Medical staff did have input to unit

EDITOR,—In their paper on a midwife managed delivery unit V A Hundley and colleagues state that "there is no input to the midwives unit by medical staff."¹ In table IV, however, they state that 246 women received epidural or spinal anaesthesia during their stay in the unit. This implies that the women benefited from a 24 hour obstetric anaesthesia service. A recent survey of patients' knowledge showed that at least 21% of patients are unaware that their anaesthetist is a doctor.² Surely this does not also apply to our obstetric and midwifery colleagues.

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1 Hundley VA, Cruickshank FM, Lang GD, Glazener CMA, Milne JM, Turner M, *et al.* Midwife managed delivery unit: a randomised controlled comparison with consultant led care. *BMJ* 1994;309:1400-4. (26 November.)

2 Hume MA, Kennedy B, Asbury AJ. Patient knowledge of anaesthesia and perioperative care. *Anaesthesia* 1994;49:715-8.

not eligible for care in the midwives unit. The table shows the confidence intervals for important complications of labour. Only nine of the 15 third degree tears in the midwives unit group occurred during spontaneous delivery, compared with all of those in the labour ward group. The occurrence of third degree tears among normal deliveries shows a difference of 0.2% (95% confidence interval -0.3% to 0.7%).

For the 16% of women who required intra-partum transfer, continuity was assured and anxiety minimised by the named midwife continuing to provide care in the labour ward. We recognise the importance of evaluating women's perceptions of all aspects of this type of care, including transfer. A paper addressing these issues is in preparation.

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1 Newell DJ. Intention to treat analysis: implications for quantitative and qualitative research. *Int J Epidemiol* 1992;21: 837-41.

2 Pocock SJ. *Clinical trials: a practical approach*. Wiley Medical, 1991:182-3.

Socioeconomic differences in mortality

EDITOR,—I was interested to see that Glasgow shows a picture of mortality associated with deprivation similar to that in Buckinghamshire, an area not otherwise known for any resemblance to Glasgow.¹ In Buckinghamshire two groups of electoral wards have been identified, the most affluent (or least deprived) and the most deprived. The least deprived are those for which both the Townsend and the Jarman scores (calculated from census data for 1991, with Buckinghamshire taken as the mean) are in the lowest 20 of the scores for the 128 wards in Buckinghamshire. The most deprived are those with scores in the highest 20. There are 15 wards in each group. Seventeen per cent of the population live in the most deprived wards and 8% in the least deprived wards.

Standardised mortality ratios for all causes of death in people aged 15 to 64 for 1986-92 were 86 (95% confidence interval 76 to 96) for the least deprived wards and 111 (103 to 118) for the most deprived wards (Buckinghamshire=100). There were also significant and persistent differences over time in age specific death rates between the two populations for both sexes over 1986-92, and death rates at ages 15 to 64 have shown little or no fall in the most deprived wards, in contrast to those in the most affluent wards (table). Death rates for the commonest causes of death at different ages show wide differentials over this period, including a pronounced fall in accidental death at ages 15 to 24 among the most affluent and a sharp rise among the most deprived.

Death rates from all causes per 100 000 people aged 15-64 in most and least deprived areas of Buckinghamshire, 1986-8 to 1990-2

Population	1986-8	1987-9	1988-90	1989-91	1990-2
Men:					
Most deprived	338	343	337	333	354
Least deprived	244	220	207	198	205
Women:					
Most deprived	184	201	192	196	198
Least deprived	173	131	133	166	162

Socioeconomic differences in mortality have increased over recent years in an area associated in the public imagination with affluence and not only in Glasgow and the north of England.

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1 McCarron PG, Davey Smith G, Womersley JJ. Deprivation and mortality in Glasgow: changes from 1980 to 1992. *BMJ* 1994;309:1481-2. (3 December.)

Failing sick doctors

EDITOR,—Martin S Wolfson believes that we are failing sick doctors.¹ I wish to remind the profession of the purpose of the General Medical Council's health procedures. The aims of the procedures are to ensure that seriously ill doctors do not practise in such a way as to put patients at risk and to offer help to those doctors, including medical supervision, so that they can overcome their problems.

Wolfson says that he contacted the General Medical Council about a local colleague with an alcohol problem and criticises the council for requiring "specific information about incidents involving the practitioner," which he was not able to provide. There is good reason for this requirement. For the council's health procedures to be started it must receive information that is sufficient, firstly, to justify inviting the doctor concerned to agree to be medically examined and, secondly, for the medical examiners who examine on the council's behalf to reach an informed opinion about the doctor's fitness to practise. The examiners are asked to make recommendations for the future management of the doctor's case, including recommendations for any restriction on medical practice that may be appropriate. It would be difficult for them to do this without specific information about incidents that have given rise to concern.

Initiating the health procedures may have serious consequences for any doctor, and it would not be appropriate to do this unless there was clear evidence of a problem that was liable to put patients at risk and was not being handled adequately at a local level.

In the circumstances that Wolfson describes, when a general practitioner has concerns that a colleague may not be fit to practise but has no direct supporting evidence, he or she should relay those concerns to an appropriate person, such as the chairperson of the local medical committee or the medical adviser or director of the family health services authority. That person would be in a position to assess and collate whatever information may be available; to identify what steps, if any, had already been taken locally to help the sick doctor; and to consider whether to make a formal report to the General Medical Council.

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1 Wolfson MS. Failing sick doctors. *BMJ* 1995;310:527. (25 February.)

Difference in proportions of women with complications between the two groups and 95% confidence interval

Complication	Difference in proportions (%)	95% Confidence interval (%)
Third degree tear	0.5	-0.06 to 1
Meconium	0.3	-0.3 to 2
Pre-eclampsia	0.9	0.2 to 2
Preterm delivery	0.4	-2 to 1
Shoulder dystocia	0.5	-0.3 to 1
Undiagnosed malpresentation	0.3	-0.3 to 0.9
Other complications	1.1	-2 to 0.3