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Emergency delays

EDITOR.—Luisa Dillner reports that one of the reasons for delay in admitting patients seen as emergencies in the accident and emergency department is that doctors from the teams on take are in theatre or outpatient clinics.¹ This situation could be improved if accident and emergency medical staff rather than ward doctors were responsible for deciding which patients should be admitted. In addition, emergency treatment could then be started by the accident and emergency staff.

The perceived advantages of ward doctors going to the accident and emergency department are that they prevent inappropriate admissions and that diagnostic accuracy is increased. A recent study of 1200 patients in Belfast compared admitting practice in two accident and emergency departments with similar staff, number of patients, and catchment population. In one department patients were seen and admitted by the accident and emergency doctors; in the other the decision to admit was taken by the team on take. There were no significant differences in rate of diagnostic error or inappropriate admissions between the two departments. A survey of 153 consultant led accident and emergency departments throughout the United Kingdom showed that the decision to admit was the responsibility of the accident and emergency doctors in only 6%. Clearly, detaining medical and surgical patients in the accident and emergency department for assessment by the ward doctor has no benefit to either the hospital or the patient, and the accident and emergency doctors should be given admitting rights.

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1 Dillner L. Emergency delays need urgent attention. *BMJ* 1995;310:283. (4 February.)

Antenatal screening for cystic fibrosis

EDITOR.—Zosia H Miedzybrodzka and colleagues¹ claim that stepwise screening for cystic fibrosis is better than couple screening is unjustified.¹ Antenatal screening for cystic fibrosis should minimise the number of women identified as being at high risk for a given proportion of affected pregnancies detected and should ensure that a diagnostic test is available for everyone defined as being at high risk. Stepwise screening fails on both counts.² It identifies about 30 times more women as being positive on screening without increasing detection and therefore necessitates more counselling to cope with the associated anxiety. About 3% of screened women will be identified as carriers, but their partners will not have a detectable cystic fibrosis mutation. These women are told they are at risk but cannot be offered a definitive diagnostic test.

The average anxiety score in women found to be positive was slightly higher after couple screening than after stepwise screening (35.4 v 32.1 compared with 34.2 v 32.7 respectively at recruitment). This is minor compared with the initial acute anxiety (average score 52.3) among the 3% of

women with positive results of stepwise screening. To dismiss their anxiety by saying that "this dissipated after receiving a negative result for their partners" is unreasonable.

The paper concludes that stepwise screening provides more "genetic information." Providing information is an advantage only if it leads to specific action that would not otherwise have been taken. Providing excess information can invite unsolicited interventions, such as tracing of relatives to determine their carrier status, with unpredictable medical and financial implications. It could be costly and upsetting while conferring little or no practical health benefit. Screening programmes should be as simple and economical as is necessary to achieve their intended aim in the population that has explicitly accepted the invitation for screening. Additional advantages should not be presumed. They should be made explicit and quantitatively assessed in both medical and financial terms.

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Short stature and diabetic nephropathy

EDITOR.—Rossing and colleagues conclude that short stature is related to the development of diabetic nephropathy in men and speculate that influences in early life could account for their findings.¹ This interpretation is based on the assumption that adult height is determined solely by factors operating in utero or early life. But height is also related to parental social class² and has been used as a proxy for adult socioeconomic status.

We have also found a relation between height and albuminuric status in a European study of the complications of insulin dependent diabetes but place a different interpretation on these findings. Patients aged 15-60 with insulin dependent diabetes were recruited from 31 European centres.³ Age at completion of education defined socioeconomic status in three groups: ≤ 14 , 15-18, and ≥ 19 . These analyses are restricted to people aged ≥ 25 to ensure that all those who would receive higher education had had an opportunity to start. Albumin excretion rate was calculated from a timed 24 hour urine collection. Macroalbuminuria was defined as a rate of ≥ 200 $\mu\text{g/ml/min}$ and microalbuminuria as a rate ≥ 20 $\mu\text{g/ml/min}$ but < 200 $\mu\text{g/ml/min}$.

Men with macroalbuminuria were significantly shorter than those without (table). This relation was present, but not significant, in women. The most educated men were also the tallest (171, 175, and 176 cm respectively, $P=0.0001$ for trend). This trend was not found in women (161, 164, and 163 cm respectively, $P=0.2$ for trend). When a term for educational status was included in the model the relation between height and

Relation between albuminuric status and height (cm) in EURODIAB insulin dependent diabetes mellitus complications study

| Albuminuric status | Men (n=1217) | Women (n=1170) |
|---|-----------------|-------------------|
| Adjusted for duration of diabetes: | | |
| Normoalbuminuric | 175 | 163 |
| Microalbuminuric | 175 | 163 |
| Macroalbuminuric | 173 | 161 |
| P value for trend | 0.03 | 0.8 |
| Adjusted for duration of diabetes and educational status: | | |
| Normoalbuminuric | 174 | 163 |
| Microalbuminuric | 174 | 162 |
| Macroalbuminuric | 173 | 161 |
| P value for trend | 0.1 | 0.8 |

albuminuric status was considerably attenuated in men (table). Adjustment for centre did not alter these relations.

