coding staff, and download these data to a standard word processing package that contains a free text module. The resulting discharge summary is then sent to the family doctor.

At St Mary's Hospital we adopted the latter approach last January. Audit of 228 summaries over two separate one month periods was performed. Summaries were sent by post, with most arriving at their destination within 12 days of the patient's discharge. Use of the postal system resulted in a median delay between dispatch and receipt of five days; fax machines are therefore now used. Comments by general practitioners were favourable ("clear and concise," "timely and comprehensive"), with support being expressed by both hospital clinicians and general practitioners for the adoption of Read coding instead of the sometimes tortuous ICD-10 (international classification of diseases, 10th revision) codes currently in use. We have already seen a considerable improvement in the accuracy of clinical coding; some clinicians were unaware of the potential for damage that incorrect coding carries. The system is also being piloted as a basis for clinical audit. Finally, the presence of a summary on the hospital information system allows access to recent clinical information in those cases in which timely retrieval of notes is difficult.

This method of producing summaries addresses many of the issues raised in the Audit Commission's report, and the summaries represent a nascent electronic patient record.

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Babies' deaths linked to suboptimal care

EDITOR,—Charles D A Wolfe makes several important points in his critique of the confidential inquiries into stillbirths and deaths in infancy, not least on the issue of interobserver variability between regional panels.[1] As chairs of the regional confidential inquiry panels in the former Northern region, we wish to defend the inquiry system as currently applied to "intrapartum deaths" fulfilling the criteria for 1994 (those babies dying in utero during labour or in the first 27 completed days of life, weighing 1500 g or more at birth, and with no severe or life threatening congenital abnormality).

We have had no difficulty in recruiting members to the panels, and all have agreed to sit on second and further panels. Several clinicians have made positive statements about the educational value of membership of the panels, and others have stated an aim to change practice in their units as a result of cases and issues discussed by the panels.

The standard applied in reaching overall grades of care in our region is that of current agreed acceptable practice as based on peer opinion and existing guidelines. We do not question the need for evidence based clinical practice, and surely one of the aims of the confidential inquiry must be to identify areas in which research is needed. In the interim, however, judgment of acceptable practice will to some extent be subjective.

In a recent, fully anonymised review of overall grades of substandard care as given by the regional panel compared with local panels, we found agreement in 18 of 36 cases for which a local panel had met. Among the 18 cases in which there was disagreement the regional panel identified the same factor(s) as the local panel in 10 cases but graded them one grade lower than the local panel in four and one grade higher than the local panel in six. In the remaining eight cases the factors that seemed crucial to the regional panel either had not been identified by the local panel (three) or had not been graded as indicating suboptimal care (five). We recognise, however, that discrepancies may reflect a lack of knowledge by the regional panel of important local factors (for example, staffing levels). Anonymised feedback on these apparently missed or misinterpreted factors will be provided in the form of a regional report on the findings of the inquiry panels.

Undoubtedly, scientific criticisms can be made of inquiry panels, but the panels seem to be fulfilling an important educational role in this region.

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1 Wolfe CDA. Babies' deaths linked to suboptimal care. *BMJ* 1995;**310**:1536. (10 June.)

Late diagnosis of HIV infection in children is common and devastating

EDITOR,—J A Evans and colleagues draw attention to the late diagnosis of HIV infection in infants not previously known to be at risk of the disease, but they only hint at the potential extent of this problem.[1] In 1993, as part of a review of services for children and families with HIV infection, we undertook in depth interviews with 10 families who had a child in the care of our paediatric HIV service.[2] This study suggested that the late diagnosis of HIV infection in children is not unusual. Of the 10 children, only three were identified as having the infection antenatally; two mothers had already been diagnosed as HIV positive, and one woman's husband had been diagnosed as HIV positive while she was pregnant. For the seven other families the child's diagnosis was the first indication of HIV infection in the family.

In Evans and colleagues' study the children had had symptoms for up to six weeks before diagnosis. In our study the time to diagnosis for the seven children diagnosed late ranged from several months (four cases) to over two years (three). The seven children had been seen by their general practitioners many times for a variety of complaints and had attended a total of nine hospitals; they had often been inpatients several times before an HIV test was suggested. The cost of this process to the families in terms of emotion, time, and money was considerable, and the final diagnosis of HIV infection, combined with the anxiety over the critically ill child, was profoundly stressful and devastating.

