vivors were interviewed about the advice they had been given during and after their admission concerning smoking, diet, and exercise. When appropriate, patients were asked whether the result of serum cholesterol estimation had been discussed with them. Results were analysed with the χ^2 test with Yates's correction.

There were 142 eligible admissions (85 men). Thirty patients died before interview, and 17 refused consent or had dementia. The 95 subjects (58 men) interviewed had a median age of 75 (range 70-86) and were interviewed a median of 8.6 (range 2.6-14) months after admission. Fifteen had regularly smoked cigarettes. Twelve had been advised to stop and 11 had either done so or cut down considerably. One of the three with whom smoking had not been discussed had also stopped.

Fifteen patients had previously been given dietary advice for medical reasons. Of these, six had been advised to make further changes and four claimed to have done so. Of the 80 patients not previously on a diet, 36 remembered having been given advice: nine from a doctor and 21 from a nurse or dietitian, while six had been given a booklet. Two thirds of these claimed to have made positive changes to their diet (specific changes were recalled by 12 of the 24) compared with eight of the 44 not given advice ($\chi^2=6.0$, $df=1$, $p=0.009$).

The serum cholesterol concentration was available in 63 cases: the median was 6.4 (range 3.8-10.0) mmol/l, and 12 subjects had a concentration ≥ 7.8 mmol/l. Nine patients could recall having discussed their cholesterol concentration with a member of staff.

Fifty one people recalled a discussion about exercise. All but five of these said that they had followed the advice. More detailed analysis was not possible because the advice given varied depending on individual circumstances.

For logistical reasons we did not attempt to verify smoking habits or change in diet, and this should be taken into account when interpreting our results. Nevertheless, we confirmed that fit older people are prepared to heed advice on lifestyle and make beneficial changes after admission to a coronary care unit for a suspected myocardial infarction.

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1 Beard K, Bulpitt C, Mascie-Taylor H, O'Malley K, Sever P, Webb S. Management of elderly patients with sustained hypertension. *BMJ* 1992;304:412-6. (15 February.)

Notifiable diseases

SIR,—Though I welcome Bryan Jefferson Heap's reminder of the statutory obligation on all medical practitioners to notify certain diseases,¹ it is not time that infectious diseases epidemiologists re-examined the methods used to ascertain cases of infection of importance to public health? Presently formal notification, laboratory returns, information from reference laboratories or "spotter" general practitioners, absences from employment, hospital discharges and deaths, and death certificates are all used by many workers but in an uncoordinated fashion with little linking of cases to obtain the true incidence or, more importantly, to initiate action in terms of public health.

The methods used should match the disease. In 1991, 37 539 cases of chickenpox were statutorily notified in Scotland.² This is a disease presently subject only to surveillance. The £75 000 spent on reimbursing practitioners would have been more appropriately used in establishing a representative sample of sentinel doctors to obtain the true incidence of this and other conditions.

It has been proposed that listeriosis should be made a notifiable disease.³ From 1967 to 1991, 155

cases not associated with pregnancy were ascertained in Scotland. One hundred and twenty four were reported by laboratories, 84 were listed in the reference laboratory records, and 67 were listed in the national hospital discharge and death files (unpublished information). Thus reporting based on clinicians would have identified only half the cases identified by laboratories.

A Hill shows the importance of notification with respect to surveillance of measles.⁴ This disease has clear diagnostic criteria and is almost invariably diagnosed clinically, and public health intervention is possible—namely, a two stage immunisation programme with mumps, measles, and rubella vaccine for boys and girls.

The challenge facing consultants in public health medicine (communicable diseases and environmental health) and communicable disease control is to develop surveillance methods appropriate to specific diseases and their potential for action in terms of public health.

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1 Heap BJ. Notifiable diseases. *BMJ* 1992;304:726-7. (21 March.)

2 Communicable Diseases and Environmental Health in Scotland Weekly Report 1992;26:7.

3 Social Services Committee. First report. Food poisoning: listeria and listeriosis: follow up. London: HMSO, 1989:iv.

4 Hill A. Measles, mumps, and rubella vaccination. *BMJ* 1992;304:779. (21 March.)

SIR,—Simon Voss has shown ignorance among doctors of the procedure for notifying infectious diseases,¹ and the accompanying editorial outlines other problems such as poor compliance and an outdated list of notifiable diseases.² The shortfalls of the notification system do not end there. The system is also inaccurate, relying on clinical diagnosis rather than laboratory confirmation; slow (notifications in Winchester Health District are often received after, and as a result of, laboratory diagnosis); and entails expensive administration of a derisory payment.

