

Bed shortages

Regional intensive care unit transfer teams are needed

EDITOR—A national bed bureau for intensive care beds was established on 1 December 1996.¹ This will undoubtedly simplify the problem of finding a suitable bed for a critically ill patient should local facilities be either unavailable or inappropriate. The fact that such a facility was urgently needed confirms that there remains a shortage of intensive care (and not high dependency) beds in the right place at the right time.

Although it is appropriate to use intensive care beds at maximum efficiency, knowledge of the whereabouts of a bed is only part of the solution. The dangers of transferring critically ill patients need to be emphasised. Safe transport requires trained and experienced staff; appropriate equipment; and a resuscitated, stable patient. The patient being transferred should occupy the equivalent of an intensive care unit bed in a vehicle, and during transfer he or she requires the full capabilities of an intensive care unit team. Currently most patients who are transferred in Britain are accompanied by a trainee from the on call anaesthetic rota at the referring hospital. One study found that one third of transfers were undertaken by a senior house officer in anaesthetics with less than six months' experience.² Failure to provide adequate care may result in significant morbidity and mortality.³

Transfers would be reduced by an increase in intensive care unit facilities in areas of low provision.⁴ If transfer is still required transfer teams must be fully equipped and skilled. Dedicated teams are common elsewhere in Europe, the United States, and Australia. In Britain most transferred patients are transferred within a clearly defined geographical area and are usually accommodated by a unit within 32 km or 30 minutes' travelling time.⁵ There is an urgent need to establish a formal transport system in each of these areas. Regional intensive care unit transfer teams would provide skilled attendants and appropriate equipment for a safer service and also spare the on call staff in referring hospitals.

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Hospitals need support for coping with emergency work

EDITOR—The NHS has succeeded again: in the face of huge demands it has managed to weather another influx of winter admissions. All grades of staff from all disciplines have toiled to keep the service going. They deserve thanks from the general public and front page acclaim from the press. Good news, however, has never sold newspapers.

The bad news is that the quality of care must suffer in the face of these extreme demands. Patients wait longer in accident and emergency departments, they are moved from ward to ward, and in some cases care is given on wards of other specialties. A patient with a stroke who is in a gynaecology ward will receive excellent basic nursing care but not the care that could be provided in a stroke unit.

Further bad news is that staff become tired. Everyone responds to the crisis, but when the crisis continues day after day, people cannot go on draining their reserves. Sickness rates rise; morale falls; and all but essential work is cancelled, postponed, or performed suboptimally. Just when the nadir is reached a story appears in the local press about long delays, early discharge, or a lack of intensive care beds.

The unacceptable news is that the more efficient a hospital is at handling these crises the greater its budget deficit. The NHS Executive rightly urged hospitals to make detailed plans to cope with winter admissions. My unit has for years invested heavily in all the components needed to respond to peaks in emergency demand: flexible use of all beds, accurate management of beds, planning of discharges, and attempts to restrict elective work. However, although the unit is reimbursed at marginal costs for "emergency overactivity," it but loses full costs for elective work; this could cost the hospital £35 000 a day. The hospital could also be heavily penalised if patients remain on a waiting list for elective surgery for more than 18 months.

Undoubtedly the NHS reforms have had a positive impact on many aspects of the

service, including emergency care. Without the management systems that have been put in place I doubt if the system would cope with the huge increase in demand. There is clearly, however, a perverse financial disincentive to any trust that reduces its elective workload to handle emergency work. This part of the system seems wrong.

The emergency service will continue to struggle in adversity, but hospitals deserve some positive messages, both human and financial, to give staff the boost they need to continue to "go the extra mile."

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Delay in diagnosis of homocystinuria

Neonatal screening avoids complications of delayed treatment

EDITOR—Johan R M Cruysberg and colleagues highlight the delay in diagnosis in patients with homocystinuria, describing a mean interval of 11 years from the onset of major signs until diagnosis.¹ Early detection reduces the development of ocular complications.² This is not achieved by good biochemical control alone, lens dislocation still developing in children when treatment is started outside the neonatal period.³

Neonatal screening affords the opportunity to improve outcome in homocystinuria, avoiding the complications that occur with delayed treatment. Untreated patients are particularly at risk of developing thrombotic disease, a clinically significant problem during surgery if the disease is undiagnosed. In his editorial David M Isherwood correctly states that hypermethioninaemia is unreliable for screening by Guthrie bacterial inhibition or thin layer chromatography, and he advocates research to develop a molecular genetic technique.⁴ However, a recent communication highlights the potential use of tandem mass spectrometry for rapid diagnosis of homocystinuria using neonatal blood spots.⁵ This has the advantage of using the same Guthrie card collected to screen for phenylketonuria in the United Kingdom, thus requiring no additional sampling to be organised and reducing the cost of screening for a rare disorder. In addition, tandem mass spectrometry may be used to screen for a number of inherited disorders amenable to early therapeutic intervention simultaneously, including phenylketonuria and medium chain acyl

coenzyme A deficiency. Molecular genetic techniques have also been proposed for the latter. Clearly, neonatal screening using tandem mass spectrometry will be a cost efficient means of screening for even rare inherited metabolic disease, and it will have a large impact on the future management of these disorders as more centres embrace the new technology.

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Total rather than free homocysteine is better for screening

EDITOR—Johan R M Cruysberg and colleagues have shown that the diagnosis of homocystinuria may be missed if appropriate samples are not sent for homocysteine assay.¹ There is, however, a discrepancy between the biochemical testing recommended by them and that suggested by David M Isherwood in the accompanying editorial.² We seek to clarify this point.

Homocysteine exists in several different forms in plasma (reduced or oxidised; protein bound or free). Cruysberg and colleagues recommend measurement of total homocysteine in plasma, whereas Isherwood suggests measurement of free homocysteine.

Assays for total homocysteine include steps that reduce and release protein bound homocysteine before measurement, which is usually carried out by a high performance liquid chromatography technique dedicated to assay of plasma thiols. The sample required for total homocysteine measurement is plasma (containing EDTA, citrate, or fluoride/oxalate) separated promptly from red cells by standard laboratory centrifugation. Delay before centrifugation will result in release of homocysteine from red cells into plasma, giving higher results, though this increase is not likely to transform a result from the normal (<16 $\mu\text{mol/l}$) to homocystinuria range (>50 $\mu\text{mol/l}$). Once plasma has been separated from red cells total homocysteine is comparatively stable (at least 96 h at 22°C)³ and can be sent to the analysing laboratory by post at ambient temperature.

