radical changes of attitude in many hospitals are concerned, I have no quarrel with the select committee's report. Surely we have learnt enough from recent changes in the NHS to plead that progress should be by evolution rather than revolution.

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1 Warden J. Home truths about maternity services. *BMJ* 1992; 304:657. (14 March.)

SIR,—The debate about antenatal and intrapartum care is unfortunately forcing further divisions between midwives, general practitioners, and obstetricians.¹ Certain practical issues have yet to be properly addressed.

As an obstetric registrar I have been called out in the obstetric flying squad to attend home deliveries when complications have developed. This has left the labour, gynaecology, and casualty wards denuded of senior obstetric and gynaecology staff (and also, sometimes, of paediatric and anaesthetic registrars). I believe that women should be allowed to choose where to give birth. That freedom, however, exposes most women, who choose to deliver in hospital, to inadequate care when the flying squad is called to a home delivery.

In many cases the flying squad is called out when expert medical treatment is not required, and the present structure of the flying squad has been debated recently.² It was suggested that an adequately trained paramedical team should be able to cope with most cases, with the obstetric team being available for advice over the telephone and attending only in extreme circumstances. If the trend away from home deliveries is reversed these changes in policy will have to be revised.

Most women who deliver at home have an uneventful labour and a healthy baby, as do most who deliver in hospital. Complications are few, but when they occur they are often unexpected and rapid intervention is required. The Dutch system is often quoted and seems to work well when everything is straightforward. When complications occur in pregnancies categorised as low risk and suitable for home delivery, however, perinatal mortality is increased to over 5%³ compared with the overall British perinatal mortality rate of roughly 1%.

Most cases of cerebral palsy are thought to originate in the antenatal period and not during childbirth. But delay in performing a complicated delivery for a distressed baby increases the risk of long term handicap. Freedom of choice must include the right of the unborn child to the best possible start in life.

I believe that the way forward is to improve inpatient hospital services by creating a less impersonal and regimented atmosphere. There is already healthy cooperation among obstetricians, general practitioners, and midwives, and together we should be able to adopt a safe and acceptable strategy for antenatal and intrapartum care.

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1 Warden J. Maternity landmark. *BMJ* 1992;304:662. (14 March.)
2 Chamberlain G, Pearce JM. The flying squad. *Br J Obstet Gynaecol* 1991;98:1067-9.

3 Van Alten D, Eskes M, Treffers PE. Midwifery in the Netherlands. The Wormerveer study—selection, mode of delivery, perinatal mortality, and infant morbidity. *BMJ* 1989;96:656.

SIR,—The report on maternity services by the Commons health committee recommends that we should return to having more home births.¹

After nine months' obstetric training in a hospital delivering 6000 babies a year I was a principal in a general practice from 1 February 1964 to 31 January 1966. During this time I attended the deliveries of 76 women either in their homes or in the local cottage hospital. Among these patients three had a postpartum haemorrhage; one had a third degree tear; two required forceps deliveries; two had maternal distress; two delivered babies weighing over 4540 g, one of whom had shoulder dystocia; two had prolonged labours; two had labours complicated by meconium staining of the liquor; and three had retained placentas. I had to call out Southmead Hospital's flying squad twice. Two babies failed to breathe spontaneously and I had to intubate them.

In this admittedly small series, which I tried to select carefully for birth at home and in the local hospital, the rate of serious complications was 20%, and 79% of the deliveries took place outside normal working hours. Is that what general practitioners and pregnant women in the 1990s wish to return to?

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1 Warden J. Maternity landmark. *BMJ* 1992;304:662. (14 March.)

Preventing coronary heart disease

SIR,—The National Forum for Coronary Heart Disease Prevention is concerned by the recent Finnish study showing increased coronary and non-coronary mortality in subjects treated by diet and lipid lowering drugs compared with controls.¹ Michael F Oliver's view that these results, though disturbing and not fully explained, must not be ignored is welcome,² particularly while the government deliberates about cholesterol testing.³ But when all trials of prevention are considered, reduction of blood cholesterol concentrations by diet or drugs has led to a fall in both fatal and non-fatal coronary events.

