nephrectomy versus £660 (three days) for laparoscopic nephrectomy. More specific, itemised analysis shows a different picture. Open nephrectomy cost £1665.64 while laparoscopic nephrectomy cost £3446.58. This is due to the increased use of theatre time reported for the laparoscopic technique—355 minutes compared with 107 minutes for the open technique. In addition, the capital costs of the laparoscopic equipment and disposable items (which can be up to £450 for a laparoscopic operation for hernia) need to be considered.

Theatre time is a costly and limited resource whose availability often determines surgical throughput and the length of a waiting list. Patients' satisfaction and recovery remain subjective and difficult to assess. Unless unequivocal clinical benefit can be shown, on the basis of hospital costs and throughput, many laparoscopic procedures seem hard to justify in today's NHS.

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Decreasing hospital stay is nothing new

EDITOR,—H David Banta warns of the lack of proper evaluation of minimally invasive surgery and the need for this to be properly funded.¹ He seems to imply, however, that earlier discharge from hospital is largely due to changes in surgical technique. Far more important is the change in the attitudes of staff and patients that has taken place gradually over the past 25 years. The inpatient stay after repair of a hernia has been reduced from 10 days to 24 hours, or less, without the surgical technique changing at all. Incisions for cholecystectomy had already been getting smaller before laparoscopic operations were introduced,² and controlled trials show little difference in the stay in hospital between procedures requiring a small incision and laparoscopic procedures,^{3,4} partly because both require general anaesthesia.

The other important factors affecting early discharge are the age, general medical state, and social conditions of the patient. An elderly person living alone in a high rise flat presents very different problems from a young adult who is taken to a family home in a comfortable car. For elderly patients, staying in hospital for an extra day or two may be both safer and, ultimately, more cost effective.

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Day surgery developing rapidly

EDITOR,—H David Banta describes his vision of the impact of minimally invasive surgery on hospitals, health workers, and patients in the near future and states that it "brings many more possibilities for short stay surgery or day surgery,

although this has not been recognised by doctors or policy makers in Europe."¹ This is not true.

Day surgery has been developing rapidly in Britain, and a recent report offered a "reasonable target" of half of all elective surgery being performed as day surgery by 2000.² The importance of day surgery and minimally invasive surgery was noted at a series of international scientific meetings last year. These meetings included the second European congress on ambulatory surgery (Brussels, 19-20 March), the founding congress of the European Society of Anaesthesiologists (Brussels, 11-16 May), and the third European congress of surgery (London, 14-17 September). New day surgery units are being constructed throughout Europe and are able to cope with a rapid turnover of patients as well as the implementation of minimally invasive surgery. The need for extensive community audit of minimally invasive surgery and day surgery has been emphasised by the Audit Commission.³

Banta refers to the importance of minimally invasive surgery and day surgery on economic grounds. Those who perform day surgery would argue that this is of secondary importance: the most important advantage of both it and minimally invasive surgery is the quality care that can be provided.

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Genetic markers in alcoholic liver disease

EDITOR,—D I N Sherman and colleagues suggest that variation in the alcohol dehydrogenase 2 gene may contribute to alcoholic liver disease.¹ Their study, however, has several shortcomings and their conclusions may be unjustified.

The initial hypothesis is unclear. The authors confuse genetic susceptibility to misuse of alcohol and genetic susceptibility to alcoholic liver disease; it is unlikely that the same genes contribute to these different disorders. If the authors intend to search for a marker for alcoholic liver disease the control group should be a population that has not developed liver disease (cirrhosis) despite prolonged and excessive alcohol intake. The control group causes particular concern because the only matching seems to have been on the basis of skin colour. This is unsatisfactory because large differences in frequencies of restriction fragment length polymorphism alleles may occur even among white populations. We have also observed different frequencies of restriction fragment length polymorphism alleles in white subjects collected from different social groups in London. Research and laboratory staff at King's College School of Medicine and Dentistry are of a higher socioeconomic class than alcohol misusers.

The authors do not discuss the problems of population association studies (better termed case-control studies), which are fraught with pitfalls and commonly result in false positive associations.² In this study the number of both patients and controls is small. Significance hinges on the genotypes of fewer than 10 subjects. In diabetes, studies of under 150 subjects are now rarely published. One group initially reported a positive association between a glucose transporter restriction fragment length polymorphism and non-insulin dependent diabetes,³ but this proved

erroneous once study numbers were increased.⁴ Similarly, comparison of subgroups, as occurs in table III, is considered to be unacceptable.

