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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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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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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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

to them to set up strong audit structures in their units (£42.1 million in 1992-3)⁴ they have only themselves to blame for a remarkable lack of initiative. But then effective audit requires not only hard work but also the active participation and commitment of senior doctors. On the other hand, picking up the telephone and complaining to the press is so much simpler and avoids the rather tedious business of systematic and critical analysis. For all that, it is time that we recognised and used the right whistle.

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Feedback from patients and colleagues

EDITOR,—The personal view written in the form of an anonymous letter to her surgeon by a patient who felt unable to challenge the consultant's management of her case at the time raises an important issue.¹ Who can be the patient's advocate in such circumstances? The patient's general practitioner is not mentioned at all in the article but was presumably the referring doctor. Was the patient unable to express her concerns to him or her, or did she do so but find the general practitioner unwilling to intervene on her behalf?

I know that an intraductal carcinoma of the breast presents difficult decisions of management,² but the patient, as she highlights, should have had the options explained to her and been allowed time to assimilate the information. As a general practitioner I acknowledge my consultant colleagues' expert knowledge, but I am sure that if I had heard this patient's story I would have contacted the surgeon with her permission to express my concern.

Who else besides her general practitioner could have acted for this patient? One would have hoped that perhaps a member of the surgical or nursing team would have recognised her distress and offered to listen and to advise her to speak to the consultant. I suspect, however, that if a general practitioner was reluctant to intervene then hospital junior staff would feel similarly handicapped.

What can be done, therefore, to remedy poor performance, particularly when the result is a damaged doctor-patient relationship? Medical students in Leicester become accustomed to receiving feedback not only from their practice and departmental tutors but from real and simulated patients, which they find invaluable in improving their consultation performance.^{3,4} It is hoped that this experience will not only encourage students to continue to ask for feedback from their colleagues and patients as they progress up the career ladder but also empower them to give appropriate feedback to others, no matter how eminent or powerful.

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Trials and tribulations in pursuing an MD

EDITOR,—David Gray's account of his first year as a research registrar makes sorry reading, and his disappointment, frustration, and anger are clear.¹ Understandably, he seeks to apportion blame for what seems to have been an unproductive year, and he chooses to assign most of it to an (unidentified) pharmaceutical company. My reading of his narrative suggests, however, that he would be well advised to assign the blame elsewhere.

He seems to have stumbled into an administrative role on a project that he did not conceive of and in which he may have had little interest. Many of his assertions do not stand up to scrutiny and should not pass unchallenged. Because the company preferred to study thrombosis in patients with myocardial infarction rather than patients having hip surgery he asserts that "Clearly emotion played a greater role in decision making than statistics" without pausing to consider alternative explanations. Indeed, the sensible size of the study population—550 patients—suggests that some careful decisions had been made on the basis of a power calculation. Things got off to a shaky start and unexpected problems arose. This is typical of clinical research, and, though it may have surprised Gray, his professor should have anticipated it.

The beneficial effects of aspirin and streptokinase were not unheralded, and a literature review before the start of the study might have indicated the consequences of the second international study of infarct survival for Gray's investigation. It seems unfair to castigate the pharmaceutical company for stopping a study that was behind schedule, with under a quarter of the patients recruited, and whose continuation some physicians might have considered to be unethical.

An MD (or an MS) is a senior research degree and is intended to recognise original work to which the recipient has made a pivotal contribution. Acting as a pair of hands for somebody else's drug study hardly fulfils these requirements. A programme of research for such a degree should have some clearly defined goals and at least one attainable intermediate objective. The responsibility for the adequacy of an MD programme rests firmly with the trainee's supervisor.

Gray has good reason to be disappointed, but he should not cast all his stones at the pharmaceutical industry; rather, he should re-examine his motives for getting the job in the first place and question whether he has been well served by his supervisor. All of us would benefit if people stopped getting involved in clinical research for career reasons alone.²

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British-Polish workshops on substance misuse services

EDITOR,—Karin Chopin has examined health issues in Poland in illuminating detail.^{1,2} Intravenous drug misuse and HIV are major public health challenges, but, numerically, the task of tackling morbidity and mortality related to alcohol is greater. Consumption of alcohol (in terms of absolute alcohol) has doubled or trebled since the 1950s, and about three quarters of the alcohol is consumed as vodka. If anything, legislation on

alcohol has been liberalised with the shift towards a market economy. Britain has little definitive advice to offer the Poles in view of the alcohol crisis here.

The articles suggest that the West's support of the evolution, planning, and provision of services in Poland has been misguided. I went to Poland last year as a member of a training team running a four day workshop entitled "Substance misuse services: treatment and rehabilitation." Twenty two participants from many disciplines and from statutory and voluntary agencies came from all over Poland. Group work, lectures, and debates went well despite, or possibly because of, Polish passions being roused. Indeed, this was no exercise in arrogant, Western paternalism: native presenters ensured lively discussion with cross fertilisation of philosophies and practices between nations and, I suspect, also between the Poles themselves.

Recently, six Polish delegates came to London for a five day intensive workshop on the strategic planning of substance misuse services: further reciprocity is planned. These workshops were organised as part of a structured academic link between the Institute of Psychiatry and Neurology in Warsaw (and other Polish institutions) and the division of addictive behaviour at St George's Hospital Medical School, London, supported by the British Council. While the World Health Organisation is an important umbrella, direct links of this sort are an adjuvant to the process of developing collaborative approaches to the health issues described. Perhaps the European Community will promote similar programmes (if it is not already doing so), given the economic and political shifts of East toward West and the link between economics and health.

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Smoke hoods in aeroplanes

EDITOR,—Ian R Hill's editorial is a reminder of the need to minimise mortality and morbidity in air crashes,¹ but smoke hoods have disadvantages in this context. We studied the use of smoke hoods, having gained approval for the study from Grampian's regional joint ethics committee.

Six fit healthy firemen (used to wearing respiratory protection, although not trained in using the device tested) put on a commercially available smoke hood. They rested and exercised for five minutes (to 100 W) in air and in an atmosphere containing roughly 5% carbon dioxide and 15% oxygen, as might be expected near an enclosed fire. The table summarises the effects on ventilation.

Mean (SD) ventilation (l/min) at rest and during exercise in six firemen wearing and not wearing smoke hoods in air and in test atmosphere

Test condition	At rest	During exercise
Air, no hood	10.1 (4.1)	38.2 (8.7)
Air, wearing hood	18.1 (2.8)	49.4 (7.8)
Test atmosphere, no hood	29.9 (5.6)	84.8 (13.5)
Test atmosphere, wearing hood	34.2 (7.3)	102 (13.1)

Donning the hood caused a considerable increase in ventilation; this was due to rebreathing within the hood, which rendered respirable gas oxygen depleted and carbon dioxide enriched and so limited exercise ability. In fire smoke oxygen depletion is accompanied by a rise in atmospheric carbon dioxide concentrations, so potentiating the effects of rebreathing in a smoke hood with a filter.