deaths (three in current users and two in past users) from pulmonary embolism have been reported.⁶ Furthermore, pills with a lower oestrogen content than those used in these studies (and so less likely to cause deep vein thrombosis) are now widely used.

The epidemiological studies relied almost entirely on cases of venous thrombosis diagnosed clinically, yet the clinical diagnosis of deep vein thrombosis is associated with both false positive and false negative results even when made by experts.⁷ A recent study reviewed young women with suspected deep vein thrombosis who were taking the contraceptive pill and found that only 17% of the clinically diagnosed thromboses could be confirmed by Doppler ultrasound scan.⁸ Similar problems apply to the clinical and radiological diagnosis of pulmonary embolism.

Vessey *et al* reported in 1986 that the incidence of deep vein thrombosis after operation in young women taking the pill (12/1244, 0.96%) was about twice that of women not taking the pill (22/4359, 0.5%), but this difference was not statistically significant.⁹ The incidence of deep vein thrombosis in young women taking the pill in this study is tiny compared with the roughly 25% incidence detected by iodine-125 fibrinogen scans in patients undergoing general surgical operations; it is also less than the 8% incidence seen in those who receive prophylaxis.¹⁰

After careful search we have found only three studies of young women taking the pill in which ¹²⁵I fibrinogen scans were used to diagnose deep vein thrombosis after operation. The incidences of thrombosis in patients taking the pill were 4.6% in 41 patients who underwent gynaecological operations for benign disease,¹¹ nil in 99 patients who underwent various abdominal operations,¹² and 20% in 33 patients who had emergency appendicectomies.¹³ Most women taking oral contraceptives are young, slim, and fit, and they mobilise early after operation. They are usually free from malignancy, varicose veins, and other risk factors for deep vein thrombosis.¹⁴ They are thus unlikely to develop deep vein thrombosis after an operation.

On present evidence the risk to young women on the pill of becoming pregnant from stopping the pill or of developing side effects from prophylaxis may be greater than the risk of developing postoperative deep vein thrombosis. We need urgently to define the true incidence of postoperative deep vein thrombosis so that a rational policy can be adopted. Meanwhile, the pill should not be withheld from young women who require abdominal operations, particularly as in our stretched health service operations are often cancelled at the last minute—increasing the risk of unwanted pregnancy. The routine use of prophylaxis for deep vein thrombosis in women on the pill is probably unnecessary, particularly in those who have no other risk factors.

H SUE-LING
Surgical registrar

L E HUGHES
Professor of surgery

University Hospital of Wales,
Cardiff CF4 4XN

Correspondence to Professor Hughes.

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Management response to childhood accidents

Slowly—too slowly—health professionals are beginning to recognise that they could do much more to prevent accidents and injuries. Accidents cause much mortality and morbidity, mostly in the young. They thus result in a tremendous loss of productive years of life as well as much grief, suffering, and long term disability. The health service's attempts to prevent accidents and injuries must be scientific and so must begin with detailed epidemiological study of accidents—where, when, how many, of what type, the means of injury, and their severity. The importance of the epidemiological analysis of accidents and the multidisciplinary approach to their prevention is the main theme of an excellent short monograph on *The Management Response to Childhood Accidents* by Pamela Constantinides.¹

The most comprehensive data on accidents are collected not by the health services but by the police (on road accidents) and by the Department of Trade and Industry's home accident surveillance system. Certainly more support is needed from the Department of Health and Social Security for the computerised accident and emergency record system or developments of it, and consideration should also be given to using the World Health Organisation basic data set developed by the European office of the World Health Organisation. But what does this lead to? "Systematically collected local data on childhood accident injuries can be used to develop policies, target resources and personnel allocation, evaluate programmes and provide a focal point for multisectional co-operation."²

Health authorities are urged by Ms Constantinides to improve the management and follow up of injured children, but it is in the possibilities of accident prevention that she makes her most important proposals. The Child Accident Prevention Trust has established an active multidisciplinary group nationally, but both Constantinides and the trust emphasise the value of establishing local groups. Naturally many people such as designers, planners, architects, bodies for setting standards, and legislators play a part in designing the environment and protecting our children from its hazards. The private member's bill on the wearing of seat belts by children in the rear seats of cars is an example of an important national development. But local multidisciplinary groups with local authority personnel—environmental health officers, trading standards officers, road safety officers, and many others—together with voluntary agencies

may produce local policies on the environment. Complementary to this activity is the direct education of parents, and Laidman's study of the job of health visitors points the way here.² As Sir Donald Acheson says in his foreword, the report "makes sound suggestions for improving, monitoring and following up accidents and provides examples of effective approaches to prevention. The challenge to NHS staff is to apply these lessons more widely and lay a firm foundation for collaborative efforts to reduce accidents to children."²

R H JACKSON

Medical Consultant,
Child Accident Prevention Trust,
London W1N 4DE

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Nurses: where do they go from here?

