

## Fundholding practice's draft policy on ethical use of resources

### Policy is inconsistent

EDITOR,—The Asbury draft policy on ethical use of resources, a document developed by a fundholding practice to clarify the ethical basis of decisions concerning rationing, contains many inconsistencies.<sup>1</sup> Two of these, in particular, must be challenged—namely, those to do with age and patients' responsibility for their conditions.

With regard to age, the authors seem to want to have it both ways. They first reject the view that treatment should be denied on the basis of age but later write, "the patients' ages may be considered and found relevant." They take this view not because of any medical criteria but because of the "fair innings" argument. In addition to being inconsistent in their views, the authors seem to ignore both the many persuasive arguments against the fair innings argument<sup>2</sup> and the difficulty of defining fairness (Rawls, for instance, tried to do so and failed<sup>3</sup>). They also imply that quality adjusted life years should not be considered in the treatment of patients who are terminally ill but seem to accept that they should be considered with regard to age. Why?

It is not only about age that the authors are in two minds: they take the same stance with patients' responsibility for their conditions. They first reject the idea that treatment should be denied on the grounds that the patient has brought the condition on himself or herself, but then they write, "the issue of a patient's responsibility for having induced the problem might be considered relevant." It is surprising that the authors have not realised the inconsistencies in their views here. It is even more important that they have not taken account of the fact that if we start allocating health care on the basis of personal responsibility there will be few people eligible for treatment.

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- 1 Crisp R, Hope T, Ebbs D, Thomasma DC, Dormer P, Toon P. The Asbury draft policy on ethical use of resources. *BMJ* 1996;312:1528-33. (15 June.)
- 2 Rawls J. Justice as fairness. *Philosophical Review* 1958;67:164-94.
- 3 Rivlin MM. Protecting elderly people: flaws in ageists arguments. *BMJ* 1995;310:1179-82.

### Policy is mechanism by which decisions might be reached

EDITOR,—The Asbury draft policy on the ethical use of resources, which was developed by a fundholding practice to clarify the ethical basis of decisions, includes a description of a fictional situation concerning rationing.<sup>1</sup> In this, only one patient can have lifesaving treatment: either patient A, a brilliant surgeon who saves hundreds of lives a year and is a single parent with three young children, or patient B who is unemployed and without dependants. It seems to me that most groups would give the treatment, without open discussion, to patient A, as is the implied outcome here. Clearly uncomfortable with this implied outcome, the authors seek to reassure us that it has nothing to do with the patient's value to society and everything to do with her three young children. What decision would have been made if the choice was as follows?

Patient A is a brilliant surgeon who saves hundreds of lives a year but has no dependants. She is personally known to one member of the practice. What is more, she successfully operates on an average of 10 patients from the practice each year. There is no other, equivalent surgeon locally.

Patient B is an unemployed single mother with three young children. There are no close relatives to take over the care of these three girls should she die. Her condition is self inflicted.

To spin a coin, as Peter Dormer suggests in his commentary,<sup>1</sup> might be morally neutral but evades responsibility in decision making and obviates the need for a policy other than that of using the coin. To discount the value of a patient to society would be of high moral principle but would be short on common sense, but to take full account of it would require the existence of an impossible scale on which societal worth could be gauged accurately. The problem is twofold: firstly, we would rather avoid than confront the moral dilemmas posed by the issue of health care rationing; and, secondly, if we decide to confront the dilemmas then we find that we have inadequate tools for doing so.

The inevitable conclusion is that more research is necessary. While this is undertaken, hard decisions continue to have to be made every day. All such decisions are compromises, but the Asbury draft policy at least outlines a mechanism by which such compromises might be reached.

