We, too, find that the experience and training of staff are factors in the quality of obstetric care but would add that locum doctors are mentioned far more often than we would expect in complaints concerning perinatal death or serious injury to mother or child. General practitioner trainees are also mentioned often as being first on call to deal with emergencies beyond their training or experience. Mothers are concerned about this. In the study by Drew *et al*, which compared mothers', midwives', and obstetricians' views on features of obstetric care that influenced satisfaction, mothers were much more concerned than doctors had realised about the qualifications of the person conducting the delivery.[2]

Seniority of staff is not the only factor. For 13 senior registrars Longue recently reported a widely different rate of haemorrhage after forceps deliveries.[3] Temperament rather than experience seemed to be the important factor. This confirms our experience that the personalities of some doctors and midwives make them unsuited to the practice of obstetrics. Other significant factors are:

(1) Lack of continuity of care (for example, "shared" antenatal care, women seeing different doctors at every outpatient visit, and midwives changing shifts when caring for women in labour). O'Brien's and Smith's study showed that a significantly higher proportion of women rated their care as very good when they were cared for by one or two people when compared with those who saw different people each time.[4]

(2) Failure to listen to and believe women, even multiparous women—for example, if the woman is sure about when she conceived she is told that the ultrasonogram can't be wrong. If she says "I'm starting to push" she is told, without examination, "Nonsense, it will be hours yet." If she says she knows something is wrong she is not believed. Women who are of low social class or black are even less likely to be believed—which may be one reason for the higher perinatal mortality in these groups.[5]

(3) Avoidable interventions, which then lead to a cascade of further interventions.[6]

(4) Uncritical reliance on technology, which is often inappropriately used and has been inadequately tested. For example, the randomised study of Shy *et al* showed that the prevalence of cerebral palsy in premature babies monitored by electronic fetal monitoring was 20% and in those whose mothers were given auscultation it was only 8%.[7]

We see many cases of avoidable serious morbidity in women after childbirth, including long term pain, mutilation and disability caused by episiotomies, and post-traumatic stress disorder after forceps or high technology deliveries. If clinical audit is to work it should include a user input and not rely solely on assessment of case notes.

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Misuse of dihydrocodeine tartrate (DF 118) among opiate addicts

SIR,—We find it surprising that Dr Harith Swadi and colleagues think that dihydrocodeine misuse is a novel finding.[1] General practitioners in Scotland are well aware of the extensive use of dihydrocodeine by drug misusers and of the drug's resale potential. Dihydrocodeine is considered by many to be a safer drug to prescribe than most opiate analgesics as it seems to be rarely injected, being a comparatively insoluble preparation and having a dysphoric rather than a euphoric effect on intravenous use. This is unlike buprenorphine, which is injected preferentially. Many other prescribed drugs are also used by injection, including diazepam, dipipanone hydrochloride, and amitriptyline.

The reduced potential of dihydrocodeine for misuse makes it of some use as a substitute drug in the treatment of opiate misusers, and our practice is to use it as an alternative to methadone mixture when this is necessary. For those drug misusers who are not keen to take methadone dihydrocodeine is an attractive alternative. Unlike methadone it is portable for holiday purposes and provides a more rapid onset of action, which many, especially younger drug misusers, prefer, and it offers a safer alternative to illegal drugs with some of the attractions.

Unlike the traditional drug treatment centres we see many drug misusers who have only recently started misusing opiates (often within recent months), a group of people who are not necessarily amenable to the more conventional techniques of treatment and who consider themselves able to cope with their situation. Our experience of these people is that they do not always wish to take methadone but are sometimes prepared to substitute oral dihydrocodeine for drug injecting. Dihydrocodeine is now successfully used by many young drug misusers. The additional advantage of the drug's reduced overdose potential is important. Most accidental deaths in our experience occur in people combining methadone and other drugs, and we have recorded no deaths due to overdose of dihydrocodeine over the past eight years. Dihydrocodeine has, in our view, much to recommend it as an alternative to methadone in selected patients, allowing for more flexibility, less toxicity, and the development of a normal lifestyle.

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1 Swadi H, Wells B, Power R. Misuse of dihydrocodeine tartrate (DF 118) among opiate addicts. *Br Med J* 1990;**300**:1313. (19 May.)

SIR,—Dr H Swadi and colleagues rightly draw our attention to the extensive use of codeine preparations by heroin addicts. It is a moot point, however, how such use of DF 118 (dihydrocodeine tartrate) should be regarded. It may be, for instance, an adaptive use of an alternative opiate preparation at times of heroin shortage (for example, either during an infrequent heroin drought or because of insufficient funds to purchase heroin); or alternatively it may form part of a constructive attempt at self detoxification (Gossop *et al*, unpublished work). If we prescribe methadone or codeine to a heroin addict with withdrawal symptoms then this is regarded as treatment, but if in the same circumstances the heroin addict obtains DF 118 from the black market and consumes it then this is regarded as drug misuse. It may be no bad thing that general practitioners are willing to prescribe opiate preparations with less potential for misuse, although they should of course be aware of the conditions they are treating (that is, opiate addiction) and the reason they are prescribing (for example, moderation of severity of the withdrawal syndrome).

We also wish to draw attention to another aspect of the report by Dr Swadi and colleagues. The authors used gas spectrometry to detect the drugs being used, whereas recently there has been an increased reliance on the new enzyme multiplied immunoassay technique. Distinction between use of codeine and other morphine based opiates is not presently possible with the immunoassay system, which gives the same opiate positive reading for heroin, morphine, codeine, and dihydrocodeine. The technique therefore needs chromatographic back up, as has previously been recommended.[2]

Finally, we were surprised that no mention was made of the route of administration. Was there any evidence of intravenous misuse of codeine preparations? If not, then for some addicts DF 118 may constitute a more acceptable drug for administration during detoxification than the longstanding "industry standard," methadone.

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Screening for carcinoma of the prostate

SIR,—With regard to the paper by Dr Knud V Pedersen and colleagues[1] and the recent correspondence it has generated[2] we would like to support the case for screening for cancer of the prostate. Carcinoma of the prostate is now the commonest cancer in the Western world, and the incidence is increasing.[3] Furthermore, there is little evidence that current available treatment prolongs survival. The only possibility of cure is by surgical removal of the affected prostate, and for this to be effective the disease has to be diagnosed at an early stage.

Evidence from the small number of previously reported screening programmes shows that screening is cost effective, identifies a high proportion of patients with early stage disease, and may prolong survival.[4-6] The paper by Dr Pedersen and colleagues shows that screening for cancer of the prostate is feasible, cost effective, and acceptable to patients.

In Bristol we are currently running a pilot study to assess the practicality of screening for cancer of the prostate in the NHS. It is based at Horfield Health Centre, a large city general practice that serves a population of 13 000. All men between the ages of 55 and 70 (a total of 850) are being offered a general health check, which includes, among other investigations, a digital examination of the prostate and measurement of serum prostate specific antigen concentration. All patients with either a palpably suspicious prostate or a raised prostate specific antigen concentration are referred for further investigation. This takes the form of transrectal ultrasonography and subsequent guided biopsy of any suspicious lesions. To date 331 patients have been screened, 52 have been referred for transrectal ultrasonography, and cancer has been detected in five. After staging with isotope bone scanning and magnetic resonance imaging of the pelvis all of the carcinomas have been shown to be intracapsular and three men