(though one meningioma occurred synchronously with a pituitary adenoma in a patient not given radiotherapy) and one case of glioma (which was paralleled by a glioma in a contemporaneous patient with Cushing's syndrome who was not given radiotherapy). The apparent disparity between these figures and those of Brada and colleagues emphasises the rarity of these second tumours and the difficulty of interpreting small numbers, particularly in the absence of a control series. Sellar fibrosarcoma, glioma, and meningioma are distinct and disparate pathological processes, each with its own propensity for development under the influence of radiation, and it is probably not justifiable to amalgamate them in an attempt to increase total numbers. Moreover, improvements in diagnostic techniques and accuracy have meant that the rate of pituitary adenoma and meningioma, occurring either together or separately, is difficult to compare with rates in earlier series.

Brada and colleagues' series of 334 patients was selected from 436 patients (102 having been excluded), which may affect its validity. On the basis of their data the authors suggest a guideline of an excess of 2.4 brain tumours in 100 patients so treated and followed up for 20 years. The series at St Bartholomew's Hospital and that of Brada and colleagues are among the largest series of patients receiving megavoltage irradiation for pituitary adenomas to date, and each has taken over 20 years to accrue; the patterns of oncogenesis in even these two large series emphasise that such second brain tumours are rare, and their true incidence could be obtained only from larger experience. On present evidence we consider that the suggested guideline regarding the risks of therapy is unwarranted.

Earlier studies showed clearly that without external beam radiotherapy there is a high rate of recurrence (up to 80% by 10 years) in patients with macroadenomas after surgery.¹ Pituitary radiation protects against this most efficiently and remains a valuable treatment for both functioning and non-functioning tumours.

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Growth hormone and recurrence of tumour

EDITOR,—A L Ogilvy-Stuart and colleagues report their study of whether giving growth hormone to children with growth hormone insufficiency after cranial irradiation for brain tumours or leukaemia causes recurrence of tumour.¹ Encouraging though it was, we are cautious about accepting the conclusion that growth hormone did not increase the risk of recurrence.

The strength of articles such as this centres on the calculation of the study's statistical power, but this was not considered. We find this surprising considering recent articles in the *BMJ* about this

important aspect of a study's design.² Small study groups will almost certainly lead to a negative result.

In Ogilvy-Stuart and colleagues' paper 15 (35%) of the 43 children with medulloblastoma who did not receive growth hormone relapsed. For 85% power and with a 5% significance on a change in relapse rate from 35% to 50% roughly 300 subjects in each group would be required. The message is clear: large, multicentre collaborative follow up programmes are required to clarify this important issue.

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- 1 Ogilvy-Stuart AL, Ryder WDJ, Gattamaneni HR, Clayton PE, Shalet SM. Growth hormone and tumour recurrence. *BMJ* 1992;304:1601-5. (20 June.)
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Medical reports for courts

EDITOR,—I was disappointed to read that there is no valid method for distinguishing psychogenic back pain from organic pain or malingering.¹ One of the sadder aspects of psychiatric practice is treating patients who are attempting to obtain compensation. Two distressing aspects are the time the cases take to reach a settlement and the need for psychiatric examination by doctors whom the patients perceive as being paid by the insurance company to prove that they are malingering, and who sometimes treat the patients with contempt. I am sure that these bitter experiences and the anger they arouse exacerbate the clinical condition.

I suggest that psychiatric reports in these cases should be requested and paid for by the court; in fact, possibly all medical reports presented to a court should be requested and paid for by that court. This would put an end to the current situation, in which a patient is forced into a professional relationship with a doctor who is being paid by someone with whom the patient is in civil dispute; this is often degrading for the patient, if not for all concerned.

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- 1 Jayson MIV. Trauma, back pain, malingering, and compensation. *BMJ* 1992;305:7-8. (4 July.)

ABO blood group and gall stone disease

EDITOR,—Tatu Juvonen and Onni Niemelä did not find any association between ABO blood group and symptomatic gall stone disease in a study of 171 patients attending one hospital for cholecystectomy.¹ The Oxford record linkage study includes statistical information on the hospital care of a large, geographically defined population. The patients' ABO blood groups are recorded when available. The data on ABO blood groups and disease from 1968 to 1978 have been tabulated (that is, for all records coded to the eighth revision of the ICD).² Work is in progress to cover more

recent years. Blood group was recorded for 7862 (53%) cases of gall bladder disease (ICD (eighth revision) 574-576) admitted from 1968 to 1978.

The table shows the distribution of blood group in these patients compared with all hospital inpatients for whom blood group was recorded. Blood group A was slightly more common in the patients admitted with gall bladder disease than in the general inpatient population. The approximate relative risk of gall bladder disease in patients with blood group A compared with group O was 1.04 (95% confidence interval 1.00 to 1.09), the increased risk not reaching significance even with this fairly large number of cases (p=0.07).

