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.

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- 2 Jewell D, Young G, Zander L. *The case for general practice maternity care*. Temple Sowerby: Association for General Practice Maternity Care, 1990.
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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.

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- 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.

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- 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.
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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.

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- 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

considered to be safe practice and open more beds to reduce bed occupancy, furore erupted among the managers again because, inevitably, we were heading towards overspending on staff costs.

The detailed assessments necessary to make the provider-purchaser arrangements work were never clearly worked out. The assumption was that by retaining the historic agreements the transfer to so called market forces would make no difference to a major regional acute service. Sadly, for our patients this has not been the case.

In summary, a shift in case mix has occurred about which we can responsibly do nothing. We have the physical capacity to accommodate these patients safely but are constrained by staffing budgets that are based on historical establishments. Our patients and we the directorate are casualties of trying to make the white paper work.

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Chromosomal abnormalities and fetal nuchal translucency in first trimester

SIR,—K H Nicolaides and colleagues describe the importance of fetal nuchal oedema as a marker for chromosomal abnormalities.¹ The presence of nuchal oedema in their population of patients was associated with a 10-fold increase in the risk of fetal chromosomal abnormality. In the absence of nuchal translucency fetal chromosomal abnormalities were one third less likely than they were in the authors' "average" population.

The prevalence of chromosomal abnormalities in their population was 3%. The authors work in one of the world's finest centres for antenatal diagnosis, and their patients are therefore different from those in ordinary district hospitals. Assuming that the accuracy of this test would be unchanged in a population with a normal risk with a prevalence of chromosomal abnormalities of one in 160 live births,² the positive predictive value of a positive test result would fall from 35.2% to 9.3%.

Nicolaides and colleagues maintain a high level of skill because of their frequent exposure to fetal abnormalities and their special interest in ultrasonographic detection of such abnormalities. For obstetricians, radiologists, and ultrasonographers in district hospitals the distinction between amnion and fetal skin oedema can be difficult. The accuracy and the predictive value of the test in district hospitals might fall to a level at which screening for nuchal translucency in the first trimester becomes questionable.

The value of the test can be assessed by Bayes's theorem. In its simplest form this compares the probability before the test is done (the prior probability) with the probability after the test has been done (the posterior probability).³ In real life in district hospitals the posterior probability might be lower than 1% (true positive results three, false positives 40, false negatives three, and true negatives 955 in an imagined fourfold table, with a slightly lower accuracy (95%) than that reported by Nicolaides and colleagues (96%) and a prevalence of one in 160).

Nicolaides and colleagues state that "the sensitivity and specificity of nuchal translucency as a marker for chromosomal defects in routine transabdominal ultrasound examination of the whole population remain to be determined." We agree.

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- 1 Nicolaides KH, Azar G, Byrne D, Mansur C, Marks K. Fetal nuchal translucency: ultrasound screening for chromosomal defects in first trimester of pregnancy. *BMJ* 1992;304:867-9. (4 April.)
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Adoption in utero is the wrong term

SIR,—Ian Craft and colleagues report having successfully treated an infertile couple with two cryopreserved surplus embryos donated by an anonymous infertile couple.¹

Embryo donation has been available for some time, the first pregnancy having been reported by Trounson *et al* in 1983²; in 1987 Devroey *et al* reported the first successful pregnancy achieved with a cryopreserved donor embryo.³ The treatment has not, however, become common, one reason being the limited number of embryos available for donation. The case reported by Craft and colleagues differs in that the frozen embryos were surplus ones after the treatment of another infertile couple was successful. More such embryos are likely to become available for donation since the introduction of the five year statutory limit on the storage of cryopreserved embryos under the Human Fertilisation and Embryology Act 1990.

We cannot agree with the authors' use of the term "adoption in utero" to describe embryo donation. Adoption is a legal process whereby a couple (or a person) seek to become the legal parents of a child who is not theirs by birth. In British law a woman who gives birth to a child is regarded as his or her legal mother, whether she has made any genetic contribution to that child or not. In the case of embryo donation the recipient of the embryo is therefore the legal mother of any ensuing child and her husband is the legal father. Adoption is unnecessary. Indeed, use of the term adoption in utero confers the status of a newborn child on the donated embryo. Other workers concerned with in vitro fertilisation have been careful to maintain the distinction between these two stages of development.

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Health and safety at fairgrounds

SIR,—Gian Singer and Lawrence Freedman's letter on the dangers of "bouncy castles"¹ highlights the important issue of public safety in fairgrounds and amusement parks—a topic that has already been addressed in some detail by the Health and Safety Executive.

Legislation relevant to this subject already exists. Section 3 of the Health and Safety at Work etc Act is interpreted as imposing a duty on operators of devices such as bouncy castles to conduct their business in a way that minimises the risk of injury to members of the public.² If they fail to do so inspectors from the Health and Safety Executive have powers to prohibit use of the device or may require the operator to carry out

improvements. A prosecution under the Health and Safety at Work etc Act may also be considered.

To help operators of fairgrounds and amusement parks fulfil their duties under the act the Health and Safety Executive and representatives of the amusement industry have cooperated in drawing up a code of safe practice at fairs.³ This sets out agreed general principles regarding such matters as the design, manufacture, operation, inspection, and maintenance of amusement devices as well as the safe accommodation of passengers. In most situations inspectors of the Health and Safety Executive will regard observance of the provisions of this code as the best means of meeting the general duties set out in the act.

In addition to the code of safe practice at fairs the Health and Safety Executive has also issued more detailed guidance concerning the safe operation of several specific amusement devices such as bouncy castles.⁴

Finally, it should be noted that if a serious accident involving an amusement device occurs the operator has a duty to report it to the Health and Safety Executive.⁵

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- 1 Singer G, Freedman LS. Injuries sustained on "bouncy castles." *BMJ* 1992;304:912. (4 April.)
- 2 *Health and Safety at Work etc Act 1974*. London: HMSO, 1974.
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On your bikes

SIR,—Fiona Godlee declares, "Urban cyclists are a heroic and selfless breed." If she was to move from the confines of her office and take to the streets of London—preferably on foot, of course—she would see that so many cyclists:

- (1) Use no lights, either front or rear, after dark;
- (2) Frequently and wilfully disregard red traffic lights;
- (3) When they do halt at such lights, make their way to the head of the queue, only to move off in advance of the traffic, not keeping to the near lane and often turning one way or the other without warning;
- (4) Despite it being a statutory offence, frequently ride on pavements to the peril of pedestrians;
- (5) Unhesitatingly ride across roads by way of pedestrian crossings, exercising a priority otherwise reserved for walkers.

If their means of propulsion does prove to be unsafe then, as I see it, cyclists themselves are not without blame. In such condemnation I am not entirely prejudiced for, over the years, I have bicycled over 160 000 km, paying, I like to think, rather more respect to the rules and the courtesies of the road than I see commonly evinced by riders today.

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- 1 Godlee F. On your bikes. *BMJ* 1992;304:588-9. (7 March.)

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.