CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Time to abolish cremation fees

SIR,—Originally cremation fees were a small token for the act of certifying that a person had died of natural causes, but we think that they have got out of hand. They are now an unwelcome tax on the disposal of the dead, the focus of income tax related discontent among hospital doctors, a source of corruption, a nuisance to undertakers, a waste of administrative time, an unearned income in the truest sense, an inefficient guard against criminal death, and ultimately a misapplication of nearly £10m annually. This last calculation is based on a 50% cremation rate for the 582 000 deaths in England and Wales in 1982.

Many hospitals do not charge cremation fees for certificates on babies who are stillborn or who die soon after birth, and we suggest that the fees should also be abolished for older people. A simpler system should be started for protection against unnatural death if this method of protection is still considered necessary.

The amount of the fee is entirely arbitrary. Currently the BMA recommends £33·60, but a signatory can demand what he wants. Senior undertakers tell us that some doctors charge up to £50 for a form C signature. Maybe they do this as a deterrent to being asked again, but there is no doubt that the families of the dead greatly resent having to pay what appears to them an unnecessary sum for a piece of paper that essentially duplicates the death certificate.

Although the signatory to the form C declares that he or she has carefully examined the body externally, we wonder how many bodies really are looked at properly. This particularly applies to hospital deaths where no necropsy has been performed. To go into the mortuary, open the fridge, pull out the appropriate body tray, uncover the body, look carefully for signs of unnatural—that is, non-iatrogenic—injury, and possibly turn the body over in the search for the knife in the back are bold moves and we suspect are rarely undertaken. How much simpler to assume from a nod from the mortuary technician that all is well, repeat what is written in form B, and collect the cash. What protection for the public then?

We pass over the uneven distribution of cremation fees in respect of different medical specialties and the potential rancour over who should be on a form C signing list (how easy to be on good terms with the mortuary technicians—for a consideration). In a way, we pathologists have a similar local problem with the distribution of coroners' necropsies and fees. More pressing at the moment is the galvanic effect on doctors of the awakening of the Inland Revenue to the possible non-payment of tax on cremation fees. Some particular problems are presented. If deductions from the fees are made, for example, to the doctors' mess or to the mortuary technicians how is the tax position of the signatory affected? How much should he declare—what he actually received, or what he thinks the Inland Revenue thinks he received from their (real or threatened) inspection of the records at crematoria? And what is the correct procedure for those senior pathologists who sign cremation forms C on behalf of their junior colleagues who have carried out a necropsy—who gets the money and who pays the tax? These problems have not been resolved.

We do not write from a sense of personal injustice: like most hospital doctors we sign cremation forms and take the money. We think, however, that the current cremation certification process is not a suitable safeguard against unnatural death. It is a curiously inequitable redistribution of wealth from the less affluent to the more affluent for a service that is not deserving. Daily we sign all sorts of documents as part of the responsibilities of our jobs; so what is the ethical basis for charging a large fee for this particular form? If it is to be regarded as only another perk of the job for doctors and mortuary technicians (we note that undertakers do not make a profit on the transaction when they hand over the fees on behalf of the estate of the deceased) then surely there are more sensible ways of effecting a pay rise.

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Which deliveries require paediatricians in attendance?

SIR,—We agree with Dr R A Primhak and others (7 July, p 16) that although theoretically desirable it is impracticable to have someone skilled in neonatal resuscitation present at the delivery of every baby. Even if attendance is limited to complicated deliveries a considerable logistic burden is imposed on the paediatric services. With a view to reducing this burden we reviewed our guidelines for paediatric attendance in the delivery room. We studied the records of 3225 mothers delivering in Aberdeen Maternity Hospital over one year, representing over 99% of the deliveries from mothers resident in Aberdeen city and suburbs. Included in this group were 10 pairs of twins so the total number of infants delivered was 3235.

Although a low Apgar score correlates with the biochemical changes of birth asphyxia, it does not necessarily indicate the need for paediatric attendance at the delivery. We therefore chose to define

asphyxia as a delay of two minutes or longer to sustained respiration (hoping thereby to include all infants likely to require active resuscitation), or the performance of active resuscitative measures (excluding mucus extraction or the giving of oxygen at ambient pressure).