Evans and colleagues point out that a late diagnosis means that opportunities for reducing the risk of vertical transmission of HIV are lost and that the children are denied the benefit of prophylaxis. These children's infection is diagnosed only because they have become ill; they are therefore more likely to require inpatient facilities, intensive care, complex drug treatment, and more medical and nursing time. Also, around the time of diagnosis there are greater stresses on the clinical staff, who may be dealing with a sensitive and difficult family situation.

The late diagnosis of HIV infection in infants and children is an important problem, with costs to the child, family, and NHS. For this reason we support the argument advanced by Evans and colleagues that policies on antenatal screening for HIV should be reviewed in areas where the prevalence of HIV infection is high.

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Analgesic effect of sucrose

Heel pricks were unnecessarily painful

EDITOR,—Nora Haouari and colleagues have clearly shown that oral sucrose reduces crying and tachycardia in term infants undergoing a standard painful procedure, blood sampling by heel prick, with a manual lance.[1] The fact that the effect is dose dependent suggests that oral sucrose has analgesic properties. The key messages point out that every newborn baby in Britain is subjected to painful procedures and that little is done to minimise the discomfort which these cause.

One way to minimise the discomfort is by changing the method of heel blood sampling. Automated, springloaded lances (for example, Autolet Lite Clinisafe, Owen Mumford, Oxford) cause less pain without a reduction in efficacy, and they are less operator dependent.[2,3] The manual lance has no place on the postnatal ward or neonatal unit.

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Cuddle deprivation may have confounded experiment

EDITOR,—While it is laudable that Nora Haouari and colleagues are concerned to minimise the trauma associated with a common neonatal procedure, the starting point for their investigation seems somewhat misplaced.[1]

Firstly, they report that "parents could be present but did not speak or touch the baby during the procedure." Three minutes is a long time to leave a baby without such comfort. I am surprised that it was considered ethical. My experience of community midwifery is that babies can be very well soothed during painful procedures by being put to the breast or at least being held. It is best if the health worker performing the test is sitting beside the mother or parent so that the health worker is in the right position to gently control foot movements during the procedure.

Secondly, the WHO/Unicef Baby Friendly Initiative, now endorsed in Britain,[2,3] clearly states that newborns should not be given food or drink other than breast milk unless medically indicated. Research such as Haouari and colleagues' not only ignores the valuable contribution of breastfeeding towards an infant's physical and psychological

wellbeing but is potentially counterproductive to promotion of breast feeding.

I suggest the following amendments to the author's key messages:

- First assess whether the heel prick is really necessary
- Minimise the discomfort of the procedure by asking the parent (or member of staff) to cuddle and soothe the baby
- If the mother is breastfeeding encourage her to put the baby to the breast before the procedure starts and allow the baby to suckle during the procedure

Lastly, before drug manufacturers seize a new opportunity to market prepacked phials of sterile sucrose solution, complete with dropper, could I urge the authors to consider mounting a study to answer their own query—namely, "whether simply cuddling a crying infant after heel prick is as effective in reducing crying as 50% sucrose." It may be that going back to the basics is all that is needed.

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Are sugar pills unsuitable placebos?

EDITOR,—Now that a solution of 50% sucrose has been shown to have analgesic properties in babies,[1] I believe it is time to discard all those trials where lactose has been used as a placebo.

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Adult survivors of child sex abuse

Group therapies are also effective

EDITOR,—In their paper on the pilot service, Breakfree, for adult survivors (both men and women) of childhood sexual abuse David Smith and colleagues leave some points unclear.[1] How many support workers were there, and how professionally trained were they? They were "initially supervised," but by whom and for how long? The average duration of a counselling session was 1·8 hours (no range was given), sometimes twice weekly. This seems a lavish use of resources. The scheme was found to be successful in this study, but care would have to be taken in replication to ensure the quality of supervision and counselling.

