Letters

Asian doctors are still being discriminated against

EDITOR—Five years ago, when we published our research on the discrimination faced by ethnic minority doctors applying for posts as senior house officers,[1] the Department of Health considered using our methodology to monitor progress in tackling discrimination. At a recent BMA conference to discuss racial discrimination in the medical profession several speakers pointed out that racial discrimination was still endemic in the NHS and that direct policy initiatives to tackle specific examples of discrimination—for example, in the shortlisting of job applications for hospital posts—were lacking.[2] We therefore assessed whether the discrimination that we highlighted in 1992 was still prevalent because it would have serious implications for the implementation and assessment of anti-discrimination policies by the General Medical Council and the NHS Management Executive.

We repeated our survey in March and April of this year, using exactly the same methods as in 1992, to see whether British trained doctors with Asian names were less likely to be shortlisted for posts as a senior house officer. Matched pairs of applications were sent for 50 advertised posts covering the specialties of paediatrics, general medicine, geriatrics, psychiatry, obstetrics and gynaecology, general surgery, orthopaedics, and vocational training schemes. Table 1 shows the results of the survey. There was again evidence that a lower proportion of Asian than English candidates were shortlisted: 36% *v* 52% (difference 16%; 95% confidence interval -0.4% to 25%).

Our results show that discrimination against ethnic minority candidates is still prevalent five years after we first highlighted the problem and despite numerous public commitments by the profession's leaders and employers to deal with it. The discrimination is being practised by consultants, who are responsible for shortlisting for junior posts. These consultants have a responsibility to maintain the highest ethical and moral standards, and their employers have the added responsibility to ensure that equal opportunity policies are being implemented and monitored. Although the NHS Management Executive specifically requires employing authorities to carry out ethnic monitoring, only five trusts out of 50 sent equal opportunity monitoring forms to our sample.

Five years ago we suggested several mechanisms, including standard and anonymised application forms together with strict enforcement and publication of the results of equal opportunity monitoring, as a means of reducing the possibility of discrimination. Sadly, little seems to have changed, and it is an indictment of our profession that we still seem to tolerate a situation in which people's careers and livelihoods are jeopardised simply because they have the wrong name (and hence the wrong colour of skin).

Aneez Esmail *Vice president*
Sam Everington *Vice president*
Medical Practitioners Union, London

1 Esmail A, Everington S. Racial discrimination against doctors from ethnic minorities. *BMJ* 1993;306:691-2.
2 Esmail A, Carnall D. Tackling racism in the NHS. *BMJ* 1997;314:618-9. (1 March.)

Table 1 Numbers of white and Asian applicants for jobs as senior house officers who were shortlisted (50 matched pairs)

White applicants shortlisted	Asian applicants shortlisted		
	Yes	No	Total
Yes	15	11	26
No	3	21	24
Total	18	32	50

McNemar's test: P=0.057 (exact).

What happens when the private sector plans hospital services for the NHS

Authors' figures were wrong for Edinburgh ...

EDITOR—Allyson M Pollock and colleagues state that they had difficulty in obtaining business plans, planning documents, and accurate bed numbers from all the trusts that they looked at.[1] None of the authors requested detailed information from the Royal Infirmary of Edinburgh NHS Trust; had they done so the trust would have corrected several mistakes in their assumptions, in the data that they used, and therefore in their conclusions. The Lothian acute services strategy was published in 1992, before the government introduced the private finance initiative. The bed numbers in that strategy are consistent with those being planned today and reflect the closure of smaller hospitals. The authors are wrong to assert that the private sector planned the size of the hospital and that, had public sector finance been available, different planning guidelines would have been used that would have led to a larger hospital.

Table 1 Bed complement at Royal Infirmary of Edinburgh NHS Trust

Specialty	At 31 March 1997	New Royal Infirmary of Edinburgh, at 2003
Gastrointestinal, liver, and renal total	124	120
Orthopaedics total	197	149
Medicine and elderly total	338	155*
Cardiology, vascular, and respiratory total	153	171
Reproductive medicine total	151	123
Head and neck total	52	25
Assessment	65	55
Intensive therapy unit and high dependency unit	56	71
Trust total	1136	869
Less:		
Communicable diseases and care of elderly (at City Hospital)	100	
Orthopaedics (at geriatric orthopaedic rehabilitation unit, Chalmers Hospital)	26	
Subtotal	126	
Plus:		
At Edinburgh General Hospital:		
General surgery	10	
Medical specialties	48	
Obstetrics	15	
Gynaecology	15	
Neonatology	8	
Subtotal	96	
Revised total	1106	869

*General medicine beds have been reallocated to specialties such as cardiology, while assessment centre replaces acute medical admissions unit.

Table 1 provides the detailed bed numbers planned for the new Royal Infirmary. The article stated that bed numbers will drop from 1292 to 814 acute beds. The figure of 1292 overstates the current numbers by 156 (actual 1136). This overstatement is more dramatic because the authors omitted the Chalmers Hospital from the hospitals comprising the Royal Infirmary group. The current total of 1136 further falls to 1106 because of planned transfers of services to other trusts. Thus the true comparison is 1106 versus 869 acute beds. A further 30 hotel beds give a total of 899, a drop of 19%, not 37% as stated in the article. No private beds are planned, and inpatient activity is planned to rise by 12%, not fall by 28% as the article suggests.

The authors are wrong to suggest that the reconstruction of acute hospital services

in Lothian was not underpinned by strategic planning. The Lothian acute services strategy was published after extensive consultation. In 1994 the secretary of state approved it. The trust, in partnership with the University of Edinburgh and Lothian Health Board, consulted staff and other stakeholders extensively in the detailed planning of the new hospital. The statutory area medical committee approved all key decisions, including those relating to clinical performance indicators.

Finally, the Lothian strategy cannot be taken in isolation. It is part of an integrated healthcare strategy which required the acute sector to release £15m annual revenue as a result of these capital projects, allowing appreciable investments in primary care and the community. Private finance has to be paid for just like public sector capital. We are proud of the outcome of this initiative, which will give the NHS one of the most modern hospitals in the world.

