κ Values when ratings of professional groups are compared with ratings of consensus panel regarding likelihood of sexual abuse

Professional group	κ	Clinical importance
Specialist psychiatrists	0·780	Excellent
General psychiatrists	0·567	Fair
Experimental psychologists	0·705	Good
Trainee social workers	0·683	Good
Trainee clinical psychologists	0·661	Good
Lawyers	0·717	Good
Police	0·821	Excellent
All groups	0·706	Good

to 0·567 for general psychiatrists. The table shows the clinical importance of each of the κ values according to the criteria of Cicchetti and Sparrow.[3] As Harrington highlights, the levels of agreement between each group of raters and consensus are not perfect (as is true for all clinical assessments); the specialist psychiatrists and police, however, have κ values that would be considered excellent levels of agreement, and only the general psychiatrists have levels of agreement below those considered to be good. We therefore stand by our original conclusions that the levels of agreement between the professional groups and the consensus panel are generally good to excellent.

We also recognise, as does Harrington, that continued efforts to standardise the interview are necessary to improve the clinical assessment of children suspected of being sexually abused. We believe that our report is an important first step in that process.

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Women prefer hospital births

EDITOR,—We have been following with interest the mixed response to the recent report of the House of Commons Select Committee on Maternity Services advocating more home births in British obstetric practice.[1] The report had a frosty reception from the Royal College of Obstetricians and Gynaecologists,[2] while the Royal College of Midwives and others welcomed its proposals.[3,4]

The views of pregnant women have not been heard in this exchange of opinion. As part of our course on public health medicine we surveyed 299 women at varying stages of pregnancy in antenatal clinics in two hospitals in Leeds, asking them where they would prefer their baby to be born and why. We started the survey in the expectation that, as the select committee suggested, there would be considerable unmet demand for home births. We were therefore surprised that only 8% of the women (95% confidence interval 4·8% to 10·6%) indicated that they would prefer to have their labour at home. The most commonly given reason for preferring a hospital birth was that skill and technology are available should any unforeseen complication arise (50%).

Because ours was a biased sample (a hospital population) and women's views may change as gestation progresses and because of regional variation we cannot extrapolate from this survey to predict the number of women nationally who would choose a home birth. Our results do, however, suggest that a large proportion of women with completely normal pregnancies prefer to deliver in hospital because of the small risk of a complication during labour. Consequently, any change in policy along the lines proposed by the select committee should be brought in with sensitivity for this view; if home births are more actively promoted women with normal pregnancies should not be made to feel that they are having the option of hospital delivery taken away from them.

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Helping Russia

EDITOR,—As recipients of a travel bursary from the European League Against Rheumatism's standing committee for European rheumatologists in training we recently visited the Institute of Rheumatology in Moscow and the Municipal Rheumatological Centre in St Petersburg. The purpose of these bursaries is to enable trainees in rheumatology to share experiences in training, clinical management, and aspects of research into rheumatic diseases in other European countries. In deciding to visit Russia we were not conscious of being missionaries, although unwittingly we may have been part of the flood of visitors interested in health care to which Tony Delamothe refers.[1]

No such flood was evident at the institutions we visited. On our first day at the institute in Moscow several members of the staff came to work to meet us, on what we later discovered was a public holiday. The lack of contact with medicine outside Russia, through lack of access to medical literature and foreign travel, was all too evident. Each new encounter with staff in the institute, which is looking at ways of maintaining its 300 inpatient rheumatology beds and 400 staff, ended in detailed discussions and proposals for us to embark on collaborative work. Everyone we met wanted contact with Western medicine, and we returned with a shopping list for journals, equipment, and reagents.

The problems are enormous and varied and have been compared to those in Third World countries. The feelings engendered in European visitors to Russia, however, are different from those engendered by a visit to countries in Africa or Asia. The broad cultural and historical similarities induced in us a strong empathy and desire to help. In both the centres we visited we found a broad intellectual and academic base and impressive dedication to work despite extraordinary difficulties and shortages. This made us believe that any well directed contribution would be gratefully received and well used. As our Russian hosts pointed out, the problems are essentially Russian problems that need a Russian solution. An end to intellectual isolation regarding health care and management, however, can only help, by providing insight into the pros and cons of other systems.

Professor Rodney Grahame, professor of clinical rheumatology at Guy's Hospital, who has travelled extensively in eastern Europe in recent years, has launched a rheumatological equivalent to Ophthalmic Aid to Eastern Europe.[1] Initially it intends to send journals, textbooks, and monographs to named people and institutions. Programmes to fund exchange visits and short postgraduate courses in eastern Europe to aid in continuing medical education are also proposed. Anyone interested in helping should contact Rheumatology Aid to Eastern Europe, Rheumatology Unit, Guy's Hospital, London SE1 9RT (fax 071 407 7532).

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Private health insurance and physiotherapy for senior citizens

EDITOR,—Rebecca Beaconsfield comments that elderly patients are denied tax relief on private health insurance for physiotherapy if they have been referred by a general practitioner.[1] Hundreds of protest letters about this were sent to MPs by chartered physiotherapists and patients, and the Inland Revenue has now accepted that it made a mistake when it ruled that tax relief was available only for physiotherapy related to hospital treatment. New regulations have been laid before parliament and the matter resolved to the satisfaction of patients, general practitioners, and private physiotherapists.

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Reaching for the wrong whistle

EDITOR,—Linda Beecham reports on the right to be a whistleblower, referring to NHS employees who wish to raise concerns about standards of care.[1] From this it seems that senior doctors are anxious to preserve the safety valve of free speech[1] while showing little interest in using the more satisfactory structure that has been handed to them through the recent NHS reforms.[2]

Are senior doctors choosing to ignore the opportunity provided by medical audit committees—for doctors, run by doctors, and accountable to doctors—which have the specific duty of organising and encouraging the "systematic and critical analysis of the quality of medical care"?[2] Is our right to pick up the telephone and complain to the press so much more important than doctors getting together with other doctors to construct a medical audit machinery that allows concerns to be properly evaluated?[3] By now, surely, senior doctors have allayed the fears of those nurses "frightened to speak out and risk their careers"[1] by emphasising the requirement for clinical audit and thus encouraging nurses to join with doctors to "analyse the quality of clinical care"?[3]

If audit shows that a worry regarding standards is valid and yet recommended changes are not addressed then frustration with an ineffective process will, understandably, lead people to consider becoming whistleblowers. The audit committee has a responsibility to bring such obstruction or obfuscation to the notice of others. If it chooses to shirk this responsibility consultants should not shirk from taking steps to replace their timid representatives. There is no place for adopting a politically correct line when assessing the quality of clinical care.

Senior doctors have been handed a powerful tool,[2] and if they have not used the money handed