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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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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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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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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