Asphyxia so defined occurred in 437 infants—that is, in 13·5% of all deliveries. Using the χ^2 test with Yates's correction the incidence of asphyxia in various subgroups was compared with the overall rate of asphyxia. Poisson's test was applied to groups of five or less.

The overall incidence of birth asphyxia in infants delivered between 26 and 36 weeks' gestation was significantly increased at 52/195 (27%) ($p<0·2$), but it can be seen from table I that preterm infants delivered from 35 weeks onwards did not have a significantly increased incidence of asphyxia. The complications of pregnancy listed in table II were associated with a significant increase in the incidence of asphyxia, but the medical complications listed in table III were not.

TABLE I—*Influence of gestational age on incidence of birth asphyxia*

Gestational age (weeks)	No of babies	No of babies with asphyxia (%)	p
26-32	30	15 (50)	<0·002
33-34	40	13 (33)	<0·002
35-36	126	24 (19)	NS
37-38	497	71 (14)	NS
39	734	98 (13)	NS
40-41	1515	175 (12)	NS
42-43	104	15 (14)	NS
Uncertain	179	26 (14·5)	NS

NS = not statistically significant.

TABLE II—*Influence of complications of pregnancy on incidence of birth asphyxia*

Complication of pregnancy	No of babies	No of babies with asphyxia (%)	p
Severe pre-eclamptic toxaemia	20	12 (60)	<0·002
Moderate pre-eclamptic toxaemia	66	21 (32)	<0·002
Other hypertension	558	96 (17)	<0·05
Placenta praevia	20	9 (45)	<0·002
Obvious accidental haemorrhage	5	3 (60)	<0·05
Other antepartum haemorrhage	127	31 (24)	<0·002

TABLE III—*Complications of pregnancy with no statistically significant effect on incidence of birth asphyxia*

Complication of pregnancy	No of babies	No of babies with asphyxia (%)
Heart disease	50	8 (16)
Diabetes	25	5 (20)
Previous major gynaecological surgery	26	3 (12)
Haemorrhage before 29th week	516	84 (16)
Multiple pregnancy*	10	3 (30)

* See text for details of additional twin deliveries.

Operative, instrumental, or abnormal deliveries of all types were associated with an increased incidence of asphyxia (table IV), and there was no significant difference in the incidence of birth asphyxia between babies delivered by emergency (63/118; 53%) and elective (47/94; 50%) caesarean section or caesarean section after a trial of labour (15/25; 60%). The presence of antenatally detected fetal distress was associated with an increased incidence of birth asphyxia (288/1371; 21%) ($p<0·002$).

Because of the unusually low incidence of twin deliveries in the study population we reviewed the records of 36 mothers who had delivered twins during the previous year, giving us a total of 46 twin pregnancies. There was a significantly increased incidence of asphyxia in twins (21/92; 23%) ($p<0·05$); for twin pregnancy the figure is of course 46%.

TABLE IV—*Influence of mode of delivery and presentation on incidence of birth asphyxia*

Mode of delivery	No of babies	No of babies with asphyxia (%)	p
Caesarean section	237	125 (53)	<0·002
Forceps—all cases	409	96 (23)	<0·002
Forceps—with general anaesthesia	56	18 (32)	<0·002
Forceps—without general anaesthesia	353	78 (22)	<0·002
Breech	90	39 (43)	<0·002
Occipitoposterior presentation	95	27 (28)	<0·002
Other abnormal presentation	45	18 (40)	<0·002
Uncomplicated vaginal delivery	2359	132 (6)	<0·001

The traditional indications for paediatric attendance at virtually all types of abnormal delivery remain valid; even in late preterm delivery, in which we failed to show an increased incidence of asphyxia, there are other good reasons for paediatric attendance. As can be seen from table IV, there is an appreciable risk of unexpected asphyxia even after uncomplicated vaginal delivery, and it should remain our long term goal to ensure that skilled resuscitation is immediately available for every baby. This need not necessarily be provided by doctors.