In testing the differences between scores at the start and end of treatment the authors have emphasised hypothesis testing by quoting z and P values. It would have been helpful, however, if they had given summary statistics, such as the median scores and percentile ranges, and indicated the magnitude of the differences by calculating confidence intervals for the differences.[2] Finally, we are not told how the sum of £70 000 was arrived at as the cost of the year's pilot scheme.

In the psychological therapies service in Southampton we have been treating women survivors of childhood sexual abuse in a weekly analytic group of one and a half hours' duration since January 1986. The learning from group therapy for these patients is particularly rapid, probably because they find that their experiences are not unique and they therefore feel less isolated. A clinical account of the first 94 patients admitted to the group from the 235 referred up until August 1990 has been published.[3] Their depressive inventory score fell during their time in the group, and the fall was maintained for between two and seven years afterwards and was independent of treatment with antidepressants. Their use of psychiatric hospital and primary care services was also reduced over five years' follow up.[4]

It will be interesting to know if the improvement during the Breakfree programme is maintained at follow up and whether it depends on continued contact with the service. If so, the cost will increase with time.

We are now estimating the cost of our method of treating women survivors. It would be useful to be able to compare the cost and effectiveness of the two methods of dealing with this vast source of psychological distress.

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Authors' reply

EDITOR,—Our study was an audit of a pilot scheme set up in response to identified needs of adult survivors requesting one to one "abuse focused" therapy in a community setting. Because of the diversity of long term effects of child sexual abuse, survivors will require and request therapy to suit their individual needs at a particular stage of their healing process. Our "imaginative" client led, community based, interagency pilot scheme reflects one sensitive and appropriate approach that clients found to be successful.

The pilot scheme had 12 sessional support workers, all of whom received training from specialists in treating adult survivors, such as Dr Liz Hall, a consultant clinical psychologist; training in issues concerning child protection and offenders' behaviour, provided by Lincoln social services' training department; and training in humanistic counselling. All staff initially received frequent debriefing by peers in addition to regular supervision (conforming to the guidelines of the British Association for Counselling) from fully qualified psychotherapists and psychologists.

Contracts for therapy were negotiated to meet individual need and ranged from half an hour a week to two two-hour sessions a week. Such flexibility of approach facilitated disclosure and allowed the clients to regain their composure before leaving the building.

The year's budget for the pilot scheme was £70 000, but this did not include any costs for the infrastructure. The Breakfree Service for Adult Survivors is now operating as an independent service but still maintains a competitive costing structure. The pilot scheme was funded for only a year, and no provision was made for long term follow up. We now intend to continue evaluating the approach and to monitor long term outcome, perhaps with comparative studies.

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Protecting adolescent girls against tetanus

Targeting both sexes may avoid misunderstandings

EDITOR,—As a surgeon working in the developing world, but home on leave, I would like to comment on the editorial by Loretta Brabin and colleagues.[1] In our rural area in Cameroon we see at least as many teenage boys with tetanus as we see girls, possibly because of their hunting and outer outdoor pursuits. The incidence in men is certainly higher than in women, because of the number of women protected through antenatal care.

A few years ago a campaign to protect teenage girls went sadly wrong due to insufficient education of the community before the campaign. Because the campaign was aimed only at girls, a rumour started that these injections were of a long term contraceptive. The rumour was taken up by some religious leaders and believed by the girls and resulted in a sharp increase in pregnancies among school students.

For both these reasons it is preferable to target primary school leavers of both sexes. I know more toxoid would be needed, but the cold chain and staff could deal with both groups as many primary schools are coeducational. Those not attending school at all should also be targeted as they usually drop out after the infant course and do not come for the booster dose five years later. Since the cold chain is of variable efficiency some of the doses given may have been ineffective and an extra dose is therefore better than one dose too few.

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Induced abortion can predispose to tetanus

EDITOR,—As participants in the course for the diploma of reproductive health for developing countries at the Liverpool School of Tropical Medicine, we read with interest the article by Loretta Brabin and colleagues.[1] Four of the six participants on the course have had experience in managing a total of seven patients with post-abortal tetanus in three countries (table).

These seven women were admitted with tetanus following induced abortions, usually undertaken by a traditional abortionist. These cases illustrate that antenatal vaccination alone misses women