John J Owens *Chief executive*
Cairns Aitken *Chairman*
Royal Infirmary of Edinburgh, Edinburgh EH3 9YW

1 Pollock AM, Dunnigan M, Gaffney D, Macfarlane A, Majeed FA on behalf of the NHS Consultants' Association, Radical Statistics Health Group, and the NHS Support Federation. What happens when the private sector plans hospital services for the NHS: three case studies under the private finance initiative. *BMJ* 1997;314:1266-71. (26 April.)

... and Bromley

EDITOR—I was concerned to read Allyson M Pollock and colleagues' article on what happens when the private sector plans hospital services for the NHS.[1] I am chief executive of Bromley Hospitals NHS Trust, and my prime concern was about the authors' references to the private finance initiative scheme in Bromley. These references included inaccurate statements about the trust's assessment of the likely number of beds required in five years' time when our new hospital is built. The information quoted about projected inpatient activity, bed occupancy, and day case rates is wrong. The principal author of the article did not contact either Bromley Hospitals NHS Trust or Bromley Health (the main purchaser of hospital services for Bromley residents) for any information or to check the figures quoted. We did pass a range of detailed information to the Community Care Protection Group in Bromley, which I see is acknowledged at the end of the article. It is a shame that this information has been misquoted. Information has been made available to the public and continues to be so.

I strongly dispute the statement that "clinicians and public health professionals have not been involved in planning the future of our acute health care services." In Bromley consultant medical staff and other professionals have been closely involved in the process of planning what will be required in the new hospital and continue to be involved in details of the design. We have specified our clinical requirements to the private sector consortium, not vice versa. Bromley Health took a leading role in planning the overall strategy for acute services and has approved our proposals as satisfying these requirements. Our main emphasis in the proposals is to make the best possible use of the resources available to us, to the benefit of patients and their carers.

The article seems to have been written from a predetermined position. I would expect a more objective approach that contributes to the debate on the future nature of acute services—which, incidentally, is not simply about the number of beds.

M D Rees *Chief executive*
Bromley Hospital NHS Trust, Farnborough Hospital, Orpington, Kent BR6 8ND

1 Pollock AM, Dunnigan M, Gaffney D, Macfarlane A, Majeed FA on behalf of the NHS Consultants' Association, Radical Statistics Health Group, and the NHS Support Federation. What happens when the private sector plans hospital services for the NHS: three case studies under the private finance initiative. *BMJ* 1997;314:1266-71. (26 April.)

An increase in hospital beds is not necessarily the best investment

EDITOR—Allyson M Pollock and colleagues criticise planning under the private finance initiative.[1] Their paper, however, has several weaknesses. The authors blame the private sector for cuts in beds, but private consortiums include construction companies, which would be pleased to build bigger hospitals. I know from wide personal experience that the restraint on numbers of beds comes from the NHS, particularly regional offices, which will not endorse a business case without substantial reductions in beds and costs.

The authors seem to accept the concept of a "right" number of beds for the NHS. In practice, funding for the NHS could rise or fall and permit more or fewer beds to be staffed. Clinical decisions would then change to fill beds with patients deemed suitable at the new threshold, with gains or losses in public health. The rise in medical emergencies has partly occurred because of reductions in the length of stay, and the clinical reasons for more admissions remain unclear. Nor is an increase in hospital beds a necessarily better investment than more community services or social infrastructure.

Those who advise NHS planners cannot ignore the wide variation in practice. When length of stay in a specialty is short in part of a region it is hard to justify extra beds locally based on a much lower throughput of cases. While developments may seem too small, this is because they assume that all local specialties will work with the intensity—and resulting higher or lower quality—of those currently achieving the fastest throughput of cases.

Faced with the apparent efficiency of the few, the planners are naturally attracted to extrapolating it to the many and trying to extract the maximum caseload from the minimum facilities and limited budgets. Those inside the NHS have not shown rigorously that the pursuit of crude efficiency leads to substantially worse care, and the evidence from readmissions is limited and unconvincing. To a considerable degree, hospitals are the victims of their own changes in performance and therefore must also "blame" themselves.

Peter A West *Senior lecturer in health economics*
Division of Public Health Sciences, UMDS, London SE1 7EH

1 Pollock AM, Dunnigan M, Gaffney D, Macfarlane A, Majeed FA on behalf of the NHS Consultants' Association, Radical Statistics Health Group, and the NHS Support Federation. What happens when the private sector plans hospital services for the NHS: three case studies under the private finance initiative. *BMJ* 1997;314:1266-71. (26 April.)

Functions of district general hospitals have changed

EDITOR—Allyson M Pollock and colleagues' conclusion that proposals made under the private finance initiative are underproviding beds is based on comparison of the proposed figure with that expected from an extrapolation of historical trends.[1] The flaw in this approach is that it assumes continuity of the historical pattern of the organisation of services along the lines of traditional district general hospitals and takes no account of important changes in practice such as day surgery. To derive a view of the impact of day surgery from the basket of cases recommended in the Audit Commission's report, which excluded, for example, treatment of hernia, varicose veins, and haemorrhoids, is not realistic. We have to recognise the better performance standards being achieved in other countries and plan our future bed requirements, taking account of achievable future standards for each discipline individually. I am a former regional director of public health medicine with experience of planning over 50 hospitals worldwide; in the private finance initiative projects on which I have advised my greatest concern has been about projects with too many beds, not too few.

To me, the main concern about hospital planning proposals, however funded, is the lack of any strategic framework that will define the desirable scope, size, and location of the components of a comprehensive healthcare system for a large population. In the absence of a strategy, trusts are simply trying to update their historical roles—a course that pressures of staffing, technology, and money will render untenable in the long run.