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## Advertisements in the *BMJ*

### Advertisements for drugs used in disorders with a negative image never feature men

EDITOR,—It is a pity that advertisements in the *BMJ* for drugs that are used to treat disorders with a negative image, such as mental illness, should feature only women. For example, the clinical research edition of the issue of 20 July contains two advertisements for drugs used in depression, one for a drug used in obsessive-compulsive disorders, and one for a drug used in epilepsy. On the back cover (a prime advertising space) the advertisement for Lustral (sertraline)—"Established in treating depression"—has a picture of an older woman; opposite p 136 the advertisement for Cipranil (citalopram)—"Specifically treating depression"—features a young woman; and between p 146 and p 147 there is a double spread for Faverin (fluvoxamine)—"A positive step for Obsessive-Compulsive Disorder"—featuring a stylised young woman. Furthermore, on the inside of the back cover (another prime location) we find an advertisement for Lamictal (lamotrigine)—"Monotherapy in epilepsy"—featuring a middle aged woman. Finally, opposite p 125 (which is the first page of the editorials and, therefore, also a key advertising position) an advertisement for Losec (omeprazole)—"Taking care of mild symptoms every day"—shows a young woman and implies that doctors do not take her complaints seriously. By contrast, when men are used in advertisements they are generally shown in a positive and decisive light.

It may well be true that women are more prepared than men to seek advice for disorders of the brain. Nevertheless, these advertisements give the impression that men are not prone to such disorders, the common denominator being the implication that these disorders carry a negative tag in society. Surely, a balanced and less typecast policy would be more fitting for the journal.

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## *BMJ* should not carry advertisements for cars

EDITOR,—The general practice edition of the *BMJ* published on 22 June carried an advertisement for a particular make of car (between p 1562 and p 1563). Addiction to cigarettes and addiction to cars are analogous in that both result in large numbers of preventable deaths and injuries every year, involving both users and non-users. Children are particularly vulnerable as the "passive" victims of addiction to cars.<sup>1</sup>

The *BMJ* does not carry tobacco advertising and is very ready to criticise the tobacco industry; the same does not seem to apply to the motor industry. Is this double standard explicable by a comparison of rates of use of cars and tobacco among doctors?

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- 1 Roberts I. Safely to school? *Lancet* 1996;347:1642.

\*The *BMJ* has discussed the health problems created by cars many times, and it will continue to do so. We think, however, that it would be excessive to refuse to carry advertisements for cars. Tobacco use is wholly bad for health, whereas cars are not. It is also true, as Douglas Salmon points out, that almost all doctors have cars while only a small minority smoke. Many doctors use cars in their daily work; it would thus seem ludicrous to ban advertisements for cars.—  
EDITOR

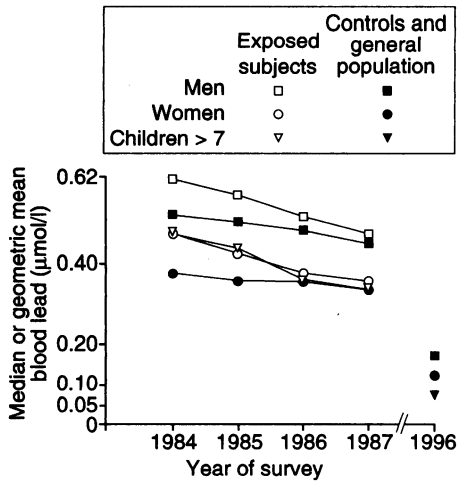
## Blood lead concentrations in United Kingdom have fallen substantially since 1984

EDITOR,—Shilu Tong and colleagues show that the effects of low level environmental exposure to lead, especially on the longer term cognitive development of children, are still of concern.<sup>1</sup> We have carried out the first major study for eight years to monitor lead concentrations in Britain. We report here our early results, which show a large fall in blood lead concentrations.

