the patients, giving them permission to change treatment and, in particular, to increase inhaled steroids as their lung function falls.

Martys misquotes our study in saying that the peak flow meter is not crucial to managing asthma. We considered that both peak flow meters and symptoms play an important part in self management by teaching the patients the importance of their symptoms and what action they should take.⁶ This is best achieved by written self management plans linked to diary cards and reinforced by colour coded labels on the peak flow meter.⁷

The Darley Dale clinic saw 78 patients in one year with six monthly review. Our clinic ran for nine hours a week and monitored 115 patients in a year with a median of four consultations with the nurse and one consultation with a doctor. The overall consultation rate did not change, but the redistribution in work resulted in a halving of emergency steroid courses, nebulisations, and absenteeism.

Martys recognises that gathering information about a patient's condition does not necessarily change the management of asthma. Unless we can develop techniques that result in steroids being taken in the right doses and at the right time then little is likely to change.

IAN CHARLTON
GILLIAN CHARLTON

Kincumber 2251,
New South Wales,
Australia

- 1 Martys C. Asthma care in Darley Dale: general practitioner audit. *BMJ* 1992;304:758-60. (21 March.)
- 2 Charlton IC, Charlton G, Broomfield J, Mullee MA. Audit of the effect of a nurse run asthma clinic on workload and patient morbidity in a general practice. *Br J Gen Pract* 1991;41:227-31.
- 3 Charlton I, Charlton G, Broomfield J, Campbell M. An evaluation of a nurse-run asthma clinic in general practice using an attitudes and morbidity questionnaire. *Fam Pract* (in press).
- 4 Hilton S, Sibbald B, Anderson HR, Freeling P. Controlled evaluation of the effects of patient education on asthma morbidity in general practice. *Lancet* 1986;i:26-9.
- 5 Jenkinson D, Davison J, Jones S, Hawtin P. Comparison of effects of a self management booklet and audiocassette for patients with asthma. *BMJ* 1988;297:267-70.
- 6 Charlton I, Charlton G, Broomfield J, Mullee M. Evaluation of peak flow and symptoms only self-management plans for control of asthma in general practice. *BMJ* 1990;301:1355-9.
- 7 Charlton I, Charlton G. New perspectives in asthma care. *Practitioner* 1990;234:30-2.

Videotaped interviews with children suspected of being sexually abused

SIR,—M R Wiseman and colleagues report that agreement between professional groups and a consensus rating was good when raters were asked to assess the likelihood of child sexual abuse on the basis of videorecorded interviews with children.¹ There are several reasons, however, for thinking that their study overestimates the level of agreement that will generally be found during such assessments.

Firstly, the design of the research tends to maximise the chances of agreement since, as they point out, the cases were not randomly selected and the professionals rating the videos were highly experienced.

Secondly, their study of videotaped interviews is mainly a test of the reliability of the criteria used to define the probability of sexual abuse. In clinical practice there will be additional variability arising from differences in the amount and quality of other information that raters have (such as direct interviews and statements). Such information was available only to the consensus panel in the authors' study.

Thirdly, the statistic that the authors use to assess agreement, the raw percentage agreement, does not correct for the fact that 50% agreement

would occur by chance. If the data in their first table are reanalysed with a statistic that corrects for chance agreement, the κ statistic, then the level of agreement for all groups is 0.71, less than the 0.85 raw agreement calculated from the same data.

Thus the level of agreement in routine clinical practice is most unlikely to be any higher than the authors report, and for the reasons given above it will probably be much lower. Even if the level of agreement in practice is just 0.2 lower, at a κ coefficient of 0.51, there would be disagreement on a considerable number of cases. For instance, two professionals rating 100 videotapes at this level of agreement (with a "true" rate of high likelihood cases the same as in the reported study) would disagree on 24 cases. Thus more work seems to be needed on standardising the assessment of children suspected of being sexually abused.

RICHARD HARRINGTON

University Department of Psychiatry,
Queen Elizabeth Psychiatric Hospital,
Birmingham B15 2QZ

- 1 Wiseman MR, Vizard E, Bentovim A, Leventhal J. Reliability of videotaped interviews with children suspected of being sexually abused. *BMJ* 1992;304:1089-91. (25 April.)