The central change, which is still not widely recognised, is that the functions of the district general hospital have polarised. They are now divided into those that need to be supported by complex technology and interaction between clinicians and those that can be undertaken on a day care basis (which now include most traditional elective work of district general hospitals) and can be carried out at decentralised local hospitals. For this pattern to work most effectively and to make the most efficient use of resources, it has to be a single healthcare delivery entity

with a unified pattern of staffing and funding.

Ronnie Pollock *Senior partner*
MPA International Health Strategy and Planning, London NW1 2EW

1 Pollock AM, Dunnigan M, Gaffney D, Macfarlane A, Majeed FA on behalf of the NHS Consultants' Association, Radical Statistics Health Group, and the NHS Support Federation. What happens when the private sector plans hospital services for the NHS: three case studies under the private finance initiative. *BMJ* 1997;314:1266-71. (26 April.)

Patients and staff need facilities required for modern medicine

EDITOR—Experience with new hospital buildings in Britain has been limited in recent years. The private finance initiative seemed to be an imaginative new scheme which could lead to the replacement of outdated hospitals. It has now been condemned as a failure.[1] It is right to be critical[1 2] but not to blame the initiative for all the faults of hospital planning. "Much would have applied equally well to health authority decision making before the private finance initiative."[3] Allyson M Pollock and colleagues have criticised lack of openness and, leading from that, question whether the proposed bed provisions are adequate.[2]

Funding through the private finance initiative depends on annual repayments of capital and interest over a number of years. The capital sum required can be reduced by sales, or leasing, of vacated sites and buildings. To be financially sound the scheme requires savings to be identified, to balance these recurrent costs. Amalgamation of several hospitals is involved in each of the three examples that Pollock and colleagues cite. Maintenance costs should be much lower in a new hospital than several old hospitals. It is also reasonable to expect that fewer beds are required when bed occupancy in the replaced beds is less than 100%. Furthermore, planning for a sufficient number of intensive care and high dependency beds allows a lower dependency in the rest of the hospital, which requires less capital expenditure, so that capital costs of 5-8% could be saved.[4]

Reducing beds saves capital and therefore repayment costs. So there is pressure not to overprovide, which is understandable, especially with uncertainty over changes in practice. If hospitals are to avoid chaos, however, plans must be included for increases in the number of beds, and core facilities must be designed to make this possible. Overflow beds will be essential until the new hospital capacity can be tested.

The private finance initiative is only a tool, and any tool can be improved on. We need to watch how the initiative operates so as to learn how to speed up schemes and ensure their cost effectiveness. We cannot do this until the first hospitals are in action. More delays therefore would not be in the interests of the NHS. It is time that our patients and medical and nursing staff had the facilities required to practise modern medicine. The private finance initiative is probably the only practical way that this can be done soon. The bureaucratic barriers must be broken down.

Michael Rosen *Chairman, Clinical Standards Advisory Group*
45 Hollybush Road Cardiff CF2 6SZ

1 Cresswell J. PFI condemned as a failure. *BMJ* 1997; 314:1222. (24 April.)
2 Pollock AM, Dunnigan M, Gaffney D, Macfarlane A, Majid FA on behalf of the NHS Consultants' Association, Radical Statistics Health Group, and the NHS Support Federation. What happens when the private sector plans hospital services for the NHS: three case studies under the private finance initiative. *BMJ* 1997;314:1266-71. (24 April.)
3 Boyle S. The private finance initiative. *BMJ* 1997;314: 1214-5. (24 April.)
4 Royal College of Anaesthetists and Royal College of Surgeons of England. *Report of the joint working party on graduated patient care.* London: RCS, 1996.

Authors' reply

EDITOR—We used publicly available data in our article. The Edinburgh data were given to Lothian Health Board's local medical committee, while those for Calderdale and Bromley were given to local community groups involved in the consultation process. M D Rees states that the data provided on behalf of Bromley Hospitals Trust were wrong. We quoted the data that the trust provided and are disturbed that they were incorrect.

The data provided to the local medical committee show a decline in bed availability of 37% at the Royal Infirmary of Edinburgh between 1995-6 and 2003. The trust's letter shows a smaller decrease as it compares projected bed availability in 1997-8, two years after the planned reductions started, with figures for 2003. The figures in the letter also include 55 24-hour day assessment beds and 30 hotel beds in 2003, even though these are not normally counted as inpatient beds. The statement that activity will rise by 12% between 1995-6 and 2003 contradicts data provided to the local medical committee. These predict a reduction in inpatient discharges of 25% from 59 812 in 1995-6 to 45 047 in 2003. The local medical committee has yet to receive detailed information about the integrated healthcare strategy.

Peter West suggests that we "accept a concept of the 'right' number of beds for the NHS," but we acknowledged that recent trends in bed availability reflect the decline in lengths of inpatient stay and the move towards day case surgery. Despite moves towards primary and community care, however, numbers of emergency admissions and inpatient episodes continue to rise, at a time when people are living longer but not becoming healthier.[1] West and Ronnie Pollock fail to acknowledge the hospital crises in the past few winters and the levelling off of bed availability.[2] These suggest that the scope for further reduction may be limited.

A major concern is the lack of flexibility in schemes involving contracts of up to 60 years. This may mean insufficient capacity in the immediate future. In the longer term the schemes may become inappropriate as patterns of service change. The private finance initiative fragments the planning process.[3]

The initiative may also be a poor use of scarce NHS funds. We draw Michael Rosen's attention to a briefing by the company that ran the previous government's database on the initiative. This questioned whether the initiative offered more benefits than the same projects financed from public funds. It added that "Increasingly the costs of ... private sector schemes ... have to be met through savings in the core clinical activities of the trust ... for which the trust and ultimately the purchaser is at risk."[4]

Allyson M Pollock
Department of Public Health Medicine, St George's Hospital Medical School, London SW17 0RE

Matthew Dunnigan
Alison Macfarlane
On behalf of the NHS Consultants' Association, Radical Statistics Health Group, and NHS Support Federation

1 Charlton J, Murphy M, eds. *The health of adult Britain 1841-1994.* Vol 1. London: Office for National Statistics, 1997. (Decennial supplement series D5 No 12.)
2 Department of Health. NHS hospital activity statistics: England. *Statistical Bulletin* 1996;No 23.
3 Boyle S. The private finance initiative. *BMJ* 1997;314: 1214-5. (26 April.)
4 Newchurch. *Newchurch PFI briefing. Delivering PFI health care solutions.* London: Newchurch, 1997.