The aims of notification are twofold: to permit rapid intervention to prevent an outbreak, and surveillance. Neither is achieved by the present system, but both are done much more efficiently by microbiology laboratories. In many microbiology laboratories the isolation of important pathogens requiring rapid intervention is reported quickly to those responsible for controlling infection, usually the hospital infection control doctor and more recently the consultant in communicable disease control. Laboratory reporting of microbial isolates to the Communicable Disease Surveillance Centre is thorough, accurate, and sufficiently rapid for surveillance purposes even though there is no statutory obligation. It is true that laboratories can report only on the specimens they receive, but this gives a far more accurate picture of the true incidence of infectious disease than a poorly compliant notification of clinical suspicion.

Is notification ever worth while? It may still have a role in community acquired infections that are less commonly confirmed by a laboratory, such as viral exanthemas and pertussis, and infection in which laboratory diagnosis is often delayed, such as tuberculosis. The table compares the numbers of statutory notifications received and of microbiology reports to the Communicable Disease Surveillance Centre for several conditions. Enteric infections are grossly undernotified. Notifications and microbiology reports for tuberculosis are identical. In contrast, viral exanthemas are more commonly notified than reported by microbiological laboratories.

The current process of statutory notification is anachronistic. Though notification of some infections may still be useful, the process needs to be reviewed. This has been initiated by the Department of Health, although no recommendations

Numbers of statutory notifications of selected infectious diseases and microbiology reports to Communicable Disease Surveillance Centre in Winchester Health District, August 1991 to March 1992

	Notifications	Microbiology reports
Enteric infection (food poisoning)	128	398
Tuberculosis	5	5
Meningitis	4	11
Measles	74	
Mumps	4	
Rubella	8	2

have yet been announced.³ A rapid response to potential outbreaks of infection is ensured if the consultant in communicable disease control maintains close liaison with the microbiology laboratory as well as general practitioners and environmental health officers. Surveillance of most infectious disease is most effectively achieved through microbiology laboratory reports to the Communicable Disease Surveillance Centre.

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1 Voss S. How much do doctors know about the notification of infectious diseases. *BMJ* 1992;304:755. (21 March.)

2 Jefferson Heap B. Notifiable diseases. *BMJ* 1992;304:726-7. (21 March.)

3 Department of Health. Review of law on infectious disease control—consultation document. London: DoH, 1989.

Maternity services

SIR,—Though I well understand the need for liberalisation of maternity services in the United Kingdom, I believe that the report of the Commons select committee goes too far.¹

For the past nine years in this district we have had the benefit of excellent maternity services from Hinchingsbrooke Hospital. Here women enjoy the best of all worlds. They are encouraged to choose and plan their own arrangements for labour and delivery, which is led by a midwife. Surroundings are pleasantly informal, and facilities are available to aid active birth. On the other hand, the full technological facilities of a modern unit are available should the need arise. The result of this is an extremely low rate of instrumental deliveries and the lowest perinatal mortality rate in the country. Therefore few women in the district see anything to be gained from a home delivery. During these nine years only three women from our practice (having five births between them) have opted for a home delivery.

I have elected to try to attend these deliveries to support the midwife, but it is ridiculous to pretend that I now have sufficient skills in intrapartum care to be of anything other than decorative value. At the same time these events are extremely time consuming, and if they occurred more frequently they would be completely incompatible with the post-1990 schedule of general practice. Our last home delivery entailed a midwife being in attendance almost continuously for 16 hours and a doctor for six hours—a service that would have been impossible to provide had the delivery not occurred on a Saturday when neither of us was on call.

The select committee is therefore being completely unrealistic in its expectation that all general practices can offer a home delivery service. This would require a massive increase in the numbers of both midwives and skilled general practitioner-obstetricians. Instead maternity services should continue to be concentrated in hospitals (including rural isolated general practitioner units, where the necessary skills in intrapartum care remain). So far as the role of midwives and the need for

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.)
- 5 Tjinstma T. The psychological and social implications of serum cholesterol screening. *International Journal of Risk and Safety in Medicine* 1990;1:29-44.
- 6 Marteau TM. Reducing the psychological costs. *BMJ* 1990; 301:26-8.
- 7 Francis J, Roche M, Mant D, Jones L, Fullard E. Would primary health care workers give appropriate dietary advice after cholesterol screening? *BMJ* 1989;298:1620-2.
- 8 Sharp I. An agenda for nutrition education in the 1990s. In: Hurren C, Black A, eds. *The food network: achieving a healthy diet by the year 2000: proceedings of a conference.* London: Smith Gordon, 1991: 83-111.
- 9 Davies MJ, Krikler DM, Katz D. Atherosclerosis: inhibition or regression as therapeutic possibilities. *Br Heart J* 1991;65: 302-10.
- 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.