

Resource restraints: what do we tell our patients?

EDITOR,—Recently there has been a progressive contraction of the resources made available for health care in New Zealand, a trend that many other countries including the United Kingdom have experienced. These financial constraints have led to increasing instances of treatment rationing or compromise. We wish to inform our British colleagues of a ruling by a New Zealand hospital ethics committee that has been lauded in the New Zealand media as a landmark decision. The Wellington Area Health Board Ethics Committee was asked two questions:

(1) Is it ethically justified in times of resource constraint to compromise the treatment of one group of patients for the benefit of another? The committee's clear advice was that such rationing of treatments (euphemistically termed prioritisation) was appropriate. However, they also advised that if it was perceived that the service was "unduly penalised in the overall structure" then the instigator of the resource constraint (management) should be approached for a review.

(2) In the situation where the optimum treatment for a patient is compromised because of fiscally directed resource constraints, is the clinician ethically required to inform the patient of this and of the possible consequences as they relate to increased side effects and reduced effectiveness of treatment? The committee answered, "The issue of informing patients comes under the principle of veracity or truth telling . . . it is important that the patient be given the truth about the parameters of treatment available . . . and the fact you would like to do more but within constraints it is not possible."

We believe that the committee's replies have important implications for all contemporary clinical practice. We suggest that the practice of clinicians concealing from the patient the consequences of treatment compromise is common and has developed because of a humanitarian concern that such information serves no therapeutic benefit and could probably increase the patient's anxiety. The Wellington Area Health Board Ethics Committee has indicated that this approach is no longer acceptable. We agree, and we feel that this approach is an example of the type of paternalism that public opinion in New Zealand has repeatedly denounced in recent times. We imagine that the same applies in the United Kingdom.

This ethical ruling is a landmark decision that instructs clinicians to be open and honest with their patients concerning issues pertaining to treatment rationing. By citing "reasons of corporate and competitive confidentiality" (the current management phrase in New Zealand) administrators may attempt to gag clinicians faced with resource constraints. The ruling of the ethics committee protects those who speak out from the

offensive label of "opportune shroud-wavers out for their own gain."

It is a chilling thought that clinicians believing that concealment is humanitarian are in effect colluding with the aims of administrative systems that are developing rationing covertly.

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Routine ultrasound scanning in pregnancy

The benefits are clinical . . .

EDITOR,—We agree with Heiner Bucher and Johannes Schmidt that patients who are having an ultrasound scan at 18-20 weeks' gestation should be informed about the purpose of the scan (and give written consent), and that a scan should not be performed in those who do not consent to screening for malformations.¹ The conclusion that routine ultrasonography does not improve the outcome of pregnancy in terms of an increased number of live births or reduced perinatal morbidity creates some confusion.

On the one hand the paper agrees that routine ultrasound scanning in pregnancy is effective in dating the pregnancy and in detecting fetal growth retardation, multiple pregnancies, severe malformation, placenta praevia, and the rest. On the other hand the analysis shows that scanning does not improve the outcome of pregnancy in terms of live birth rate and of perinatal morbidity.¹ Live birth rate or perinatal morbidity is influenced by several other factors occurring during the antenatal and perinatal period. Considerable clinical benefit is gained from dating of gestational age; reduction in the number of induced labours and iatrogenic prematurity; detection and monitoring of fetal growth retardation and multiple gestation; detection of placenta praevia, particularly in the asymptomatic group. Proper management of these clinical conditions has an appreciable effect on reducing maternal morbidity and perinatal mortality and morbidity as well. The value of routine ultrasound scanning at 19 weeks' gestation in a low risk population has been shown previously.² We think Bucher and Schmidt in analysing the data have forgotten the clinical application of the findings of ultrasound and concentrated more on the crude outcome levels. If it is done as a one stage procedure then screening for malformation is not the only purpose of doing the ultrasound scan and the other information has an important effect on the subsequent management of the pregnancy.

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1 Bucher HC, Schmidt JG. Does routine ultrasound scanning improve outcome in pregnancy? Meta-analysis of various outcome measures. *BMJ* 1993;307:13-7. (3 July.)

2 Luck CA. Value of routine ultrasound scanning at 19 weeks: a four year study of 8849 deliveries. *BMJ* 1992;304:1474-8.

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EDITOR,—We disagree with the conclusions of the meta-analysis by Heiner Bucher and Johannes Schmidt.¹ In the four main articles analysed the stated objectives were different. In addition, ultrasound scanning was performed at gestational ages varying from as early as 10 weeks² to as late as 32 weeks.³ Since ultrasound scanning at different gestations is often for different indications or objectives it becomes difficult to group these studies together in a meta-analysis. Also, Neilson concludes that routine ultrasound in early pregnancy generally reduces the incidence of induced labours for apparent postmaturity, a conclusion differing from that in this article.⁴ Finally, although there may be no significant differences in live birth rates once fetal malformations have been excluded, there are other unmeasurable aspects of routine ultrasound scanning, and one of the most important is the psychological effect on couples (especially on their attitude towards the pregnancy).

In "Can meta-analysis be trusted?" Thompson and Pocock conclude that "meta-analysis is not an exact statistical science that provides definite answers to complex clinical problems," and that quantitative results must be interpreted cautiously.⁵ We feel that this is exactly what is wrong with the strongly worded conclusions from this meta-analysis.

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- 1 Bucher HC, Schmidt JG. Does routine ultrasound scanning improve outcome in pregnancy? Meta-analysis of various outcome measures. *BMJ* 1993;307:13-7. (3 July.)
- 2 Bakketeig L, Jacobson G, Brodtkorb C, Erikson BC, Eik-Nes SH, Ulstein MK, et al. Randomised controlled trial of ultrasonographic screening in pregnancy. *Lancet* 1984;ii:207-11.
- 3 Ewigman B, LeFevre M, Hesser J. A randomised trial of routine prenatal ultrasound. *Obstet Gynecol* 1990;72:189-94.
- 4 Neilson JP. Routine ultrasonography in early pregnancy. In: Enkin MW, Keirse MJNC, Redfrew MJ, Neilson JP, eds. Pregnancy and childbirth module. *Cochrane database of systematic reviews* 1993;No 03872. (Cochrane Updates on Disk, Oxford: Update Software, Spring 1993.)
- 5 Thompson SG, Pocock SJ. Can meta-analysis be trusted? *Lancet* 1991;338:1127-30.

Apgar scores are poor predictors of outcome

EDITOR,—I wish to express concern regarding the basis for Heiner Bucher and Johannes Schmidt's conclusion that routine ultrasonography has no impact upon perinatal morbidity.¹ Their sole criterion for assigning morbidity is Apgar score at 1 minute of <7, which is not appropriate. The 1 minute score is used as a practical guide to the necessity or otherwise of neonatal resuscitation. The poor correlation of low 1 minute and 5 minute Apgar scores with acid-base status at birth is well recognised,² as is the poor predictive ability of these scores for subsequent neurologic disability.^{3,4} Alternative, and more appropriate measures of morbidity include the necessity and duration of admission to a neonatal unit, which also has short term staffing and financial implications, and the presence of postasphyxial encephalopathy, which is superior to the Apgar score in pre-

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