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SIR,—Two important points are emphasised in the paper by Dr R A Primhak and others. Firstly, they identified successfully the factors most likely to increase the need for resuscitation and then linked these with the need for a paediatrician to be present at the delivery to perform the resuscitation. I do not think it matters who performs the resuscitation, however, whether it is a doctor, nurse, or the Lone Ranger, provided that it is successful.

All that is required is effective mask and bag ventilation after clearing the airway. Intubating babies at delivery is never an emergency and undue emphasis is placed on slick intubations, at the expense of the more simple technique. It takes very little time to teach a nurse how to clear the airway and bag a baby so that good chest movements result. The problem, as with all practical procedures, is to use the technique correctly.

Secondly, with scarce resources more efficient use of them is needed. Presumably, the resource is paediatric senior house officers. Yet with medical unemployment increasing each year, this paper must seem ironic to some of your readers.

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Bran yesterday . . . bran tomorrow?

SIR,—The review of bran and dietary fibre by Dr Rodney H Taylor (14 July, p 69) is a useful introduction to a large problem. Regrettably the article reflects difficulties inherent in reviewing any subject of which the literature has not been collected and classified. The dietary fibre bibliography compiled by one of us (HCT) closed in 1977.[1] *Index Medicus* started to list articles on dietary fibre only in 1982. Recent British bibliographies on dietary fibre close the four year gap and have over 2000 citations.[2-4] Only two of 25 articles cited in Dr Taylor's review came from the 1980s. It is impossible to write an up to date review without consulting this vast literature; fortunately in the bibliographies referred to the citations are classified in terms of the various diseases.

The crucial factor in this whole study of diet and disease was not even mentioned by Dr Taylor. This is the extent to which the alleged list of the diseases of civilisation (now called Western diseases) has stood the test of time. A provisional list of 25 Western diseases was sent recently to 26 doctors nearly all of whom had been working in medical schools of five continents. They were asked for evidence of the rarity of these diseases in their primitive communities and whether incidence increased during westernisation of the diet and lifestyle; there was a strong consensus of agreement on both points.[5] A comparable list was published 25 years ago.[6]

The enormously important implications of this observation have been neglected until recently but can no longer be ignored. Although a high fibre diet coincides with a low incidence of nearly all these diseases in Third World communities we have long ago abandoned any idea that it is the only factor in all these diseases.[7 8]

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[1] Trowell HC. *Dietary fibre in human nutrition: a bibliography*. London: John Libbey, 1979.
[2] Avenell A, Leeds AR, Trowell HC. Dietary fibre in human nutrition. *Journal of Plant Foods* 1982;4: 145-77, 199-232.
[3] Avenell A, Leeds AR, Trowell HC. Dietary fibre in human nutrition. *Journal of Plant Foods* 1983;5: 81-112.
[4] Avenell A, Leeds AR, Trowell HC. Dietary fibre in human nutrition. *Journal of Plant Foods* 1984 (in press).
[5] Trowell HC, Burkitt DP, eds. *Western diseases: their emergence and prevention*. London: Edward Arnold, 1981.
[6] Trowell HC. *Non-infective disease in Africa*. London: Edward Arnold, 1960:465-6.
[7] Burkitt DP, Trowell HC, eds. *Refined carbohydrate foods and disease: some implications of dietary fibre*. London: Academic Press, 1975.
[8] Trowell HC, Burkitt DP, Heaton KW, eds. *Dietary fibre, fibre-depleted foods and disease*. New York and London, Academic Press, 1985 (in press).

SIR,—As Dr Rodney H Taylor says, the fibre hypothesis has survived—indeed, it is flourishing. But to understand it fully one must go beyond the idea that a high intake of dietary fibre is protective against disease. This is a valid concept, but it is only one side of the coin.

Cleave, who did more than anyone to start off the fibre story,[1 2] viewed dietary fibre as something which should be left intact in our food not as something which should be added to it. Fibre depleted food, or refined carbohydrate as he called it, was intrinsically harmful. It was harmful in several ways. Certainly it would reduce intake of dietary fibre if the alternative was a fibre rich product, but this is not necessarily the case. The eskimo who switches from seal meat and fish to a Western diet may even increase his fibre intake since some fibre depleted products like white flour still contain appreciable amounts of fibre. But the eskimo still suffers the intrinsic harmful