Sensitivity and specificity can both improve as more investigations are used

EDITOR—We wish to reply to Davie and McMurray's comments about our article on the assessment of acutely dyspnoeic patients with suspected heart failure; we did not see it before publication.¹ We too were surprised by the excellent sensitivity of clinical examination in our study. We suspect that all our patients with systolic dysfunction had advanced disease and that assessment by general practitioners before admission resulted in referral of only those with New York Heart Association grade III or IV heart failure.

Davie and McMurray criticise the sensitivities obtained when combinations of investigations were used in addition to clinical examination. The apparent misunderstanding relates to the fact that we used clinical examination *and/or* the various investigations (chest radiography, electrocardiography) in the detection of systolic dysfunction. The left hand column in table 2 in our paper shows the collection of investigations that were used to reach the diagnosis in each case, but the final diagnosis was based on the appropriate abnormality on clinical examination and chest radiography or electrocardiography. This is why sensitivity and specificity can both improve as more investigations are considered. We apologise if this was unclear from our table 2.

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1 Davie A, McMurray J. Investigation of left ventricular dysfunction in acute dyspnoea. *BMJ* 1997;315:604-5. (6 September.)

Voluntary agreement for tobacco advertising at retail premises not being adhered to

EDITOR—The voluntary agreement on tobacco products' advertising and promotion, dated 21 December 1994, has two clauses for retail premises, which came into force on 1 January 1997.¹ Firstly, the tobacco

industry undertook "to remove all external permanent advertising material at retail premises for all tobacco products ... by 31 December 1996." Secondly, "The companies will endeavour to ensure that their existing shop advertising material carries the health warnings prescribed by this agreement by 1 January 1997." The Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship confirmed (personal communication, June 1996) that health warnings such as "Smoking can cause fatal diseases" rather than "Smoking causes fatal diseases" would breach the voluntary agreement after 1 January 1997. We have monitored the compliance with these new clauses at off licences in the Borough of Solihull.

In April 1996 we visited all 56 off licences and recorded details of all external and internal tobacco advertisements. Seventeen had advertisements that would breach the voluntary agreement if still present after 1 January 1997. These 17 were revisited in April 1997. All 12 permanent external tobacco advertisements had been removed from six off licences (table 1). However, 11 advertisements with old health warnings remained ("Smoking can cause fatal diseases" (10 items), "Cigarettes can seriously damage your health" (one item)) (table 1); these were reported to the Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship. The reply from the committee, dated 4 June, indicated that eight advertisements had been removed, two items had been updated with new health warnings, and one item was an inadvertent breach (the retailer had covered the health warning), but none were considered to breach the voluntary agreement. We lodged an appeal with the committee, whose reply of 23 June reversed its decision and confirmed that the 11 items with old health warnings did indeed breach the agreement.

Annual surveys to monitor compliance with the voluntary agreement on tobacco advertising have been carried out since 1993 in the Borough of Solihull and have detected breaches (table 2).²⁻³ One possible explanation for the tobacco companies' failure to comply with one of the new clauses in the voluntary agreement is that the agreement is so complex that even the Committee

Table 2 Number of breaches and inadvertent breaches (fault of retailer) of voluntary agreement on tobacco products' advertising and promotion, from annual surveys in Borough of Solihull

Year	Site	No of sites	Breaches	Inadvertent breaches
1993	Newsagents	84	10	5
1994	Motor show at National Exhibition Centre	1	3	0
1995	Petrol stations	40	1	0
1996	Off licences	55	0	5
1997	Off licences	17	11	0

for Monitoring Agreements on Tobacco Advertising and Sponsorship is not clear as to what constitutes a breach.

The breaches in Solihull and other localities⁴ make it imperative that the government achieves its proposal to ban tobacco advertising, sponsorship, and promotion. A voluntary agreement does not provide adequate protection for young people.

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1 Department of Health. *Voluntary agreement on tobacco products' advertising and promotion*. London: DoH, 1994.

