J B Sharma and colleagues raise the question of whether smoking could account for the lower bone density in women using depot medroxyprogesterone.⁴ We agree that smoking is a potential confounder and discussed this in our earlier publication.³ We are puzzled by Sharma and colleagues' reference to the two groups in our recent study. There were three groups. The control subjects certainly smoked less than the women who used depot medroxyprogesterone, but the proportion of women smoking was the same in those who continued to use depot medroxyprogesterone and those who stopped using it. Bone density increased only in those who stopped using the contraceptive. Finally, we note Sharma and colleagues' (unreferenced) assertion that measurements of the bone density of the femoral neck and wrist by dual energy x ray absorptiometry might be more accurate and reliable than measurements of the bone density of the spine. This is contrary to our experience and to most published data. We believe that the reason we saw greater changes in the spine than the hip is that the spine contains a larger proportion of trabecular bone and is more sensitive to oestrogen.

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- 1 Cundy T, Cornish J, Evans MC, Roberts H, Reid IR. Recovery of bone density in women who stop using medroxyprogesterone acetate. *BMJ* 1994;308:247-8. (22 January.)
- 2 Szarewski A, Hollingworth B, Guillebaud J. Depot medroxyprogesterone and osteoporosis. *BMJ* 1994;308:717. (12 March.)
- 3 Cundy T, Evans M, Roberts H, Wattie D, Ames R, Reid IR. Bone density in women receiving depot medroxyprogesterone acetate for contraception. *BMJ* 1991;303:13-6 (correction 303:202).
- 4 Sharma JB, Newman MRB, Smith RJ. Depot medroxyprogesterone and osteoporosis. *BMJ* 1994;308:717. (12 March.)

Towards investing in health gain

Evaluation of interventions is needed

EDITOR,—John Gabbay and Andrew Stevens¹ have misrepresented the process through which the Welsh Office's protocols for health gain were written. As a member of two of the panels, I disagree that informed consensus was actively "substituted for scientific proof." The cancers protocol² was the first one attempted; a technical document was commissioned from Professor Jocelyn Chamberlain to give a starting point; this was sought from outside the principality to ensure an impartial view. For the pain, discomfort, and palliative care protocol,³ the group members wrote a series of technical documents that were critically discussed by the group and externally reviewed by Dr H McQuay (Oxford) and Dr A Diamond (Bristol). The imposition of deadlines is always required to make a group function, but they did not inhibit consultation or discussion.

Unfortunately, very few medical outcomes have been subjected to rigorous scientific scrutiny. If the groups had waited to include only research data, they might have waited for ever. However, the protocols have acted as a stimulus to research into needs assessment in an attempt to gain firm data. Such a project on palliative care is under way, but will take at least a further year to complete.

The Welsh targets aim at improving mortality and morbidity. The consultation was wide and in reaching the targets the views of the consumers were actively sought. Quality of life is a concern of patient groups and the "patient centred" approach has been welcomed by the Expert Advisory Group on Cancer at the Department of Health.

It is easy for those who failed to have the imagination to initiate such an exercise elsewhere

to criticise a "first," which these documents are. They provide a stimulus to improve the quality in the care for patients, not "demands from the centre." Changes are already evident in the approach to cancer patients and to palliative care to increase scientific evaluation of interventions; the importance of this for patients should not be underestimated.

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- 1 Gabbay J, Stevens A. Towards investing in health gain. *BMJ* 1994;308:1117-8. (30 April.)
- 2 Welsh Health Planning Forum. *Protocol for investment in health gain: cancers*. Cardiff: WHPF, 1990.
- 3 Welsh Health Planning Forum. *Protocol for investment in health gain: pain, discomfort and palliative care*. Cardiff: WHPF, 1992.

