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Nomogram for number needed to treat will be of limited use

EDITOR,—Gilles Chatellier and colleagues suggest that in calculations of the "number needed to treat" a nomogram based on the formula $\frac{1}{P_c \times \text{relative risk reduction}}$ should be used in preference to $\frac{1}{P_c - P_i}$.¹ The two formulas are, however, equivalent and will both suffer from the same problems when P_c and P_i differ by an amount greater than P_c . The nomogram is consequently useful in only a limited number of circumstances—for example, when published study results have been adjusted for confounding effects and only relative risks or odds ratios are reported. In these cases such estimates could then be combined with an estimate of the baseline risk to yield the number needed to treat.

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Children and sport

De-emphasise team sport

EDITOR,—The report *Raising the Game*¹ is, as Helen Trippe notes,² a start. Unfortunately it is a start down the wrong path. The report places the emphasis firmly on developing competitive team sport at the centre of physical education. In doing so it intensifies the connection between healthy exercise and vigorous sport. The evidence shows that vigorous exercise is neither necessary to provide a health benefit nor suitable for all people in society.

Competitive sport is not liked by a sizeable number of children, particularly girls. As children get older, they tend to stop participating in sports outside school. For boys, participation in soccer outside school drops from 59% in 11 year olds to 42% in 16 year olds, and similar falls are seen in sports such as rugby and cricket. For girls, the participation in netball decreases from 19% to 6% between ages 11 and 16. This fall continues as people age, and *Social Trends* identifies that at 45-59 participation in team sports is 11%.³

As has been shown by a number of surveys, such as the Allied Dunbar National Fitness Survey,⁴ as a nation we are not taking enough exercise. Though team sport can be a beneficial source of exercise for some individuals, it is a minority interest. It would not be physically possible to increase the use and provision of facilities to allow the nation to get its exercise from team sports. Concentration on team sport at school will also confirm the link between exercise and health with sport and make the message of increasing moderate activity more difficult. It will alienate the substantial number of children who for one reason or another dislike sports and will reduce the time available for wider activities, such as dancing, walking, or cycling.

Policies must be developed that take the range of activities that will provide healthy exercise into account, and action developed to ensure that

these occur. In a recent report from the Royal Society of Health we set out several recommendations for action in various settings to encourage an increase in activity.⁵ These settings included the family, the community or local authority, schools, the workplace, and health bodies. It is by developing a wide range of measures to encourage and facilitate moderate exercise such as cycling and walking that we will be able to achieve a healthier nation.

Increasing the emphasis on competitive sport ignores those who do not enjoy it or cannot participate and alienates them from all forms of exercise. We should pay attention to the World Health Organisation and the International Federation of Sports Medicine who noted that "daily physical activity would be accepted as the cornerstone of a healthy lifestyle. Physical activity should be re-integrated into the routine of everyday living. An obvious first step would be the use of the stairs instead of lifts, and walking or cycling for short journeys."⁶

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Walking to school has future benefits

EDITOR,—Helen Trippe highlights the important role of government policy in encouraging physical activity in schoolchildren.¹ The government's new policy statement on sport, *Raising the Game*, proposes a minimum of two hours of sport and physical education a week for all children up to age 16.² For Trippe, the policy statement is a start but is not enough: "Interventions to change children's preferred activity levels need to start early, probably in primary schools, or better still at home," she writes. Here she, like the government, is missing out on the action. The journey to school accounts for 35% of all journeys made by children and has the potential to make an important contribution to levels of physical activity. However, since 1975, the average distance walked by schoolchildren has fallen by 27%, largely because of the increasing proportion of journeys to school made by car, which has risen from 12% in 1975 to 23% in 1989-94.³

The change in childhood travel patterns has important implication for health and equity. Firstly, patterns of physical activity forged in childhood may carry over into adult life. The school-home journey of childhood melds seamlessly into the work-home journey of adulthood. With only a handbrake and a handful of birthdays between the passenger's seat and the driver's seat, it may be unrealistic to expect the chauffeured children of today to become the ambulant adults of tomorrow.

Secondly, driving children to school increases the risk of injury, as pedestrians, for the children who walk. As might be expected, poorer children, from families without a car, are more likely to walk. Traffic volume is the strongest environmental risk factor for child pedestrian injury, and the Department of Transport estimates that 20% of traffic during the weekday morning travel period is made up of children being driven to school.³ Taken together, this

amounts to the motoring equivalent of second-ary smoking.