For measurement of free homocysteine immediate deproteinisation is required before analysis as part of general amino acid chromatography. As pointed out by Isherwood, failure to deproteinise within a few minutes of collection (using sulphosalicylic acid or similar) can lead to spuriously low free homocysteine concentrations. Although measurement of other amino acids, particularly methionine, may be helpful to fully characterise homocystinuria, it is not necessary for a screening test.

If the diagnostic issue is the presence or absence of homocystinuria then the measurement of total plasma homocysteine has the most to recommend it. This approach has advantages of diagnostic sensitivity, easier sample collection, and lower assay cost.

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Future of the NHS will be one of change

EDITOR—Does Chris Ham really believe that we are in for “a period of organisational stability” in the health service?¹ His editorial on “a service with ambitions”² ignores the previous white paper, *Choice and Opportunity: Primary Care: the Future*, which had as its central proposal the deregulation of general practice and, indeed, all health care.³ We are in for one of the most intensive periods of change within the health service that we have ever experienced.

It would be nice to think that *Choice and Opportunity* was designed to allow progressive general practitioners and trusts to pilot good ideas for health care. Unfortunately, a closer look at the document is disturbing. The statement that general practitioners may be salaried “either within partnerships or with other bodies” suggests that the concept of partnerships and general practitioners as gatekeepers of the NHS will be swept away. By merging budgets for general medical services and hospital and community health services the government will succeed in cash limiting primary care by the back door. Marrying the budgets will put at risk the development of primary care and the shift from secondary to primary care.

The voluntary nature of any changes that result from *Choice and Opportunity* is emphasised, but experience from trust status and fundholding should make us wary of believing this. Both becoming an NHS trust and taking on fundholding were presented

as voluntary in the early 1990s, yet most hospitals and general practitioners felt pressurised into joining. Evaluation of pilots does not reassure either, since the little evaluation that was carried out on the previous changes did not have any impact on their development.⁴

Perhaps the most frustrating and depressing message of *Choice and Opportunity* is the lack of cohesion, direction, or even consensus on why all these changes should be made. How will we judge which pilots should be approved? Who will judge which pilots should go ahead? Do we need to change that specific area of organisation?

Since opposition to the white paper during its passage through parliament seems unlikely, perhaps the best thing we can do in the immediate future is to agree, at district level and with all interested parties (including the public), what underlying principles we should use to vet new proposals for our own population's health care. This might go some way to preventing further inequalities in the health service, preserve the philosophy that health decisions should be made on the basis of need and not profit, and allow general practitioners to keep their role as advocates for patients and gatekeepers to the NHS.

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Advice to authors

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Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

We may post some letters submitted to us on the worldwide web before we decide on publication in the paper version. We will assume that correspondents consent to this unless they specifically say no.

Letters will be edited and may be shortened.

Many claims about passive smoking are inadequately justified

EDITOR—George Davey Smith and Andrew N Phillips suggest that the tobacco industry attempts to promote confusion about passive smoking and disease.¹ Although I was not involved with the report of the European Working Group on Environmental Tobacco Smoke and Lung Cancer, their central concern, I am cited as an “enthusiastic recipient of tobacco industry financial support who ... has presented models ... most favourable to the tobacco industry case.” Insinuating that I distort evidence for money is most unfair. I am widely consulted on many issues and attempt always to present an unbiased assessment. For passive smoking, which I have studied in detail, I strongly believe that many claims are inadequately justified, and I say so. In fact, the authors’ own article promotes confusion by presenting the relevant evidence misleadingly.

They wrongly criticise my work on bias due to misclassified smoking habits for ignoring the fact that spousal smoking inaccurately measures total exposure. There are two distinct questions here. Firstly, after account has been taken of misclassification, does a significant relation between spousal smoking and risk of lung cancer exist? Secondly, if such a relation exists, by how much does it underestimate that with total exposure? As the answer to the first question is no, the second becomes irrelevant. They also mislead by ignoring evidence that other exposure variables (for example, exposure in the workplace) show no association with risk.²

They say that “associations between diet and lung cancer could be due to confounding by smoking.” But associations with diet are seen for many cancers, regardless of their relation to smoking, and studies of lung cancer have shown strong associations in non-smokers.³ The fact that intervention trials of vitamin supplements have shown no benefit⁴ hardly shows that diet itself is unimportant.

In 1981, results from the “million person study” on passive smoking and lung cancer were published.² Despite repeated requests, findings relating to heart disease were withheld until two independent scientists obtained the data and, in 1995, reported finding no association.⁴ Their analyses are based on five times more deaths than the combined evidence published previously. How can Davey Smith and Phillips support claims that publication bias is irrelevant and the evidence on heart disease compelling?

Given their keen awareness of residual confounding, I find it remarkable that the authors consider the association of cot death and maternal smoking to be due to passive smoking when studies such as Mitchell *et al*s have found that adjustment for numerous risk factors massively weakens the association.⁵

Biased reporting is not something that can occur in only one direction.

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- 1 Davey Smith G, Phillips AN. Passive smoking and health: should we believe Philip Morris’s “experts”? *BMJ* 1996;313:929-33. (12 October.)
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Congenital anterior abdominal wall defects

A national congenital malformations register is needed

EDITOR—Kelvin H Tan and colleagues’ paper analysing the incidence of congenital abdominal wall defects highlights the need for adequate antenatal and postnatal data collection nationwide.¹ The authors retrospectively analysed abdominal wall defects coded according to the ninth revision of the *International Classification of Diseases*, using data from the Office of Population Censuses and Surveys (now the Office for National Statistics). It is not possible to differentiate between gastroschisis and exomphalos with these codes, and reanalysis of the original forms was therefore necessary. Records of the incidence of such defects may be influenced by differing regional uptakes of abortion services and variations in methods and skill in antenatal diagnosis and postnatal management. There are too many variables in the study to draw firm conclusions.

In our unit, with 17 000 deliveries over the past seven years, there were seven cases of exomphalos and four of gastroschisis. Six fetuses with exomphalos and one with gastroschisis were terminated after detailed counselling and karyotyping. These diagnoses are now made at between 11 and 14 weeks’ gestation as part of the nuchal thickening programme. Earlier diagnosis tends to influence the decision to terminate and emphasises the need for meticulous record keeping.

