

Letters

Promoting walking and cycling as an alternative to using cars

Vested interests doom puny healthcare interventions

EDITOR—Ogilvie et al's systematic review on promoting walking and cycling as an alternative to using cars treats motoring as if it were a disease that can be cured, without examining the social forces that lead to car use.¹ The effects they find in their review are hardly surprising, given the social currents opposing them: car advertising, predict and provide road planning, the giant car "park," and other horrors of suburbia. Big business and big government alike have a vested interest in its continued growth.

Those who have bought into this motor dependent lifestyle can be trusted to extend the infliction of motor tyranny on everyone else: motorists object to being taxed, although they are major polluters, or confined by speed limits, although they killed 3508 people in Britain last year.

I try to undermine this metal carapaced horde. Any driver suffering from a condition in which lack of exercise is a factor: hypertension, obesity, stress, depression—much of the general practice caseload in fact—is told to sell their car and get a bike instead. I do have my successes—for example, a man in his 50s who came back to his follow up appointment, saying he wished he lived further from work so he had more time on his bike every day.

But when I look at the vested interests lined up against me—not least George W Bush's latest oil grab—I wonder why I bother. Urban doctors who continue to drive are particularly depressing. Since when do you need a car to carry a briefcase?

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Competing interests: DC owns five bikes and might sell one of them soon.

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¹ Ogilvie D, Egan M, Hamilton V, Petticrew M. Promoting walking and cycling as an alternative to using cars: systematic review. *BMJ* 2004;329:763-0. (2 October.)

Comfort of cycling needs to be akin to that of using cars

EDITOR—Regarding the content of the paper by Ogilvie et al on promoting walking and cycling as an alternative to cars,¹ I am disappointed to see that the various "interventions" have such negligible effects on behaviour. I have been cycling for over 40 years, in Britain, all over Europe and, for the past 20 years, in Australia.

In Sydney traffic conditions are so dangerous to cyclists that my riding is reduced to a Sunday morning ride with friends and occasional organised rides. I am disillusioned that my children cannot enjoy the affordable freedom and pleasure that cycling gave me in my youth.

If an infrastructure "intervention" increased my frequency of cycling, or made it feasible to commute to work, I

would see that as a great improvement.

Most drivers seem wedded to the comfort of their cars and the protection they offer from the elements. Compared with public transport, cars give people the freedom to go where they wish, when they wish. There is also a social cocooning effect.

To give cycling a chance of competing on the comfort and protection front I believe a whole new approach needs to be considered. I'm thinking of covered, off road cycleways. There needs to be a serious trial where cyclists are protected from rain, strong winds, exhaust fumes, and, in places such as Australia, the damaging rays of the sun.

Of course the cost of this level of "intervention" is unthinkable in the present car dominated era. In the near future though, dwindling petrol stocks will force governments to focus on alternatives. Perhaps this is one worth pursuing.

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Competing interests: MJM is a community representative on the Bicycle Committee, Manly Council, Manly, Australia.

¹ Ogilvie D, Egan M, Hamilton V, Petticrew M. Promoting walking and cycling as an alternative to using cars: systematic review. *BMJ* 2004;329:763-0. (2 October.)

Perception of safety is biggest obstacle

EDITOR—The article by Ogilvie et al highlights the urgent need to promote cycling and walking as a way of promoting individual health.¹ Compared with Europe, not many people in the United Kingdom cycle. For example, in England only 1% of children's journeys are by cycle, compared with 50% in the Netherlands (P Lingwood, unpublished). However, I take issue with the authors' main conclusion that "targeted behaviour change programmes" are more effective than general promotion or physical and economic interventions.

Transport planning and travel behaviour do not allow such easy conclusions. We are dealing with a dynamic environment—a combination of many factors, including the road environment, personal circumstances, national and local policy, travel assumptions, etc. In this environment it is very difficult to prove that any single intervention will have a notable effect.

The weight of evidence, however, shows that the most prominent barrier to cycling is the perception of safety, principally determined by driver behaviour and traffic speeds and volumes. There is no use by itself promoting cycling unless cyclists can make their journeys in a cycle friendly road environment.

The English Regions Cycling Development Team (ERCDDT) has highlighted a range of changes necessary by local authorities to increase cycling. The reports are available on the National Cycling Strategy website (www.nationalcyclingstrategy.org.uk) with a 2004 update.

Currently the most important issue is for health professionals to work with local authorities in preparing their second round of local transport plans (2006-11) to ensure that the promotion of walking and cycling (by the whole range of interventions) is central to future policy.