As part of the 1995 health survey of England, blood samples were collected for lead analysis from 6868 subjects from eight regions throughout England; the subjects were considered to be a geographically representative sample of the whole population. Most of the subjects (95%) were adults aged  $\geq 16$ , of whom 3139 (45.7%) were men and 3389 (49.3%) were women. The remainder were children aged 11-15 (180 (2.6%) boys and 160 (2.3%) girls). The blood samples were analysed for lead by atomic absorption spectrometry,<sup>2</sup> and the analyses were validated as described previously.<sup>3</sup>

Blood lead concentrations decreased in the order men, women, boys, girls. The median (95th centile) concentrations for these subgroups were respectively 0.17 (0.49), 0.13 (0.33), 0.11 (0.27), and 0.08 (0.16)  $\mu\text{mol/l}$ . Only 166 (5.3%) of the men and 41 (1.2%) of the women had blood lead concentrations of  $\geq 0.48$   $\mu\text{mol/l}$ ; the concentration did not reach this value in any of the children. These data indicate that most (97%) subjects in the United Kingdom who are exposed only to environmental sources of lead will have blood lead concentrations below the action limit of 0.48  $\mu\text{mol/l}$  (10  $\mu\text{g/dl}$ ) proposed for other countries.<sup>4</sup>

The concentrations that we found recently are much lower than those found in the environmental monitoring programmes in the United Kingdom in 1984-7 (fig 1). The monitoring programmes compared groups at risk of increased lead uptake from traffic emissions with control subjects living in areas without heavy traffic.<sup>3</sup> At that time the expo-



**Fig 1**—Decrease in blood lead concentrations in groups at risk of increased lead uptake from traffic emissions and in control subjects living in areas without heavy traffic and in general population, United Kingdom, 1984-96

sure of the general population to lead from traffic emissions would have been intermediate between that of the exposed and control groups. Figure 1 shows that, since 1984-7, blood lead concentrations have fallen by a factor of 2.6-3.0 in adults and by a factor of 3.6-5.0 in children.

A wide range of measures to reduce lead were implemented in Britain throughout the 1980s—for example, lead solder was removed from tins containing food, lead in paint was controlled, and lead in petrol was reduced. All of these, together with the reduced emissions of lead by vehicles owing to the increased sales of lead free petrol since 1987,<sup>5</sup> will have contributed to the substantial decline in blood lead concentrations that we observed.

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- 1 Tong S, Baghurst P, McMichael A, Sawyer M, Madge J. Lifetime exposure to environmental lead and children's intelligence at 11-13 years: the Port Pirie cohort study. *BMJ* 1996;312:1569-75. (22 June.)
- 2 Delves HT. A micro-sampling method for the rapid determination of lead in blood by atomic absorption spectrometry. *Analyst* 1970;95:431-8.
- 3 Department of the Environment. *UK blood lead monitoring programme 1984-1987. Results for 1987*. London: HMSO, 1990. (Pollution report No 28.)
- 4 Centers for Disease Control. *Preventing lead poisoning in young children. A statement*. Washington, DC: US Department of Health and Human Services, 1991.
- 5 Department of the Environment. *Digest of environmental statistics No 17*. London: HMSO, 1995.

## Predicting which psychiatric patients are at risk of suicide

### More information needs to be taken into account

**EDITOR**,—In the past the *BMJ* has published several articles pointing that "absence of evidence is not evidence of absence."<sup>1</sup> John A Dennehy and colleagues' short report on the prediction of suicide among psychiatric patients after discharge from hospital is a good example of this.<sup>2</sup> The authors conclude that, because they found no significant difference in several

variables thought to be associated with suicide between patients who had committed suicide and controls, there is no association. They then go on to state that these factors cannot be used to identify those patients who go on to commit suicide. The wide confidence intervals for the variables linked to past or present contact with psychiatric services indicate that there is considerable uncertainty about the true odds of these variables predicting suicide. For example, a duration of illness of less than five years could be over four times more common in those who kill themselves than in those who do not. Unfortunately, the chance of detecting a difference in this variable with the numbers in this study is less than 50%. Having more than one control per case would have increased the chance of detecting a significant difference.

The case for these factors not being clinically useful remains unproved. The prediction of suicide is difficult and has a high false positive rate. Traditionally, as in this study, attempts to predict which patients are at high risk of suicide have relied on the history and demographic characteristics. Perhaps a more useful approach would be to combine this with information about the nature of the difficulties faced by the patient.