Being a house officer

SIR,—Most of us prefer to forget about our house jobs as soon as we reach the relative sanctuary of a senior house officer post. We each spent our preregistration year working in different institutions in different parts of Britain, yet we found that John Lear's comments described accurately the misery and frustration of our own experiences as junior house officers¹; we would be surprised if many other readers did not have the same response. The comments of Lear's consultants, with their implication that he was out of the ordinary in having problems, show their perception that the fault lies with the people rather than with the system within which they work. Junior doctors are still not listened to when they are honest and brave enough to express their feelings of inadequacy.

If we are not to train another generation of doctors who become disillusioned so quickly with their first experience of work, two changes are necessary: firstly, medical undergraduate training must prepare new doctors for the job they have to do when they qualify instead of trying to produce brilliant diagnosticians; and, secondly, senior doctors need to take their juniors' complaints seriously and lobby on their behalf for more humane conditions of work.

JEREMY GRIMSHAW

Department of General Practice,
University of Aberdeen,
Medical School,
Aberdeen AB9 2ZD

BRENDA WILSON
DANNY RUTA

Department of Public Health,
University of Aberdeen

- 1 Lear J. The beginning of the end. *BMJ* 1992;304:1122. (25 April.)

SIR,—I am intrigued that at the end of John Lear's personal view the *BMJ* decided to publish a response from his consultants.¹ The response seems to cast doubt on the veracity of Lear's eloquent description of the difficulties he faced as a house officer. The suggestion that he has been economical with the truth tends to diminish the impact of the message he is conveying. In the short response from the anonymous consultants I am reminded obliquely of the importance of a referee and a referee. Unfortunately, this may have the effect of discouraging other disaffected preregistration house officers from speaking out.

I think it should concern all in the medical profession that the consultants wrote, "The patients were as well 'protected' during this time as we could devise." The crucial issue must be the protection of house officers. Recognition that the preregistration year is, and must remain, primarily a training experience would ensure that house officers no longer had to "survive" a traumatic first year in their chosen career. Awareness has been raised; change has surely got to occur.

O JUNAID

Department of Health Care of the Elderly,
University Hospital,
Queen's Medical Centre,
Nottingham NG7 2UH

- 1 Lear J. The beginning of the end. *BMJ* 1992;304:1122. (25 April.)

SIR,—John Lear speaks for many in his personal view on being a house officer.¹ The open acknowledgment of the difficulties of this challenging year allows for change.

Stress in students and junior doctors may affect their physical, psychological, and social health as well as impair their performance as doctors.^{2,3} We are looking at the experience of house officers with a view to preparing students for this extraordinary year. Key topics that we have identified as being appropriate for training are clinical skills,⁴ personal support,⁵ and management skills at both the personal and the professional level.⁶

This summer we plan to run the first of a series of workshops for our clinical students, entitled "Being a doctor: are you ready?" We would be interested to hear from other groups running similar or alternative projects.

C VAUGHAN
S PEZESHGI

Department of General Practice and Primary Care,
King's College School of Medicine and Dentistry,
London SE5 9PJ

- 1 Lear J. The beginning of the end. *BMJ* 1992;304:1122. (25 April.)
- 2 Dowling S, Barrett S. *Doctors in the making. The experience of the pre-registration year.* Bristol: Bristol University, 1991.
- 3 Dyer C. Manslaughter convictions for making mistakes. *BMJ* 1991;303:1218.
- 4 Moss F, McManus IC. The anxieties of new clinical students. *Med Educ* 1992;26:17-20.
- 5 Firth-Cozens J. Emotional distress in junior house officers. *BMJ* 1987;295:533-6.
- 6 Calman KC, Donaldson M. The pre-registration house officer year: a critical incident study. *Med Educ* 1991;25:51-9.

Maternity services

SIR,—Correspondents are critical of the report of the Commons select committee aiming at empowering women to have more choice and control over the place and style of birth.¹ Indeed, it would be surprising if the medical profession did not oppose recommendations to "demedicalise" a service that doctors have tried to monopolise for generations. But the select committee's findings reflect accurately both the needs of women and the views of enlightened health professionals.

Paul Sackin misses the point in claiming that the report is unrealistic in its expectation that all general practices can offer a home birth service.¹ Though it is true that many general practitioners do not wish to provide intrapartum care themselves, they can and should offer every woman a genuine choice (which includes home birth for women considered to be at low risk), referring her to colleagues if necessary.