Consensus statement on criteria for the persistent vegetative state is being developed

EDITOR—Clare Dyer reports on a patient in a persistent vegetative state who the English High Court said should be allowed to die, and she refers to concern about the diagnostic criteria drawn up by the Royal College of Physicians.[1 2] Although all three medical experts in the case testified that the patient was, in their opinion, in a persistent vegetative state, she did not satisfy all the criteria of the royal college. This led to headlines about the court sanctioning withdrawal of artificial feeding from a patient who was not in a persistent vegetative state.

While visual fixation and tracking are often the first sign of emergence from the vegetative state, it is recognised that some patients who remain in this state do show such activity.[3] By itself this behaviour need not reflect the return of conscious awareness but can indicate reflex activity mediated through brainstem structures, according to the United States Multi-society Task Force[4] and more than one study since. Similarly, a blink response to visual menace, particularly when the patient does not show habituation, does not imply consciousness. Neither does nystagmus indicate consciousness. Postmortem neuropathological studies indicate that some cortical areas are often spared in patients who were indubitably vegetative on bedside examination before they died, although subcortical connections are always severely damaged. Given that the vegetative state is a behavioural diagnosis, it is not necessary to show that there is no cortical activity. What matters is to be as certain as possible that there is no behaviour indicat-

ing conscious awareness or, in the words of the original description of this state, "no evidence of a working mind."[5]

We are members of a working group currently involved in producing a consensus statement on both the vegetative state and the minimally conscious state. This will emphasise the need for more research into the features of these two states and their importance for the prognosis and management of each.

Bryan Jennett *Emeritus professor of neurosurgery*
Department of Neurosurgery, Institute of Neurological Sciences, Glasgow G51 4TF

Ronald Cranford *Professor of neurology*
Department of Neurology, Hennepin County Medical Center, Minneapolis, MN 55415, USA

Nathan Zasler *Director*
National Rehabilitation Consortium, Glen Allen, VA 23060, USA

1 Dyer C. PVS criteria put under spotlight. *BMJ* 1997; 314:919. (29 March.)
2 Royal College of Physicians. Working group on the permanent vegetative state. *J R Coll Physicians* 1996;30: 119-21.
3 Giacino JT, Zasler N. Outcome following severe brain injury: the comatose, vegetative and minimally responsive patient. *J Head Trauma Rehab* 1995;10:40-56.
4 Multi-society Task Force on PVS. Medical aspects of the persistent vegetative state. Part I. *N Engl J Med* 1994; 330:1499-508.
5 Jennett B, Plum F. Persistent vegetative state after brain damage; a syndrome in search of a name. *Lancet* 1972;i:734-7.

The future of Britain's high security hospitals

Primacy of patients must be re-established as sole reason for hospitals' existence

EDITOR—Elaine Murphy's editorial on the future of Britain's high security hospitals, though historically informative, naively focuses on the need to oust the Prison Officers' Association in order to facilitate changes in both the culture and values of Britain's three special hospitals.[1]

The fundamental role of special hospitals is to treat mentally disordered offender patients who present a "grave and immediate danger" to the public. It is not unreasonable to argue that the patients we currently care for in special hospitals could be cared for elsewhere. Indeed, the government's 1994 review of high security services came to just such a conclusion.[2] It is the lack of ownership of such a radical vision that is the most important impediment to change. It will not be easy persuading the myriad interested parties that the special hospitals must reconfigure themselves. The agency responsible for brokering this development is the High Secure Psychiatric Services Commissioning Board, which is yet to announce publicly its strategic purchasing intentions.

Each of the three special hospitals is a large institution; they joined the NHS as three separate health authorities in April 1996. The complexity of their internal dynamics is bewildering. There are, however, certain key challenges that are acknowledged by all staff committed to the agenda for change. From a clinical perspective there is an urgent need to re-establish the primacy of the patient as the sole reason for the hospitals' existence. Once this has been achieved it will be easier to direct the clinical resources to maximise benefit for patients. From a managerial perspective the challenges are similar. The clinical agenda needs to drive the managerial agenda and not vice versa. Clinicians need to be actively involved in the business planning cycle, there needs to be real devolution of budgetary responsibility, and there is an urgent need to raise the "psychological-mindedness" of managerial systems and processes to reflect more accurately the extremely traumatising nature of the work in which the staff are involved.

In conclusion, the future of Britain's high security hospitals will depend not only on the leadership qualities shown by staff employed by the hospitals but also on the courage and vision of the members the High Secure Psychiatric Services Commissioning Board, the regional offices of the NHS Executive, and government officials. Otherwise any paradisal expectations will only shatter against granite realities.

Raymond F Travers *Consultant forensic psychiatrist*
Ashworth Hospital Authority, Parkbourn, Maghull, Liverpool L31 1HW

1 Murphy E. The future of Britain's high security hospitals. *BMJ* 1997;314:1292-3. (3 May.)
2 Department of Health and Home Office. *Report of the review of high security services.* London, HMSO, 1994.

Many staff working in secure psychiatric facilities want to become members of Prison Officers' Association

EDITOR—I am writing on behalf of all members of the Prison Officers' Association working not only in special hospitals but in the overcrowded penal system. Over the past decade the penal system has become the dumping ground for those whom the government and academics such as Elaine Murphy have abandoned in the name of liberalisation and financial expedience.[1] Murphy contacted the Prison Officers' Association to discuss her editorial. She stated that she welcomed the association's help but expressed concern that she would have only three days to write the editorial—a fact that is obvious to anyone reading it.

