proportion of patients requiring high dependency and intensive care. To accommodate the additional emergency caseload we have returned about one third of elective cases, scheduled for high dependency care on the unit, direct to the ward. This has put additional strain on the ward staff. Cancellations of elective surgery requiring postoperative intensive care have unavoidably increased.

Our experience highlights the underprovision of intensive care beds in the south east of England. We welcome the recent announcement by the secretary of state for health of increased provision of intensive care services,³ but in the neurosciences we think that it may be too little too late.

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Severe problems with interhospital transfer of critically ill children will continue

EDITOR,—Like many others involved with interhospital transfer of critically ill children, we find that it is extremely difficult. We have much sympathy with the predicament of Dr Ruth Jameson and her team during the transfer of Nicholas Geldard on the night of 2 December 1995.¹ It has been suggested that, once Nicholas was found to be dead at Hope Hospital (although formal tests to confirm brain stem death had not been done), a bed should have been found for him nearby. It is further suggested that the transfer to Leeds should have been cancelled. This is the nub of the criticism of Dr Jameson's team in the report on the case by North West Regional Health Authority.²

Our unit was the nearest paediatric intensive care unit and was full on the night that Nicholas died. We do not provide ventilatory support on wards other than the intensive care unit. This practice was instituted many years ago after an audit of ventilatory support on general wards at our hospital showed that the results were bad. We have also prospectively audited critical incidents among patients coming into our unit, of which there are a depressingly high number.³

It is extremely difficult to effect a major change in the direction of treatment during interhospital transfer. The report does not explain how Dr Jameson was expected to effect this when a local paediatric intensive care bed was not available, although paragraph 143 of the report is critical that this was not done—a criticism that we regard as unjustified. The people who criticise should try transferring a few sick children before they speak again. Those who have experience of interhospital transfer are well aware of the difficulties that can arise.

The counsel of perfection is to have a paediatric emergency transfer service and sufficient intensive care cots. Until that time, doctors transferring patients can expect to encounter severe problems during transfer and unjustified criticism after it.

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Surgeons will not want jobs in hospitals that do not do emergency surgery

EDITOR,—Proposals to rationalise the delivery of accident and emergency, trauma, and emergency surgery have a good clinical basis and are a response to the pressures of junior staffing, hours of work, and cost effective care. Many advantages accrue to patients, staff, and the delivery of services when a hospital's routine does not have to accommodate emergency surgery. Patients sleep better, and theatre lists can be planned with confidence.

When these proposals become a reality, there are several unexpected byproducts. The loss of acute trauma and emergency surgery from a hospital changes its character. Minor accident and emergency services and elective surgery become the norm, and the physicians may be reluctant to admit medical emergencies without surgical cover. The Royal College of Surgeons withdraws the hospital's recognition for training junior staff. Surgeons deprived of emergency surgery, if still chasing the "bubble reputation," decamp to hospitals that satisfy their aspirations. Their replacement is the problem. Surgical posts that exclusively provide elective surgery are unlikely to attract accredited senior registrars who aspire to practise the full range of the discipline. Consultants in the later stages of their career, surgeons from overseas, or some of the numerous surgeons based in Britain who have been unsuccessful in achieving a substantive consultant appointment are likely to apply. The main problem facing the trusts is the attitude of the college assessor, who may stick rigidly to the view of "no accreditation, no job." This then places the trust in the position of making an appointment that may conflict with the assessor's recommendation—an unsatisfactory but necessary decision so that surgical services can be provided for the population.

Those planning the centralisation and rationalisation of services need to consider how surgical services can continue to be provided in those hospitals deprived of emergency surgery. It is also necessary to be aware of the political consequences that result when a local population and politicians are convinced that rationalisation is about cutting services to which they are accustomed.

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Television and radio should be used to disseminate important information

EDITOR,—Since the Committee on Safety of Medicines' statement about the safety of third generation oral contraceptives¹ concerns have been expressed about how information was disseminated during the "pill scare." Sally Hope is concerned about how similar messages might be handled in future.²

The National Coordinating Unit for Clinical Audit in Family Planning has looked at the recent dissemination of information warning of the risks associated with oral contraceptives. In initial reports, family planning professionals complained that they received information from the media before seeing the official statement from the Committee on Safety of Medicines, which caused some confusion, anxiety, and misinformation. In

Table 1—Initial and subsequent sources of information about recent pill scare reported by 234 family planning professionals

	Initial	Subsequent
Public media:		
Television, radio	111	156
Newspapers, magazines	9	160
Orally from colleague	49	127
Committee on Safety of Medicines' letter	21	181
Orally from patient	18	71
Letter from Faculty of Family Planning and Family Planning Association	4	187
Pharmaceutical company	4	170
Email	1	19
World Health Organisation's statement	0	39
Other	17	23

December 1995 the unit circulated a questionnaire to regional advisers of the Faculty of Family Planning and delegates who attended the national audit conference. Of the 242 respondents who returned their questionnaire by 18 January, 103 were general practitioners, 60 family planning doctors, 59 family planning nurses, 12 practice nurses, and 7 "other."