Data from the Office for National Statistics are unsuitable for epidemiological research because of underreporting, but such research is vital to support current trends in primary health care. In the same issue of the *BMJ* a news item reports on the Gulf war syndrome²; the possibility of associated fetal anomalies cannot be analysed because of inadequate data. A further news article reports a possible connection between fluoxetine and minor birth defects.³ Do we have to have another disaster of thalidomide proportions before a national

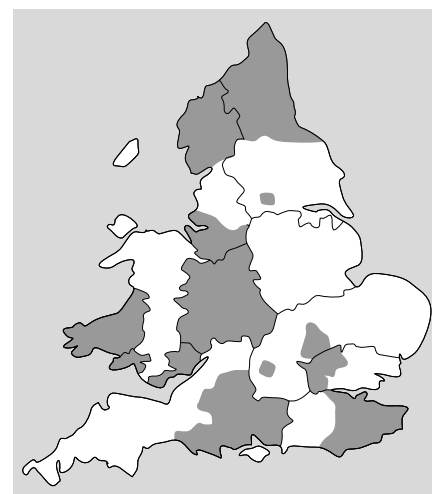


Fig 1 Catchment areas for nine local registers of congenital malformations in England and Wales. Lines indicate new regional boundaries

register of congenital malformations is instigated?

One of us (JS) wrote her master of science dissertation on the provision of local registers of congenital malformations in England and Wales. In 1995 there were nine such registers, situated in different health regions and with varying catchment areas. Two registers related to regional referral centres, one covered roughly half a region, and the six others served entire regions (old boundaries). Figure 1 shows the areas covered. Several centres stated that their funds were precarious, and most relied on voluntary notification from motivated maternity units.

The Office for National Statistics collects national data, but the data are inadequate. Local registers collect adequate data but are not nationwide. A national lobby is urgently needed to initiate and fund a congenital malformations register.

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Rate of abdominal wall defects is higher in Scotland than England and Wales

EDITOR—Kelvin H Tan and colleagues report their analysis of routine data on abdominal wall defects in England and Wales.¹ In response to this, we have performed an initial analysis of Scottish data for a similar period using the congenital anomaly register, which is maintained by the information and statistics division of the NHS in Scotland.

The method of data collection is substantially different in Scotland from that in England and Wales and takes advantage of record linkage in the Scottish morbidity recording (SMR) systems. There is no

Table 1 Number of cases of abdominal wall defects in Scotland (with relevant code according to *International Classification of Diseases*, ninth revision), 1988-95

Year	Total (756.7)	Exomphalos (756.70)	Gastroschisis (756.71)	Prune belly syndrome (756.72)	Unspecified
1988	23	11	8	2	2
1989	17	2	11	0	4
1990	26	11	10	2	3
1991	23	10	11	1	1
1992	19	4	13	1	1
1993*	20	8	10	2	—
1994*	28	6	21	1	—
1995*	24	11	13	—	—

*Provisional.

specific notification system for recording congenital anomalies, but, instead, data are captured and matched with probability linkage techniques from the record of a live birth (SMR11), the record of discharge from a neonatal unit (SMR11(E)), the Scottish stillbirth and neonatal death survey, and the registrar general's death records and record of discharge from an acute hospital (SMR1) for children aged under 1 year. This latter data source is valuable for children requiring operations in the first year of life.

Table 1 shows the data for the years 1988-95. The overall rate of abdominal wall defects for this period was 3.49 per 10 000 births (1.89 for gastroschisis and 1.22 for exomphalos). For the period 1988-93, which is closer to the years studied by Tan and colleagues (1987-93), the rates were 3.25, 1.60, and 1.17 respectively. This compares with the rates for England and Wales of 2.15, 1.11, and 0.92 respectively.

Obviously, the numbers are small and so it is difficult to separate any trend from random variations, but, as with the data for England and Wales, the number of cases of exomphalos seems to be stable. Unlike in England and Wales, however, there was no pronounced upward trend in the number of cases of gastroschisis, although the number was high in 1994.

Although we acknowledge the different method of data collection, there seems to be a higher rate of abdominal wall defects in Scotland than in England and Wales. This is in keeping with the increasing gradient from south to north observed by Tan and colleagues.

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Authors' figures for Northern region are underestimates

EDITOR—Kelvin H Tan and colleagues report an increase in the incidence of gastroschisis in England and Wales between

1988 and 1993, using data from the Office of Population Censuses and Surveys (now the Office for National Statistics).¹ The Northern regional fetal abnormality survey has collected data on all fetal abnormalities arising in the population of the former Northern region since 1984, whether occurring in miscarriages, terminations, or registered births.²

Our experience of abdominal wall defects during the five years 1988-92 has been reported,³ and we have detected no rise in the incidence of gastroschisis or fall in the incidence of exomphalos during this period (table 1). Preparation of the published report entailed review of all original hospital case records, as a result of which 11 cases originally classified as exomphalos were reclassified as gastroschisis. It should be noted that our mean incidence for all cases of gastroschisis and exomphalos (4.90 (95% confidence interval 3.94 to 5.87)) for the five years greatly exceeds the figure quoted by Tan and colleagues for the Northern region in their table 5. We suspect that misclassification in the earlier years and absence of data on unregistered births account for most of the apparent change in incidence that they report.

Our data suggest that 40% of cases of exomphalos are associated with other structural abnormalities and 28% with chromosomal anomalies, usually a trisomy.³ This is not so with gastroschisis, which is usually an

isolated defect. In the future we would therefore expect gastroschisis to form an increasing proportion of anterior abdominal wall defects among registered births because of improved antenatal classification and increased terminations of babies with exomphalos.

The true incidence of congenital anomalies cannot be ascertained from notifications to the Office for National Statistics alone because its records are known to be incomplete. We strongly support Lyn Chitty and Joseph Iskaros's recommendation that local population based malformation registers such as ours should be set up.⁴ We would urge these to register all abnormalities, including those in miscarriages and terminations, and would also encourage stronger collaboration between the registers already in existence.

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Gastroschisis has a good prognosis

EDITOR—Kelvin H Tan and colleagues and Lyn Chitty and Joseph Iskaros discuss possible reasons for an increase in the incidence of gastroschisis in England and Wales.^{1 2} We were alarmed to read that more than one in five pregnancies with fetal gastroschisis in the North West Thames region were terminated during 1990-3.¹ Only 5-10% of fetuses with gastroschisis have additional anomalies,³ and gastroschisis has a good

Table 1 Number of infants with exomphalos and gastroschisis born in 1988-92 to mothers resident in former Northern region by year of birth (including non-registered births), with incidence per 10 000 registered births and 95% confidence interval

	1988	1989	1990	1991	1992	Total 1988-92
No of registered births	40 324	39 297	40 841	41 348	40 163	201 973
Gastroschisis:						
No of cases	16	8	7	11	14	56
Incidence	3.96	2.04	1.71	2.66	3.49	2.77
95% CI	2.02 to 5.91	0.62 to 3.45	0.44 to 2.98	1.09 to 4.33	1.66 to 5.31	2.05 to 3.50
Exomphalos:						
No of cases	9	8	6	10	10	43
Incidence	2.23	2.04	1.47	2.42	2.49	2.13
95% CI	0.77 to 3.69	0.62 to 3.45	0.29 to 2.64	0.92 to 3.92	0.95 to 4.03	1.49 to 2.77
Total:						
No of cases	25	16	13	21	24	99
Incidence	6.19	4.07	3.18	5.07	5.97	4.90
95% CI	3.77 to 8.63	2.08 to 6.07	1.45 to 4.91	2.91 to 7.25	3.59 to 8.37	3.94 to 5.87

prognosis postnatally, with at least 90% survival.⁴ Furthermore, the limited data on long term outcome are encouraging, with most patients achieving normal growth and development and enjoying healthy lifestyles.⁵