Documents should be updated regularly

EDITOR,—We support the call from John Gabbay and Andrew Stevens for a consolidation of the scientific base as an essential prerequisite for an evolving purchasing plan.¹ We have recently written a technical document for East Anglia: *Coronary Heart Disease—Opportunities for Prevention and Treatment*. This document is aimed at purchasers, most particularly directors of public health, and reviews the recent evidence on effective interventions while illustrating the subject in the context of local epidemiology. In preparing this document we came across several similar documents, none of which we felt able to cite as they neither clearly specified their aim as informing purchasing based on evidence nor included recent research findings.

We firmly believe that these documents have great value. Their value will, however be sustained only if they are kept readable and up to date. Such documents should be produced at a national level and updated annually. The new arrangements for public health within the regional office structure as part of the NHS Executive could ensure the coordination of such documents.

These publications, however well received today, will be left to gather dust unless the need for regular view and updating is recognised as a central responsibility.

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Supporting protocols exist

EDITOR,—John Gabbay and Andrew Stevens's praise for the Welsh Health Planning Forum's series of protocols for investment in health gain is qualified by their criticism of the comparative lack of evidence to support many of the recommendations.¹ Accepting that, for many medical interventions, the evidence simply does not exist, as chairman of one protocol panel² I can confirm that a 500 page technical document, copiously referenced, supported the protocol. The technical document had two external referees; the authors separately ranked the strength of the evidence to provide for learning disabilities interventions—a "shopper's guide" from 1, "substantiated as increasing health gain," to 4, "should be abandoned in light of available evidence."

Gabbay and Stevens also consider the protocol exercise as "top down" target setting. This was not my experience. The process consisted of consumers (voluntary organisations, parents,

patients) working towards a consensus document, which was then presented as a menu of targets for local purchasers to choose their own priorities for local strategies for health.

In chaotically diverse European provision for health services for people with learning disabilities, the document has been warmly received for what it is: a protocol based on sound evidence from professionals and consumers to help decision making at national and local levels.

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- 1 Gabbay J, Stevens A. Towards investing in health gain. *BMJ* 1994;308:1117-8. (30 April.)
- 2 Welsh Health Planning Forum. *Protocol for investment in health gain, mental handicap (learning disabilities)*. Cardiff: WHPF, 1992.

New public health

Research is part of the political process

EDITOR,—Jan P Vandenbroucke, in commenting on the new public health, acknowledges the perennial relevance of equity, ecology, and the environment but advises that the energy behind the rhetoric be directed in "good ways" to avoid "academic downfall."¹ His point is well made, but he says nothing of the opportunities and progress that are being made. We recently addressed these issues at a conference in Liverpool (Health in cities: research and change in urban community health) drawing on experience of the WHO Healthy Cities Project² and Health for All initiatives to address two key questions:

(1) what research methods are appropriate for assessing needs and evaluating the Health for All process and outcomes, and

(2) how can the research findings be translated into policy, and what are the barriers?

The conference heard that, if research is to be made more relevant to policy makers, there needs to be greater recognition that research is part of the political process, more integration of qualitative and quantitative research, and selection of research topics more in line with current priorities. The research community also needs to be aware of how policy makers view research; often it is seen as fine in principle, but time consuming and threatening in practice, and always subject to the receptiveness of the political environment.

The growing experience of community participation in needs assessment was reported through varied case studies, using focus groups, surveys, geographical information systems, and artistic expression. A theatre performance showed how powerfully drama can be used to research children's experience of relationships, drugs, and family and to present this in a way that teachers and children can work with. Community participation and variety in methods give breadth, depth, and policy relevance.

The focus on implementation included primary care, health promotion, housing, and transport. It drew out the opportunities presented by community participation and intersectoral collaboration, but also the practical difficulties. These processes—central policy³—require commitment, resources, and experience. The conference heard much about that experience, and about the first steps towards evaluation—for instance the Health Education Authority/Wessex multi-sectoral collaboration for health project.