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Competing interests: PL's role for the English Regions Cycling Development Team (ERCDDT) is to promote cycling but there is no financial or personal benefit from his statements. ERCDDT was set up at the request of (and reports to) the National Cycling Strategy Board. It is funded and supported by the Department for Transport and run (after winning a competitive tender) by AEA Technology.

¹ Ogilvie D, Egan M, Hamilton V, Petticrew M. Promoting walking and cycling as an alternative to using cars: systematic review. *BMJ* 2004;329:763-0. (2 October.)

Author's reply

EDITOR—We agree that many of the interventions about which we found evidence were unlikely to have large effects in the face of strong economic and personal interests to the contrary. The complexity of transport related behaviour and interventions also makes it difficult to establish causal relations between interventions and outcomes.

However, these do not constitute arguments against our approach. The evidence about barriers to cycling is undoubtedly relevant. But measures that seem to address these factors cannot be assumed to lead necessarily to the desired results.¹ The UK Department for Transport recently admitted that the National Cycling Strategy has had no effect on the overall level of cycling in England despite its good intentions.² One reason is a lack of political will to address the deeper causes and competing interests,³ another is that transport policy often seems to pursue conflicting goals.

We hinted in our discussion that more ambitious measures might be more effective, and our findings are consistent with (if not proof for) a view that much more radical changes in society would be required to achieve significant population health gain through a modal shift towards walking and cycling. Carnall complains that we treated driving as a disease and ignored the social forces which underlie it, but we set out with an entirely open mind about what types of “intervention” might be relevant, searching for evidence accordingly (see bmj.com). We hoped to find evidence about the effects of policies on, for example, car advertising and suburban planning and would certainly have included it had we found it.

Readers may have been unduly influenced by the editorial summary for This week in the BMJ. This contains an error of fact in the second sentence—“Reviewing 22 studies analysing the effect of targeted behaviour change programmes”—and readers will struggle to find the opening sentence—“Encouraging people to use alternative and healthier modes of transport may not be enough to improve the health of the population”—anywhere in our paper. We did not see the paragraph before publication and do not endorse it now.

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How to deal with influenza

Fever may be used as treatment

EDITOR—Because there is no specific treatment for influenza, Jefferson's editorial and the accompanying articles concentrate on vaccination and chemoprophylaxis.¹ However, I plead for recognition that fever may be used as a non-specific treatment of flu. The fever is not just an unpleasant symptom of flu but a crucial part of the body's defence mechanism that should be encouraged.

Infectious organisms are adapted to the temperature of the part of the body they colonise, so it follows that they will grow best at that temperature. Rhinoviruses, which infect the cooler upper airway and sinuses, grow best between 33° C and 35° C, so inhaling air at about 45° C for 20 minutes will much improve the symptoms of a common cold.² Conversely, treating the common cold with aspirin causes an increase in the rate of production of the virus.³

By contrast, influenza viruses, which infect the whole body, grow best at temperatures slightly below body temperature, and at 40° C they will die off after 12-24 hours. So it is not surprising that if fever is suppressed in ferrets infected with the flu virus, their illness is prolonged.⁴

There seem to be no studies of the effect of lowering or raising body temperatures in humans with flu. But there are obviously good reasons for trials of treating flu by raising the temperature to 40° C and maintaining this for at least 24 hours. The absence of such trials may result from a deep seated fever phobia, stemming from prescientific medicine when fever was perceived as an illness in itself. A famous 17th century physician, Thomas Sydenham, said, “Fever is nature's engine which she brings into the field to remove her enemy.”⁵ The public and the medical profession have still not realised the full importance and potential of this statement.

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Competing interests: None declared.

- 1 Jefferson J. How to deal with influenza? *BMJ* 2004;329:633. (18 September.)
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- 5 Payne JF. *Thomas Sydenham*. London: T Fisher Unwin, 1900.

Author's reply

EDITOR—Fowler raises some important issues. My editorial was focused primarily on influenza, but I agree that efforts to contain the ravages of influenza-like illness have mainly been concentrated on preventing and treating the effects of infection with influenza A and B viruses. These agents cause only a variable but “on average” minor share of the yearly burden of influenza-like illness. The development of effective vaccines and antivirals against influenza-like illness has so far failed for various reasons.

For example, topical interferon, although effective against the common cold, caused unintended effects similar to the symptoms of influenza-like illness.¹ Manufacture of effective rhinovirus vaccines would have to include antigens from more than 100 different serotypes.² As influenza-like illness is a syndrome, the only realistic current alternatives are the building of local and general immunity or the symptomatic or natural remedies that Fowler advocates. Apart from hyperthermia, there are a few interventions that are based on evidence (table). All of them are cheap and have few, if any, unintended effects.