Murphy makes the point that in the past 10 years many "mentally disturbed offenders" (not a very scientific term) have not been held in special hospitals. We agree. Most of this group of mentally ill offenders are in overcrowded prisons. The main cause of this is a failure to provide medium secure psychiatric beds. The government plans to provide only 1000 beds, when we believe that 3000 are needed.

Many of the recommendations by the committee of inquiry into Ashworth Hospital chaired by Louis Blom-Cooper had a disastrous effect on the control and stability of special hospitals.[2] Patients and staff were living and working in near anarchy, with patients staying awake all night and then being incapable of receiving treatment because they spent the daytime asleep; this regime was directly attributable to the inquiry teams' "uncaring" recommendations. So what of "first rate" managers? Even when they were informed, they failed to take any managerial action or to make the secretary of state aware of many serious allegations. The chairman of the National Committee for Special Hospitals was thanked in the House of Commons for raising these matters.

The Prison Officers' Association finds it disturbing that Murphy has resorted to old fashioned trade union bashing. We have been approached by many staff working in regional secure units and other secure psychiatric facilities who want to become members of the association. Our national executive committee is currently considering this. We make no apology to Murphy that those who work with these dangerous, violent, and psychiatrically damaged people choose the Prison Officers' Association as the most appropriate representative body.

I would ask that people who express similar views to those of Murphy, Louis Blom-Cooper, the mental health charity MIND, and the professional associations (the Royal College of Nursing, BMA, etc) stop regurgitating outdated bigoted nonsense that does nothing to address the real problems that we all face.

Brian Caton *Secretary, national committee for special hospitals*
Prison Officers' Association, North Regional Office, Leeds LS10 1BH

1 Murphy E. The future of Britain's high security hospitals. *BMJ* 1997;314:1292-3. (3 May.)
2 Blom-Cooper L, Brown M, Dolan R, Murphy E. *Report of the committee of inquiry into complaints about Ashworth Hospital.* London: HMSO, 1992. (Cmnd 2018-1.)

Young people, alcohol, and designer drinks

Conventional drinks are a much greater threat to health than designer drinks

EDITOR—Kirsty Hughes and colleagues report associations between young people, alcohol consumption, and designer drinks, but their conclusions are not fully supported by the data.[1]

Firstly, the definitions of designer drinks in their tables and analyses are unclear. In their introduction they define designer drinks as "a new range of fortified wines, such as MD 20/20 or 'Mad Dog' and strong white ciders, such as White Lightning and Ice Dragon." In table 6, however, only MD 20/20 is included, and in table 7 strong white cider, fortified/tonic wines, MD 20/20, and Buckfast appear. In table 8 only strong white cider and fortified wines are included. Which of these constitute designer drinks in each table or the authors' conclusions is unclear.

Secondly, the authors suggest that designer drinks are particularly attractive to 14-16 year olds. Yet table 7 shows strong white cider ranking third, fortified/tonic wines fourth, MD 20/20 sixth, and Buckfast eighth, according to the number of 14-16

year olds who had drunk conventional and designer drinks. By far the most popular drinks in this age group remain beer (ranked first) and spirits (ranked second).

Thirdly, the authors claim that designer drinks are associated with heavier alcohol consumption, but the data to support this are not adequately presented. Only the average number of units consumed on one occasion are presented for strong white cider (6.8 units), fortified/tonic wines (6.0 units) and conventional wines (2.1 units); beer or spirits are omitted entirely.

Clearly there is a problem with young people and alcohol. Although the qualitative research presented in this paper indicates that designer drinks are an emerging problem, however, the quantitative results suggest that conventional drinks (particularly beer and spirits) remain a much greater threat to health in adolescents.

Paul Catterson *Third year medical student*
Sarah Hilton *Third year medical student*
Medical School, University of Newcastle, Newcastle upon Tyne NE2 4HH

Martin White *Senior lecturer in public health*
Department of Epidemiology and Public Health, School of Health Sciences, Medical School, University of Newcastle

1 Hughes K, MacKintosh AM, Hastings G, Wheeler C, Watson J, Inglis J. Young people, alcohol, and designer drinks: quantitative and qualitative study. *BMJ* 1997; 314:414-8. (8 February.)

Authors' reply

EDITOR—Paul Catterson and colleagues raise three queries about our paper. We will respond to each in turn.

Firstly, the definition of designer drinks given in our opening paragraph, and quoted by Catterson and colleagues, applies throughout the paper. For the sake of brevity we limited ourselves to individual brands in the tables: adding the category "designer drinks" (table 1) simply confirms our findings and was therefore, we thought, unnecessary.

Secondly, with regard to the popularity of conventional drinks, Catterson and colleagues are right: our data do show that conventional alcoholic drinks are more likely to be consumed by young people than are designer drinks. This is to be expected, given that, in the year the research was done, beer and lager accounted for 53%, spirits for 21%, and light wines for 18% of total spending on alcohol, while cider and perry accounted for only 5% and fortified wines 2%.[1] The point of our paper, however, is that if we examine these apparently reassuring data more closely we find two worrying trends:

- designer drinks decrease in popularity with age while conventional drinks do the reverse, which suggests that designer drinks particularly appeal to young people
- the consumption of designer drinks is more strongly associated with drinking in less controlled circumstances, higher alcohol consumption, and greater drunkenness than is the consumption of conventional drinks.

Thirdly, alcohol intake was measured by asking subjects about their last drinking occasion—a standard procedure in this field.[2] Figures for spirits and beers were omitted, again for the sake of brevity. They confirmed the data and conclusions already presented in the paper and were therefore thought to be unnecessary. In detail, young drinkers consumed, on average, the following units from individual types of drink: strong cider 6.8 units; fortified wine 5.7 units; beer 5.1 units; spirits 4.6 units; liqueurs 4.1 units; conventional cider 4.1 units; and conventional wines 2.1 units.We would repeat our conclusion that, while the consumption of conventional alcoholic drinks by young people is unlikely to be free from risk, the advent of designer drinks represents a worrying new development that requires a focused response.