This is an important stage for the "new public health," as all sectors of society get to grips with implementing Health for All ideas. There is ample substance for academic endeavour, although conceptual and practical challenges in developing methods for needs assessment and evaluation,

funding, and achieving effective implementation undoubtedly remain. Conference proceedings will be available later in the year.

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- 1 Vandenbroucke JP. New public health and old rhetoric. *BMJ* 1994;308:994-5. (16 April.)
- 2 Ashton J. *Healthy cities*. Milton Keynes: Open University Press, 1992.
- 3 Secretary of State. *Health of the nation*. London: HMSO, 1992.
- 4 NHS Management Executive. *Local voices: the views of local people in purchasing for health*. Leeds: NHSME, 1992.

Epidemiology is not the only science

EDITOR,—Jan P Vandenbroucke predicts a similar academic downfall for the "new public health" as he claims befell its 19th century predecessor, the hygienic and sanitarian movement.¹ He argues that by wishing to divorce themselves from "the erstwhile star discipline, epidemiology" some proponents of the new public health are leading the fledgling movement away from "good science" towards mere political controversy and the "repetition of old style rhetoric," which will be the undoing of the new movement. While the proponents of the new public health may have overemphasised the newness of their societal view of the causes of disease, Vandenbroucke is unduly restrictive in seeing epidemiology as the science of public health. He seems to equate any criticism of, or movement away from, epidemiology as a movement away from science, rather than part of a debate about appropriate forms of knowledge for public health policy.² This fails to recognise that public health research and practice draw on a wide range of scientific disciplines for concepts, methods, and knowledge—including epidemiology, management science, economics, sociology, psychology, anthropology, statistics, marketing, and a number of clinical disciplines. It is divisive and unhelpful to regard any one of these as the "pilot discipline," as Vandenbroucke regards epidemiology. Furthermore, it does scant justice to the fact that public health activity is no longer, if it ever was, the exclusive domain of medicine or of epidemiologists (medical or non-medical).

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- 1 Vandenbroucke JP. New public health and old rhetoric. *BMJ* 1994;308:994-5. (16 April.)
- 2 Population health looking upstream [editorial]. *Lancet* 1994;343: 429-30.

Social sciences provide a framework for epidemiology

EDITOR,—Given the rhetorical style of Jan P Vandenbroucke's blast against a variety of targets, it is difficult to identify the substance of his criticism of the "new public health."¹ I will therefore pick out three things he seemed to be saying.

Firstly, he says that "many proponents of the new public health wish to divorce themselves from" epidemiology. This, I think, is a misreading

of the current critique of classical ("clinical") epidemiology. Rather than bury this "star discipline," the intention is to reapply it as a powerful set of investigative tools within a framework of understanding provided by social sciences. This will not detract from hard data but will allow more relevant and searching questions to be asked—for example, does unemployment cause coronary heart disease? does low income cause cancer? These questions are scientific, and the standards of scientific evidence are applicable. But causation here is unlikely to be of an all or nothing type; rather, concepts such as component causation, chains of causation, and effect modification² are necessary. The simple fact is that a clinical epidemiology that has overconcentrated on "downstream" biological factors has not proved powerful (explanatory) enough.

Secondly, he seems to take the historical disappearance of previous incarnations of the new public health as proof of the emptiness of their various critiques of medicine. This view says nothing about the truth of such critiques; it simply passively accepts the outcomes of a history forged by vested interests and power play. While the academy (with exceptions) found it easier to keep its analysis of health and disease in a clinical and individual perspective, the truth of the matter was (and is) that the determinants of health are overwhelmingly based on the way we live: the way we act on our society and environment and the way it offers us opportunities and constraints regarding physical, mental, and social health. The wider understanding of this reality may threaten the role of a reductionist clinical medicine and threaten its proponents' self image. Consequently, continued debate on these matters is certain.

