

These variations in rate are probably due partly to differences in maternal characteristics and complications and not just to the mode of delivery. Nevertheless, obstetricians will lack credibility if they make statements that are inconsistent with published data.

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An office at last

EDITOR,—I have been a consultant since 1972 (head of department, faculty tutor) and am thrilled to have just been given my first office.¹ This is, of course, because we have fewer beds and fewer nurses with the result that some outpatients are seen in a former ward and we can have the former outpatient department. My gain is the patients' loss, isn't it?

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- 1 Campbell RHA. An office at last. *BMJ* 1994;308:417. (5 February.)

Preventing the hand-arm vibration syndrome

EDITOR,—The hand-arm vibration syndrome is caused by prolonged use of vibrating tools, including pneumatic tools, rotary burring tools, swaging or fettling tools, chain saws, chipping hammers, grinders, concrete vibrothickeners, and concrete levelling vibrotables. The syndrome comprises musculoskeletal and neurological symptoms and vibration white finger (Raynaud's syndrome).¹ In Britain the tools are used for long periods by roughly 150 000 people,² and some 20 000 people suffer from vibration white finger.³ Workers exposed to vibration can take steps that might reduce the risk of developing the hand-arm vibration syndrome. They should hold tools as loosely as possible and in varying positions, ensure that tools are well maintained, and consider the use of antivibration gloves. Other measures believed to be of prophylactic benefit include taking regular breaks of at least 10 minutes from exposure to vibration, keeping warm while at work, and not smoking. In addition, heavy, old tools usually generate more vibration than their newer, lighter, and better designed equivalents.

We conducted a roadside survey in south London of workmen who used vibrating pneumatic tools for at least five hours a week. We interviewed 53 men employed by 16 companies; they had been exposed to vibration for an average of 13 years. Musculoskeletal complaints (pain and stiffness) were common. Nine men experienced paraesthesia of the hands even when not using the tools, and two complained of nocturnal paraesthesia. We estimate that at least three had vibration white finger, although exact diagnosis was not possible at the roadside. Fourteen workmen knew that the symptoms of Raynaud's syndrome could be caused by using vibrating tools.

Only four men knew of measures they could take to prevent the hand-arm vibration syndrome, and

three of these worked for the same company. Failure of employers to educate their workers about preventing injury and about the hazards of tools they are required to use may contravene the Health and Safety at Work Act 1974. The fact that workers at high risk are ignorant of the hand-arm vibration syndrome suggests that employers generally either do not provide education or provide ineffective education. Doctors who are aware of their patients' occupational exposure to vibrating tools could help to correct this deficiency.

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Pertussis immunisation and neurological illness

EDITOR,—The national childhood encephalopathy study was set up in Britain in 1976 to answer the question, does whooping cough vaccine cause brain damage in children?¹ Last year the simple answer to that question was an unequivocal no.² The complex answer, stated in the recent report by David Miller and colleagues, is that the vaccine "may on rare occasions be associated with the development of severe, acute neurological illness that can have serious sequelae."^{3,4}

The simple answer comes from a three year epidemiological survey of patients with neurological conditions admitted to hospitals in England, Scotland, and Wales. No cases of a "pertussis vaccine syndrome" or a syndrome associated with the vaccine were found in the survey. Some two million injections have been administered to children aged 2 months to 3 years, but only 35 children who had been vaccinated with diphtheria, tetanus, and pertussis vaccine were found among the first 1000 of 1182 patients in hospital. In their present study Miller and colleagues have added more reassurance about the safety of the vaccine. During a 10 year follow up no neurological disorders that developed late among patients who had been vaccinated with diphtheria, tetanus, and pertussis vaccine were unique to the vaccine.

The complex answer, repeated in the present study, is that on rare occasions pertussis vaccine may cause an acute, serious neurological illness that can be lethal or result in permanent brain damage. This answer is misleading and mistaken. All that these case-control studies have shown is how admissions to hospital increase when parents are frightened by the news media about alleged reactions to vaccine and that physicians share their fright. The number of notifications in the national childhood encephalopathy study were about double what was expected. Miller and colleagues counted some patients who would not have been admitted to hospital were it not for anxiety about reactions, especially febrile convulsions.

Looking at the national childhood encephalopathy study in its entirety shows how a well designed case-controlled study can be statistically correct and clinically wrong. Clinically, all patients admitted to hospital who died or developed brain damage were later found to have a disease unrelated to diphtheria, tetanus, and pertussis vaccine, except possibly for one child.⁵ One

possible damaging reaction out of two million injections can be classified only as anecdotal information, no matter what any statistical construct concludes about these patients.