Adam Balen and John McGarry are shroud waving.¹ A growing body of evidence shows that care by a general practitioner and community midwife is no less safe than consultant care for women already selected to be at low risk,² and there is no evidence to support the claim that the safest policy is for all women to give birth in hospital.³

Implementing the select committee's recommendations will take time. For example, although Sheffield Health Authority's maternity service agreements allow for a potential quadrupling of the number of home births this year, the problem of demand exceeding supply has yet to be addressed. Support needs to be offered urgently to the small band of caring general practitioners who continue to provide intrapartum care at considerable personal expense.

In childbirth in particular, women have the right to informed choice. The Commons select committee has reaffirmed that right and should be congratulated for having done so.

PAUL SCHATZBERGER

Directorate of Public Health and Medical Staffing,
Trent Regional Health Authority,
Sheffield S10 3TH

- 1 Correspondence. Maternity services. *BMJ* 1992;304:1056-7. (18 April.)
- 2 Jewell D, Young G, Zander L. *The case for general practice maternity care*. Temple Sowerby: Association for General Practice Maternity Care, 1990.
- 3 Campbell R, Macfarlane A. *Where to be born? The debate and the evidence*. Oxford: National Perinatal Epidemiology Unit, 1987.

Babycover insurance

SIR,—I write as the author of the article in the *Evening Standard* referred to by Julie Welch,¹ the founder of the Nigel Clare Network Trust, and the mother of two children who had cystic fibrosis.

I understand that rigorous adherence to precise use of the five W's (who, what, when, where, why) may be an old fashioned concept. It is, however, one I believe to be essential to reliable journalism. I attended the press launch of Babycover. I interviewed the principals. I read the independent market research on the product. I interviewed parents with healthy children and parents with disabled children and people wishing to become parents.

Welch writes that she "gathers" (once), "supposes" (once), "presumes" (twice), and "bets" (once) and asks several questions which were answered at the press briefing and in the company's literature and available from the number published in my article. The answers do not match her independent suppositions.

The diagnosis of a child's life limiting or life threatening condition is too often a prognosis of career disaster, and thus financial disaster, for parents. I suggest that before Welch again takes up her cudgels she should check her facts. Clearly, affected families face enormous stress. Alleviation of any stress must therefore be of benefit. As a parent I deeply resent Welch's presumption that parents who approve of the policy regard their children's conditions "as a misfortune similar to burst pipes. . . ."

I hope that Welch's ill informed words do not deter the *BMJ*'s readers from making information available to patients. The Nigel Clare Network Trust has raised half the funds it needs to extend its initial pilot study of career and financial hardship to a nationwide base. Results to date indicate that as many as 70% of families suffer serious financial hardship. An initial insurance payout would do no more than buy time for parents to assess situations fully. Perhaps this would lead to a change of career, perhaps not; it would provide time for rational assessment. The Nigel Clare Network Trust can be contacted at PO Box 44, Woking, Surrey GU21 5TE.

MAIRI PUTT

London SW16 6LP

- 1 Welch J. Insurance against disability. *BMJ* 1992;304:989. (11 April.)

SIR,—Julie Welch vents her outrage at the insurance company that is offering a new policy to

cover a range of congenital disabilities.¹ She considers the idea of Babycover, as the policy is called, to be "gruesome," capitalising on "a pregnant woman's greatest fear," and denounces the insurance company for its genetic entrepreneurialism.

I disagree with her emotive rhetoric. Such insurance, in principle at least as I have not seen the policy itself, does indeed have its place.

Although teratology as a science has existed since the eighteenth century, only in the past two decades have great strides been made: to the point that American teratologist Robert L. Brent states that "Nature does eliminate most abnormal embryos spontaneously and it is very likely that by the year 2000, biomedical science will have available electronic, biochemical, and genetic techniques to evaluate the status of every embryo at very early stages of gestation."²

As I have explored elsewhere, the moral questions associated with detecting abnormalities and potential treatment are becoming both complex and subtle—and yet also remain relatively unexamined by health care practitioners.³ To evaluate the status of embryos, as Brent mentions, is certainly a medicoscientific issue, yet it is also a moral concern.