Two hours of sport a week is a step in the right direction, but a healthy transport policy would do far more to encourage physical activity.

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Not all schoolchildren prefer team sports

EDITOR,—I read Helen Trippe's editorial on sport in schools in my mother's copy of the *BMJ*.¹ I am writing as a sixth former with an inside view on physical education in schools.

There are two main points. First is the question of team games as the main form of physical education in schools. While many people do enjoy "the fun of playing as a member of a team," this is often true only of those with an aptitude for the game. For those without this aptitude, physical education lessons can become an experience in abject humiliation, without there being any exercise benefit. I have found netball to be like this. For many of us, it is better if we can exercise at our own pace without the competitive element—for example, playing games on the understanding that the rules do not have to be strictly observed, or dancing, or doing aerobics to music. As well as being more enjoyable, this sort of physical education allows us to use all the time available in actual exercise, which rarely happens in a team game.

Second, we "sedentary 16-18 year olds still at school" are there because we are studying for our A-levels, and time is precious. Most of us do appreciate the benefit of exercise on the body and for mental relaxation, but physical education in school can add to stress rather than relieve it; it is unpleasant to spend parts of the working day hot and tired, and physical education lessons bring considerable extra hassles, practicalities that may not be obvious to policy makers, such as having the correct kit and changing and being late for lessons. Exercise outside the school day is a good alternative, but practical matters such as transport often make this difficult.

From my own experience, I have found some of our most successful physical education sessions, in terms of exercise done, enjoyment, and attendance levels, were the aerobics to music. These taught us exercises which we were able to do at home if we chose, and they encouraged some people to start attending step classes in the evenings.

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Health care rationing

Oregon asked people about moral values

EDITOR,—David Price's tale about rationing of health care based on the case of child B, who had leukaemia, conveys sorrow for the child, grief for the parents, empathy for the physician, sympathy for the judges and administrators, and even pity for the barristers who struggle over the fate of a sick child in a strange dialect of legal abstraction.¹ They seem, together, to be helpless victims of a system without moral direction.

With regard to the Oregon health plan, I must point out that the author has both the name of the commission and the question it asked wrong.

The commission's name is the Health Services Commission, and the question was not "What would most people find satisfactory?" but "What are the moral values you expect in the delivery of Oregon's health care?" The question was put by Oregon Health Decisions, a free standing citizens' organisation that the legislature directed the commission to use in ascertaining a moral foundation for the plan.

The commission (12 citizens) also asked doctors for the facts of prudent, effective care for over 1000 diagnostic-treatment categories—for example, appendicitis-appendectomy. It then combined the experts' facts and the people's values into a list of priorities, which was presented to the legislature for its decision on a cut off point below which there would be no reimbursement.

The legislature decided that we could afford everything above number 583, which included organ transplantation—presumably the place where child B would fall. Organ transplantation may be an expensive individual item but represents a small cost in the overall budget. In effect, by eliminating unnecessary, ineffective, and futile medical care Oregon finds the money for expensive life and death cases in which there is reasonable hope for improvement in quality of life.

In Oregon the process of determining priority of care is determined not by case law—a slow process of circumstantial precedence—but by public consensus on what is morally acceptable. Whenever possible Oregonians make a point of avoiding confronting the legislature with moral questions, the courts with technical issues, and administrators with the need for independent judgment.

My comments should not be taken as prescribing a course of action for the NHS since the eventual outcome of each country's attempts at solving tough rationing issues may reside in our cultural genes. This was recently pointed out by a Swiss visitor, who, after examining our system, remarked, "Unlike the British, who quietly line up for a queue, you Oregonians noisily get together to determine consensus on a list."

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Who will be patients' advocate if doctors assume the rationing role?

EDITOR,—The case of child B has important implications for patients seeking expensive potentially lifesaving treatment within the current economic climate.¹ The Court of Appeal's decision was disappointing but unsurprising. The master of the rolls made it clear that the courts are not the forum for making decisions on the allocation of resources in health care (no doubt he could envisage the floodgates opening to scores of disappointed patients). What is surprising, however, is that he assumed that the decision making process is determined by a utilitarian framework of justice.² Clinicians usually adopt an egalitarian framework of justice such that resources are allocated according to need. The definition of need is complex, and attempts have been made to define need according to capacity to benefit, although people with a poor prognosis are still in need.³ If cure is possible, albeit unlikely, at what level of probability does utility become futility?⁴