As George Davey Smith and Juha Pekkanen point out, mortality from non-coronary causes seems to be raised in trials of drugs but not of diets.⁴ Certainly, cholesterol lowering drugs could have toxic actions, but evidence for their adverse effect on mortality is conflicting. The multiple drug approach in the Finnish trial makes assessment difficult. Furthermore, cholesterol concentrations in both intervention and control groups remained identical and high at 10 year follow up.¹

Much more knowledge of lipid lowering drugs is needed. But in the mean time it would be wrong to start a witchhunt against established principles of preventing coronary heart disease.

Measuring cholesterol concentrations on a widespread opportunistic basis without assessing other risk factors can lead to inappropriate (and perhaps dangerous) use of lipid lowering agents and turn normal people into anxious patients.^{5,6} With limited knowledge of nutrition among members of primary care teams, dietary counselling may well be ineffective.^{7,8} Average blood cholesterol concentrations in the United Kingdom are high, and the need for effective dietary advice is wide.

But there is another important issue. Patients with established coronary heart disease (especially those who have had coronary artery bypass grafting) are in particular need of measures to reduce risk. Evidence is accumulating that reducing cholesterol concentrations by dietary intervention alone, and diet plus drugs, can slow progression and perhaps promote regression of coronary heart disease.^{9,10}

While further knowledge of cholesterol lowering drugs is being obtained caution should be exercised in their use. They should be used only when diet

has failed. But patients at particularly high overall risk of coronary heart disease with high cholesterol concentrations that cannot be reduced by diet alone should not be denied drugs.

In the mean time rigorous monitoring of such drugs and education on nutrition for health professionals are needed. Health authorities could ensure, through contracts, that lipid tests are always part of overall assessment of the risk of coronary heart disease. Recent reports strengthen rather than undermine the need for a population wide strategy on nutrition, especially one beginning at an early age.

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- 1 Strandberg TE, Salomaa VV, Naukkarinen VA, Vanhanen HT, Sarna SJ, Miettinen TA. Long-term mortality after 5-year multifactorial primary prevention of cardiovascular diseases in middle-aged men. *JAMA* 1991;266:1225-9.
- 2 Oliver MF. Doubts about preventing coronary heart disease. *BMJ* 1992;304:393-4. (15 February.)
- 3 Standing Medical Advisory Committee. *Blood cholesterol testing: the cost-effectiveness of opportunistic cholesterol testing. Report to the secretary of state for health.* London: Department of Health, 1990.
- 4 Davey Smith G, Pekkanen J. Should there be a moratorium on the use of cholesterol lowering drugs? *BMJ* 1992;304:431-4. (15 February.)
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- 10 Watts GF, Lewis B, Brunt JNH, Lewis ES, Coltart DJ, Smith LDR, et al. Effects on coronary artery disease of lipid-lowering diet, or diet plus cholestyramine, in the St Thomas' atherosclerosis regression study (STARS). *Lancet* 1992;339:563-9.

Photographs misrepresent Romanian health care reforms

SIR,—We were most distressed to see that photographs of Romanian children in institutions had been added, without our knowledge or approval, to our article on the Romanian health and social care system for children and families.¹ We think that the photographs (especially the image of the foreign nurse playing with no fewer than five children in a cot) misrepresent and distort the current situation in Romanian institutions. As we and our Romanian colleagues point out in the article, conditions for children in institutions have improved greatly since the revolution. While foreigners have helped in the effort, they can by no means walk away with the credit. The Romanian government and Romanian health care workers have engineered sweeping reforms, but in our opinion they receive little recognition or encouragement for their efforts.