Anne Marie MacKintosh *Research officer*
Gerard Hastings *Director*
Kirsty Hughes *Research officer*
Centre for Social Marketing, University of Strathclyde, Glasgow G4 0RQ

Colin Wheeler *Senior lecturer*
Department of Marketing, University of Strathclyde

Jonathan Watson *Specialist development and evaluation officer (substance misuse)*
James Inglis *Consultant in public health medicine*
Health Education Board for Scotland, Edinburgh EH10 4SG

1 Key Note. *The UK drinks market.* Middlesex: Key Note, 1995.
2 Aitken PP. *Ten-to-fourteen-year-olds and alcohol. A developmental study in the central region of Scotland.* London: HMSO, 1978.

Table 1 Consumption of designer and conventional drinks by age (all subjects consuming up to 30 units on last occasion; n=548, weighted)

	Age (years)							
Type of drink	All ages (n=548)	12 (n=61)	13 (n=68)	14 (n=88)	15 (n=105)	16 (n=112)	17 (n=115)	P value*
Beer	267	22	29	44	51	64	57	<0.05
Non-fortified/non-tonic wine	89	17	19	15	18	12	8	<0.0001
Strong white cider	83	10	16	20	16	12	10	<0.01
Conventional cider	91	9	14	16	18	14	20	0.621
Spirits	166	8	13	22	26	41	56	<0.0001
Fortified/tonic wines	68	11	10	11	15	12	8	<0.05
Fortified wines	49	8	8	8	12	9	4	<0.05
MD 20/20	35	7	7	6	10	6	0	<0.01
Tonic wines	24	4	3	4	4	4	6	0.578
Buckfast	24	4	3	4	4	4	6	0.578
Liqueurs	38	2	3	4	5	9	15	<0.01
Designer drinks†	116	13	22	25	25	18	14	<0.01

*χ^2 test for trend. †Strong white cider or fortified wine.

Legal abortions save women's lives

EDITOR—As doctors who saw the serious and sometimes fatal consequences of illegal abortion before 1967, we believe strongly that equating legal abortion with the inhumanity practised by doctors in Nazi Germany is wrong.[1] In all societies throughout history women faced with an unwanted pregnancy have resorted to abortion, and millions have died in the attempt. While we all wish that we lived in a society in which women did not feel the need to deal with an unplanned pregnancy in this way, no country has yet reached that ideal state. The tragic experience in Romania in 1966, where the maternal death rate rose sixfold when access to legal abortion was restricted, is an example of the strength of women's resolve not to bear a child they do not want.

In 1935 the BMA set up a committee to look at the question of changing the abortion law because of concerns about the high and static maternal mortality of 4-6/1000 deaths for almost a century. At that time it was estimated that the number of abortions performed illegally was anywhere between 50 000 and 150 000 a year. Doctors who perform abortions consider that the lives of women are saved by their performing abortions legally rather than leaving women to kill themselves in the attempt. Most doctors today in Britain have never seen a woman die from such an abortion, and we hope that they never will. Working to reduce the need for abortion is much more useful than suggesting that doctors are acting like Nazis.

Wendy Savage *Press officer, Doctors for a Woman's Choice on Abortion*
19 Vincent Terrace, London N1 8HN
(w.savage@qmw.ac.uk)

John McGarry **Kathleen Frith**
Marcus Filshie **Malcolm Macnaughton**
Barbara Clayton **Peter Huntingford**
Peter Diggory **Fleur Fisher**
Ian McGillivray **David Paintin**

1 Thomson HJ. The BMJ's Nuremberg issue. *BMJ* 1997; 314:439. (8 February.)

Abortion must not be advocated as preventive solution to unwanted pregnancy

EDITOR—Jacqui Wise's coverage of the MORI survey on abortion was biased, mainly because of her misleading interpretation of the findings but also because the survey was commissioned by and commented on only by proabortion groups.[1]

The title and article gave the impression that the public supports all abortions carried out in Britain. The figures given show that the public does support legal abortion. The noteworthy findings, however, are that people have different views on abortion depending on the circumstances. Most peo-

ple in this survey "disapproved" of "social abortions" (the categories of "when the woman cannot afford to have the child" and "when the woman does not wish to have the child for any reason"). Since over 95% of abortions carried out in Britain are done for these reasons (according to the Office for National Statistics' data), a tightening of the law may well be supported by the public. One could also conclude from the survey that the current media attention given to the antiabortion campaign is warranted and that more balanced coverage of the realities (rather than hyperbole) is needed.

We have allowed abortion to become a form of contraception, which is unacceptable, whether you believe that it concerns potential or full life. This issue should be the domain not of extremists but of a responsible society. We must put more resources and emphasis on prevention, in schools and throughout society, so that unwanted children are not conceived in the first place. Those who oppose giving widespread contraceptive advice must regard it as the lesser of evils and look on education as an opportunity rather than a threat.

No one can seriously advocate abortion over a preventive solution to unwanted pregnancy. It is this solution we should be working towards.

Sarah Ross *Final year medical student*
22 Wallfield Place, Aberdeen AB25 2JP

1 Wise J. British public supports legal abortion for all. *BMJ* 1997;314:627. (1 March.)

Neonatal risk factors for cerebral palsy in very preterm babies

Time oriented analyses of risk are useful

EDITOR—Deirdre J Murphy and colleagues recently reported a case-control study comparing 59 children with cerebral palsy with 234 without.[1] One of their key messages was "Neonatal pneumothorax, sepsis, and transfusion are associated with preterm cerebral palsy independently of adverse antenatal factors." We are not convinced that they have shown an independent effect.

To identify the contributions of exposures and characteristics occurring at one time independent of the contributions of exposures and characteristics that occur later, we have performed time oriented logistic regression analyses in which risk factors are ordered in a temporal pattern. The earliest occurring predictors and covariates of the outcome are entered first and are not displaced by covariates occurring later.[2] An odds ratio significantly different from 1 for the variable occurring later suggests that it contributes risk information that supplements the information provided by the earlier factor for which one adjusts.