During the past four years we have managed 32 newborn infants with gastroschisis in our regional surgical neonatal unit, 29 of whom have survived. On the basis of the incidence reported by Tan and colleagues and our regional birth rate, we would have expected 22 babies with gastroschisis. This supports our impression that few pregnancies in which the fetus has gastroschisis are terminated in our region. To our knowledge, during the past four years only one such pregnancy has been terminated at our institution. This was in a woman requesting a termination on social grounds at 15 weeks' gestation; the gastroschisis was an incidental finding. With fetal gastroschisis, prospective parents should be offered counselling by both an obstetrician and a paediatric surgeon if they are to be adequately informed about the fundamental aspects of this condition and its outcome.

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Giving influenza vaccination to all elderly people would raise ethical issues

EDITOR—We agree with Carolyn Diguseppi that evidence exists for giving influenza vaccine to everyone aged over 65.¹ Interestingly, medical insurance companies in the United States have shown that it is cost effective to vaccinate people aged over 65 to reduce the burden of morbidity and mortality. This age related targeting of influenza vaccine would certainly make things simpler in Britain.

Currently the Department of Health recommends vaccination of those patients who are at high risk of influenza who have specific medical conditions—for example, chronic respiratory disease, heart disease, and renal disease and those with diabetes mellitus as well as residents of nursing homes and residential homes. We found that out of 100 elderly inpatients with appropriate medical conditions only 37 had been vaccinated, and a tenth of these had initiated vaccination themselves by requesting it from their doctor.² Three quarters of the patients would have accepted vaccination if it had

been offered. There was disparity on how general practitioners targeted patients for the vaccine: 47% sent out letters and asked patients to attend for vaccination, while 42% relied on the media and notices in the surgery to encourage patients to come forward.

If all patients aged over 65 were to be vaccinated then general practitioners' job of targeting would be straightforward and more patients would be vaccinated. Nevertheless, blanket influenza vaccination raises some ethical issues. It may be inappropriate, for example, to vaccinate a severely demented bedbound elderly patient whose quality of life is extremely poor. Clearly, the issue of quality of life can be discussed with a competent patient when consent for vaccination is being obtained, in the way that "do not resuscitate" orders are sometimes discussed with patients. These situations require the doctor to have sensitivity and good communication skills.

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Helping parents to cope when their preschool children are acutely ill

Educational interventions may defuse parents' concern

EDITOR—Joe Kai used a qualitative study to explore parents' concern and information needs in coping with acute illness in preschool children.^{1,2} We recently conducted a survey in Italy to examine mothers' knowledge, perceptions, and attitudes about fever in their child.

Eligibility for our study required that a mother had coped with a febrile episode in her child during the previous month and that the child was aged between 6 months and 6 years. Of 707 mothers who fulfilled the criteria for inclusion, 416 reported that they had been concerned during the febrile episode and 118 that they had been very worried.

At the start of the fever 127 mothers immediately called the doctor, and during the febrile episode the doctor made a home visit in 537 cases. Altogether 615 mothers reported that they had received information from a doctor in the past about the management of fever (240 during a control visit and 375 during a previous febrile episode); 92 had received no information. The absence of previous information was significantly correlated with mothers' concern (odds ratio 2.3 (95% confidence interval 1.3 to 3.8)) and with a request for a consultation (3.4 (2.0 to 5.5)).

We used multiple logistic regression to evaluate the association of the mothers' con-

cern and a request for a visit by the doctor with sociodemographic characteristics, body temperature, and the information received in the past on the management of fever. Five variables were jointly significant for the mothers' concern: the absence of information (2.2 (1.2 to 3.8)), a temperature above 39°C (3.3 (1.9 to 5.9)), if the child had no siblings (1.6 (1.2 to 2.4)), a low educational level (1.7 (1.1 to 2.9)), and living in the south of Italy (1.6 (1.1 to 2.6)). For a request for a visit by the doctor the only explanatory variable was the absence of previous information on the management of a febrile child (2.7 (1.6 to 4.8)).

Fever in children is often caused by relatively harmless, self limiting viral infections. Parents' unfounded concern and misconceptions about the potential harmful effects of fever have given rise to the term "fever phobia."³ Mothers clearly need to be educated about fever, and educational programmes have been proposed and are useful in counteracting fever phobia in parents.^{4,5} As our findings show, educational interventions may defuse parents' concern and reduce unnecessary calls to the doctor for minor, transient febrile illnesses. We agree with Kai that, to be effective, information on acute illness in preschool children must be developed according to parents' perceived needs and should draw on parents' skills and experience.

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Patients and GPs need to understand each other's perceptions of a consultation

EDITOR—Joe Kai reports parental concerns about childhood illnesses and communication difficulties between parents and health professionals.^{1,2} We have just reviewed literature on patients' satisfaction and on quality in general practice. Kai's conclusions corroborate other evidence of divergence between patients' and general practitioners' criteria of good general practice. For example, whereas patients valued having a general practitioner who listens, a general practitioner who sorts out problems, the same doctor, and a 48 hour appointment system, general practitioners emphasised an efficient appointment system, working to a protocol, appropriate referrals to a specialist, shorter consultations, and patients with lower illness scores.³

Patients, concerned not to burden their doctor too often with problems that may be considered trivial, accumulate problems for one consultation to make good use of general practitioners' time. By contrast, several general practitioners told us of the difficulty and irritation that they experienced with this strategy, which extends the consultation time. They did not object to patients presenting at several appointments with a minor problem. General practitioners did, however, object to visiting patients for a minor problem.

There seems an urgent need to understand the perspectives of patients and general practitioners and to reconcile the expectations that each brings to the consultation. Mutual understanding would allow better use of the consultation, particularly since patients' satisfaction has been shown to influence consultation rates and rates of compliance⁴ and to be directly associated with therapeutic outcomes and health status.⁵

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Many trusts find labour productivity index useful

EDITOR—John Appleby concludes that "there is a clear need for robust and meaningful comparative performance indicators to help promote efficiency" but only after damning existing summary indicators such as the labour productivity index and the efficiency index.¹ Unfortunately, much of his criticism of the labour productivity index is founded on misunderstandings. The main index is:

- based on staff costs, not staff numbers
- already adjusted for teaching and research
- now adjusted for inpatient case mix
- relatively insensitive to cost weights for comparisons between trusts with similar profiles of activity
- too high level to provide much guidance in local pay negotiations
- not exclusively for trusts: it is also routinely sent to health authorities, the

Treasury, and academics and is available to others on request.

