of parenting in school; support groups and phone lines for parents; a change in the law to outlaw physical punishment; and recognition that corporal punishment is a human rights issue

The Institute for Public Policy Research has recommended the repeal of the provisions of the Children and Young Persons Act 1933 that allow "reasonable chastisement" and an additional provision to prohibit corporal punishment.[15] An alliance of over 220 organisations, including five royal colleges ("Children are unbeatable"), also believes that the defence of "reasonable chastisement" should be removed, thus giving children the same protection as adults under the law on assault. But the Department of Health does not include this measure in its consultation paper, claiming that "it would be quite unacceptable to outlaw all physical punishment of a child by a parent." The government has agreed to amend the law but recommends that legislation should outline the factors that courts should take into account in considering whether physical punishment has been moderate and reasonable following a ruling by the European Court of Human Rights that British law inadequately protects children. It is disappointing that the British government has chosen not to follow the Swedish example of enlightened thinking.

There can be no more important activity within society than bringing up our children, and discipline is crucial to this. Parents need detailed and consistent information and support. Barnardo's, EPOCH (End Physical Punishment of Children), Save the Children, and the National Society for the Prevention of Cruelty to Children already provide guidance on positive discipline without smacking. The Health Education Authority advises on positive parenting and against smacking in its book *Birth to Five*, given to every new parent. These and other initiatives need to be built into a public education campaign of the kind that has accompanied legal reform in other European countries.

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Keeping patients out of hospital

Patients like it

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Secondary care consumes a large proportion of the healthcare budget and the need to spend wisely is ever pressing. The prevailing political philosophy of the past few decades in Britain has meant that efficiency and effectiveness have become part of NHS vocabulary. Doctors have probably been better at adopting new practices than they have been at dropping outdated methods, but in both areas there is room for improvement. Moreover, government funding is unlikely to improve unless the profession can show not only its commitment to best practice but also its ability constantly to examine its procedures and implement improvements or abandonment when necessary. Clinical governance should nourish this process, but if success is to be achieved it will come from leadership, drive, and initiative from within the profession. The move to keep patients out of hospital is clearly part of the search for efficiency and effectiveness, but it is important to know what patients think of it and that clinical effectiveness is maintained.

In a health service substantially driven by emergency and urgent pressures, elective waiting lists have functioned in the past as a safety valve. Now that waiting list targets limit that flexibility, optimal bed management becomes essential. In fact the bed base in many elective specialties has halved over the past 15 years, and it is hard to recall that patients undergoing minor procedures such as dilatation and curettage used to be admitted for up to two nights. The move, initially to day care and then to ambulatory or even office care, has become inexorable.

In some cases procedures have become virtually obsolete. Dilatation and curettage itself, the most common gynaecological procedure a decade ago, has been replaced by endometrial outpatient biopsy or by hysteroscopy. Even for major surgery, preassessment clinics now enable same day admission; and hospital at home[1] and early discharge schemes mean that patients may be home within two to three days of their operation, albeit under hospital supervision. The shift to outpatient diagnostics has produced increasing opportunities for "one stop" clinics. Gynaecological conditions such as premenopausal and postmenopausal bleeding are particularly suitable for such manage-

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ment, and new thin diameter and flexible hysteroscopes aid this approach. One stop clinics reduce the need for patients to reattend for investigation, which not only uses hospital services efficiently but also minimises the burden on patients, their employers, and their families by valuing patients' time.

Patients should and do have a much greater voice in the way care is delivered than used to be the case. National initiatives to assess patient satisfaction[2] are important, but randomised trials such as that reported in this issue by Kremer and colleagues (p 279)[3] will carry weight with the profession and add an important third pillar to those of efficiency and effectiveness. This study provides fresh evidence that outpatient hysteroscopy procedures meet with high patient satisfaction. Also, significantly, when patients were asked at study entry, 52% opted for an outpatient procedure, 22% expressed no preference, and only 25.9% opted for an inpatient procedure. This reflects the experience in centres where outpatient hysteroscopy has become standard practice and which have published large series.[4 5] At Leicester our service allows an ultrasound examination, outpatient hysteroscopy, and biopsy to be performed in one session, with the biopsy specimen processed and reported on the same day. Patient satisfaction with this model of care is very high (unpublished results).

The commonest indication for hysteroscopy is the investigation of abnormal uterine bleeding. Less well established here is the role of ultrasound or sonohysterography.[6] However, endometrial changes require histological examination, and, although hysteroscopy followed by biopsy may, through allowing direct visualisation, enhance the accuracy of blind endometrial biopsy, this has not been subject to clinical trials. On the other hand, while small diameter hysteroscopes are associated with higher patient satisfaction, we found their accuracy in diagnosing intrauterine structural lesions to be limited by the smaller visual field and by the difficulty of achieving adequate distension (submitted for publication). Thus although the evidence presented by Kremer et al supports the practice of performing hysterosopy as an outpatient procedure, further studies are needed to determine the situations in which hysteroscopy might be useful, and to inform purchasers of its utility.

There also remains the issue of transferability. The factors that drive or inhibit the implementation of change in practice are complex, and the best champions of new procedures are likely to be published authors. Peer reviewed articles and posters and presentations at scientific meetings are an important means of disseminating new ideas but do not contain any inbuilt mechanism to encourage uptake at other centres. Among the many levers for change, public opinion is a powerful force and where evidence exists that satisfaction is significantly enhanced by changed practice we owe it to our patients to ensure that such change happens. Commissioners of health care and gynaecologists have an opportunity now to respond positively to this evidence.

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Psychosocial factors in selection for liver transplantation

Need to be explicitly assessed and managed

The findings of an opinion poll commissioned to examine liver transplant selection preferences among the general public, general practitioners, and gastroenterologists were published in the *BMJ* last year.[1] Vignettes of eight potential candidates were given; four livers were available. The constituencies agreed the bottom of the pecking order—a prisoner, preceded by a man with alcoholic liver disease—but if only two candidates were to be chosen, those selected by the specialists (a teenager with an impulsive paracetamol overdose and a woman who had acquired viral hepatitis through drug abuse 20 years before) differed from the public's choices (a baby and a pregnant woman with a cancer that offered little hope of prolonged life). The authors concluded that selection was more emotionally driven for the public, although varying degrees of prejudice is perhaps a more accurate description. In the face of such apparent prejudices not being confined to the public, what can we do to ensure that livers are allocated "fairly"?

The scenario may have been artificial, but it did reflect the reality that demand will increasingly outstrip supply of livers: the latest figures show a 23% increase in the waiting list against no change in the number of transplants during the first quarter of 1999 compared with 1998.[2] Despite measures to eke out resources such as using living donors and split grafts, the waiting list is set to grow, condemning patients and their families to this awful limbo and leading to more deaths and withdrawals as the wait lengthens.

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