results were obtained for survival up to six months. The analysis was repeated for specific age groups: women aged 60-69 had a worse chance of survival to six months ($P < 0.03$) but not to two years ($P > 0.075$). No difference was found in either the younger or the older age groups.

Age specific Kaplan-Meier survival curves in men and women with acute myocardial infarction in first two years after admission to hospital ($P > 0.44$)

These Scottish data suggest that the poorer survival of women may be attributed to the different age distributions of the men and women admitted to hospital. The use of statistical methods that adjust for age across whole populations may, however, disguise differences in particular age groups' experience of disease.

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1 Wilkinson P, Laji K, Ranjadayan K, Parsons L, Timmis AD. Acute myocardial infarction in women: survival analysis in first six months. *BMJ* 1994;309:566-9. (3 September.)

Deaths due to coronary heart disease during sport

EDITOR,—Although W S Hillis and colleagues' article on sudden death in sport gives a fair account of a complex subject, the caption to the photograph of a collapsed runner—"Marathon running is one of the most common causes of sudden death from coronary artery disease"—seriously misrepresents the facts.¹

Firstly, the photograph, from the world championships at Stuttgart, shows not a runner with coronary artery disease but one who collapsed from heat exhaustion and who made a good recovery after standard treatment with fluids and rest.

Secondly, marathon running is not a common cause of sudden death; most cases of sudden death occur at rest, including during sleep or light activity.² Marathons are public events, and the high drama surrounding anyone who collapses during such a race generally ensures considerable publicity. Despite this I can recollect only one or, at the most, two deaths from ischaemic heart disease among competitors in marathons. Deaths have occurred from other causes, such as hypertrophic obstructive cardiomyopathy or haemorrhagic pneumonitis. By contrast, the number of deaths associated with squash has been estimated at 27 a year,³ and Opie estimated that one death will occur in every 50 000 rugby hours in players and in every 3000 referee hours.⁴ Thus neither in absolute terms nor in comparison with other sports can marathon running be claimed to be a common cause of sudden death.

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Chronic back pain

EDITOR,—Michael I Jayson's editorial on the causes of chronic back pain is to be lauded for two reasons.¹ Firstly, it emphasises the disparity between clinically demonstrable findings and subjective complaints of pain: the wider the acknowledgement that a minor abnormality evident in a scan or x ray film may be coincidental to the complaint of pain the less harm will be done to backs by treatments based on attempts to correct innocent lesions. Secondly, the editorial supports the growing realisation that while peripheral nociception cannot account for many of the clinical symptoms of chronic back pain, disordered central neural processing can.

Unfortunately, Jayson fails to cross other, arguably more important, conceptual divides. The real challenges of back pain lie in channelling medical endeavour from a purely biomedical perspective (be it peripheral or central) to a broader model incorporating social and psychological perspectives. The real divides we need to bridge are from brain to psyche, from biomedicine to holism, and from point aetiology to process.

Searching for a lesion in a different part of the nervous system is the easy way out: we prolong the denial of our therapeutic impotence by ordering other expensive investigations. Meanwhile the patient becomes ever more convinced that he or she has a demonstrable, and presumably treatable, lesion. When the patient finally realises that this is not the case the anger and frustration caused by years of misinformation make rehabilitation even more difficult.

The mountain of disability caused by back pain stands a chance of being levelled only when doctors can translate the broad canvas of the epidemiological picture to the difficult patient sitting in front of them. This nearly always means diminishing the conviction of disease, encouraging normal function with advice and rehabilitation, and doing not more investigations but fewer.

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1 Jayson MIV. Mechanisms underlying chronic back pain. *BMJ* 1994;309:681-2. (17 September.)

Preventing suicide

EDITOR,—H G Morgan's article on the prevention of suicide ignores an important issue: even if general practitioners can be taught how to prevent suicide how justified are they in doing so?¹ Suicide is no longer illegal in Britain, so we can assume that there is at least a case for it being permissible. This, in conjunction with a basic right to non-interference, means that people are free to choose to take their lives if they so wish. The conscientious doctor is thus presented with a dilemma. He or she is forced to reconcile the obligation to save life with the obligation not to infringe a person's autonomy.

The upshot is that adequate reasons must be given for curtailing a person's liberty to act as he or she chooses. Such reasons are especially important in a community setting, where there is no implicit consent to forcible medical intervention as may arguably be the case when the patient has voluntarily been admitted to a psychiatric unit. Merely

being guided by our compassion is not a sufficient reason for this infringement. Can we be sure that by being guided by our compassion we are doing the right thing if, as may be the case, the person who wishes to commit suicide passionately resents our interference?

As Morgan intimates, doctors' beliefs about suicide vary considerably, so how can compassion serve as a reliable guide to action? One doctor may believe that intervention is right in every case; another may believe that a suicidal person's autonomy takes precedence over his or her rationality. Some may even believe that suicide is always wrong. The problem is compounded by doctors' role in society. Doctors are an established social institution, and the moral spotlight is on us. If we always act to prevent suicide we are sending a message to society that suicide is objectively wrong. We need a coherent moral theory of suicide, a principle of action that affords us reasons for prevention or otherwise, which can be applied prospectively to individual cases, rather than relying on ad hoc justification applied through the "retrospectroscope." Before we talk of prevention we must first discuss permission and no longer be afraid to confront the moral issues behind the tragedy of suicide.

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1 Wilkinson G, Morgan HG. Can suicide be prevented? *BMJ* 1994;309:860-2. (1 October.)

Obtaining useful data from primary care

EDITOR,—F M Haste points out the need for good quality data on preventive issues in primary care and the shortcomings of the current banding system for health promotion.¹ M C Record and colleagues found that general practitioners had similar concerns and would prefer more relevant standardised data.²

We have adopted a standard procedure for documenting preventive activities recorded by general practitioners in inner London to provide comparable data among practices and over time. Sixty general practitioners participated in a study. We found that only half of preventive activities recorded by general practitioners were recorded on the practice computer and that a system that relied entirely on this source would not necessarily reflect what was being done. Secondly, there were major differences in the denominator: when a simple procedure was used between 15% and 37% of the registered population aged 30-64 were excluded from the final denominator because they had moved or died or had no notes. Finally, the definition of the numerators differed among practices unless standard definitions were specified and maintained. We are currently expanding this system to include 150 general practitioners in three health districts.

Given resources and support, reporting and audit systems that use standard definitions of the numerator and denominator can produce high quality, comparable data. Many general practitioners would welcome the option of contributing to a standard dataset, which might include quantitative measurement, delivery of preventive care, and consultation rates. The current banding system, though not as awful as the "health clinic" system of payment it replaced, still confuses performance with the production of a reliable dataset. Performance needs to be separated from the generation of standard data if quality and planning are to be reliably informed by documentation of quantity and process. Amassing dubious information to obtain resources discredits the cause of applied epidemiology and makes the development