Finally, the conceptual separation of analysis and knowledge from political choice is a comforting but naive position for public health, as it is for the "hard" physical and biological sciences.³

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- 1 Vandenbroucke JP. New public health and old rhetoric. *BMJ* 1994;308:994-5. (16 April.)
- 2 Rothman K. *Modern epidemiology*. Boston: Little Brown, 1986.
- 3 Ravetz JR. *The merger of knowledge with power: essays in critical science*. London: Mansell, 1990.

Training and reaccreditations in general practice

EDITOR,—Once again the Royal College of General Practitioners has sold the profession down the river.¹ When questioned about the demands of the government quangos of family health services authorities and trusts that general practitioners should spend 11 years in training to meet the quango's requirements the president of the college agrees that "general practitioners should be brought up to speed to cope with the modern situation."

The half of graduates who are women would have to be fully trained before having children. As locums would have to be accredited in the future they would have to follow a five year course of study before they would be employable, even part time. Any doctor returning from abroad might also have problems in satisfying the requirement for having followed an agreed course of study over the previous five years in order to be reaccredited. The proposal also means that general practitioners could replace expensive partners with cheaper trainees, now available for another two years. This would suit the government as its bills would be reduced and general practitioners would end up with a lower pension.

With regard to the reaccreditation, either it is so easy that everybody achieves it (in which case why do it?) or people are intended to fail. Once doctors fail they become unemployable. We are faced with doctors aged 50 and over failing to be reaccredited and having no means of earning a living. As the family health services authorities also want reaccreditation of practices, presumably one requirement would be that all general practitioners were accredited: soon we will all be on five year contracts. Would a bank lend money to build a surgery if you were on a five year contract? We would be working in a high risk occupation as opposed to a secure one, and our salary should reflect this. If a manager of an NHS trust, who may have a degree, is paid £70 000 plus perks for a 40 hour week, how much should a general practitioner, after 11 years' training and on a five year contract and working 70 or more hours, be paid? We also must insist that general practitioners could retire on a full pension from the age of 55 as it is not right to ask those of 60 or over to sit examinations and risk being expelled from the profession every five years.

I trust that our leaders will address the problem of retirement and correct remuneration for the increased risk in the profession. We know, however, that they will agree to everything and then say afterwards, "Oh dear, we didn't realise. And they did say there would be new money."

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Increase in parasuicide in Scotland

EDITOR,—Peter Beck and colleagues report an increase in the absolute number of men, and the ratio of men to women, admitted for self poisoning in South Glamorgan during 1986-92.¹ The increased mortality in the decade after an admission for self poisoning^{2,3} or other form of deliberate self harm¹ is well recognised.

As part of a wider review of suicide being undertaken in our department the information and statistics division of the Directorate of Information Services provided us with the annual numbers of male and female patients discharged after parasuicide (E950-959) in Scotland for 1982-92. Both the absolute number of such discharges and the ratio of males to females have risen (table).

Possible explanations for the increase in admissions and change in sex ratio include altered clinical practice, more accurate coding of discharge forms, and a true change in the epidemiology of parasuicide. Deaths by suicide among men increased in England and Wales and in Scotland during the 1980s.⁴ It is unclear whether the increases in absolute numbers and change in the sex ratio of parasuicide in Scotland and self poisoning in Wales are part of the same process as the increase in completed suicide among men.

Numbers of people resident in Scotland who were discharged from hospital after parasuicide, 1982-92

	Male	Female	Total	Male:female ratio
1982	3 897	5 670	9 567	0.69
1983	3 675	5 400	9 075	0.68
1984	4 013	5 608	9 621	0.71
1985	4 046	5 371	9 417	0.75
1986	3 850	5 484	9 334	0.70
1987	4 209	5 435	9 644	0.77
1988	4 136	5 519	9 655	0.75
1989	4 266	5 441	9 707	0.78
1990	4 664	5 759	10 423	0.81
1991	4 999	5 926	10 925	0.84
1992	5 533	6 312	11 845	0.88