The purpose of the article was to update readers on how much had been done in the way of health care reform and how much there is left to do. The article itself was one end product of a successful health services research project for the purpose of policy development conducted by representatives of the Ministry of Health, a leading research and clinical teaching institute, and the United Nations Children's Fund. The whole exercise was characterised by an open and receptive attitude on the part of our Romanian colleagues. Though everyone had a hand in revising the article before submission, none of us had a chance to even comment on the suitability of the photographs selected to accompany it.

Our Romanian colleagues will be particularly distressed to find that, despite their best efforts, a negative image of child care in Romanian institutions continues to prevail abroad. We can only hope that this incident will not compromise their readiness to cooperate with us in similar ventures in the future.

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1 Children's Health Care Collaborative Study Group, Romanian health and social care system for children and families: future directions in health care reform. *BMJ* 1992;304:556-9. (29 February.)

Report of the International Chernobyl Project

SIR,—I wish to respond to a few of the points in Ian Munro and Mary Brennan's letter about the overview document of the International Chernobyl Project.^{1,2} I believe that they are responding to inappropriate use of the overview documents by people who would like to suggest that there will be no health effects from the accident at Chernobyl. Such a view is clearly wrong. I suggest that anyone seriously interested in Chernobyl should read the technical report thoroughly.³

The primary purpose of our medical survey was to confirm or deny claims in the media that more than 30% of people suffered from anaemia and that over 70% of people in Byelorussia suffered measurable thyroid damage in the five years after the accident. The size of our sample was certainly adequate for this.

In addition to carrying out the medical survey, people from the project spent many weeks in the Soviet Union interviewing scientists and examining their raw data regarding both thyroid abnormalities in Byelorussia and hereditary malformations. Their studies were not "arbitrarily dismissed." The project undertook specific missions that brought in independent experts from other countries (including the United Kingdom) to peer review the raw data on thyroid function, fetal malformation, haematology, epidemiology, and radiation effects. These experts' opinion was that no effects related to radiation could be substantiated in the general population.

It is true that no attempt was made to study the people who had moved away from the villages. The original request from the Soviet government was specifically restricted to determining the health of the general population remaining in contaminated areas.

Munro and Brennan suggest that the location of the control villages was a problem and that the contamination in the external environment would have been higher than elsewhere. But contamination in the control villages was checked by the project's environmental and dosimetry teams and was lower than in many west European countries.

I agree with Munro and Brennan that prospective epidemiological studies should be conducted, and this, indeed, was one of the project's conclusions.

There are certainly limitations to investigations of the International Chernobyl Project, and these are detailed in the 600 or so pages of the technical report. It is unfair to criticise a study for limitations that its authors have already pointed out or for not having extended beyond the host government's mandate.

The technical report clearly points out that the risk of future neoplasms and genetic effects is increased for the population living in contaminated areas. At the time it was written no effects other than increased stress and anxiety were obvious in

the general population studied. Whether current claims of an increased incidence of thyroid cancer can be substantiated by careful peer review of data remains to be seen. Obviously, serious health effects have occurred in emergency workers and other groups that were not included in our mandate from the Soviet government.

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- 1 Munro I, Brennan M. Lessons of Chernobyl. *BMJ* 1992;304:254-5. (25 January.)
- 2 International Advisory Committee. *International Chernobyl project. An overview*. Vienna: International Atomic Energy Agency, 1991.
- 3 International Advisory Committee. *International Chernobyl project. Technical report*. Vienna: International Atomic Energy Agency, 1991.

Public opinion and purchasing

SIR,—Like Andrew Richardson and colleagues I welcomed the introduction of surveys of public opinion on health priorities because I thought that they would help health authorities in taking informed decisions on purchasing.¹ I rapidly discovered that, as in Oregon,² public preference is being used selectively to justify cuts in services—when it accords with the views of decision makers. (When it does not, as was the case with the 46% of respondents in Bath who found help with stopping smoking to be of little or no importance,¹ I suspect that it is being disregarded.) Such surveys require a healthy dose of scepticism. Separate from the questionable ethics of obliging an unaware public to collude in rationing is the equally disturbing way in which strategies borrowed from economics, such as "rationing for health gain," are being promoted as an appropriate basis for setting priorities. Grounded as such ideas are in the relativist notion of "capacity to benefit from health care" (which depends on what health care is currently available), these approaches have no necessary relation to health need (which depends on individuals' health status) and, indeed, are likely to increase existing inequalities in health. Informed and public discussion is urgently required so that these concepts can be examined,^{3,4} debated,^{5,6} and put in their proper context—whatever that may turn out to be.