Goldstein and Spiegelhalter quote McKee and Hunter in saying that the comparison of institutions and the attempt to understand why institutions differ are extremely important and best carried out in a spirit of cooperation rather than confrontation.^{2,3} The labour productivity index is published in this spirit and contains a paragraph explaining that it can provide only a partial picture and that its interpretation requires the detailed knowledge and skill of local NHS managers.⁴

Three quarters of trusts responding to the latest consultation on the labour productivity index said that they found the index useful. Some of these will have found it so as one among many useful indicators, but I am aware of others who have used it as a major lever for change to release resources for increased patient care. The NHS Executive wishes to provide opportunities for other trusts to do the same. The labour productivity index will continue to be refined and published until it is superseded by a better measure or until it stops being useful.

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- 1 Appleby J. Promoting efficiency in the NHS: problems with the labour productivity index. *BMJ* 1996;313:1319-21. (23 November.)
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The Babinski sign

Eliciting the sign brings out doctors' masochistic tendencies

EDITOR—The Babinski sign may be a well accepted indicator of dysfunction in the pyramidal tract,¹ but it has a lot to answer for. Neurologists take professional pride in the manner with which they show the response. I have heard neurologists claim that they can make the great toe go up or down at their bidding, and some claim that a positive response is important only if elicited with a Yale-type key. How many final year undergraduates or candidates for membership of the Royal College of Physicians have failed their clinical examination because of the vagaries of this physical sign?

What do patients think of the Babinski sign? I have had Parkinson's disease for over 20 years, and recently I have had spondylosis, which has necessitated cervical (C3-7) and lumbar (L1-5) decompressions. Thus a lot of interest has been taken in the movement of my first toes. The demonstration of the Babinski response is the most excruciatingly uncomfortable physical examination I know. Students, house physicians, registrars, research fellows, neurologists, and neurosurgeons alike cannot resist

the masochistic urge to elicit a response, even when they know that it has been strongly positive for years. How many hours of neurological time have been expended on the performance of this ritual? I would estimate that if this test was outlawed we could dispense with about a tenth of consultant neurologists. Yes: the sign has a lot to answer for.

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- 1 Ditunno JF, Bell R. The Babinski sign: 100 years on. *BMJ* 1996;313:1029-30. (26 October.)

Reliability of new technology must be alarmingly low

EDITOR—John F Ditunno and Rodney Bell compare the reliability of the Babinski sign favourably with that of more technologically advanced diagnostic equipment.¹ Readers may recall a study by Maher *et al* of the reliability with which the sign was elicited by experienced physicians.² The percentage agreement beyond chance, κ , was on average only 16.7% (95% confidence interval 0.4% to 33.0%) for interobserver agreement. If Ditunno and Bell are justified in their opinion then the reliability of the new technology must be alarmingly low.

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- 1 Ditunno JF, Bell R. The Babinski sign: 100 years on. *BMJ* 1996;313:1029-30. (26 October.)
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Associate specialists are included in colleges' scheme for continuing medical education

EDITOR—Rosemary Macdonald and colleagues do well to draw attention to the plight of associate specialists, whose professional development has been badly neglected in the past.¹ Other non-consultant career grade staff in the NHS experience similar difficulties.

There are many such doctors who, because of their arduous and badly constructed work programmes, find it impossible to undertake educational activities to allow them to keep up to date. Trusts and other employing authorities seem to be reluctant to offer this group of doctors study leave and expenses. Since the implementation of formal continuing medical education by the three Royal Colleges of Physicians (of Edinburgh, Glasgow, and London) it has been our policy to include these doctors in the scheme and to recommend that non-consultant career grade staff should have the same facilities for continuing medical education as consultants. This means that time for continuing medical education must be written into job plans and appropriate study leave must be available for all. Most of

the other medical royal colleges share these views.

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1 Macdonald R, Khan MA, Singleton C. Continuing medical education and training for associate specialists: results of a survey in Yorkshire. *BMJ* 1996;313:918. (12 October.)

Inquiry into homicides by psychiatric patients

Why inquiries are necessary

EDITOR—There was much good sense in Nigel Eastman's article criticising the current guidance on mandatory inquiries after homicides by psychiatric patients.¹ Systematic internal audit should surely follow all serious untoward incidents whether or not an independent inquiry is to be held.

Independent inquiries are established primarily, however, at the request of bereaved relatives or because of grave public or media concern. They also provide explanations for the mentally ill person's family, who may feel guilty as well as let down by health or social services for a failure, as they see it, to provide sufficient protective care. Protests that psychiatrists and other professionals are exposed unfairly to public criticism merely serve to fuel the suspicion, however ill founded, that professionals prefer to keep their working practices hidden from scrutiny.

There is much to be learnt about the most cost effective way to conduct inquiries. Not all require lawyers, although the panel must have expertise in applying the principles of natural justice and fairness. Lingham and I have proposed a timely, economical, and fair process which we believe meets many of Eastman's criticisms but retains the important element of independence usually felt to be essential by relatives and the general public.²

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1 Eastman N. Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries. *BMJ* 1996;313:1069-71. (26 October.)

2 Lingham R, Murphy E. Deadly services. *Health Service Journal* 1996;106(5527):22-3. (31 October.)

Confidential inquiry is best

EDITOR—We share Nigel Eastman's concern about the proliferation of individual inquiries after homicides by people with mental illness,¹ but we are less convinced that an audit of mental health services in general would be an adequate substitute. Although audit could identify important service omissions, it could not be assumed that there was any link between such omissions and the risk of homicide.

We prefer Eastman's other suggestion, that a modified national confidential inquiry into suicide and homicide by people with mental illness could be of considerable benefit. Since the inquiry relocated to Manchester earlier this year its aims and methods

have been overhauled.² We have now established a data collection system that draws on information from the Home Office's homicide index, psychiatric reports held by courts, and mental health teams. As a result we will collect some information on all homicides, including mental state at the time of the homicide and detailed information about contact with services by those who have been seen by mental health services at any time.

We shall therefore be able to compare psychiatric and non-psychiatric homicides and to examine the relation between psychiatric illness and homicide, regardless of contact with mental health services. In particular, we shall study the process of risk assessment in cases in which contact with services has occurred and chart the sequence of events, including violent incidents, that eventually led to tragedy. This would present opportunities for prevention.

Once we have information on possible indicators of risk and have recommended how services should intervene, we can then conduct an audit of all services, confident that specific omissions in specified circumstances are not only undesirable but dangerous.

