LETTERS

We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

HUW EVANS/REX

TEENAGE PREGNANCY

Education programme has changed since study

Henderson et al studied sexual health and relationships education (SHARE) delivered between 1996 and 1999 in east Scotland.[1] They showed no statistically significant influence on conceptions or terminations by age 20 years.

In the article by Henderson et al, SHARE was delivered exclusively by school teachers,[1] but an earlier study on the same cohort highlighted the limitations of using such an approach.[2] Recent advice to local authorities and NHS organisations reinforces the need for a multidisciplinary approach in working to reduce teenage pregnancies.[3] A review of the evidence in preparation for the second phase of the national health demonstration project, "Healthy Respect," shows that a multifaceted approach combining education, information, and services has the best chance of improving sexual health outcomes.[4] In Scotland, teachers now work alongside youth workers, school nurses, and voluntary organisations to deliver SHARE[5] with improved access to services for young people.

D Graham Mackenzie locum consultant in public health medicine, Public Health Department, NHS Fife, Leven, Fife, KY8 5RG gm@nhs.net

John Taylor development manager, Blood Borne Virus Task Group, Health Promotion Department, NHS Fife, Leven, Fife KY8 5RA

Competing interests: None declared.

1 Henderson M, Wight D, Raab GM, Abraham C, Parkes A, Scott S, et al. Impact of a theoretically based sex education programme (SHARE) delivered by teachers on NHS registered conceptions and terminations: final results of cluster randomised trial. *BMJ* 2007; 334: 133-6. (20 January.)
2 Wight D, Raab G, Henderson M, Abraham C, Buston K, Hart G, et al. The limits of teacher-delivered sex education: interim behavioural outcomes from a randomised trial. *BMJ* 2002;324:1430-3.
3 Department for Education and Skills. *Teenage pregnancy: accelerating the strategy to 2010*. London: Department for Education and Skills, 2006.
4 Henderson S. *Briefing paper 2. Promoting a healthy respect: what does the evidence support?* Edinburgh: Health Scotland, 2006.
5 Scottish Executive. *Respect and responsibility. Strategy and action plan for improving sexual health*. Edinburgh: Scottish Executive, 2005.

Systematic review addresses socioeconomic inequalities

We have grappled with social disadvantage and teenage pregnancy in our recent systematic reviews evaluating the effectiveness and appropriateness of interventions to reduce the social exclusion associated with teenage pregnancy.[1] As Henderson et al postulate,[2] we found that programmes aiming to change life opportunities for young people have a considerable positive effect on reducing pregnancy in this group. Our meta-analysis of high quality controlled trials indicated that pregnancy rates could be reduced by 39% in young people who themselves were recipients of day care as children or received youth development programmes in American studies. However, studies of young people's views also showed important research gaps. These include the development and evaluation of policies to promote young people's involvement in schooling, further education and training, and to support families experiencing problems linked with social disadvantage and poverty.

Happiness, enjoyment of school, and ambition can all help to delay parenthood in young people. The available research evidence also points both to day care and to youth development programmes as effective and appropriate ways of supporting children and young people. These findings imply a need for further research into the socioeconomic and cultural influences that shape young people's choices about when they become parents, and what other options are open to them for a happy and satisfying life.

Ginny Brunton research officer g.brunton@ioe.ac.uk, **Ann Oakley** founding director, **Angela Harden** senior research scientist in evidence synthesis, Evidence for Policy and Practice Information and Coordinating (EPPI-) Centre, Social Science Research Unit, Institute of Education, University of London, London WC1H ONR

Competing interests: None declared.

1 Stephenson JM, Oakley A, Johnson AM. A randomised intervention trial of peer-led sex education in schools in England (RIPPLE). *Lancet* protocol 01 PRT/6. 2001.
2 Henderson M, Wight D, Raab GM, Abraham C, Parkes A, Scott S, et al. Impact of a theoretically based sex education programme (SHARE) delivered by teachers on NHS registered conceptions and terminations: final results of cluster randomised trial. *BMJ* 2007;334:133-6. (20 January.)