It is also a financial concern, even if Welch finds the idea of actuarial intervention in the evaluative process offensive. The reality is that most disabilities—of whatever magnitude—are expensive to evaluate and to treat, whether in costs to the NHS or in the private sector. The reality, too, is that not all insurance policies, for those fortunate enough to have them, cover unforeseen congenital disabilities or cover them adequately. And given the medical reality that over 700 recognised disabilities and deformities exist, such specialised cover has its place and should be encouraged, not condemned.

JONATHAN SINCLAIR CAREY

London W8 7SH

- 1 Welch J. Insurance against disability. *BMJ* 1992;304:989. (11 April.)
- 2 Carey JS. I am not yet born but that won't stop me suing you. *New Statesman and Society*. 1991 Nov 15:29.
- 3 Carey JS. The Quasimodo complex: deformity reconsidered. *Journal of Clinical Ethics* 1990;Fall:212-22.

SIR,—It is unfortunate that Julie Welch didn't undertake more research before she wrote her emotive article about Babycover insurance.¹ Babycover does indeed allow women to insure against the unforeseen circumstances resulting from their child being born with one or more of several specified conditions: cystic fibrosis, muscular dystrophy, Down's syndrome, spina bifida, and mental handicap. The insurance is designed to help with the costs of caring for an infant with special needs, such as the costs of home nursing, domestic help, adapting the home, and special equipment.

Welch is wrong in most of her presumptions about the policy:

- Babycover is available to expectant mothers aged 18-42 for a one off premium payment that does not vary with age
- Applicants do not need to undergo any diagnostic tests whatsoever
- The policy can be taken out during any stage of pregnancy
- The insurers could not be involved in any decision regarding termination
- The levels of cover available respond only to the amount of the premium paid and bear no relation to the age or occupation of the parents
- Babycover policies are clearly worded, and there are no hidden clauses in the "microprint."

Babycover insurance has been developed by a team of Lloyd's underwriters who have personal

experience of babies with special needs. LRG Services, the administrators of Babycover, consider that there is a need for an insurance policy of this kind, and current sales support this view.

N WALKER

LRG Services,
London EC3V 3NB

- 1 Welch J. Insurance against disability. *BMJ* 1992;304:989. (11 April.)

APOLOGY

We acknowledge that incorrect and misleading remarks were made about Babycover in Julie Welch's article, and we apologise to LRG Services Ltd for any damage or embarrassment caused to them by the publication of the article. We also fully accept that the product was developed sensitively in response to market needs and that its terms are clear.—Ed, *BMJ*.

Beware shifts in case mix under the block contract

SIR,—Rightly or wrongly Wessex Neurological Centre has embraced the philosophy of resource management and the white paper. We have had a neuroscience directorate for over five years and have managed our own budget and with some difficulty have broken even. The centre is a tertiary referral centre with budgetary control of the service and has been given no choice but to accept block contracts, which use as the baseline the workload in 1989-90. We have long recognised the danger that the large shifts in case mix that could occur within such contracts would have considerable implications for resources and seriously affect our ability to deliver a safe neurosurgical service.

Traditionally, because of the paucity of neurosurgical facilities nationwide, many neurosurgical problems—for example, some head injuries—are managed outside specialist centres. The recent welcome addition to districts of neuroimaging facilities, especially computed tomographic scanners, is such, however, that low dependency cases requiring only investigation or non-operative management, and hence using few resources, are not being referred but the numbers of increasingly complex cases requiring more resources have risen.

During April to December last year we saw a major shift in case mix. Day cases and non-operative cases using few resources were, respectively, 48 and 188 finished consultant episodes below target; major intracranial operations and spinal operations, however, were, respectively, 133 and 60 finished consultant episodes above target. Therefore in the language of block contracts we were 43 cases short of our target. In the language of cost and volume contracts, if we look at the extreme of cost per case then we would have generated £235 000 additional revenue (we appreciate that marginal costs would apply to an appreciable proportion of this sum).

Our acute 24 bedded neurosurgical ward runs at a bed occupancy of 110-135%. We recognise that this is unreasonable and probably unsafe but are powerless to reverse the trend. Patients with intracranial disease requiring surgery cannot sit on comfortable waiting lists providing us with political muscle. Many patients presenting to a neurosurgeon with spinal disease become seriously neurologically impaired on those same waiting lists.

What is particularly distressing is that we have had appreciable bed closures for almost two years as we cannot afford the nurses required. When this was recently announced in the local press furore erupted among the managers; the purchasers were upset. When we attempted to achieve what we