Overall, the underlying problem is insufficient research on the mechanisms and containment of influenza-like illness. Had the MRC Common Cold Unit not closed in 1989 we might have a better understanding of this very common illness and not rely on the unwelcome arrival of new infective agents to stir up temporary interest in the topic. It is a sad fact that lack of commercial appeal and passing trends have stunted research in this important health field.

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Competing interests: TJ has received consultancy fees from Roche, GlaxoSmithKline, and Sanofi Synthelabo. He was HC Roscoe fellow for the study of the common cold between 2000 and 2002.

- 1 Jefferson TO, Tyrrell D. Antivirals for the common cold. *Cochrane Library*. Issue 3,(1). Chichester: John Wiley, 2004. (Cochrane Database Syst Rev 2001(3):CD002743.)
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 Additional references w1-w10 are on bmj.com

Evidence based interventions for influenza-like illness

Perspective	Intervention	Rationale	Reference
Prevention	Hand washing	Interrupts transmission of most ILI agents	w1-w4
	Not blowing nose	Forces mucus into sinuses and Eustachian tubes	w5
Treatment	Drink spicy chicken broth	Accelerates clearance of nasal mucus and vasodilates	w6, w7
	Steam inhalation or sauna	Conditions of high temperature and humidity impede transmission and replication of respiratory viruses	w8, w9, w10

- 1 Macintyre S, Petticrew M. Good intentions and received wisdom are not enough. *J Epidemiol Community Health* 2000;54:802-3.
- 2 Department for Transport. *Walking and cycling: an action plan*. London: DfT, 2004:7. www.dft.gov.uk/stellent/groups/dft_control/documents/contentservertemplate/dft_index.hcst?n=12069&d=2. (accessed 10 Nov 2004).
- 3 *Bike for the future: the NCS board for England's strategic action plan—“more people cycling, more safely, more often.”* London: National Cycling Strategy Board, 2004:5-6. www.nationalcyclingstrategy.org.uk/fileuploads/ncsb/NCSB098.pdf (accessed 10 Nov 2004).

Worthwhile surveillance system is in action

EDITOR—We support Jefferson's recommendation to strengthen surveillance capability for influenza, especially the identification of circulating virus amidst non-specific respiratory illness.¹ In north west England the Health Protection Agency has been developing influenza surveillance to increase the coverage of the national consultation system for general practitioners (run by the Royal College of General Practitioners),² after a successful pilot scheme in 1999 that detected a local epidemic of influenza A in Merseyside.³

This year more than 80 general practices are contributing weekly data on influenza and influenza-like illness to local health protection units. Weekly data are submitted through a web based capture system and viewed over the NHSnet in real time at age specific rates. An electronic weekly bulletin produced by the agency's north west office is disseminated to a wide audience, including primary care trusts and strategic health authorities, and is also available on the website.⁴

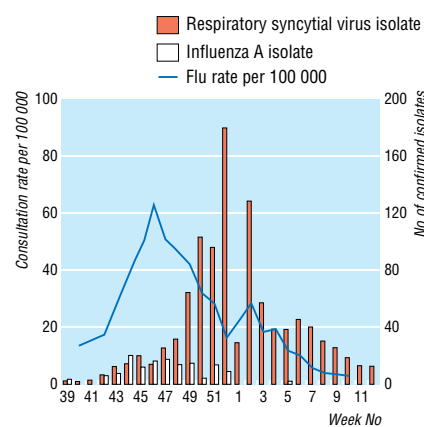
The bulletin includes data on respiratory isolates identified in microbiology laboratories throughout the region. Last winter, good correlation existed between the period of influenza virus isolation and consultations for influenza in primary care (figure), indicating the surveillance system's ability to distinguish increases in influenza from influenza-like illness, despite low levels of circulating influenza compared with respiratory syncytial virus.

Feedback received indicates that this system is particularly useful to health service staff involved in planning services, by alerting them to local increases and facilitating bed management. In addition, the data are used to determine the appropriate time period for use of antiviral compounds. This system is therefore a good example of surveillance delivering timely intelligence for action.

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Laboratory isolates of influenza A and respiratory syncytial virus compared with consultation rate for influenza and influenza-like illness in general practice, by week in 2003-4 in north west England

Competing interests: None declared.

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National service framework for children

Framework ignores children's growth

EDITOR—The Child Growth Foundation finds it unbelievable that the national service framework for children, in the editorial by Lachman and Vickers,¹ ignores the need to check a child's growth, either routinely or opportunistically, other than at school entry.

