essence an issue not of medical science but of human rights.

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Brachial plexus neuropathy after radiotherapy can be treated by specialist surgeons

EDITOR,—Neuritis is an unfortunate complication of radiotherapy,¹ for which patients may be denied treatment. I have been told by several patients that their oncologist told them that the pain was untreatable. I have also been told by oncologists that the pain is due to tumour infiltration and is a sign of untreatable recurrence. Both these statements are untrue.

Treatment of neuritis after radiotherapy has been extensively documented.^{2,3} It consists of exploration of the plexus, an extensive neurolysis of all affected nerves, and placement of free vascularised tissue on top of the scarred area in an attempt to revascularise the scarred tissues and to prevent further scarring. Le Quang used this technique and followed up 60 cases for a minimum of two years, reporting good results in 84%.² In the remaining 16% there was partial loss of sensation or motor power. In all the patients, however, the pain was ameliorated. After the preoperative investigations metastases were found at the time of surgery in only three cases. Le Quang was still willing to perform surgery to relieve pain in cases of tumour involvement, although the prognosis is necessarily more guarded.

In conclusion, although brachial plexus neuropathy after radiotherapy is an unfortunate complication, the outlook is not totally bleak and these patients should be referred for consideration of surgery. The surgery is extremely specialised, and patients should be referred to a specialist surgeon. These surgeons have a major interest in brachial plexus surgery and can transfer free tissue with a high success rate.

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Benefits of fetal surgery must be carefully evaluated

EDITOR,—The expanding role of intrauterine fetal surgery is creating much interest.¹ At the fetal medicine centre in Birmingham we have performed an intrauterine angioplasty for critical pulmonary stenosis, which led to the birth of a viable baby (J Wright *et al*, meeting of Fetal Medicine and Surgery Society, Belgium, 1994).

Fetal surgery should be used only in properly evaluated cases and when the prognosis of postnatal correction is poor. In his editorial on fetal surgery François I Luks uses intrauterine treatment of congenital diaphragmatic hernia as an illustration. At our regional fetal therapy unit we reviewed 48 consecutive cases of congenital diaphragmatic hernia referred between 1988 and 1995 and found that, once babies with coexistent anomalies and karyotypic abnormalities had been excluded, half of the babies survived (unpublished findings). Thus the benefits of prenatal surgery may not be that much greater than those of traditional management in appropriately selected cases. Any intrauterine surgery should be assessed by randomisation of cases to traditional or prenatal surgery and by the establishment of a register noting both perinatal and maternal mortality and morbidity.

Disappointingly, the editorial makes no mention of the need to improve our understanding of the natural course of congenital anomalies. Surely greater emphasis should be placed on this if real progress in fetal survival is to be made.

We look forward to participating in the acquisition and analysis of potentially exciting data.

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NHS will be left with high risk, low profit services under private finance initiative

EDITOR,—Chris Ham's editorial highlights genuine concerns about the government's private finance initiative in the NHS.¹ In Carlisle, where a single consortium has tendered to build and manage a major development of the hospital, we already have experience of private finance in the form of a contracted dialysis service. Under the terms of the contract (which is usually described as a "partnership" by the company), equipment, disposables, and nursing cover are provided for a fixed fee per treatment.

Several consequences arise from the contractual relationship between the private dialysis company and the publicly funded health service. In the first place, the company has been able to increase its charges substantially because any increase in the number of dialysis treatments is fully funded under the contract, in addition to the cost per dialysis session being linked to inflation. Our NHS trust, on the other hand, has been required to find annual cost improvements of the order of 5% a year. Secondly, the financial risk taken on by the company in providing a dialysis service has been minimal, as evidenced by the unit, quite predictably, reaching full capacity within three years. In contrast, the health service retains the risk of increasing numbers of patients and the responsibility for preparing patients for dialysis, including providing vascular access, and for complications arising from dialysis, which often necessitate admission to hospital. This has to be achieved on a

fixed budget. The NHS also has the expense of monitoring the performance of the contracting company in respect of not only the number of dialysis treatments performed but also the varieties of treatment, the quality of service delivery, and the training and performance of the company's nursing staff.

The financial risk of building, equipping, and staffing any medical facility is trivial compared with the risk of providing potentially open ended clinical services with their attendant medicolegal obligations, which remains with the NHS. Our experience of private finance partnership in Carlisle is that the private sector adopts the low risk, high profit element of the service. Increased financial returns, which can be generated through operational efficiencies possibly at the expense of quality, go to private shareholders. Meanwhile the NHS is left with high risk and low or non-existent "profits."

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Advertisement's selective quotation from old article misrepresents current situation

EDITOR,—Readers of the *BMJ* may have noticed that a private health care insurance company is currently running an advertising campaign that selectively quotes from articles on waiting lists that were published in the journal in 1993 and 1994.^{1,2} I am currently corresponding with the marketing director of the insurance company and with the Advertising Standards Authority in an attempt to prevent further use of the first of these articles, an editorial that I wrote.

I am concerned that the use of my name in this advertisement may be taken to imply that I endorse or recommend private medical insurance. This is not my personal view, nor is it a view expressed in my editorial. As a health services researcher I have not been uncritical of many of the changes associated with this government's reforms of the NHS. However, the use of a small part of my editorial, which is now rather dated, misrepresents the current situation with regard to inpatient waiting times: the Department of Health's latest figures indicate that 85% of people wait less than six months for elective admission.

As well as presenting out of date information the advertisement perpetuates misunderstandings about waiting lists. It confuses the size of the waiting list and waiting time, and it makes no distinction between urgent and non-urgent cases, life threatening conditions, and elective admission and thus implies that immediate admission is always necessary or desirable.

Evidence from countries such as the United States suggests that one of the first casualties of systems funded by private health care insurance is equity: people who are uninsured (for example, poor and unemployed people) or uninsurable (for example, chronically ill people) do not get health care. For all the problems with the NHS, I feel obliged to defend waiting lists rather than see the 1948 vision of a health service free at the point of delivery destroyed.

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