As well as there being no deaths or chronic neurological disorders that could be attributed to the vaccine there were no acute serious disorders that can have serious sequelae—in short, no acute encephalopathy and no chronic encephalopathy. The reactions that can be reasonably attributed to the vaccine are fever or pain, or both. Statistical studies such as these should not be allowed to transform anecdotal information into something more.

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- 1 Alderslade R, Bellman MH, Rawson NSB, Ross EM, Miller DL. The national childhood encephalopathy study. In: *Whooping cough. Report from the Committee on Safety of Medicines and the Joint Committee on Vaccination and Immunization*. London: HMSO, 1981:79-169.
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Old fashioned photographs

EDITOR,—My colleagues working in child health would like to meet Stuart Handysides and the picture editor who presented such an out of date, unhelpful image of the school doctor in one of the articles in Handysides's series on careers in general practice.¹ If they come to our office, form an orderly queue, and bare their left arms we will go to our museum and find a genuine old reusable needle so that they can enjoy the complete old fashioned experience.

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- 1 Handysides S. Building morale through personal development. *BMJ* 1994;308:114-6. (8 January.)

** We received seven other letters complaining about the photograph and its caption. We apologise for the offence, which was not intended.

Access to specialist palliative care

May be expnding too quickly

EDITOR,—How do you decide when enough is enough? Previous estimates had suggested that around 15% of patients with cancer in Britain receive access to specialist care.^{1,2} Anthony M Smith and Ann Eve now suggest that the figure is much higher, offering the example that perhaps two thirds of patients dying of cancer are seen by specialist home care nurses.³ These higher estimates are offered with understandable pride in a movement that has established palliative care at many levels of health care, including the specialty of palliative medicine. But at what point does increasing availability of specialist care start to deskill other professionals?

We believe that palliative care is a resource to existing services, not a replacement for those services. This belief was expressed in 1980⁴ and is still shared today.⁵ Yet palliative care teams,

charities, and organisations continue to build inpatient units and recruit staff, including home care nurses, as if nothing has changed in the past 14 years. Is the goal that every dying patient is seen by a home care nurse? If so, this will guarantee that deskilling occurs and produce resistance against existing resources for palliative care. Contracting, combined with effective health planning, is probably the most effective deterrent to such excesses.

To their credit, some palliative care groups are beginning to recognise the issue of resourcing, although their recruitment drives continue. It is time for palliative care groups to collaborate or enter into partnerships with existing services. This implies shared planning based on identified needs, joint ownership of strengths and weaknesses, and the willingness of palliative care teams to make resourcing their primary role. Specialist palliative care teams will continue to have a service role owing to the sheer numbers of patients with advanced disease (not just cancer) and the disappointingly slow rise in general skill in palliative care. The demands on specialist care are not just to provide education and specialist support but to lead in clinical development and research, to work alongside colleagues when needed, and, just as importantly, to withdraw when not needed.

Certainly we must be proud of the achievements suggested by Smith and Eve. These new estimates, however, should now trigger the second wave of development described by Clark,⁵ in which specialist palliative care is a vital resource in health care partnerships.

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3 Smith AM, Eve A. Access to specialist palliative care. *BMJ* 1993;308:273. (22 January.)

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Purchasers come between complementary specialties

EDITOR,—Anthony M Smith and Ann Eve¹ are correct in suggesting that many more people with advanced cancer receive specialist palliative care than Geoffrey Hanks suggested.² Roughly half of the patients with advanced cancer in Britain are managed throughout their illness by oncologists (either medical and clinical), most of whom also have specialist skills in palliative care. Patients may be referred to a palliative medicine specialist—if they are referred at all—only during the last few days or weeks of an illness that has lasted months or even years since attempts at curative treatment were abandoned.

The division between palliative oncology and the relatively new specialty of palliative medicine has become increasingly blurred. Oncology centres now offer outreach teams, counselling, and specialist pain relief services. Palliative care physicians now become involved with patients with cancer at a much earlier stage in their disease, during the transition from curative treatment to relief of symptoms. This can only benefit the patients.

Unfortunately, current purchasing practice seeks to divide palliative care from medical and clinical oncology. Cancer treatment is purchased in terms of the chemotherapy or radiotherapy given, and the many hours of specialist time that are devoted to supportive care and control of symptoms are often inadequately recognised. This

may eventually deny patients the possibility of being cared for in their terminal illness by the specialist who has been with them since their cancer was diagnosed. It also puts the complementary specialties of oncology and palliative care into direct competition when we are all trying to work more closely to provide seamless specialist care for our patients.