The assessment of growth should be a basic paediatric measure throughout a child's growing years, and *Health for all Children*, for all its woes, agrees that it should be considered at every health contact. When the framework fails to list any requirement to measure weight, length, or occipitofrontal circumference in the first four years of a child's life, one can be forgiven for thinking that no one in the Department of Health has any knowledge of endocrinology.

Recommending a single growth check at school entry is fairly useless, too, since it shows only how tall, short, thin, or fat the child is on the day. It will not show whether he or she is growing normally, which should be the object of any assessment. When the public health white paper is published with, presumably, a call to identify the early signs of unhealthy weight gain in children and intervene to prevent them getting fatter what measure does the department propose is taken? Body mass index must be a candidate—supported by a waist circumference measurement—but so far as the national service framework is concerned, body mass index does not exist.

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Competing interests: None declared.

1 Lachman P, Vickers D. The national service framework for children. *BMJ* 2004;329:693-4. (25 September.)

Framework shows a new vision of health, in life

EDITOR—Lachman and Vickers grasp both the context and the opportunity of children.¹ Before the framework, the Children's Tsar saw the fundamental constraint on change: "The English don't value childhood."² But in terms of poor adult health, lifecourse research has

consistently shown that the environment, experience, and capacity for learning in childhood set the scene for future illness.³

I was unexpectedly moved by the section dealing with the mental health of children and adolescents. Upfront, its focus was on the wellbeing and development of children and young people in England. It particularly challenged professionals in every area of practice to build genuine partnerships with children, young people, and families. In other words, if things are to improve for the whole population, children must cease to be invisible—they must be seen, and heard, and listened to. Active participation, the sort of public involvement that makes a difference both to the services provided and to the self efficacy of the young person, is close to a new vision of "health."

Many of us, whatever our professional discipline,⁴ come across young people who are struggling with difficult circumstances and have few obvious resources. For mental wellbeing that will last and last, we all need to learn new skills of working with children and families (even the most socially excluded ones) that enable them to become "mentally and emotionally resilient."⁵ I have taken that quote from a recent strategy addressing stigma as the biggest and most important challenge we face. For child health, indifference is the biggest and most important challenge we face—and it will be transformed, when we start to value health across the lifespan.

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1 Lachman P, Vickers D. The national service framework for children. *BMJ* 2004;329:693-4. (25 September.)

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5 National Institute for Mental Health in England. *From here to equality*. Leeds: NIMHE, 2004.

Headline about basal cell carcinoma was misleading

EDITOR—The headline "Basal cell carcinoma should be excised" given in This week in the *BMJ* for the systematic review by Bath-Extall et al of interventions for basal cell carcinoma of the skin was a misleading misrepresentation of the conclusions.¹ The authors conclude that inadequate research is available on the choice of treatment for basal cell carcinoma but that on this limited evidence surgery and radiotherapy seem to be the most effective treatments.

The authors emphasise the lack of evidence for different treatments, not evidence of lack of efficacy. Most effective is not equivalent to most appropriate. Basal cell carcinomas are a very heterogeneous group of tumours, and factors such as tumour site, general health, and particularly patients' preferences are important in determining optimum treatment in each individual case.

To state that basal cell carcinoma should be excised is an oversimplification and likely to mislead readers.

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1 Bath-Extall F, Bong J, Perkins W, Williams H. Interventions for basal cell carcinoma of the skin: systematic review. *BMJ* 2004;329:705-8. (25 September.)

Making sense of rising caesarean section rates

Editorial made no sense of rising rates

EDITOR—In his editorial on making sense of rising caesarean section rates, Anderson does not mention why or whether rising rates are bad for women, or even disadvantageous if seen in a public health context.¹ One way to do this might be to compare perinatal and maternal outcomes or even a cost benefit analysis in women at term intending to try for a normal delivery versus those intending to have an elective caesarean section, matched principally for age and parity. A sizeable proportion of those trying for a normal delivery, and a smaller proportion of those having an elective section, would end up having an emergency caesarean section, where the risks of the operation to mother and baby particularly lie.

But to argue, as Anderson does, for large, well designed randomised trials for specific indications—for example, in relation to fetal distress or dystocia—is a bizarre non-starter. How could a woman in labour with fetal distress as evidenced by a profound bradycardia on cardiotocograph and acidotic results from fetal blood sampling be randomised ethically to a “non-delivery” arm? Similarly, could withholding a caesarean section from a woman with a transverse arrest in a prolonged dystocic labour be justified ethically?