Alcoholic fatty liver occurs in almost all long term misusers of alcohol, but cirrhosis occurs in only a minority. This suggests that genes encoding proteins involved in the regulation of hepatic fibrosis are far better candidates for conferring an inherited susceptibility to cirrhosis than is alcohol dehydrogenase, which is responsible only for the initial metabolism of alcohol.

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Covert video surveillance in Munchausen's syndrome by proxy

EDITOR,—The measures proposed by D M Foreman and C Farsides to promote the interests of all concerned in the use of covert video surveillance to detect Munchausen's syndrome by proxy are to be applauded.¹ It is therefore worrying that those interests have not been better protected when a surveillance programme has been implemented. The fact that the services of the local research ethics committees have not been used highlights loopholes in the process of ethical review. The doctors concerned have chosen to regard their procedures as clinical practice, thus avoiding the scrutiny of the committee.²

Such surveillance does not constitute clinical practice. No treatment is offered to the child, save in the event of the expected physical assault. The investigation is entirely forensic in character, which stretches the notion of medical diagnosis beyond normal parameters. No underlying pathophysiological condition or disease process in the child is sought, simply the incidence of violent assault on him or her. Increasing the likelihood of such assault to obtain forensic evidence exposes the child to harm—and this not in the course of treatment.³ Though forensic investigation is important, it ought always to be separated from the provision of medical care to the patient.

Covert surveillance is largely a research exercise on human subjects in the NHS. The hypothesis that there is a significant correlation between multichannel tape recordings of physiological variables during episodes of asphyxia and those observed in other apnoeic episodes and that this makes certain patterns of data pathognomonic of imposed apnoea has been tested against the results of attempts at suffocation observed covertly by video.³ This is a research activity. Many uncertainties surround Munchausen's syndrome by proxy. Any investigation of the syndrome therefore carries important overtones of research. To proceed as though the categories were clear and to assume that there is only one patient is to risk ignoring the clinical needs of one of the parties concerned.

These observations are intended to raise the question of the proper role of the doctor. While doctors have the responsibility to protect the health of their patients, they do not have a monopoly of such responsibility. Their duty is

limited by their specific range of skill and their professional role. Not all forms of protection count as medical care. While, for example, a doctor has a responsibility to protect Salman Rushdie from the consequences of an attempt on his life, he or she has no responsibility to protect him from that attack. Others, of course, do.

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Publishing the findings of clinical research

EDITOR,—A J Munro¹ and Andrew Herxheimer² raised important issues about the publication and dissemination of the results of clinical research. For universities the release of results of research into the public domain is a condition of their status as educational charities. Universities are exempt charities whose primary purpose is the advancement of education through teaching and research. There must be some benefit to the public if the advancement of education is to be charitable. Research undertaken for the private benefit of a sponsor, where the results are not finally released into the public domain, is outside the charitable status of the institution.

Universities recognise that commercial sponsors of research may need time to gain some advantage over competitors by delaying publication of results. This is why the Committee of Vice Chancellors and Principals of the Universities of the United Kingdom has recommended that universities should allow sponsors the right to delay publication for a specified period, normally not more than 12 months. A longer delay of two years or, at the very most, three years may be appropriate in exceptional circumstances, but only if the sponsor presents a compelling case and this is agreed with the researchers concerned.

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Dutch model of maternity care

May not suit Britain

EDITOR,—In her comprehensive paper Christina Oppenheimer looked at aspects of the Dutch model of maternity care of relevance to establishing care led by midwives in Britain.¹ The internal market in the health services in Britain, inspired by a free market ideology, seems to be fundamentally different from the Dutch way of organising the provision of services. In the Netherlands state intervention limits competition between general practitioners and midwives, the weakest competitors in the maternity services, through a reimbursement system. Likewise the competition between providers of primary care and obstetricians is limited through national selection

criteria that favour midwives and general practitioners for low and medium risk deliveries. The Dutch system ensures midwives a market share. It also ensures, in contrast to the British system, that women—whether at a low, medium, or high risk—receive care in the appropriate place and from the appropriate birth attendant. The Dutch government recognises that its system is cheaper than that of its neighbours. Consequently, support of midwives and home births is strong and representative of support for a wider policy to move care out of the hospital into the home.²