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1 Eastman N. Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries. *BMJ* 1996;313:1069-71. (26 October.)

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Stabilisation of the population is necessary for health for all

EDITOR—In Alexander R P Walker and colleagues' letter the words "Despite the fearful outlook for developing populations" are followed by "the involvement of women must certainly be supported."¹ The authors do not, however, mention women's right to control their fertility through family planning methods^{2 3}—or that stabilisation of the population might improve the fearful outlook. When will we grasp that shortage of food and water is caused partly by people "longage"; that poverty and violence are both exacerbated by the increasing numbers to share limited resources; that "the stork is the bird of war"? In short, on a finite planet we cannot meet human needs (including health) without getting to grips with human numbers.

King and Elliott cite Rwanda as a "demographically entrapped country" with human numbers exceeding carrying capacity.⁴ I feel this keenly because I was born and brought up there, and my childhood playmates were among those slaughtered in the first week of the genocide, in April 1994. Clearly, the causes of that and the adjacent, more recent, humanitarian disasters are many, including tribal politics,

squalid propaganda, and abuses of power. But it has to be relevant that my friends shared their tiny landlocked country with around 2.5 million in the 1940s but with over 7 million by 1994.

Overpopulation is not the cause of all the world's ills. But it is the great multiplier of them, not least because more people are there to suffer the miserable outcomes: lack of health for most, and death for many. Nevertheless, I part company with King and Elliott over the issue of one child families. This treatment has too many unwanted side effects. We must take the people with us. In Central Africa the preference for at least one son promotes large families. We should campaign for girls to be valued as highly as boys. Cairo I, in 1994, was right to focus on empowering women. But helping women achieve an average family size of two (as is now often desired⁵) allows one child of each sex to many; it is demographically slower, but attainable without coercion (as Britain and Thailand show).

In 1994 I initiated the environmental time capsule project, apologising "to our grandchildren" for the overcrowding, violence, pollution, and scarcity of resources to be expected when each capsule is opened (in Britain, Mexico, South Africa, Australia, and the Seychelles) on 5 June 2044.⁵ It became an empowering opportunity, appealing to all for action—to make the apology unnecessary. Readers from a new country who wish to join this project should contact me.

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Telling the diagnosis to patients with Alzheimer's disease

Relatives should act as proxy for patient

EDITOR—I was interested to read Conor P Maguire and colleagues' short report about the attitudes of family members toward telling patients with Alzheimer's disease their diagnosis¹ because I recently performed a similar (though smaller) study in central Liverpool. In contrast to Maguire and colleagues, I found that 17 of 30 first degree relatives wanted their relative to know of the diagnosis of Alzheimer's disease. Reasons for this included "it's no use hiding it," "they could try to keep their mind working," "they could sort out their legal affairs," and "they could explain why they couldn't remember things." Several suggested that, even if not told, patients would "work it out for themselves."

The issue is important for several reasons. Firstly, there are legal matters (for

example, enduring power of attorney) that need to be resolved early in dementia, while the patient is still capable. Secondly, research on the "use it or lose it" hypothesis suggests that a patient may be able to delay the progression of disease with continued intellectual effort.² Thirdly, ethical issues and issues of confidentiality arise if a relative is told the diagnosis before (or instead of) the patient.

Best practice is probably to allow the relatives to act as proxy for the patient. They should be told the diagnosis, prognosis, and proposed management plan and should be given information about necessary legal and social matters. Once this is done, a joint decision can be made about telling the patient. The difficulties are well summarised by a local colleague, who suggests that "patients should be informed if there is positive benefit and not told if negative. This leaves an awful lot in the middle."

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- Maguire CP, Kirby M, Coen R, Coakley D, Lawlor BA, O'Neill D. Family members' attitudes toward telling the patient with Alzheimer's disease their diagnosis. *BMJ* 1996;313:529-30. (31 August.)
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Geriatricians' and psychiatrists' practice differs

EDITOR—Conor P Maguire and colleagues report that most relatives of patients with Alzheimer's disease would not want the patient to be told the diagnosis but would themselves wish to know if they developed the disease.¹ Practice in giving information to patients with dementia has been unexplored until recently and is fraught with difficulty, both ethical and practical.

We surveyed the practice of consultants in the psychiatry of old age and found that it varied widely.² Carers were almost invariably told of the diagnosis, whereas patients with severe dementia were almost never told. There was a tendency to tell patients who were moderately affected, but practice varied for patients with mild dementia. The frequencies with which patients were told their diagnosis and their prognosis were similar in all groups except those with mild dementia, who tended to be told their diagnosis more commonly than their prognosis.

We later used a similar method in a population of geriatricians, sending a questionnaire to a sample from the membership list of the British Geriatrics Society (n = 318). Subjects were asked to indicate the frequency with which they gave information on the diagnosis and prognosis to patients with dementia and to carers. They were to consider only cases in which the diagnosis was established, and patients were to be categorised as having severe, moderate, or mild disease.

A total of 138 subjects returned the questionnaire. Among the 133 (42%) who had completed the questionnaire in full and had experience of telling patients of the diagnosis of dementia, practice varied widely. The low proportion of severely

demented patients who were told (105 of 136 respondents told less than 20% of patients) contrasted strongly with the situation for carers (104 of the 138 respondents told over 80% of carers). The proportions for moderate and mild dementia fell between these extremes. The results for mild dementia show the wide variation in practice (39 of 133 respondents told less than 20% of patients, 40 told 20-80%, and 54 told over 80%). These results are similar to those obtained in the psychiatrists. The results for patients with mild dementia and carers are interesting in that the geriatricians seemed to tell patients more commonly and the carers less commonly than did the psychiatrists.

We believe that patients with mild dementia should generally be given enough information for them to understand their diagnosis and prognosis. Carers should not usually be given information that cannot also be imparted to the patient. Exchange of information should be patient led. The wide variation in practice suggests that further debate is needed on this issue.

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20% of patients may refuse consent to disclosure of information for Benefits Agency

EDITOR—Like many practitioners, I am increasingly being asked for medical reports relating to various benefits. These reports are requested by patients themselves, the Citizens Advice Bureaux, or the Benefits Agency. They attract no fee despite the considerable amount of both medical and secretarial time they require. Although the Citizens Advice Bureaux provide signed consent from the patient to the disclosure of clinical details, the Benefits Agency fails to do so, despite my having written to it specifically requesting this on several occasions. The agency states that the person making the claim has given consent, but it fails to provide evidence that this is the case.