Some procedures in current practice cannot practically and should not ethically be answered by randomised controlled trials. Before making a case against a woman's right to choose her preferred mode of delivery, some hard facts about the risks of elective caesarean section compared with those of an intended vaginal delivery would be welcome.

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1 Anderson GM. Making sense of rising caesarean section rates. *BMJ* 2004;329:696-7. (25 September.)

Caesarean section on demand is obstetric dilemma

EDITOR—Anderson's editorial on rising caesarean section rates highlights an important medical and ethical dilemma in current

obstetric practice—the relevance of patients' choice in deciding the mode of delivery.¹ Anderson points out the lack of clear evidence supporting caesarean section as a safer option in terms of immediate and long term pregnancy outcomes.

Clarification of this issue can help resolve the ethical and moral conflict of doctors who agree to perform a caesarean section at the mother's request in the absence of a medical indication. In addition, it would make the informed consent for a vaginal delivery more complete, with information on the short and long term complications, including risk of pelvic floor dysfunction.

Fetal distress, labour dystocia, and previous caesarean section are the commonest indications for caesarean section. However, at least for the first two indications it is not possible to carry out randomised controlled trials to study the safer route of delivery. By the time the fetal distress or labour dystocia is diagnosed, a continued trial of vaginal delivery is not feasible in many cases. For example, a baby cannot be delivered vaginally when cephalopelvic disproportion is diagnosed in active labour or when fetal acidemia worsens far from delivery. Therefore such cases cannot be randomised to vaginal delivery or caesarean section.

Instead, a feasible and informative trial may be to randomise women during early pregnancy into two groups—a trial of vaginal delivery versus elective caesarean section, with analysis on an intention to treat basis rather than actual mode of delivery. Comparison of outcomes for mothers and babies from such a trial will go a long way in guiding evidence based obstetric practice.

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1 Anderson GM. Making sense of rising caesarean section rates. *BMJ* 2004;329:696-7. (25 September.)

Reducing caesarean section rates should not be the primary objective

EDITOR—So long as the studies suggested by Anderson in his editorial on rising caesarean section rates take into account the sole conventional criteria,¹ a caesarean section without procrastination will always seem the most advantageous attitude in well equipped obstetric units. But we as doctors must also think long term, given the wide research on the life long consequences of prenatal and perinatal environmental factors. We must also learn to think in terms of civilisation.²

Meanwhile the most dangerous guidelines would be those recommending a limit to the rise in caesarean section. The first effect would be (and in some places already is) to increase the rates of difficult instrumental vaginal deliveries, which should become exceptionally rare in the age of the safe caesarean. The priority, after millennia of culturally controlled childbirth, is to rediscover the basic needs of labouring women. These needs are easily expressed in

terms of physiology. Labouring women need to be protected against any sort of neocortical stimulation (privacy, silence) and to maintain a low level of adrenaline (feeling secure in a warm enough place). Today very few people can imagine how easy the birth of a baby and the delivery of its placenta can be when there is nobody around but an experienced, motherly, and silent midwife sitting in a corner and knitting (knitting as an example of repetitive tasks that help to maintain a low level of adrenaline).

Decreasing caesarean section rates should be a consequence of a better understanding of the physiological processes: it should not be the primary objective.³

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1 Anderson GM. Making sense of rising caesarean section rates. *BMJ* 2004;329:696-7. (25 September.)

2 Odent M. *The scientific of love*. London: Free Association Books, 1999.

3 Odent M. *The caesarean*. London: Free Association Books, 2004.

Trials and speaking with patients take time

EDITOR—We agree with Anderson that we should have a more comprehensive and frank debate about the ethical issues related to the role of doctors, preferences of patients, and informed consent with respect to caesarean section.¹ In response to Minkoff et al,² we argued that not offering caesarean section was incompatible with the principle of autonomy.³

Particularly in English speaking countries, the historical role of the doctor is changing, thanks to the increasing reliance on a model where the patient is seen as the consumer and the doctor as supplier of services.⁴ The paternalistic model is still strong in Europe, and the debate about caesarean section may simply reflect today's difficulties in building a new form of doctor-patient relationship.

Nowadays, trust is not enough for patients: they need proof and evidence. But medicine is both an art and a science, and sometimes there is no clear proof or evidence. Is trust still possible at the very time a major medical liability crisis is happening worldwide?⁵ Answering this question may be as long, difficult, and important as waiting for the results of any randomised controlled trial.

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1 Anderson GM. Making sense of rising caesarean section rates. *BMJ* 2004;329:696-7. (25 September.)

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