Further information is available from a review of 21 published studies of blood group and cholelithiasis, with a total of 14 660 cases from different geographical locations.³ The pooled data from these studies show that blood group A was more common (relative to group O) in patients with cholelithiasis than in the general population, with a relative incidence of 1.15 (p<0.001).

These data give some support to the hypothesis that ABO blood group is a marker for the risk of developing gall stones, but the relative risks are small. In Oxford the data are less likely to be confounded by geographical factors than they are in the pooled review, and there may be geographical differences in the association between blood group and disease. Calculation of the population attributable risk fraction⁴ suggests that this association (whatever its mechanism may be) accounts for only 2% or 6% of the total risk of developing gall stones, depending on whether 1.04 or 1.15 is taken as the best estimate of relative risk.

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- 1 Juvonen T, Niemela O. ABO blood group and gall stone disease. *BMJ* 1992;305:26-7. (4 July.)
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Videotaped interviews with children suspected of being sexually abused

EDITOR,—Richard Harrington raises several points¹ about the methods of our study about professionals' ratings of videotapes of interviews of children evaluated for suspected sexual abuse.² We agree that our selection of professionals who were interested in participating in the project may have maximised their levels of agreement.

Although we reported the number of raters in each group who agreed with the consensus ratings, we also calculated (but did not include in the report) the κ statistic for each professional group. This statistic, which varies from 1.0 (perfect agreement) to -1.0 (perfect disagreement), takes into account agreement expected by chance alone. As the table shows, κ ranged from 0.821 for police

Distribution of ABO blood group in patients with gall bladder disease compared with all inpatients (figures are numbers (percentages))

	Blood group				Total
	A	AB	O	B	
Gall bladder disease	3 525 (44.8)	233 (3.0)	3 468 (44.1)	636 (8.1)	7 862 (100.0)
All inpatients	72 462 (43.5)	5 202 (3.1)	74 400 (44.7)	14 501 (8.7)	166 565 (100.0)

κ Values when ratings of professional groups are compared with ratings of consensus panel regarding likelihood of sexual abuse

Professional group	κ	Clinical importance
Specialist psychiatrists	0.780	Excellent
General psychiatrists	0.567	Fair
Experimental psychologists	0.705	Good
Trainee social workers	0.683	Good
Trainee clinical psychologists	0.661	Good
Lawyers	0.717	Good
Police	0.821	Excellent
All groups	0.706	Good

to 0.567 for general psychiatrists. The table shows the clinical importance of each of the κ values according to the criteria of Cicchetti and Sparrow.³ As Harrington highlights, the levels of agreement between each group of raters and consensus are not perfect (as is true for all clinical assessments); the specialist psychiatrists and police, however, have κ values that would be considered excellent levels of agreement, and only the general psychiatrists have levels of agreement below those considered to be good. We therefore stand by our original conclusions that the levels of agreement between the professional groups and the consensus panel are generally good to excellent.

We also recognise, as does Harrington, that continued efforts to standardise the interview are necessary to improve the clinical assessment of children suspected of being sexually abused. We believe that our report is an important first step in that process.

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- 1 Harrington R. Videotaped interviews with children suspected of being sexually abused. *BMJ* 1991;304:1382. (23 May.)
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Women prefer hospital births

EDITOR,—We have been following with interest the mixed response to the recent report of the House of Commons Select Committee on Maternity Services advocating more home births in British obstetric practice.¹ The report had a frosty reception from the Royal College of Obstetricians and Gynaecologists,² while the Royal College of Midwives and others welcomed its proposals.^{3,4}

The views of pregnant women have not been heard in this exchange of opinion. As part of our course on public health medicine we surveyed 299 women at varying stages of pregnancy in antenatal clinics in two hospitals in Leeds, asking them where they would prefer their baby to be born and why. We started the survey in the expectation that, as the select committee suggested, there would be considerable unmet demand for home births. We were therefore surprised that only 8% of the women (95% confidence interval 4.8% to 10.6%) indicated that they would prefer to have their labour at home. The most commonly given reason for preferring a hospital birth was that skill and technology are available should any unforeseen complication arise (50%).

Because ours was a biased sample (a hospital population) and women's views may change as gestation progresses and because of regional variation we cannot extrapolate from this survey to predict the number of women nationally who would choose a home birth. Our results do, however, suggest that a large proportion of women

with completely normal pregnancies prefer to deliver in hospital because of the small risk of a complication during labour. Consequently, any change in policy along the lines proposed by the select committee should be brought in with sensitivity for this view; if home births are more actively promoted women with normal pregnancies should not be made to feel that they are having the option of hospital delivery taken away from them.

