have been overtreated. However, the current policy of biopsy and subsequent ablation or conisation resulted in overtreatment of 23 women if the same criteria were used. Thus introducing a "see and treat" policy would result in a further 23 (15·2%) "unnecessary" conisations.

Comment

People in prisons are often socially disadvantaged, and a satisfactory follow up programme is difficult to establish because they move around once released and tend to avoid contact with those in authority. Our results suggest that if a see and treat policy were introduced the overtreatment rate would be similar to that in other see and treat studies,[3] but most women would be cured of their condition at first presentation. In this group of women, however, the advantages of prompt successful treatment outweigh possible overtreatment because of the high incidence of high grade disease and the high default rate from treatment and follow up.

1 Moghissi KS, Mack HC, Porzak JP. Epidemiology of cervical cancer. Study of a prison population. *Am J Obstet Gynecol* 1968;**100**:607-12.
2 Will M, Moffet M. Cervical cytology in a Scottish prison. *Scot Med J* 1970;**15**:219-21.
3 Luesley DM, Cullimore J, Redman CWE, Lawton FG, Emers JM, Rollason TP, *et al.* Loop diathermy excision of the cervical transformation zone in patients with abnormal cervical smears. *BMJ* 1990;**300**:1690-3.

Commentaries

Overstating overtreatment?

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Women in prison are at high risk of diseases of the reproductive tract. In an independent review of one high security prison for women serving long sentences Lester and I found a high hysterectomy rate (on average nearly three a year over six years in a stable population of about 35 women), which seemed to reflect genuine physical disease.[1] Cervical carcinoma was cited as a reason in only one case, but as Downey *et al* point out, women in prison are at particular high risk of this potentially fatal disease. The immediate reaction to their paper must be that it represents an important advance for the health of these women. The only ripple of concern is created by their description of low voltage diathermy loop excision of suspected cervical tissue as overtreatment.

The concept of overtreatment is deceptively simple. It implies giving more treatment than would be required to produce a desired effect. The authors seem to take a strictly physical view on both counts. The treatment consists of excision of suspect cervical tissue under local anaesthesia, a procedure which generally takes about four minutes and only rarely more than 10 minutes. Morbidity after treatment is minimal,[2] but cervical carcinoma has serious morbidity and mortality, and this intervention is important in preventing its emergence. Arguably, then, the main desired effects are treatment of existing disease and prevention of more serious disease.

The authors perhaps should have emphasised that, just as the procedure is not 100% specific, it is not 100% sensitive—some true positive results will be missed. It does, however, offer a much better prospect of prevention than more conservative repeat smear examinations, not least because it is well documented that a substantial minority of women attending any clinic will not keep attending for the duration of repeat tests or other interventions necessary. The drop out rate for the high risk group of women in prison in this paper was nearly 40% at first follow up, and over three quarters failed to follow advice.

Best treatment for women

The problem of attending for follow up may, then, affect any woman. Though women are unlikely to be concerned whether a slightly larger or smaller number of cells is removed from their cervix, since healthy tissue will almost invariably regenerate within weeks, they are likely to be concerned about how much time and misery it is going to take to restore themselves to health and safety. Most women likely to need such interventions, including former prisoners, are likely to be busy with children, paid employment, or domestic work and often all three. A desired treatment is thus one that does not require repeated, long, wearisome journeys and probably even longer waits in outpatient halls. These women might argue that, in the circumstances, overtreatment is that which requires them to commit, say, four or five afternoons rather than two.

A related issue is the fact that most women dislike vaginal examinations, but some of the most potentially vulnerable women—for example, those who have been sexually abused in childhood or adulthood—experience not just anxiety, but panic under gynaecological examination. They do their best to avoid examination, putting their longer term health at risk. Wilkins and Coid noted that of a sample of 74 women from the same prison, 15% reported being incest victims, 24% other sexual abuse in childhood, 34% sexual assault in adulthood, and nearly one third current evasion of sexual activity.[3] These are likely to be underestimates but do give some indication of the risk of phobic avoidance of repeated gynaecological procedures.

Proper consent

The balance of considerations might be different if the proposed intervention were to carry a risk of serious side effects, or if it was destructive and irreversible. But for the situation presented here, it seems to me that there is hardly a dilemma at all, provided that the women have given informed consent. A recent survey of psychiatric disorder among women serving a prison sentence showed that, although rates of psychiatric illness were high, few women had illnesses likely to impair their competence for making decisions about medical treatment.[4] They will, however, need information about the physical nature of the procedure, its physical consequences, and the population adjusted physical risks of not attending to the warning signs found in the cervix; they also should have information about the time commitments that the different approaches will entail and the risk that, whatever their intentions at the time of discussion, they may not return for follow up. If despite this the woman chooses a conservative approach her doctor must accept that. Only if the woman were mentally incapable of making such a decision would there be any case for medical paternalism (or maternalism), although it would require careful legal consideration. There is no ready procedure for cover against a possible suit for battery in treating a patient with incapacitating

mental disorder for a physical disease if that patient has not given real or valid consent. The Law Commission has provided useful guidance through the maze.[5]

In summary, while commending the caution of Downey *et al* and acknowledging that there are issues of principle that would have to be addressed if the procedure recommended were more destructive or less reversible, I believe that the real issue for service purchasers and providers is whether it is ethically defensible not to have this treatment available in every NHS gynaecological clinic and particularly in all closed institutions that house women. For the individual doctors and patients the issue is almost exclusively of real consent.