2 Robertson W, Field NJG, Bird C, Parfitt DE. Voluntary agreement on tobacco advertising. *BMJ* 1995;310:124.

3 Robertson W, Archer P, Jeffreys W, Parfitt D, Field N. Survey of tobacco advertising and display of the "under-16" sign: influencing compliance with the voluntary agreement. *Health Educ J* 1996;55:382-8.

4 Mindell JS. The UK voluntary agreement on tobacco advertising: a comatose policy? *Tobacco Control* 1993;2: 209-14.

Epidural anaesthesia does not cause long term backache

EDITOR—MacArthur et al comment¹ on our editorial on back pain, pregnancy, and childbirth. In the editorial we indicated that no prospective study has shown a link between epidural analgesia in labour and long term backache, while referring to their study, which did suggest a link,² as retrospective. We are sorry that this has caused concern. In our editorial we pointed out that prospective studies consistently show an incidence of backache during pregnancy of around 50%. Yet in the survey of women delivering in Birmingham Maternity Hospital over eight years only 9% recalled having had backache during pregnancy.² Our own retrospective survey found half the expected rate of gestational backache.

We are aware of the considerable effort made to avoid bias in the Birmingham survey. While data were collected at delivery for all women in Birmingham, recording of long term symptoms required recollection for up to nine years. Though no evidence of

Table 1 Tobacco advertising material at 17 off licences in April 1996, and results of follow up visit in April 1997 to monitor compliance with new clauses of voluntary agreement of 1 January 1997

Advertising affected by new clause of voluntary agreement	Initial survey April 1996	Follow up survey April 1997
Permanent external tobacco advertisements	6 Full window dressings	All removed
	4 Fascias	
	1 Awning	
	1 Illuminated hanging sign	
Tobacco advertisements with "old" health warnings	9 Showcases	7 Showcases—for Benson and Hedges (5), Marlboro, Silk Cut
	3 Open/closed signs	3 Open/closed signs—advertising Embassy (2), Benson and Hedges
	1 Window bill	1 Window bill—advertising Raffles
	1 Swinging sign on pavement	Removed
	1 Waste bin	Removed

biased recall could be detected, the fact that about two fifths of women must have forgotten that they had had backache during pregnancy casts doubt on the accuracy of these findings. When we conducted a fully prospective survey the appropriate incidence of gestational backache was elicited, and the difference in postpartum backache between the epidural and non-epidural groups disappeared.³ Moreover, the incidence of backache was almost identical in epidural and non-epidural groups in our own and other prospective studies, including a randomised study in which >400 women have been recruited so far.⁴ This suggests that any undetected difference between the groups is unlikely to have been great. Not surprisingly, those attempting to establish a link have failed to find any characteristic of the epidural (duration, difficult insertion, motor block, etc) that was predictive of backache.^{3, 5}

It should not be overlooked that all the women in the Birmingham survey who had received epidural analgesia in labour (but not all of those who had not) were questioned daily about their immediate postpartum experience throughout their stay in hospital, as part of this painstaking ongoing audit. Such close questioning of one section of the study population might affect recall.

Women are inclined to fear the worst, and our desire to reassure them stems from compassion and conviction rather than self justification.

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- 1 MacArthur C, Lewis M, Knox. Finding of relation between epidural anaesthesia and long term backache remains valid. *BMJ* 1997;315:679. (13 September.)
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- 5 MacArthur C, Lewis M. Anaesthetic characteristics and long-term backache after obstetric epidural anaesthesia. *Int J Obstet Anesth* 1996;5:8-13.

Over half of proposed indicators for hospitals' performance relate to surgery

EDITOR—Jacqui Wise's news article gives a list of the proposed indicators for hospitals' performance.¹ While individually these indicators may have merit, collectively they could have an unintended consequence. Of the 15 indicators, over half (eight) focus on adverse events after surgery. Others deal with fractured neck of femur (two), stroke (one), heart attacks (one), and dilatation and curettage in women under 40 (one). Only two are likely to cover more than one specialty: emergency readmission within 28

days of discharge, and adverse events related to drug use.

