the low predictive value of the tests (30-35%) is welcome.

What, then, is the future? The logical approach would be to carry out prospective randomised studies comparing the results of the available, potentially curative forms of treatment (radical prostatectomy, radiotherapy) with those of delayed treatment. This approach is being taken in Scandinavia and Britain. But results will not come quickly—because of methodological difficulties in randomisation schemes, exclusion of the most aggressive tumours, the “learning curve” for those carrying out radical prostatic surgery, and the need for a 15 year follow up for a final verdict. Meanwhile pressure is mounting for patients in general practice to be offered screening.

The approach in the United States is at the other extreme. Lu-Yao and Greenberg have clearly shown that the incidence of prostate cancer is rising while mortality stays unchanged.⁸ The most likely explanation of these figures is the growth of screening. The increasing discrepancy between incidence and mortality during 1989-93 does not, however, mean that the approach across the Atlantic is doomed to fail. Changes in mortality from prostate cancer will occur later if at all. Believers in screening point out that every clinical prostate cancer has to pass through a localised stage. Time will have to show whether the enormous effort made with early diagnosis and treatment in the United States will bring down mortality from this cancer.

My own view is that the best compromise is to carry out randomised screening studies that compare screening with no screening and use mortality from prostate cancer as the main end point.⁹ Such studies are in progress in Europe (the European randomised study of screening for prostate cancer) and in the United States, where a screening trial for prostate, lung, colon, and ovarian cancer is run by the National Cancer Institute. This approach has recently been criticised in the

Lancet, but the critics underestimated the risk of localised prostate cancer.¹⁰

For the time being I think that the available screening tests should not be applied to the whole population—because the balance of risk and benefit has not been clearly shown to favour screening and early treatment. The tests are useful in symptomatic men presenting themselves for consultation and should also be made available when men ask for them. More publicity should be given to the potential benefits and uncertainties of screening. Another uncertainty is that the upper age limit for treatment has not yet been defined conclusively. Men much beyond the age of 70 seem likely to have limited benefit. In older men—and possibly in others too—the treatment of locally confined disease should include the possibility of watchful waiting.

FRITZ H SCHRÖDER
Chairman

Department of Urology,
Erasmus University,
3000 DR Rotterdam,
The Netherlands

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Perinatal and infant postmortem examination

Difficult to ask for but potentially valuable

The relatively large concentration of deaths in the perinatal period and infancy and the need to provide explanations for parents might suggest that clinicians frequently turn to pathologists for information from postmortem examinations. Yet Cartledge and colleagues in this week's *BMJ* draw attention to the fact that the rate of postmortem examination for perinatal and infant deaths in Wales is only 58% (p 155).¹ Their results are probably typical of the rest of Britain. For example, the confidential inquiry into stillbirths and deaths in infancy in the North Western region found a similarly low rate of only 53% in 1993 (A J Barson and J A Sands, personal communication).

The value of the perinatal postmortem examination extends beyond its ascertainment of factors that contributed to death. It may provide the basis for informed genetic counselling; it may challenge or verify diagnoses made by new techniques before death; it serves to monitor possible adverse effects of new treatments; it is a basis for research and education; and, finally, it can be a source of information in epidemiological surveys.² All this assumes a high quality postmortem examination, but the evidence suggests that this is far from guaranteed. In the Welsh survey a postmortem examination was not requested in 17% of all deaths and not permitted in 25%. Clinicians are urged to take a more positive attitude towards postmortem examination, and others have suggested the same

with respect to deaths in children.³⁻⁵ Yet there is a difficult problem here, partly because of changing attitudes towards perinatal death. Whereas previously the idea of a funeral service for a stillborn infant would have been looked at incredulously, it is now quite common.⁶ Obstetricians are faced with the uncomfortable prospect of letting parents nurse and bond with their stillborn infant, perhaps for some hours, and then asking for consent for a postmortem examination.

Similarly, there has also been a change in the circumstances surrounding neonatal death. Deaths now commonly occur after prolonged intensive neonatal care, particularly in extremely immature babies. Life support may be withdrawn after distressing discussions with parents, who often express a wish to nurse and perhaps bath and dress their dead baby. In these circumstances an understandable reason for parents declining consent for a postmortem examination is that their baby has “already suffered enough.”

There is no euphemism to describe a postmortem examination. On the one hand, parents desire their last memory of their baby to be one that is disentangled from technology; on the other hand, there is the perception of their loved one's body being desecrated.