Aware that it is the doctor's responsibility to know that the patient has given consent before medical details can be released, I wrote separately to 10 consecutive patients for whom the Benefits Agency had requested a report, asking for their signed consent. Eight patients gave their consent, but two refused to do so. If the results from my small survey can be general-

ised this would mean that a fifth of the reports provided to the Benefits Agency are being provided without the patient's full consent to the disclosure of clinical details.

I suggest that either the Benefits Agency should provide a photocopy of the signed consent allowing disclosure or practitioners should write to their patients separately asking for such permission.

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Study about prehospital emergency care was cited incorrectly

EDITOR—In their editorial on prehospital emergency care Matthew Cooke and colleagues claim that "giving fluid to patients with blunt chest trauma before transport to hospital increases mortality."¹ To support this claim they cite a study by Bickell *et al*, who concluded that, for hypotensive patients with penetrating injuries to the torso, delaying aggressive fluid resuscitation until operative intervention improves outcome.² This study, however, compared immediate and delayed fluid resuscitation in patients with penetrating chest or abdominal injuries, or both; no patients with blunt chest trauma were included. Patients assigned to the delayed resuscitation group received minimal fluid resuscitation until they entered the operating theatre; the period of delayed resuscitation did not end simply on their arrival in hospital.

Bickell *et al*'s study clearly challenges traditional accident and emergency practice, although the authors point out that it was not the need for fluid resuscitation that was under scrutiny but the timing and extent of this resuscitation. They also state that "the study results should not be directly extrapolated to hypotensive patients with blunt trauma" and that similar trials in such cases are clearly needed.

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- Cooke M, Hodgetts T, Smith R. Prehospital emergency care. *BMJ* 1996;313:1220-1. (16 November.)
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Women need to be warned about dangers of hormone replacement therapy

EDITOR—We welcome the responses generated by our letter emphasising the various risks of hormone replacement therapy.¹ The possibility of an aggregate net loss of life was discussed by Klim McPherson in his editorial.² This concern is strengthened by doubts about cardioprotection and the clear evidence, recently uncovered, that hormone

Table 1 Risk of breast cancer with hormone replacement therapy (HRT) in various studies

Study	Category	No of cases	Relative risk (95% CI)
Wingo <i>et al</i> , 1987 ⁴	Ever users:		
	Oestrogen for 75-99.9 months	32	1.9 (1.1 to 3.3)
	Ever users without ovaries:		
	Age 50-54 years	165	2.0 (1.2 to 3.2)
	Oestrogen for 25-49.9 months	41	1.9 (1.1 to 3.4)
Hunt <i>et al</i> , 1987 ⁵ and 1990 ⁶	Oestrogen for 75-99.9 months	21	2.4 (1.1 to 5.2)
	Ever users:		
Bergkvist <i>et al</i> , 1989 ⁷	HRT	50	1.59 (1.18 to 2.1)*
	Ever users:		
	Oestrogen + progestin	10	4.4 (0.9 to 22.4)
	Oestradiol 73-108 months	17	2.3 (1.2 to 4.3)
Persson <i>et al</i> , 1992 ⁸	Oestrogen ≥109 months	29	2.3 (1.1 to 4.8)
	Ever users:		
	Oestrogen + progestogen	14	1.3 (1.1 to 1.6)
Stanford <i>et al</i> , 1995 ⁹	Oestrogen + progestogen 7-11 years	NA	1.6 (1.1 to 2.1)
	Ever users with ovaries removed:		
Folsom <i>et al</i> , 1995 ¹⁰	Oestrogen + progestin	17	19.0 (1.8 to 199.4)
	Current users:		
	Any HRT	95	1.24 (0.99 to 1.56)
Colditz <i>et al</i> , 1995 ¹¹	HRT ≤5 years	NA	1.45 (1.03 to 2.06)
	Current users:		
	Conjugated oestrogens	270	1.32 (1.14 to 1.54)
	Oestrogen + progestin	111	1.41 (1.15 to 1.74)
	Progestin only	12	2.24 (1.26 to 3.98)

NA=Not available.

*Figures for 1987; incidence not given for 1990; mortality doubled between 1987 and 1990.

replacement therapy increases primary venous thromboembolic disease.³

Findings of an increased risk of breast cancer in large, well conducted studies are not cancelled out by the existence of apparently negative studies. In fact, all of the studies quoted in the responses found increased relative risks with exposure to hormone replacement therapy, either overall or in subgroups, ranging from 1.3 to 19 (table 1). Any increase in a common and fatal disease affects large numbers of women. There are about 30 500 new cases of breast cancer in England and Wales and 12 500 deaths annually. Even a 30% increase means several thousand extra cases and premature deaths each year. Would these women be happy with the explanation of a "small acceptable risk"?

When exogenous hormones are given as contraceptive pills an increase in breast cancer is no longer denied. Eleni Hemminki's editorial about the reanalysis of 54 combined studies by a collaborative group lists many reasons why the increases (24% for current users and 59% for those starting the pill before age 20) could be underestimated.¹² The median duration of use was only three years and the median starting age 26. Today, women are exposed from much younger ages.

Should not women be warned of the dangers? Warnings about the contraceptive pill in the 1970s were followed by pronounced falls in registrations of breast cancer for a decade among the specific age groups involved. This was against the prevailing trends.¹³ Overall, data from the Office for National Statistics show large increases for England and Wales. For women now aged 55-64 the incidence of breast cancer has more than doubled,

increasing by 137% between 1962 and 1991. These women were aged 25-34 in the 1960s, when they became the first generation to be exposed to the contraceptive pill.

Doctors must now review whether it is defensible or ethical knowingly to give healthy women contraceptive or menopausal hormones when increases in breast cancer, ovarian cancer,¹⁴ and thrombosis have been shown in reputable studies. Even any long term benefit in the prevention of fractures by hormone replacement therapy is being questioned.¹⁵ These concerns will be discussed at a meeting of DASH (Doctors Against Abuse from Steroid Sex Hormones) in London next June.

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1 Use of hormone replacement therapy [letters]. *BMJ* 1996;313:686-7. (14 September.)

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Effect of psychogeriatric team on depression in frail elderly people at home

More information is needed on subjects and interventions in study

EDITOR—Sube Banerjee and colleagues suggest that intervention by a psychogeriatric team produces a better outcome than standard care by a general practitioner.¹ Discussion of their paper in our journal club, however, raised several questions.

Firstly, from the methodological description in the paper it is not clear whether the general practitioners of the patients and the controls were told that the patients had fulfilled the criteria for caseness for depression or whether they were simply told that the patients were taking part in a controlled trial, with no further details given. This distinction is important for readers to ascertain whether the study simply compared interventions in a group who had been identified as depressed or also included effects of detection or non-detection.