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1 Smith AM, Eve A. Access to specialist palliative care. *BMJ* 1994;308:273-4. (22 January.)

2 Hanks G. Review of "The future of palliative care: issues of policy and practice." *BMJ* 1993;307:1367. (20 November.)

Arbitration and the NHS

EDITOR,—Malcolm Forsythe's editorial on arbitration and the internal market is thought provoking.¹ He suggests that guidance on the use of arbitration to resolve disputes between the public and NHS purchasers once other attempts at resolution have been exhausted would benefit everyone. A recent editorial in the *Times* said: "With [the British government's] current ethos of competition and comparison... politicians have encouraged citizens to scrutinize the institutions that serve them. The effect is paradoxical. Standards rise, but so too do knowledge, expectations, dissatisfaction and disappointment."² In this climate one can see the expectations and militancy of the public increasing, against the backdrop of the publicly stated statistic that over half of the population has no access to justice, the reason being cost.

To ease this situation in medicine the Chartered Institute of Arbitrators has proposed to the Department of Health that one or two pilot schemes should be run for disputes between patients and doctors; these would be based on the institute's mediation and arbitration scheme. So far there has been no response. Surely the following factors demand that this proposal should be taken up: the finite resources of the NHS; the increasing cost of treatment; the increasing expectations of the public, encouraged by the citizen's charter; and the lack of access to justice for many citizens.

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2 The new Britishness. *Times* 1994 Jan 18:19 (cols 1-2).

Sunburn and melanoma

EDITOR,—Robin Marks and David Whiteman raise two interesting points in their editorial on the link between sunburn and melanoma—namely, that recall as a measure of assessing the prevalence and severity of sunburn is unreliable and that there is a possibility that the risk associated with sunburn is not constant throughout life but is more important in childhood.¹ In considering these two issues the North Western Regional Health Authority has set as an interim local target a reduction in the prevalence of skin burning in children. The first stage is to measure the prevalence of sunburn in the younger age groups.

We recently undertook a pilot study aimed at validating a questionnaire for use as an instrument for the self reporting of episodes of sunburn by children aged 7 to 11. In addition to giving a

baseline prevalence it includes a measure of severity. Initial analysis of the pilot study has shown that 250 of the 540 children surveyed reported an episode of sunburn this summer; many of the children reported more than one episode. Altogether 334 of the 584 episodes occurred in the British Isles. Twenty one of the children reporting episodes of sunburn had non-white skin types.

This level of sunburning in childhood supports the argument for a programme aimed at altering behaviour to reduce the prevalence. Such a programme would need to take into account the pattern of exposure—that is, that 57% of episodes occurred in Britain—and should not be complacent about people with non-white skin types as they too seem to be at risk. Further work needs to be done, including measurement of the baseline prevalence of sunburn in all age groups as well as the development and evaluation of effective interventions.

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Doctors and execution in Turkey

EDITOR,—As Tessa Richards points out, the considerable problems besetting the World Medical Association should not mislead us into underestimating the importance of its ethical declarations.¹ One of its more important resolutions was that passed in 1981 prohibiting the active participation of physicians in capital punishment other than to certify death. This resolution was in effect adopted in 1992 as one of the recommendations of the BMA's working party on the participation of doctors in abuses of human rights.²

Unfortunately, many countries demand in law that a doctor be present at an execution not only to certify death but also to confirm that the prisoner is fit for execution and possibly to indicate if the execution needs to be repeated. One such country is Turkey, and the Turkish Medical Association has several times expressed its opposition to this legal requirement, calling for changes in the law to bring it into line with the World Medical Association's resolutions.

The last execution in Turkey occurred in 1984. Since then no death sentences have been approved by the parliamentary judicial commission, although the courts continue to hand them down. Last November, however, for the first time in over nine years, the commission approved a sentence of death in the case of a (non-political) murderer. All that is now needed for the execution to take place is a simple majority in the Turkish parliament when the case is sent to it for approval; this may happen in the next few months. In December the Turkish Medical Association issued its most recent statement on the issue, reiterating its ethical position and calling for urgent changes to the law.³

Amnesty International is gravely concerned about the situation in Turkey; these events have taken place against a background of a violent uprising in the mainly Kurdish south east of the country, in which both government forces and armed opposition groups have been responsible for brutal abuses of human rights. The death sentence is mandatory after conviction for "acts of separatism" (which include the expression of certain non-violent opinions), and if executions resume in Turkey many political prisoners, some of them prisoners of conscience, will probably be executed. Amnesty International fully supports the Turkish Medical Association in its attempts to prohibit the participation of doctors in the execution process