The Committee on Safety of Medicines' statement preceded other sources of information in only 9% of cases (table 1). Over half of the respondents obtained their initial information from the media, a fifth received it orally from a colleague, and 8% heard the information first from their patients. The number of official sources from which the respondents had heard differed, with 34 respondents receiving only the committee's letter, 40 only the letter from the Faculty of Family Planning and Family Planning Association, and 147 both letters; 21 were still waiting for either.

With any urgent statement concerning medical practice it is important that experts act as the primary sources of information to clinicians so that patients can receive correct information. Acting as the primary distributor is difficult: family planning is provided by a wide range of specialists, including general practitioners, community nurses, family planning doctors and nurses, gynaecologists, and midwives. There is the added challenge of contacting other medical colleagues for whom contraceptive problems may not be a major focus of clinical services. Thus a variety of methods for disseminating information will probably be necessary. If the public media of television and radio result in the most rapid dissemination of information, as our survey indicates, then they should be consciously used to disseminate official statements, with rapid follow up of written information sent by more than one route.

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1 Committee on Safety of Medicines. *Combined oral contraceptives and thromboembolism*. London: CSM, 1995.

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Gynaecological problems should continue to be treated in primary care initially

EDITOR,—S K Smith's provocative editorial argues that a more medical approach is needed in gynaecology.¹ We are general practitioners in a

busy group practice. One of us (DS) has a diploma from the Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists; the other (CS) is a member of the same faculty, an instructing doctor in family planning, and a member of the British Menopause Society. We therefore have an interest in general practice gynaecology, which is a considerable part of our everyday work.

We think that Smith should elaborate on one of the sentences in the editorial: "The gynaecologists' bias against medical treatments is unlikely to be reduced while general practitioners, understandably less knowledgeable as they are, embark on ineffective medical treatments before referring patients to specialists." Is Smith suggesting that all patients with any sort of gynaecological problem should be referred to a consultant gynaecologist? We assume that this is not the case, unless the author is unaware of the sheer volume of this work that is dealt with in primary care. We would like some clarification of what these "ineffective medical treatments" are. All the medical treatments that we use are also used by our local consultant gynaecological colleagues. We are aware, in this age of evidence based medicine, that some medical treatments are hard to evaluate and may not have been scientifically proved in trials comparing them with the gold standard. We would appreciate comments on the effective medical treatments that Smith uses so that we can improve our practice.

We see the future of gynaecology as starting within primary care, where appropriately trained and interested doctors can pursue the medical investigations and treatments with appropriate funding. The hospital specialist's domain could remain the surgical procedures and more complicated medical treatments. The focus of the editorial is also on women and their needs and wants. We suspect that many women are more comfortable being investigated and treated by their own general practitioners. For some, seeing a hospital gynaecologist is daunting.

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1 Smith SK. Gynaecology—medical or surgical? *BMJ* 1996;312:592-3. (9 March.)

Home versus hospital delivery

Analysis was flawed

EDITOR,—R S Settatree's analysis purporting to show that delivery in hospital is safer than delivery at home is flawed.¹ The 388 deaths among normally formed infants weighing 2500 g or more on which this analysis was based were the subject of confidential inquiries in 1993. Such inquiries into stillbirths and deaths in infancy are initiated when relevant deaths have been identified through a voluntary rapid reporting system. In 1993 there was no case by case cross checking between statutory registration of deaths and the rapid reporting system, but a comparison with the total numbers of deaths indicated considerable underreporting to the rapid reporting system.² Furthermore, the annual report for 1993 noted that the results of 45 confidential inquiries into deaths in this category were submitted too late to be included in the analyses.³

Not only were the numerators of the ratios quoted for home and hospital deliveries incomplete but the adjustments made to the denominators to take account of unplanned

births at home are also questionable. It was suggested that estimates of the proportion of births at home that are unplanned range from 10% to 60%, although references were not cited to support this. Settatree's calculations shown are based on an estimate of 26%, which is almost certainly too low. A national survey of all births at home in 1979 found that a third were unplanned.⁴ A more recent survey of births in the former Northern Regional Health Authority found that 40% of births at home had not been planned to occur there.⁵

There is a further error in the calculations in that the numerator data include deaths in England, Wales, and Northern Ireland while the denominator data are for only England and Wales.