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- 1 House of Commons Select Committee on Maternity Services. *Maternity services, second report*. London: HMSO, 1992.
- 2 Royal College of Obstetricians and Gynaecologists. *Response to the report of the House of Commons Select Committee on Maternity Services*. London: RCOG, 1992.
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Helping Russia

EDITOR,—As recipients of a travel bursary from the European League Against Rheumatism's standing committee for European rheumatologists in training we recently visited the Institute of Rheumatology in Moscow and the Municipal Rheumatological Centre in St Petersburg. The purpose of these bursaries is to enable trainees in rheumatology to share experiences in training, clinical management, and aspects of research into rheumatic diseases in other European countries. In deciding to visit Russia we were not conscious of being missionaries, although unwittingly we may have been part of the flood of visitors interested in health care to which Tony Delamothe refers.¹

No such flood was evident at the institutions we visited. On our first day at the institute in Moscow several members of the staff came to work to meet us, on what we later discovered was a public holiday. The lack of contact with medicine outside Russia, through lack of access to medical literature and foreign travel, was all too evident. Each new encounter with staff in the institute, which is looking at ways of maintaining its 300 inpatient rheumatology beds and 400 staff, ended in detailed discussions and proposals for us to embark on collaborative work. Everyone we met wanted contact with Western medicine, and we returned with a shopping list for journals, equipment, and reagents.

The problems are enormous and varied and have been compared to those in Third World countries. The feelings engendered in European visitors to Russia, however, are different from those engendered by a visit to countries in Africa or Asia. The broad cultural and historical similarities induced in us a strong empathy and desire to help. In both the centres we visited we found a broad intellectual and academic base and impressive dedication to work despite extraordinary difficulties and shortages. This made us believe that any well directed contribution would be gratefully received and well used. As our Russian hosts pointed out, the problems are essentially Russian problems that need a Russian solution. An end to intellectual isolation regarding health care and management, however, can only help, by providing insight into the pros and cons of other systems.

Professor Rodney Grahame, professor of clinical rheumatology at Guy's Hospital, who has travelled extensively in eastern Europe in recent years, has launched a rheumatological equivalent to Ophthalmic Aid to Eastern Europe.¹ Initially it intends to send journals, textbooks, and monographs to named people and institutions. Programmes to fund exchange visits and short post-

graduate courses in eastern Europe to aid in continuing medical education are also proposed. Anyone interested in helping should contact Rheumatology Aid to Eastern Europe, Rheumatology Unit, Guy's Hospital, London SE1 9RT (fax 071 407 7532).

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- 1 Delamothe T. Helping Russia. *BMJ* 1992;304:1432-4. (30 May.)

Private health insurance and physiotherapy for senior citizens

EDITOR,—Rebecca Beaconsfield comments that elderly patients are denied tax relief on private health insurance for physiotherapy if they have been referred by a general practitioner.¹ Hundreds of protest letters about this were sent to MPs by chartered physiotherapists and patients, and the Inland Revenue has now accepted that it made a mistake when it ruled that tax relief was available only for physiotherapy related to hospital treatment. New regulations have been laid before parliament and the matter resolved to the satisfaction of patients, general practitioners, and private physiotherapists.

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- 1 Beaconsfield R. PPP and physiotherapy for senior citizens. *BMJ* 1992;304:1693. (27 June.)

Reaching for the wrong whistle

EDITOR,—Linda Beecham reports on the right to be a whistleblower, referring to NHS employees who wish to raise concerns about standards of care.¹ From this it seems that senior doctors are anxious to preserve the safety valve of free speech¹ while showing little interest in using the more satisfactory structure that has been handed to them through the recent NHS reforms.²

Are senior doctors choosing to ignore the opportunity provided by medical audit committees—for doctors, run by doctors, and accountable to doctors—which have the specific duty of organising and encouraging the "systematic and critical analysis of the quality of medical care"?² Is our right to pick up the telephone and complain to the press so much more important than doctors getting together with other doctors to construct a medical audit machinery that allows concerns to be properly evaluated?³ By now, surely, senior doctors have allayed the fears of those nurses "frightened to speak out and risk their careers"¹ by emphasising the requirement for clinical audit and thus encouraging nurses to join with doctors to "analyse the quality of clinical care"?³

If audit shows that a worry regarding standards is valid and yet recommended changes are not addressed then frustration with an ineffective process will, understandably, lead people to consider becoming whistleblowers. The audit committee has a responsibility to bring such obstruction or obfuscation to the notice of others. If it chooses to shirk this responsibility consultants should not shirk from taking steps to replace their timid representatives. There is no place for adopting a politically correct line when assessing the quality of clinical care.

Senior doctors have been handed a powerful tool,² and if they have not used the money handed