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- 1 Altman DG, Bland JM. Absence of evidence is not evidence of absence. *BMJ* 1995;311:485.
- 2 Dennehy JA, Appleby L, Thomas CS, Faragher EB. Case-control study of suicide by discharged psychiatric patients. *BMJ* 1996;312:1580. (22 June.)

### Author's reply

**EDITOR**,—Simon Hatcher makes an important general point about statistical significance, but it does not apply to our study as we did not make the statement that he attributes to us. Our conclusion that risk factors for suicide in the general population do not identify people with mental illness who go on to commit suicide was based not on the absence of significant differences between cases of suicide and controls but on the fact that the rate of some putative risk factors was virtually identical in the two groups. We drew no conclusion about the duration of illness, for the reasons that Hatcher gives.

We suspect that the difficulty in predicting suicide from risk factors is explained partly by findings such as ours and partly by the oversimplicity of risk factor models. Risk of suicide may be better understood as a balance of both risk and protective factors, with suicide occurring after a sequence of key events in which risk accumulates. Our research is now directed at identifying models of cumulative risk which may be the target of preventive intervention.

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### Care programme approach does not focus on need for services

**EDITOR**,—John A Dennehy and colleagues comment on the limited value of the care programme approach in identifying the risk of suicide in psychiatric patients.<sup>1</sup> Similar findings were observed when documentation relating to the care programme approach was studied for all psychiatric patients from Warrington who died unexpectedly of unnatural causes and were the subject of a coroner's inquest since the implementation of the approach some four years ago.

Of the 31 patients identified, 19 were on the register for the care programme approach and had had at least one admission since the introduction of the approach. Ten of the patients had required admission to hospital in the year that the death was reported. Only nine of the 19 patients on the register had an identifiable care plan for low or medium intensity care. None of the patients had a full care programme of the type normally reserved for patients with serious mental illness and those considered to be at a distinct risk. A suicide verdict was recorded for seven patients, only three of whom had an identifiable care plan, and a verdict of misadventure or an open verdict was recorded for 12, six of whom had an identifiable care plan. Although lengthy documentation for the patients showed that some needs had been identified, there was no mention of risk of suicide or any other risk or unmet needs for any of the patients who had a care plan and an identifiable key worker.

We agree with Dennehy and colleagues that the care programme approach does not seem to detect unmet needs or risk of suicide in this vulnerable group of patients. It seems to focus on service needs and not on need for services, with an increasing emphasis on the completion of numerous forms. There is a danger that the excellent concept of the care programme approach may end up as yet another exercise in paperwork that does not work.

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## Mental health teams should concentrate on psychiatric patients with greatest needs

**EDITOR**,—Valerie Murray and colleagues measured the needs for care of patients with major mental illness who were and were not in contact with their community mental health team.<sup>1</sup> They have usefully moved the debate on community care on from simplistic arguments about the adequacy of numbers of psychiatric beds.

The methods they used to identify patients, however, are likely to have missed a considerable proportion of people with psychotic illnesses, and their sample cannot therefore be regarded as representative. Studies have shown consistently that around one in four patients with psychosis have no contact with mental health services and are looked after entirely within general practice.<sup>2</sup> Simply asking the local practices for the names of such patients known to the general practitioners is inadequate. Even if all the practices in the Hamilton district had cooperated with the authors (which they did not), many patients with psychosis would have been missed in the absence of searches of general practice records. We have shown that identifying patients through searches of repeat prescription systems and diagnostic labels on computer is quick and identifies many more patients than the general practitioners can remember.<sup>3</sup> Murray and colleagues' paper sheds little light on the needs, met or unmet, of patients with psychosis who are in contact only with general practitioners.

More importantly, their data offer no basis for the conclusion that expanding their community service to include all patients with psychosis would be beneficial. Many such patients may not wish to be referred back to psychiatric services. Also, patients who comply with drug treatment and whose illness is stable may not need long