1 Lester A, Taylor PJ. *Women in prison: H Wing, HM Prison Durham.* London: Women in Prison, 1989.
2 Luesley DM, Cullimore J, Redman CWE, Lawton FG, Emens JH, Rollason TP, *et al.* Loop diathermy excision of the cervical transformation zone in patients with abnormal cervical smears. *BMJ* 1990;**300**:1690-3.
3 Wilkins J, Coid J. Self-mutilation in female remanded prisoners. 1. An indicator of severe psychopathology. *Criminal Behaviour and Mental Health* 1991;**1**: 247-67.
4 Maden T, Swinton M, Gunn J. Psychiatric disorder in women serving a prison sentence. *Br J Psychiatry* 1994;**164**:44-54.
5 Law Commission. *Mentally incapacitated adults and decision-making: an overview.* London: HMSO, 1991.

Present system could be improved

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This paper raises several important issues about current clinical practice guidelines for the investigation and treatment of women with abnormal cervical smears. Equipment to excise the abnormal cervical transformation zone while preserving specimens for histology (loop excision, laser miniconisation) is now widely available for outpatient use. Downey *et al* propose a policy of see and treat for women in prison, but it could be extended to women in whom factors other than imprisonment identify them as being at high risk. Careful examination is needed to establish the costs and benefits of this approach, to define criteria for its use, and to ensure that women and their general practitioners are clear what to expect and which policy is followed by the local service. Four points require comment.

Defining the problem

We assume that the high prevalence of cervical abnormalities in these women is real. It may, however, be exaggerated by the relative frequency of early repeat smears for the comparison group of women in Hampstead with a low risk of abnormality and the three and six monthly early repeat smears for women with abnormal results.

It seems that women who left Holloway before completing their recommended treatment or follow up were expected to return to the Royal Free Hospital. As Holloway is one of only 11 prisons in England for women, however, it is likely that it would be impractical for many women to attend this hospital once they had left prison. The authors have not attempted to identify those women who may have continued treatment or follow up within their local service.

The women's view

The authors seem to have made little attempt to understand why, from the women's perspective, their behaviour may well be rational and thus susceptible to modification. Unless women are enabled to understand the causes and progression of cervical abnormalities, the importance of their abnormal smear result, and the requirement for and availability of continuing care, they are disadvantaged in terms of making informed decisions about their future health care. All women deserve a full and careful explanation of their cytology results and any treatment should be recommended in a context free of judgmental or patronising attitudes. Where appropriate this discussion should be backed up with written information. Women who leave prison during treatment or follow up should be helped to identify where they might go for continuing care and provided with a letter for the next doctor.

Improving the present system

The above arguments could suggest that the problems may not be as great as implied by the authors. Moreover, the proposed approach to giving information and participation in decision making could provide real improvements. Unfortunately, the authors do not give detailed information about the protocols for the present service or for the proposed see and treat regimen or about the understandings and suppositions about the course of cervical disease which underlie the protocols. There is also no definition of operative treatment. Because of this it is difficult to establish the clinical validity of the approach.

We would argue that with better understanding of the women and the context in which they live their lives, together with the provision of a service which takes this into account, the outcome of care could be considerably improved without the need for a see and treat regimen. The potential adverse sequelae of destruction of the cervical transformation zone on the physical, reproductive, and mental health of the women are not discussed; nor is there any proposal to research this important issue. The adverse effects must be considered to understand the cost benefit ratio for treatment.

Treating women in prison different from rest of community

There is a considerable irony in this paper in that NHS doctors seem to be advocating a system of care for women in prison that would be significantly different from that offered to most women. Changes within the prison health care system over the past few years have supported the integration of NHS services with prison health care services—one of the aims being to provide similar services within and outside prisons. It is essential to see women in prison not as female prison inmates but as women.

However, the paper also raises the wider question of how best to provide services for any woman deemed to be at high risk of developing cervical cancer and considered to be unlikely to return for treatment. These women require the very best services available, provided in an appropriate way for them, and not an approach that will stigmatise them and may increase the risk of their not completing an effective course of treatment.

Correction

Early identification of patients at low risk of death after myocardial infarction and potentially suitable for early hospital discharge

A printer's error occurred in this paper by Dr R W Parsons *et al* (16 April, pp 1006-10). The initials of the fourth author are P L (P L Thompson) and not D L as printed.