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.

F Reynolds *Emeritus professor of obstetric anaesthesia*
UMDS, St Thomas's Hospital, London SE1 7EH

R Russell *Consultant anaesthetist*
John Radcliffe Hospital, Oxford OX3 9DU

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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.

Iain K Crombie *Reader in epidemiology*
University of Dundee, Ninewells Hospital and Medical School, Dundee DD1 9SY

- 1 Wise J. Goodbye to the "hello nurse" in casualty departments. *BMJ* 1997;315:145. (19 July.)
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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.

Jonathan Reggler *General practitioner*
The Doctor's House, Victoria Road, Marlow, Buckinghamshire SL7 1DN

- 1 Creese A. User fees. *BMJ* 1997;315:202-3. (26 July.)
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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.

Wai-Ching Leung *Senior registrar in public health medicine*
Department of Public Health, Sunderland Health Authority, Sunderland SR3 4AF

- 1 Barker A. ABC of mental health: mental health and the law. *BMJ* 1997;315:590-2. (6 September.)
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- 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.

Author's reply

EDITOR—Leung's comment is useful, and anyone treating this age group will find Jones's book helpful.¹ To summarise Jones, a child under 16 can consent to treatment (be "Gillick competent," a fact reiterated in *Re R*).² However, "no minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and *a fortiori* a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor" (Lord Donaldson in *Re W*).³

The approach that a clinician should adopt when assessing whether a child is Gillick competent was identified in the following passage from Lord Donaldson's judgment in *Re R*: "What is really being looked at is an assessment of mental and emotional age, as contrasted with chronological age.... What is involved is not merely an ability to understand the nature of the proposed treatment... but a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects, and equally important, the anticipated consequences of failure to treat." Such competence "is a developmental concept and will not be lost or acquired on a day-to-day or week-to-week basis. In the case of mental disability, that disability must also be taken into account, particularly when it is fluctuating in its effect."

Ann Barker *Consultant forensic psychiatrist*
Bracton Centre, Oxleas NHS Trust, Bexley, Kent
DA5 2BW

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All women with abnormal genital tract bleeding should have gynaecological examination

EDITOR—Everett is concerned that "many thousands of women who miscarry may be excluded from important health planning processes," and he attempts to quantify and monitor miscarriage rates.¹ He may be setting a wrong precedent by relying on ultrasonography and ignoring the value of a gynaecological examination.

All women with abnormal genital tract bleeding should have a gynaecological examination; this includes women who are pregnant. The possibility of a local cause for such bleeding should be excluded by a speculum examination aided by a good light source. Furthermore, digital examination distinguishes the different forms of miscarriages (spontaneous abortions) into threatened abortion, incomplete abortion, and

inevitable abortion based on the dilatation (or not) of the cervix.²

Recently, three pregnant women in my unit underwent radical hysterectomy because of cervical cancer discovered in pregnancy. In two cases the presenting symptom was abnormal bleeding in pregnancy; one patient was under 20 weeks' gestation. Ultrasonography was of little help in the patients' management and possibly hindered early treatment because it generated a false sense of security by showing "placenta in the fundus" and "viable fetus seen."

Furthermore, a history of a recent smear test might misguide clinical judgment, as cervical carcinoma has been diagnosed in women who are compliant attenders of cervical screening programmes (interval cancer)³; the result of a smear test may be negative despite the presence of invasive cervical cancer.⁴ However, those women at greatest risk of cervical cancer are the ones most likely to fail to accept an invitation for screening.⁵

Kirki J Chin *Senior registrar in obstetrics and gynaecology*
Department of Obstetrics and Gynaecology,
University Hospital of Wales, Cardiff CF4 4XW

- 1 Everett C. Incidence and outcome of bleeding before the 20th week of pregnancy: prospective study from general practice. *BMJ* 1997;315:32-4. (5 July.)
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Physician assisted suicide, euthanasia, and withdrawal of treatment

Full debate is needed in Britain...

EDITOR—In view of the recent conclusion by the BMA that the practice of euthanasia should not be sanctioned¹ and the admission by some doctors of their own practice,² it is important that the central issues of the debate over euthanasia and assisted suicide are fully clarified.

The legal framework, although extremely important in regulating practice, is unlikely to be able to resolve the individual moral dilemma presented to a practitioner who is contemplating euthanasia or assisted suicide for a patient.³ It is important to differentiate legal from moral frameworks in this respect. Legal frameworks are designed to enforce a baseline of reasonable behaviour in society. If individuals behave in an illegal way then they can expect to receive punishment for their actions. Moral frameworks, in contrast, are meant to achieve more than this. They are concerned not only with minimal standards of behaviour but also with ideals. In short, moral frameworks can inform how we ought to behave as well as how we must behave if we are not to be punished. Clearly, in some cases of euthana-

sia and assisted suicide, practitioners believe that they ought to help suffering patients but are not legally permitted to do so.

The two main moral arguments used to condemn euthanasia and assisted suicide are the "doctrine of double effect" and the "slippery slope" argument.⁴ The doctrine of double effect essentially differentiates between the morality of the action of a doctor who intends rather than foresees a patient's death. For example, pain relief for a terminally ill patient is seen as morally acceptable, whereas an injection of potassium cyanide is not.⁵ In normal medical practice, however, the distinction between intending and foreseeing death is far from clear. There are occasions when doctors give patients pain relief knowing that their actions will dramatically shorten the patients' lives. In short, how much morphine must a doctor give a patient before the action becomes morally indefensible?

The other argument against euthanasia and assisted suicide is that if it were to be legalised, patients would be open to abuse and doctor-patient trust would substantially decrease. In view of the recent admissions by doctors that they have practised euthanasia, we must now question whether a regulated framework would protect patients more than the current official and legal ban, which is not adhered to. A full debate on the moral issues of euthanasia and assisted suicide is now needed between the public and professionals.

Peter Bradley *Specialist registrar in public health medicine*
Northamptonshire Health Authority, Northampton
NN1 5DN

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... and Argentina

EDITOR—Further to the editorial by Churchill and King on physician assisted suicide, euthanasia, and the withdrawal of treatment, we wish to report data on physician assisted death in Argentina.¹ We assessed doctors' attitudes about decisions not to treat, physician assisted suicide, and the ending of life without an explicit request from the patient. We interviewed young Argentinean doctors who attended the sixth national congress of medicine organised by the Argentinean Society of Medicine in November 1996 in Argentina. To be eligible, doctors had to be ≤ 34 years old and to have practised medicine for ≤ 10 years.

Of the 407 doctors who participated in the survey, 287 supported the withdrawal of life sustaining interventions; of these, 145 had already withdrawn such interventions. A quarter (97) of the doctors supported physician assisted suicide. Almost two thirds of the respondents (257) supported active euthanasia in terminally ill patients unable