The authors might have done something similar, but it is not clear which of the six antenatal variables remained in each final model (with no more than six variables, including the neonatal variable and gestational age). Entering variables into logistic regression models, as Murphy and colleagues did, might have allowed neonatal variables to displace highly interrelated antenatal variables already in the model. Antenatal variables might thus lose their significance and be dropped from the model after correlated postnatal variables are entered. For example, maternal infection, a documented antecedent of cerebral palsy in this sample, might produce its effect either directly or through postnatal phenomena such as hypotension. Maternal infection is not adequately adjusted for if it is displaced by the variable for postnatal hypotension.

The problems posed by the analytic strategy of the authors are exacerbated by the authors' selection of variables for multivariable analyses only if univariable associations with the outcome of interest had P values of ≤ 0.05. This approach can inappropriately exclude confounder variables from further analysis. Dales and Ury suggested using P values of < 0.25, or even no significance testing at all.[3]

In conclusion, the authors' methods of sequential processing and variable selection may have limited their opportunity to achieve what they wanted. We invite them to clarify what they did and what they found.

Elizabeth N Allred *Instructor in neurology, Harvard Medical School*
Olaf Dammann *Research fellow in neurology, Harvard Medical School*
Karl Kuban *Assistant professor of neurology, Tufts Medical School*
Alan Leviton *Professor of neurology, Harvard Medical School*
Marcello Pagano *Professor of statistical computing, Harvard Medical School*
Neuroepidemiology Unit, Children's Hospital, 300 Longwood, Boston, MA 02115, USA

1 Murphy DJ, Hope PL, Johnson A. Neonatal risk factors for cerebral palsy in very preterm babies: case-control study. *BMJ* 1997;314:404-8. (8 February.)
2 Leviton A, Kuban KC, Pagano M, Allred EN, Van Marter L. Antenatal corticosteroids appear to reduce the risk of postnatal germinal matrix hemorrhage in intubated low birth weight newborns. *Pediatrics* 1993;91:1083-8.
3 Dales LG, Ury HK. An improper use of statistical significance testing in studying covariables. *Int J Epidemiol* 1978;7:373-5.

Author's reply

EDITOR—Elizabeth N Allred and colleagues highlight the difficulties of using logistic regression techniques to identify independent associations, particularly in the context of observational data where temporal relations are of interest. In our study the strategies available to us were to design logistic models on the basis of clinical plausibility, statistical strength, or a combination of both. In the first instance we selected the antenatal variables associated with preterm cerebral palsy identified from an earlier study.[1] We selected variables both on the basis of significance and if an interaction with neonatal events seemed plausible. For example, an odds ratio for antepartum haemorrhage of 1.5 (95% confidence interval 0.8 to 2.6) was selected as an antenatal variable of interest despite the 95% confidence interval including the null value as clinically this factor could be related to postnatal hypotension or the need for neonatal blood transfusion.

The earliest multivariate analyses involved a single antenatal factor, a single neonatal factor, and in each case gestational age (the strongest potential confounder). A pattern emerged identifying a small number of antenatal factors (maternal infection, chorioamnionitis, pre-eclampsia, and caesarean section without labour) that altered the associations between preterm cerebral palsy and neonatal events. We then built on the single factor approach by adding in a second antenatal factor exploring all the possible combinations of the aforementioned variables. This then led to the final models including a maximum of six variables where in fact all the variables had P values of ≤ 0.05 but the opportunity had been explored of incorporating other variables that did not reach this level. As Allred and colleagues advise, we entered the antenatal factors first in the model, followed by the mode of delivery and then the neonatal factors. We hope that this clarifies some of the issues raised.

Deirdre J Murphy *Specialist registrar*
Department of Obstetrics and Gynaecology, St Michael's Hospital, Bristol BS2 8EG

1 Murphy DJ, Sellers S, MacKenzie IZ, Yudkin PL, Johnson AM. Case-control study of antenatal and intrapartum risk factors for cerebral palsy in very preterm singleton babies. *Lancet* 1995;346:1449-54.

United States has recommended screening for colon cancer

Why has barium enema been suggested?

EDITOR—Some readers may have been surprised by the American Gastroenterological Association's decision to include the barium enema in its guidelines for screening for colon cancer,[1] especially because in a review in the *BMJ* two weeks earlier the barium enema hardly rated a mention.[2]

Why should such a recommendation have been made? Screening has to be affordable, and a barium enema examination costs roughly a third of the cost of a colonoscopy. Safety also has to be considered; the mortality associated with a barium enema is roughly a fifth to a tenth that of that associated with a diagnostic colonoscopy.[3] Flexible sigmoidoscopy is safer and less costly than colonoscopy and is therefore more often considered as a first line screening test. Although this examination is undoubtedly more sensitive and specific than the barium enema for diagnosing rectosigmoid tumours, it does not examine the right half of the colon, where 30-40% of tumours are found. The barium enema is an accurate examination for detecting polyps and cancers over 1 cm in size. The risk of radiation needs to be considered when young patients are screened but is insignificant when the over 50s are screened.

The fact that flexible sigmoidoscopy and colonoscopy can be therapeutic is important when colonic disease is likely to be present

but less so when decisions must be made on the best screening examination. Annual faecal blood testing supplemented by a barium enema every three to five years has been suggested as the most cost effective of a variety of screening strategies.[4] The barium enema and flexible sigmoidoscopy can be performed by radiographers and nurses, respectively—an advantage for a screening test—but the barium enema more readily lends itself to quality controls, and now over 300 radiographers in Britain have been trained to perform routine barium enemas.