SEMANTICS

Schizophrenia can and should be renamed

Lieberman and First make the case against renaming schizophrenia on the grounds that changing the term would not change the stigma attached to the underlying condition.[1] Yet renaming is a key strategy used by marketing and public relations industries to improve image, alongside attitude change and education.

But what should it be replaced with? One of the conclusions emerging from the "Deconstructing psychosis" conference, part of the DSM-V Prelude project was for replacing the current categories with a general psychosis syndrome.[2] However, this would increase still further the heterogeneity that currently bedevils biological and psychosocial research, clinical practice, and resource management, when differentiation is really needed.

Trauma has recently been recognised as relevant to a significant group of patients with this diagnosis.[3] Since the 1950s, a new group has also been included to broaden the diagnosis further: those in whom there is an association with hallucinogenic drugs.[4] Renaming and differentiation of these two groups ("traumatic" and "drug precipitated" psychosis) is clinically possible from those patients who develop systematised delusions and those who seem to be particularly vulnerable to

stress ("sensitivity psychosis"). In a study of the use of these terms with medical students (n=241), we found that they were associated with reduced perception of dangerousness and much increased expectation of recovery than "schizophrenia." Most importantly, patients and carers themselves, when asked, find the term unacceptable.[5]

David G Kingdon Professor of mental healthcare delivery dgk@soton.ac.uk **Yoshihiro Kinoshita** PhD student, **Farooq Naeem** PhD student, **Maged Swelam** honorary lecturer, University of Southampton, Royal South Hants Hospital, Southampton SO14 0YG

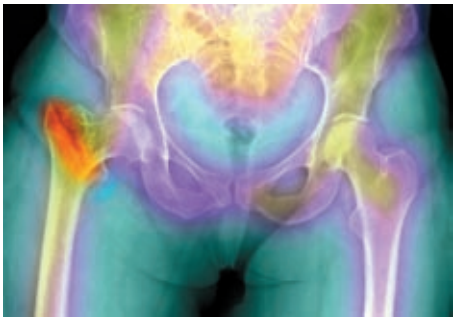
Lars Hansen consultant psychiatrist, **Selveraj Vincent** specialist registrar, Hampshire Partnership Trust, Southampton SO40 2RZ

Shanaya Rathod consultant psychiatrist, Hampshire Partnership NHS Trust, Tadley RG26 3HX

Competing interests: None declared.

1 Lieberman JA, First MB. Renaming schizophrenia. *BMJ* 2007;334:108. (20 January.)
2 First MB. Deconstructing psychosis. http://dsm5.org/conference5.cfm.
3 Read J, Agar K, Argyle N, Aderhold V. Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychol Psychother: Theory, Research and Practice* 2003;76:22.
4 Hall W. Is cannabis use psychotogenic? *Lancet* 2006;367:193- 5.
5 Kingdon D, Gibson A, Turkington D, Rathod S, Morrison A. Acceptable terminology and subgroups in schizophrenia: an exploratory study. *Soc Psychiatry Psychiatric Epidemiol* (in press).

RESUSCITATION ORDERS



DU CANE MEDICAL IMAGING LTD/SPL

Orthopaedic consultant is responsible in hip fracture

Anwar and Ahmed highlight the difficulties making cardiopulmonary resuscitation (CPR) decisions for elderly people with hip fracture.[1] Published guidance and the law are confusing,[2 3] but there is a logical approach to using them.

It is not practicable to make a resuscitation decision on everybody in hospital. If an arrest is "foreseeable," guidelines supported by common law and common sense dictate that a decision needs to be made. If it is not foreseeable then, provided the option to refuse CPR is available, no decision need be made, leaving a patient "for CPR" by default.

The appeal court decision in the case of Burke makes clear that doctors are not obliged to offer treatment they believe will be ineffective, simply because a patient wishes to receive it.[4] If an arrest is foreseeable but prospects of CPR succeeding are very poor it should not be offered and a "do not attempt resuscitation" (DNAR) order should be made.