This case diverges from other cases centred on minors and medical treatment, for in other cases the best interests of the child have been evaluated. It is clear that the physicians looking after child B also used the "best interests" test

and concluded that the burdens of treatment outweighed the benefits to her. They did not consider the opportunity cost to others. But in judicial review the role of the court is to decide whether the health authority's decision is lawful and not the merits or demerits of the decision itself. In the case of child B the treatment was considered to be experimental and of uncertain outcome. Furthermore, medical opinion was divided. One can only speculate on what would be the court's decision in a case in which the doctors and parents agreed that lifesaving standard treatment was in a child's best interests but a health authority refused to pay on the grounds that the probability of benefit was too low and the costs too high. Such a scenario is unlikely but not impossible. The physicians with a duty of care would be placed in a very difficult situation. Non-treatment would conflict with their professional ethics, and serious criticism—even allegations of criminal negligence—might follow.

The Court of Appeal's decision does not augur well for patients in the new order. Who will be the patient's advocate if doctors, including fund-holding general practitioners, assume the rationing role and make their decisions (as the courts seem to do) by reference to a distributive utilitarian framework?⁵

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Boosting women consultants

EDITOR,—As *Minerva* is the most widely read of medical columnists, we were concerned to find our paper¹ so conspicuously misquoted.² Far from arguing that women should be promoted on the basis of their gender and patient preference, our article questioned the impact of such blatant consumerism on quality of care and medical professionalism. We do not want women practitioners, after 10-15 years' postgraduate training to be dismissed with "she only got the job because she was a woman." Special promotion of women does not address the issue of standards in patient care. We want to understand why patients (women and men) prefer woman doctors.³ Until we understand the gender differences in practice it will not be possible to improve patient care for all regardless of the doctor's character or sex. The evidence so far suggests that women perform better at communicating, listening, minimising embarrassment, and providing continuity of care.¹

Patients do not benefit from a fatalistic attitude to male and female medical practice. We do not accept superficial cosmetic changes in favour of women that will ultimately undermine our collective professionalism. Our article concludes that, however well intentioned, strategies (including Opportunity 2000) that merely increase numbers on gender grounds will not improve training, will not help women doctors, and do not help patients.

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Problems with the penis and prepuce

Preputioplasty should be performed more often

EDITOR,—I applaud Mark Davenport's reassurance that phimosis is the only real medical reason for circumcision.¹ What puzzles me is that preputioplasty is not performed more commonly than it is. If preserving the prepuce is important then should this not be preferred to formal circumcision?

I am surprised that eye ointment is not used more commonly to treat bacterial infections under the prepuce. This has the advantage that systemic antibiotics are avoided. It is also unnecessary to retract the foreskin to apply the ointment as the small narrow eye of the tube fits easily through even quite a tight prepuce, and gentle massaging will spread the antibiotic underneath the foreskin. A 5 g tube of 1% fusidic acid viscous drops will be enough for a single attack.

Sadly, many mothers seem still to be under the impression that it is vital to retract small boys' foreskins regularly to "keep them clean."

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Author's reply

EDITOR,—I have no way of proving or disproving H C Coleridge's key statement "if preserving the prepuce is important...." As far as I am aware, no studies have been carried out on the vexed issue of whether removal of the prepuce affects the sensitivity of the glans. Harnes attempted such a project in New York in the 1970s in men who had been circumcised as adults, looking at their experiences before and after.¹ Unfortunately, he failed to enrol sufficient numbers because no one took the subject seriously at that time. I am aware that a number of people currently believe that an intact prepuce is important and regard circumcision (even for legitimate medical reasons) as a mutilating procedure with severe long term problems.²

In preputioplasty (or preputial plasty)³ a dorsal slit of the foreskin is, in essence, sutured back the "wrong way," thereby enlarging the preputial ring; this is certainly an option in phimosis. The procedure requires parental intervention and commitment (daily retraction is necessary once the initial swelling has settled) and may be associated with recurrent stenosis requiring revision if such retraction is not done. I suspect that in practice only a small proportion of surgeons would offer this as an alternative to circumcision, probably because of innate surgical conservatism; circumcision is a well established, well-rehearsed day case operation with few long term problems, and most surgeons therefore remain to be convinced of the need for change.

Several ways of treating balanitis exist, including local application of an antibiotic ointment. Again, I suspect that few practitioners would rely on this route alone for a presumed bacterial bal-