported in an eight day period in the laboratory of the Gilbert Bain Hospital, Lerwick. Samples are also being examined by the Department of Forensic Medicine and Science, Glasgow University, the National Poisons Unit, Guy's Hospital, and the Medical Research Council's cell mutation and toxicology units.

This inquiry is a joint initiative of the Shetland Health Board and the Environmental Health (Scotland) Unit, a Scottish Health Service organisation. Though funded by the Scottish Office, Home and Health Department, the study is totally independent of central government and will present its findings directly to its clients, the people of the Shetland islands.

That the initial phase of the project has been carried out so quickly and smoothly is a tribute to the dedication and professionalism of many health care workers throughout Shetland. I doubt such a venture could have been undertaken so rapidly elsewhere.

D M CAMPBELL

Environmental Health (Scotland) Unit,
Ruchill Hospital,
Glasgow G20 9NB

- 1 Christie B. Shetland oil spill prompts health checks on islanders. *BMJ* 1993;306:230. (23 January.)

Receiving new patients' notes from FHSAs

EDITOR,—New patients registering with our general practice often complain about the time it takes us to get their NHS notes from the family health services authority. The patient's charter

states that general practitioners should receive new patients' notes from their family health services authority within six weeks of requesting them. To assess the extent of the problem and attempt to bring ourselves into line with the patient's charter we conducted a simple audit of the delays in our practice.

Manor House Surgery serves 7200 patients in a medium sized industrial town. All patients new to the practice are given a temporary folder, which is stamped with the date that the permanent notes were requested from the family health services authority. The temporary notes are then kept together in a box, separate from the other files of notes. When the permanent notes arrive the two sets are joined up and filed in the usual way.

On 16 September 1992, 115 patients were waiting for their notes. On that day we scrutinised all the temporary folders in the box and noted the time that had elapsed since the proper notes had been requested. About half of the patients had been waiting for their notes for less than six weeks, but 19 had been waiting for over six months, 14 for over a year, and six for over two years. The average wait was 20 weeks.

This simple audit, which took less than nine hours, has led us, as a first step, to chase up all notes that have not been received within 12 weeks. This should reduce the average wait for notes from 20 weeks to 4-6 weeks. This approaches the standard set by the patient's charter.

New patients' NHS notes are essential for general practitioners: they contain specific details of past treatment and confirm what the patients say about their current treatment. General practitioners are best placed to ensure that this particular specification in the patient's charter is met.

J BEAVEN
LINDA MASSEY
CAROL WEST

Manor House Surgery,
Glossop,
Derbyshire SK13 7PS

What the regions say

EDITOR,—In West Midlands Regional Health Authority "one or two" providers have been "in difficulty," a spokesperson said.¹ Those are weasel words. The West Midlands is a desert.

Take our non-trust district general hospital. We had finished most of the contractual work by late November 1992. If we had continued to treat patients at the same rate—there has been an unprecedented, inexplicable, and hence unforeseeable rise of 12% in medical emergencies—we would have been at least £0.5m in the red by the end of the financial year. To husband that 1.7% of our income we have had to close half of our operating sessions, a third of our operating theatres, and a sixth of our beds, most of them surgical. We also closed beds at the satellite rheumatology hospital—a subregional centre. The effect on staff has been dreadful. The spectre of redundancy has been raised, and morale from top to bottom has become a cause for deep concern. All this six years after the hospital was opened at a cost to the taxpayer of £27m (the region's "flagship"). In short, we are seriously poor.

True, we have reopened a few beds—for the patients of fundholding general practitioners. And we treat emergencies, "urgencies," and also-rans who may or may not survive two years on a waiting list. So that's all right, then. Just a small local difficulty.

P V SCOTT

Alexandra Hospital,
Redditch,
Worcestershire B98 7UB

- 1 Kingman S. What the regions say. *BMJ* 1993;306:228-9. (23 January.)