Together these indicators seem unlikely to give a representative picture of inpatient hospital care, but they are likely to be studied carefully by chief executives and trust boards. Those who are anxious to improve their rating in the league tables might decide that surgery in particular, and one or two other specialties as well, could benefit from increased funding.

The value of performance indicators has been challenged on many grounds.²⁻⁴ Influencing the distribution of resources on grounds other than healthcare need may be a new hazard of these measures.

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- 1 Wise J. Goodbye to the "hello nurse" in casualty departments. *BMJ* 1997;315:145. (19 July.)
- 2 Davies H, Crombie IK. Assessing the quality of care. *BMJ* 1995;311:766.
- 3 McKee M. Indicators of clinical performance. *BMJ* 1997;315:142. (19 July.)
- 4 Davies H, Crombie IK. Interpreting health outcomes. *J Eval Clin Pract* (in press).

User fees would both yield money and encourage more responsible use of NHS

EDITOR—Creese attacks user fees but fails to make a proper case against them in Britain, basing his arguments predominantly on evidence from countries in the second and third worlds.¹ Creese's statements about the disadvantages of user fees may be true for underdeveloped nations, where absolute poverty is common and the main diseases are infections and illnesses associated with real deprivation. The situation in first world nations is different. Both the media and politicians have encouraged what is effectively a disengaging of demand from absolute need, at least as far as primary care is concerned. As a result, demand spirals upwards while real need increases little, if at all. Ham has described the situation in Singapore, where user fees are the key to reducing demand in a first world system.² User fees are also used extensively in western European countries to reduce demand.

Creese believes that supporters of user fees are attracted to them because they will simply reduce total demand. For general practitioners in Britain the point is that user fees will not only reduce total demand (which Creese concedes) but also particularly reduce inappropriate demand, allowing general practitioners to provide a better service for their needier patients.

Creese complains that user fees will bring in little extra revenue and that they do not reduce costs overall. But the aim is not to make the NHS cheaper. It is to bring in a bit more money and to encourage more responsible use of the service, thus allowing the NHS to be more effective. Goldsmith has shown that user fees might increase NHS funding by 5%, although his suggested fees

are low and he excludes several services which should be included.³ Nevertheless, 5% is better than nothing.

Finally, Creese argues that user fees increase inequity. He cites evidence from the second and third worlds, where fees are levied on the very poor. In Britain, user fees could be combined with a simple exemption system for poor people, linked to benefits for those with low incomes. It is better for all users that there is slightly less than perfect equity in a system that copes with the reasonable demands placed on it, rather than perfect equity in a system overwhelmed by unreasonable demands. In general practice especially, user fees would achieve the necessary balance.

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- 2 Ham C. Learning from the tigers: stakeholder health care. *Lancet* 1996;347:951-3.
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Mental health and the law

Parental consent to treatment is needed for those aged 16-18 who are incompetent

EDITOR—Like many practising clinicians, Barker is under the impression that the upper age limit at which legal consent to treatment can be given by a person with parental responsibility is 16.¹ In fact, it is 18, the age of majority.² It is true that children who have attained the age of 16 and are competent can give effective consent to any medical or surgical treatment, and parental consent is not required.³ However, for young people aged between 16 and 18 who are incompetent to give consent due to mental incapacity, anyone with parental responsibility can give legal valid consent to medical treatment. The consent from those with parental responsibility may, on rare occasions, override the refusal to treatment by the young person.^{4, 5}

Knowledge of this is relevant and important for clinicians seeking to give physical medical treatment to mentally incompetent young people aged between 16 and 18 when the treatment cannot be given under the Mental Health Act 1983.

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- 1 Barker A. ABC of mental health: mental health and the law. *BMJ* 1997;315:590-2. (6 September.)
- 2 Re R (a minor) (wardship: medical treatment) (1992) 3 WLR 592.
- 3 *Family Law Reform Act 1969*. London: HMSO, 1969: section 8.
- 4 Re W (a minor) (medical treatment: court jurisdiction) (1992) 4 All ER 627.
- 5 South Glamorgan County Council v W and B (1993) 1 FLR 574.