Furthermore, introducing midwifery led care in Britain would be difficult without some form of help for midwives, such as that given by maternity home care assistants (maternity aids) in the Netherlands. These assistants help midwives during home births, provide much of the postnatal care, and thus free midwives to attend more deliveries while also strengthening midwives' sense of professional autonomy.³ They are an integral part of the provision of maternity care and facilitate home deliveries and deliveries necessitating only a short stay in hospital. At present, similar support for new mothers in Britain is limited to exceptional cases—for example, mothers with triplets or quadruplets—and the assigned home helps seldom have formal training.⁴ While supporting the changes towards more midwifery led care, I would emphasise that you have to be careful in picking out desirable aspects of maternity care in the Netherlands and assuming that they can be easily transferred into the different British framework.

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Dutch model limits choice

EDITOR,—A paper¹ and an editorial² have commented favourably on low risk care led by midwives in the Netherlands, and the editorial suggested that this might reduce the number of unnecessary caesarean sections performed in Britain for fear of litigation.

The main reason for the difference between caesarean section rates in Britain and the Netherlands is that women's choice is denied in the Netherlands because the midwife decides when and to whom to refer the woman when problems arise, whereas in Britain women can opt for an elective caesarean section after discussion with their obstetrician—for example, because of a previous difficult vaginal delivery, breech presentation, etc. One of us is Dutch, and his sister had a three hour second stage in the Netherlands without being referred to an obstetrician despite her repeated requests for this. Informed choice is one of the important elements of the Cumberlege report,³ and obstetricians are concerned that this system may result in more emergency obstetrics. Similarly, active management of labour achieves even lower rates of caesarean section,⁴ but it has not been widely adopted in Britain probably because it is also perceived as restricting women's choice.

Emergency obstetrics is associated with a poorer outcome for babies and to some extent for mothers. There is no system of routine audit of obstetric care in the Netherlands, whereas Britain has longstanding traditions of audit (perinatal mortality meetings, the confidential inquiry into maternal deaths). Both the paper and the editorial quoted

the Wormerveer study in the Netherlands, of 8055 births during 1969-83, which showed an unacceptably high perinatal mortality among babies transferred to obstetricians by midwives. In Britain the risks of caesarean section to the mother are greatest after an emergency procedure, maternal mortality being similar after elective caesarean section and vaginal delivery.⁵ The British confidential inquiry for 1985-7 noted that inexperience or the decreasing frequency of problems resulted in substandard care and that greater involvement of consultants was necessary for the best possible care to be achieved.⁶

Finally, midwives in the Netherlands are paid according to the number of deliveries they conduct, and 30% of the population has to take out private insurance to pay for this system (personal communication, Dutch Ministry of Health). The British, cost effective system already offers women the widest choice in childbirth.

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Confidentiality, contraception, and young people

EDITOR,—The recent "guidelines" to doctors¹ referred to by Gabriel Scally² perpetuate the myth that most underage girls obtain contraceptives from family planning clinics.

Nine years ago a survey of general practitioners revealed that doctors were providing contraceptives to between 2-12 girls a year.³ On a national level this meant that, at the very least, 60 000 schoolgirls (one in six) were being prescribed the pill by their general practitioners, at a time when only 18 000 were attending family planning clinics.

My experience as a parent of schoolage children and as a counsellor with a national pregnancy care charity is that multiple sexual partners and the incidence of sexual infections are now common among 14 and 15 year old girls. And just as before, the great majority of these girls have been prescribed the pill by their general practitioners.

Gabriel Scally and the authors of the guidelines offer no solution to this deteriorating situation other than to urge general practitioners to make themselves even more easily available to the young, and to warn doctors that they may face disciplinary proceedings if they break confidentiality with their young patients. This means keeping as much information as possible secret from parents, especially those who might raise objections to underage sex.

The adverse reaction of the media to these guidelines is indicative of a general feeling that the medical profession has gone well beyond its brief and is now attempting to ride roughshod over the legitimate rights and responsibilities of parents in the upbringing of their children. If confusion now reigns, it is the fault of those high profile organisations, who seem to regard parents as irrational obstacles blocking the path of childrens' uninhibited sexual freedom. Two quotations from the