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- 1 Richardson A, Charny M, Hanmer-Lloyd S. Public opinion and purchasing. *BMJ* 1992;304:680-2. (14 March.)
- 2 Honigsbaum F. *Who shall live? Who shall die? Oregon's health financing proposals*. London: King's Fund College, 1991. (King's Fund College papers 4.)
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- 4 Smith A. Setting a strategy for health. *BMJ* 1992;304:376-8. (8 February.)
- 5 Harris J. QALYing the value of life. *J Med Ethics* 1987;13:117-23.
- 6 Breen D, Chalmers J, MacLean I. Setting a strategy for health. *BMJ* 1992;304:641-2. (7 March.)

Raw deal for academics

SIR,—I congratulate D K Peters on his editorial in defence of academic medicine.¹ I particularly endorse his comments that the accreditation process should be rationalised so as not to demoralise clinical academics and delay their usefulness in senior supervisory posts.

The recent introduction of the (T) system is a retrograde step in this regard. This is the scheme whereby a practitioner's trained status will be indicated in the medical register by a (T) after his

or her entry. To be regarded by the Royal College of Psychiatrists as trained you need to do four years of approved higher clinical work; without this a (T) will not be granted. It has been mooted that without such accreditation academic consultants should not be allowed to train juniors on an approved rotation. I suggest that an (R) should be introduced to indicate proper research training, without which no clinician should be allowed to supervise any research student or research fellow.

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- 1 Peters DK. Academic medicine. *BMJ* 1992;304:651-2. (14 March.)

SIR,—D K Peters points out many of the problems faced by clinical academics.¹ A further inequality has arisen with the recent replacement of units of medical time by additional duty hours as payment for extra duties. Currently in Leeds the university pays junior clinical academics for their extra duties and has no plans to change from the units of medical time system to additional duty hours. My NHS colleagues are paid 50% of the standard rate for on call work, whereas I and my junior clinical academic colleagues are paid 34% of the standard rate for on call work.

I think that many applicants for junior clinical academic posts are unaware of the extra demands that these posts carry and the uncertainty about parity of salaries. If these problems remain unresolved young doctors will soon not take up careers in academic medicine.

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- 1 Peters DK. Academic medicine. *BMJ* 1992;304:651-2. (14 March.)

Telephoning for an ambulance

SIR,—Minerva reports that general practitioners can save valuable minutes if they "tell the patient to phone for an ambulance" when the patient telephones and gives a history suggesting cardiac pain.¹ I think that this recommendation is misguided. Sudden death may occur before the patient can telephone, and lesser medical events such as vomiting could also delay the telephone call.

An even greater delay in the chain of events leading to admission to hospital with cardiac type chest pain occurs when the patient telephones and the general practitioner is not in the surgery. Sometimes the receptionists relay the call; at other times patients must telephone an independent doctors' answering service. On the receiving end, general practitioners may have to find a working telephone box to answer their bleep. These delays have been eliminated in our area by training receptionists and operators of answering services to call an emergency ambulance themselves if the story strongly suggests cardiac pain and then to notify the general practitioner.

In these circumstances, well trained operators can save minutes and lives. That is, if patients can get through to them. In this age of the patient's charter should there not be a maximum time for which patients should expect to ring when calling an emergency ambulance (in my experience, sometimes four minutes) and doctors' surgeries or answering services (which are often engaged)?

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- 1 Minerva. *BMJ* 1992;304:788. (21 March.)