How can we work towards resolving this problem? Firstly, seeking parental consent for postmortem examination

requires communication skills and experience. It is best done by the person who has already established rapport and understanding with the parents. In most cases this will be a consultant clinician, but often a midwife, nurse, junior doctor, family doctor, or religious minister may have established a close relationship with the parents and this aids communication.

Secondly, many parents erroneously consider the post-mortem examination to be solely for research and linked with the notion of "donating the body for science." Informed discussion is needed about how an examination might be helpful. In truth, a fine line sometimes exists between the true benefits for the parents and the broader and indirect benefit to other babies. If this is the case then it must be acknowledged. Confusing the issue is a recipe for creating guilt on both sides, whereas a scrupulously honest approach is often rewarded by a genuine desire of parents to see their baby's death as in some way helping others.

Thirdly, those seeking consent must be prepared to answer questions about how the body will appear after the post-mortem examination has been completed. The notion of "suffering" may in fact be based on an erroneous perception that the body will be damaged beyond recognition before the burial or cremation.

Fourthly, if this fear cannot be alleviated by discussion it is often possible to obtain permission for a "limited" post-mortem examination and the advice of the pathologist should

be sought. The idea of damage to the head may underlie refusal to give consent, and one might negotiate consent to an examination that specifically excludes examination of the intracranial contents. This is useful when, for example, there are specific pointers towards congenital heart disease or liver or kidney disorders. Information can also be obtained from needle biopsy of organs. If there is a suspicion of dysmorphism then examination of the body by a clinical geneticist is important, and this can be supplemented by blood sampling or skin biopsy for chromosome analysis and a radiological skeletal survey. Valuable bacteriological, biochemical, and toxicological information can be obtained by examination of appropriate body fluids. Finally, the placenta should not be neglected as an important source of information.

MALCOLM CHISWICK

Professor in child health and paediatrics

Saint Mary's Hospital,
Manchester M13 0JH

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Shared care in diabetes

Better evaluation is needed

Interest is increasing in the greater integration of primary and secondary health care,¹ and purchasers are exerting pressure to shift patients from secondary to primary care, partly for financial reasons and often regardless of effectiveness. Examples of such integration in managing chronic diseases are schemes of "shared" or "integrated" care—for example, for patients with diabetes, asthma, or hypertension. Such schemes are loosely characterised by joint participation of hospital consultants and general practitioners in the planned delivery of care and an enhanced exchange of information over and above routine discharge and referral letters.²

Despite the growing enthusiasm for these schemes, they have not yet received sufficient critical evaluation to justify national adoption. This has been recognised by the NHS research and development initiative, which has identified shared care as a priority area for research.

Most research attention has been devoted to shared care for patients with diabetes, and this has recently been the subject of an extensive literature review.³ This review identified five randomised controlled trials and several other comparative, longitudinal, and descriptive accounts of shared care. In none of the randomised controlled trials does shared care improve the clinical outcomes, compared with hospital care and in two of the studies where care was less structured it was associated with poorer care or outcomes. These findings are in line with those of an earlier review.⁴

Given the contradictory evidence on this topic and the importance of ensuring that policy is based on reliable evidence for research,⁵ shared care obviously needs further evaluation before it is widely adopted. In addition we need much better methods for evaluating different forms of care if the results are to provide useful and reliable information.

Even though the most reliable way of comparing the effectiveness of shared care with that of hospital based care is by performing a randomised controlled trial, the existing trials are hard to interpret for two reasons. Integrated care is used as a "black box," which has a different content in different studies. For example, this may vary from giving a general practitioner a protocol to patient held shared care record cards and a range of responsibility for decision making from the hospital, primary care professionals, and patients. Until we have clearer definitions of the key features of a programme of shared care,² evaluations will be of limited use, not least because those aspects of shared care that might be important in influencing process and outcome will remain unclear. Once the content of shared care is more clearly defined then trials can be set up to compare the efficacy of different elements of a scheme. A good example is the 2×2×2 design used by the Grampian asthma study of integrated cases, which allowed comparison of levels of education, use of peak flow self monitoring, and integrated versus conventional care.⁶ Such trial designs will provide more insight into which features should be incorporated into an optimal shared care programme and possibly codified in practice guidelines.

The results of studies may be difficult to interpret and generalise from because the studies used shared care schemes that either predated the study or were set up in volunteer practices, likely to be run by more enthusiastic professionals (who might achieve better results⁷). Such biases are important to assess so that, for example, doctors who are more interested in other clinical issues are not forced to deliver what might be poorer care on the basis of unrepresentative trials. It might be that the optimal policy is to let general practitioners decide in collaboration with their patients what scheme of