It is important that gastroenterologists put partisan interests aside and work with radiologists to investigate the role of the barium enema as a screening test. A single flexible sigmoidoscopy between the ages of 55 and 60 has been suggested as an effective screening strategy,[2] but a single screening barium enema may have the potential to achieve more.[5]

A H Chapman *Consultant*
A Blakeborough *Senior registrar*
Department of Radiology, St James's University Hospital, Leeds LS9 7TF

1 Charatan FB. US recommends screening for colon cancer. *BMJ* 1997;314:396. (8 February.)
2 Mulcahy HE, Farthing MJG, O'Donoghue DP. Screening for colorectal cancer. *BMJ* 1997;314:285-91. (25 January.)
3 Blakeborough A, Sheridan MB, Chapman AH. Complications of barium enema examinations: a survey of UK consultant radiologists 1992-1994. *Clin Radiol* 1997; 52:142-8.
4 Eddy DM, ed. *Common screening tests.* Philadelphia: American College of Physicians, 1991.
5 Ferrucci JF. Screening for colon cancer: programs of the American College of Radiology. *Am J Radiol* 1993; 160:999-1003.

Reply from American Gastroenterological Association

EDITOR—I wish to correct the description of the guidelines on colorectal cancer screening and surveillance.[1] The guideline was not a document from the American Gastroenterological Association, although we were responsible for administering the project (I was the project manager). It was actually developed by an independent, multidisciplinary expert panel established by the federal government. Only three members of the panel were gastroenterologists. We believe that the multidisciplinary nature of the panel and its independence are two of its strengths.

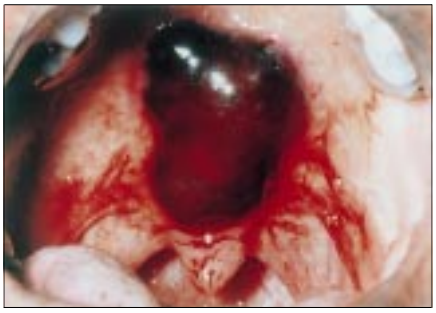
I urge readers to consult the original guidance because it describes the circumstances in which the panel considered double contrast barium enema to be an acceptable test option. The strength of the evidence behind each recommendation is also presented and is an important part of the report.

Michael H Stolar *Senior vice president*
American Gastroenterological Association, Bethesda, MD 20814-3015, USA

1 Winawer SJ, Fletcher RH, Miller L, Godlee F, Stolar MH, Mulrow CD, *et al.* Colorectal cancer screening: clinical guidelines and rationale. *Gastroenterology* 1997;112: 594-643.

Oropharyngeal blood blisters are known as angina bullosa haemorrhagica

EDITOR—Stephen Price and T B Hassan comment on a patient with a sizeable palatal haematoma; eating confectionery does not usually lead to this degree of oral mucosal trauma.[1] The condition is known as angina bullosa haemorrhagica, a term first used by Badham in 1967 to describe oral blood blisters that could not be attributed to a blood dyscrasia, vesiculobullous disorder, or other known systemic disorder.[2] Stephenson *et al* reviewed the laboratory features of the condition and concluded that, despite the presence of a subepithelial split histologically, there was no evidence of autoimmune mediated damage as with mucous membrane pemphigoid.[3] Similarities between angina bullosa haemorrhagica and the acquired form of non-dystrophic epidermolysis bullosa have been suggested.[4]



Angina bullosa haemorrhagica seems to affect men and women equally, and middle aged to elderly people. It is fairly common, and the severity of the blood blisters may cause a sensation of choking (hence the term "angina"). Casualty officers should be aware of angina bullosa haemorrhagica and the need to deroof such blisters to alleviate the sensation of choking. Any discomfort may be lessened by use of a benzydamine hydrochloride mouthwash or spray. Chlorhexidine mouthwash may reduce secondary infection and thus accelerate healing.

John Gibson *Clinical lecturer*
University of Glasgow, Glasgow G2 3JZ

1 Price S, Hassan TB. Minerva. *BMJ* 1997;314:528. (15 February.)
2 Badham NJ. Blood blisters and oesophageal casts. *J Laryngol* 1967;81:791-803.
3 Stephenson P, Lamey P-J, Scully C, Prime SS. Angina bullosa haemorrhagica: clinical and laboratory features in 30 patients. *Oral Surg Oral Med Oral Pathol* 1987;63:560-5.
4 Stephenson P, Scully, C, Prime SS, Daly HM. Angina bullosa haemorrhagica: lesional immunostaining and haematological findings. *Br J Oral Maxillofac Surg* 1987;25:488-91 .

Vasospasm of the nipple was described in 1970

EDITOR—Like most of the problems encountered during lactation, the condition reported by Laureen and Carolyn Lawlor-Smith—vasospasm of the nipple[1] —was well described by Gunther more than 25 years ago in a book that remains a much neglected repository of wisdom on such issues.[2] Sudden localised pain, sometimes associated with a burning sensation, and an abrupt biphasic or triphasic change in colour are the cardinal features. Gunther spoke of the nipples suddenly blanching because of vasospasm and then becoming a mulberry colour as the blood supply was restored. The symptoms often develop quite suddenly after, or between, feeds. This is unlike the pain (and, occasionally, the blanching) experienced when poor positioning causes nipple trauma during lactation. Unfortunately, both conditions can coexist. Most women will have discovered for themselves that local warmth can help and that keeping warm can sometimes forestall trouble.

The Lawlor-Smiths have done women a service by redescribing this entity. The challenge is to know what to do about it. We will have stronger grounds for identifying it as a form of Raynaud's phenomenon when nipple pain has been shown, under controlled trial conditions, to respond to some of the pharmacological manipulations that ease other symptoms of that condition.[3] It seems odd that none of the women reported on had any other symptoms of the phenomenon. Labels are only of real use when they help us develop a logical therapeutic strategy.

Edmund Hey *Retired paediatrician*
51 Alwinton Terrace, Newcastle upon Tyne NE3 1UD

1 Lawlor-Smith L, Lawlor-Smith C. Vasospasm of the nipple—a manifestation of Raynaud's phenomenon: case reports. *BMJ* 1997;314:644-5. (1 March.)
2 Gunther M. *Infant feeding.* London: Methuen, 1970.
3 Cooke ED, Nicolaides AN. Raynaud's phenomenon. *BMJ* 1990;300:553-5.

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the BMJ article to which they relate); references should be in the Vancouver style. We welcome pictures.

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 world wide 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.