Secondly, we thought that further data on the interventions in the control group should have been included. It could be argued that it was not the individual interventions themselves but their coordination by a multidisciplinary team that was important in terms of the eventual outcome. It could also be argued that the low rate of use of antidepressants in the control group at follow up was due to the fact that in primary care many patients prescribed antidepressants receive prescriptions of short duration.²

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- 1 Banerjee S, Shamash K, Macdonald AJD, Mann AH. Randomised controlled trial of effect of intervention by psychogeriatric team on depression in frail elderly people at home. *BMJ* 1996; 313:1058-61. (26 October.)
- 2 MacDonald TM, McMahon AD, Reid IC, Fenton GW, McDevitt DG. Antidepressant drug use in primary care: a record linkage study in Tayside, Scotland. *BMJ* 1996;313:869-1. (5 October.)

Results may have been due to intervention by a specialist

EDITOR—Sube Banerjee and colleagues report the effect of intervention by a psychogeriatric team on the outcome of depression in frail elderly people at home.¹ The overall design of their study was good, particularly as this is a difficult area to research. Our main criticism concerns the methodology, because the intervention used was not the usual team intervention. The subjects were all allocated to a senior psychiatrist as the keyworker, which is not usual practice and is not the team's usual philosophy. Might not the perceived benefits have been a result of medical intervention by a specialist? The keyworker was not blinded and would have been highly motivated and highly skilled. It cannot be concluded that the study showed the effect of the team. The study would have been better designed if the patients had been allocated to a range of keyworkers within the team, as is the team's usual practice.

Although the study suggests that antidepressants did not alone account for the difference between the patients and controls, its design does not allow the degree of effect resulting from any single component of the intervention to be determined. There was a fivefold difference in the rate of prescribing of antidepressants. A similar study investigating intervention by a community psychiatric nurse did not show such a pronounced effect, and, interestingly, the rate of use of antidepressants in that study was low.² A more detailed study investigating the effective components of intervention by a team is required. The response shown may reflect lack of access to care, as the usual practice of both primary and secondary services is to take a passive stance rather than be proactive. This was a proactive study, and the benefits produced may reflect this. The result might have been seen with any type of intervention given.

Although the paper concludes that referral to a specialist team is helpful, it also raises the issue of how the most vulnerable people in our population gain access to treatment for depression, whether from a general practitioner or a specialist team. Perhaps psychogeriatric services should be encouraged to target those people identified by social services as being most vulnerable, as the benefits of this have been shown in this paper. How can those with depression be identified and treated? Would more liaison and training with social services be helpful? What are public health measures such as the defeat depression campaign achieving in this area?

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- 1 Banerjee S, Shamash K, MacDonald AJD, Mann AH. Randomised controlled trial of effect of intervention by psychogeriatric team on depression in frail elderly people at home. *BMJ* 1996;313:1058-61. (26 October.)
- 2 Blanchard MR, Waterreus A, Mann AH. The effect of primary care nurse intervention upon older people screened as depressed. *Int J Geriatr Psychiatry* 1995;10:289-98.

Authors' reply

EDITOR—Roger Walters and Hilary Evans ask whether the general practitioners were informed that all the subjects fulfilled the criteria for caseness for depression. They were. Thus the control group received normal general practice care apart from the fact that the general practitioner had been told that the subject was depressed; this suggests that simply providing information is insufficient to change behaviour. Walters and Evans's second point concerns the intervention. The main aim of the research was to investigate whether these people could be successfully treated rather than to evaluate individual components of the management package. We agree that the multidisciplinary approach is likely to have led to optimum efficacy. No control subject was started on an antidepressant and then stopped it during the study. Our observations are unlikely to be a function of the duration of the prescription.

Gillian Pinner and colleagues suggest that the intervention differed in practice and philosophy from normal intervention by the team. We acknowledged that the intervention group had a doctor as their keyworker; this was the only way in which management differed from normal team processes. Around two fifths of the patients managed by the team have doctors as their keyworkers, so such management is not atypical. Pinner and colleagues question whether the effect was due to medical intervention by a specialist. This was not the case. Only one patient in the intervention group was prescribed a drug by the team; the rest were prescribed drugs by their general practitioners and managed jointly with them, as is the team's practice. Drug treatment was reviewed at multidisciplinary team meetings, and physical reviews were completed by general practitioners or appropriate medical teams. The comparison that Pinner and colleagues make is flawed. The cases of depression in the study that they cite were derived from general population screening rather than a disabled population,¹ and the low rate of prescription of antidepressants was due to low take up of advice to prescribe by the general practitioners rather than differing psychiatric practice.

Pinner and colleagues comment on the proactive nature of our study. An important finding was that the team approach was acceptable to depressed disabled elderly people identified through screening rather than through their seeking help; we achieved a high level of compliance with antidepressant treatment. We are glad that Pinner and colleagues agree with the need to develop and evaluate screening and management packages for primary health care and social services so that these patients' mental health needs can be better met.

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Plagiarism in the *BMJ*

Author should have acknowledged his source

EDITOR—In his article on the inadequacy of language Liam Farrell plagiarises an idea without crediting it to its originators¹: Douglas Adams and John Lloyd have provided a book of definitions of many place names, *The Meaning of Liff*.²

"Droitwich" is defined as "A street dance. The two partners approach from opposite directions and try politely to get out of each others way. They step to the left, step to the right, apologise. Step to the left again, apologise again, bump into each other and repeat as often as unnecessary."² The suggestion that place names "loaf around on signposts" is taken directly from the introductory page of Adams and Lloyd's book.

I would have hoped that a journal such as the *BMJ* would work to eliminate such plagiarism.

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- 1 Farrell L. The unbearable inadequacy of language. *BMJ* 1996;313:1660. (21-28 December.)

- 2 Adams D, Lloyd J. *The meaning of Liff*. London: Pan, 1983.

Author's reply

EDITOR—Firstly, I must thank Helen Vecht for the tullywinney. The basic concept of coining new words is not new and has been used by, among others, Lewis Carroll ("to gyre and gimble in the wabe") and James Thurber. The original version of my article acknowledged the debt to *The Meaning of Liff*, but when I requested permission from Douglas Adams's agent about this it was refused. I believe, however, that my article was the first to use this literary device to augment our lamentably limited medical vernacular.

Secondly, I didn't know about the Droitwich; I was quoting from Thurber, so this may be a case of great minds thinking alike. Cogging from one author is indeed plagiarism, but cogging from two counts as research—mandatory for all serious writers.

Thirdly, for loafing about the crossroads I have no defence; the phrase was obviously droitwicking about in my subconscious.

Tullywinney (n): the rush that a columnist gets from proof that somebody out there actually reads his stuff and is inspired enough to complain. He lay back and lit a cigarette; "Darling," he said, "That was almost as good as a tullywinney."

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