If the patient has capacity—which may be difficult to judge in the context of acute illness—then as part of the explanation of the treatment plan doctors should generally explain that CPR would not be offered because it would not succeed. If confusion or distress will probably result from such discussion then under common law[5] a doctor may decide it is not in a patient's best interests to be told that an ineffective treatment will not be offered and a DNAR order is made without discussion. If the patient lacks capacity a relative may be told the reasons for a DNAR order when the treatment plan is explained.

Many elderly people would not wish to receive CPR. The principle of autonomy and the common law gives patients the right to refuse it. If an arrest is foreseeable and CPR has reasonable prospects of success patients should be asked if they wish to receive it. If they are not competent, relatives should be consulted to try and judge what the patient would have wished.

Paul Diggory consultant orthogeriatrics, **Mayday University** Hospital, Croydon CR7 7YE pdiggory@aol.com

Competing interests: None declared.

1 Anwar R, Ahmed A. Who is responsible for "do not resuscitate" status in patients with broken hips? *BMJ* 2007;334:155. (20 January.)
2 BMA. *Decisions relating to cardiopulmonary resuscitation. A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing*. London: BMA, 2001.
3 General Medical Council. *Withholding and withdrawing life-prolonging treatments: good practice in decision-making*. London: GMC, 2002.
4 Burke, R *v* General Medical Council & Ors [2005] EWCA 1003.
5 Sidaway *v* Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] ALL ER 1018 (HL).

NHS CATARACT SERVICE

ISTC programme is an expensive option

The improvement report in relation to cataract surgery[1] is further evidence that the independent sector treatment centre (ISTC) programme was an expensive over-reaction to the need to increase rates of cataract surgery.[2] Many ophthalmology departments had improved cataract surgery pathways, as part of Action on Cataract, an NHS initiative supported by the college,[3] before the ISTC programme was proposed.

Modest sums of capital pump-primed increased cataract surgical activity by improved facilities and pathway redesign. As this report confirms,[1] such targeted investment quickly pays for itself. The experience in NHS ophthalmology units elsewhere is similar.

Had the Department of Health followed the advice of clinicians, the royal colleges, and the BMA when the cataract and other ISTC schemes were proposed, improved access to cataract surgery would have been realised with much less expenditure, without adverse effects on surgical training, and without destabilising NHS eye departments. However, an alternative direction was taken.[4] Despite the paucity of clinical outcome data, a cause of increasing concern,[5] and the lack of evidence of cost effectiveness of phase 1 of the ISTC programme, further investment in cataract surgical facilities continues in phase 2. Meanwhile, for long term stability of the service, the best option for the public is to support local NHS units, which brought down cataract waiting times, which patients need to call on in an emergency or for chronic eye disease, and which train the next generation of surgeons while meeting waiting time targets. A constructive partnership of clinicians, managers, and commissioners is a surer way to achieve sustained improvements in access and quality of care, rather than centrally imposed initiatives and diktat, such as the needless cataract ISTCs.

Simon P Kelly consultant ophthalmic surgeon, Bolton Eye Unit, Bolton Hospitals NHS Trust, Bolton BL4 0JR simon.kelly@RBH.nhs.uk.

Brenda Billington president, **Richard Smith** vice president, Royal College of Ophthalmologists, London NW1 4QW

Rhod Daniel chairman, **Ophthalmic Group Committee, BMA**, London WC1H 9JP

Competing interests: The Bolton Eye Unit is an NHS Action on Cataract site.

1 Tey A, Grant B, Harbison D, Sutherland S, Kearns P, Sanders R. Redesign and modernisation of an NHS cataract service (Fife 1997-2004): multifaceted approach. *BMJ* 2007;334:148-52. (20 January.)
2 House of Commons Health Committee. *Independent sector treatment centres*. Fourth report of session 2005-6. Vol 1. www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934i.pdf
3 Department of Health. *Action on cataracts—good practice guidance*. NHS Executive. Feb 2000. www.dh.gov.uk/assetRoot/04/01/45/14/04014514.pdf
4 Kelly SP. Cataract care is mobile. Is the direction correct? *Br J Ophthalmol* 2006;90:7-9.
5 Mooney H. Data on ISTCs' clinical quality is "extremely poor," says Healthcare Commission. *Health Serv J* 2007;117:5.