The nine out of ten nurses dissatisfied with this government's handling of the health service¹ are not spoiled for choice. They have only three options: stay and shut up, stay and protest, or leave.

Staying and shutting up may be nursing's traditional response, but nurses are finding it increasingly difficult. As the *BMJ*'s recent series on nursing grievances suggested, nurses' job satisfaction has plummeted: they are having to do much more with less and can no longer cope. Productivity is up—since 1979 day cases have increased by 77%, inpatients by 19%, outpatients by 11% (how many times nurses must have heard those statistics),² although the number of nursing whole time equivalents has increased only by 5.5% when adjusted for the reduction in nurses' working hours.^{3,4} Not only have nursing duties increased: since the introduction of competitive tendering and the "rationalisation" of patients' services nurses have found themselves filling in as cleaners, porters, and ward clerks. However much money has been poured into the health service, hospitals are still not awash with cash—the latest estimates of the cumulative underfunding of the hospital and community services since 1981 range between £1100 and £1800m. Nurses can no longer manage this increased workload with inadequate resources and are suffering as a result from stress and poor morale. And then there is the small matter of their salary.

Staying and protesting seem more risky. For a start such a course is liable to serious misinterpretation. Trying to help patients in this way has already earned nurses ministerial rebukes that they are deliberately hitting at patients, despite the fact that they have bent over backwards to maintain adequate standards of care. (Last week some nurses voted to reduce staffing levels at their hospital as part of their protest only to discover that they were already at emergency levels. So they abandoned their action.) Action by nurses is also apt to be misinterpreted by their governing body: it seems to favour a narrow interpretation of the first clause of its code of practice, which states that nurses should always act

to promote and safeguard the wellbeing and interests of patients.⁵

Friends of the nurses remind them that the Royal College of Nursing's no strike policy is the profession's greatest asset and that striking will alienate the public's support for them. (But then apparently 79% of the public sympathised with the recent Manchester strike,⁶ 61% support the principle of striking to draw attention to the level of NHS services,⁷ and 85-92% of people support substantial pay increases for nurses.^{6,7}) The government has hinted that any strike action may endanger its commitment to the pay review body, which the Prime Minister sees as the nurses' reward for not striking.⁸ Until last month, however, nurses had not struck, although the government had not fully honoured its side of the bargain—staging the review body's recommendations in two of the four years it has reported. More galling to nurses than this is to see some of their modest salary increases come out of existing hospital budgets—so reducing resources for patients.

The third option, to leave, was taken by about 600 qualified nurses each week in 1986 (the latest reliable estimate).⁹ Some were leaving for domestic reasons and about 200 of them will return, but others were leaving for good—for jobs in the private sector, for overseas, or for different jobs entirely. They were obeying market forces—in keeping with the government's philosophy, although wreaking havoc as they did so. Shortages of trained staff account for some of the empty operating theatres, the cancelled operations, the half full intensive care units, the lengthy waiting lists. More patients have suffered from nurses quietly resigning from the National Health Service than ever have from industrial action.

Which option should nurses choose? They run the risk of harming themselves with the first, of harming the health service with the third, and of harming both with the second. Last week, uncharacteristically, some nurses made the second choice, jeopardising much, as everyone was quick to point out. Fewer people, however, were prepared to admit to nurses that it is the only option that carries with it the possibility of worthwhile change.

There is much on nursing's agenda. Last week nurses' demands for rescuing the health service almost eclipsed their own for better pay, conditions, education, career structure, and professional recognition. The two are inextricably linked, however, which nurses seem to appreciate better than most. Doctors have been slow to make this connection, although it is in their interests to do so. Unless nursing can attract enough recruits from the shrinking pool of school leavers and keep them in nursing, a major crisis will be on us in the 1990s. That is why the nurses' struggle should be the doctors' struggle, too.

TONY DELAMOTHE

Assistant editor,
BMJ

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