In discussing intrapartum deaths at home the report of the inquiry for 1993 stated, "A consistent theme with the small number of home deliveries which resulted in the death of the baby was insufficient surveillance and monitoring of the labour, and a lack of experience in the community management of problems such as shoulder dystocia and breech presentation. These points were equally evident in the cases of hospital delivery."³ Its authors also strove to examine the deaths "without drawing potentially erroneous conclusions from the limited sample which incorporated both planned and unplanned home deliveries."² Other commentators would be wise to display similar caution.

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Author's reply

EDITOR,—The data from the 1993 confidential inquiry into stillbirths and deaths in infancy¹ have weaknesses, but none of those suggested by Rona Campbell undermine the conclusion that the relative risk of fetal or infant loss due to intrapartum causes is greater in planned home delivery than in delivery in hospital.

The lack of national denominator data on planned and unplanned home delivery forces consideration of a range of estimates based on regional studies. My analysis showed that if 26% of home births are assumed to be unplanned then the relative risk of planned home birth becomes significantly greater than unity. If the most recent estimate referred to by Campbell (40% in the Northern region²) is reflected nationally then the relative risk increases to 2.50 (95% confidence interval 1.29 to 4.85, $P=0.012$ by Fisher's exact test).

The possibilities arising from missing data are more serious. However, even if all of the 45 cases for which results of the confidential inquiries were not received in time for analysis were hospital deliveries, the relative risk, on the same assumption of 40% of all home deliveries being unplanned, is still 2.24 ($P=0.023$), and if only one of them followed planned home delivery this rises to 2.49 ($P=0.0087$).

I would have expected professional awareness of intrapartum deaths to result in high reporting

rates. If, however, there were some missed cases among the admitted underreporting of all cases to the inquiry this would render the current findings non-significant only if there were an improbably high number of unreported deaths after hospital delivery. If the report of the confidential inquiry erroneously excluded live births in Northern Ireland from its denominators then restoring them would reduce the estimate of absolute risk but would be unlikely to affect relative risk.

Total annual national data can hardly be regarded as a sample, but the number of deaths after planned home birth was small and 1993 may have been a freak year. If a similar result is observed for the years 1994 and 1995 then some current assumptions on the safety of home birth³ will have to be reviewed. One major advantage of the data from the confidential inquiry is that they exclude congenital anomaly, prematurity, and fetal death before the onset of labour. This avoids the problem of comparisons of crude perinatal mortality, which Campbell and others have rightly noted cause confusion in the statistical debate that surrounds the issue of the safety of home birth.⁴

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1 Confidential Inquiry into Stillbirths and Deaths in Infancy. Annual report for 1 January-31 December 1993. Part I. London: Department of Health, 1995.

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Good quality evidence is lacking

EDITOR,—T Dowswell and colleagues report that in a feasibility study of a randomised controlled trial of home and hospital births 14.2% (71/500) of women were considered eligible for randomisation; 15% of them (11/71) consented to be randomised.¹ Participation rates depend both on the expectations of the inviting physician and on women's willingness to participate, and neither of these is free from the influences of experience, context, and personality. The low proportions suggest that the obstetrician perceived childbirth as a dangerous event and was confident in his or her ability to judge risk, even though prediction of obstetric risk is notoriously unsuccessful. The reluctance of most of the selected women to participate may reflect an expectation that hospital delivery is "normal" and their being unprepared for a different suggestion. This pair of findings should therefore not be accepted as universally generalisable to all circumstances, especially as we agree with Gavin Young that one cannot reliably generalise on the basis of an overall participation rate of 2%.¹

Two types of information are required. Firstly, the difference in the risk of perinatal death, however small, between home and hospital births must be quantified. A randomised controlled trial that can answer this question is probably not feasible. Secondly, the relative frequency of non-fatal outcomes (both clinical and psychological) should be established, given the high population impact of these events; home delivery may have some advantages in this respect. The randomised controlled trial remains the most powerful means of doing this but depends on a better participation rate being achieved than has been the case in the past.

These two types of information taken together will help pregnant women put the risk of perinatal death into perspective by viewing it in the context of other risks and benefits of place of