We showed that height was related to nephropathy in men and confirmed that height was also related to educational status, a proxy for social class in adults.² Educational status accounted for much of the relation between nephropathy and height. Longitudinal data are required before we can jump to hasty conclusions about influences in early life and diabetic nephropathy.⁴

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Shared care in diabetes

EDITOR.—We agree with Amanda J Sowden and colleagues' conclusion that evaluation of shared care must take into account many factors that influence effectiveness and efficiency, but the authors do not address the reasons why current systems of care fail.¹ The main problem with traditional management of chronic conditions is that the provision of care is not matched to need. Some patients receive a lot of care, a lot of patients receive some care, while other patients receive little or no care.² Many patients are lost to follow up. A good system of shared care should rectify this imbalance by providing, efficiently, the best possible care with maximum coverage of the population at risk. Without such long term follow up schemes, determining what is best is not possible since data on outcomes are usually not available. In addition, to focus only on the clinical outcomes of those who are receiving care is to confuse assessment of the effectiveness of the delivery of care with that of the clinical care itself.

Two recent rigorous trials of similar models of shared care for diabetes³ and hypertension⁴ showed that shared care was associated with lower drop out rates and was more cost effective for the patient. Cost to the patient is likely to be an important determinant of continuity of care. The hypertension study and an earlier study of shared care for thyroid disease² showed cost effectiveness for the health service and a reduction in the number of patient-clinician contacts while the standard of

review was maintained. Far from being "black boxes," the components of these approaches are clearly discernible and essential for any successful system: shared records; improved communication between doctors and with patients; a clear role for the patient; specialist input (for example, screening of results from general practice or an annual consultation); agreed management plans (which can be flexible to accommodate preferences); and the possibility of patients moving up and down the levels of care and a fail safe system for coordination.

In the management of chronic disease a structured approach to matching levels of care to need and ensuring long term follow up has already been shown to be cost effective. We believe that these findings are widely applicable in the health care services. The next generation of trials should be concerned with identifying the best approaches to shared care, not comparison with traditional methods. Furthermore, all shared care should incorporate routine evaluation, including, in the longer term, assessment of clinical outcomes.

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Consultants' response to clinical complaints

EDITOR.—Nicholas Summerton reports a questionnaire survey of general practitioners to investigate their defensive medical practices.¹ We recently completed a similar study for Oxford Regional Health Authority, which examined the impact of clinical complaints on hospital consultants. The views of all 848 consultants in the region were surveyed, and replies were received from 443 (52%), 246 of whom had received at least one complaint.

A major finding was that much activity in response to complaints occurs in the shadow of the formal procedures. Most consultants tended to respond directly to the complainant even though the patient's charter now calls for all responses to complaints to come from senior management. On at least one occasion 136 consultants had contacted the complainant by letter or telephone or had had a face to face encounter with the complainant as their first response to the complaint without liaising with a manager. Consultants who took such action were likely to have done so for one of three reasons. Firstly, if they had received the complaint personally they thought that it was a courtesy to respond directly to it. Secondly, some did not know of the existence of the formal complaints procedure and the management role in it. Finally, a large proportion did not think it appropriate for managers to respond to complaints about clinical care.

Complaints have an important effect on consultants at an emotional level, which is particularly striking when the complaint is considered to be unjustified. Consultants rely heavily on medical networks when they receive a complaint and hardly ever seek support from management. Complaints also have a major impact at a professional level. Extensive evidence of defensive medicine was not found. Rather, many of the

responses indicated an improvement in patient care—for example, better record keeping (42 responses), fuller consultations with patients (37), and increased clinical vigilance (32)—as a response to complaints.

Our research shows that much needs to be done to forge partnerships between clinicians and managers for handling complaints. While existing networks go some way towards alleviating the harmful effects of complaints, our findings show that consultants need greater reassurance and support when they believe that they are the subject of an unfair complaint.

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- 1 Summerton N. Positive and negative factors in defensive medicine: a questionnaire study of general practitioners. *BMJ* 1995;310:27-9. (7 January.)

Interpreting hospital death rates

EDITOR.—N W Harry raises several issues related to the indicators of clinical outcome published by the Clinical Resources Advisory Group.¹ As he rightly points out, the intention was to promote discussion about variations, and if the information has been used in league tables that is contrary to the specific advice repeatedly given in the report and in related briefing. Copies of the report and briefing for handling inquiries were sent one week before publication to all chief executives and medical directors of trusts in Scotland. Several, including Harry, discussed these with central information services, but, clearly, misunderstandings persist.

Elderly people were not included by mistake. The specific intention was to include all patients with acute myocardial infarction because all should receive optimal care regardless of age and the hospital to which they are admitted. The tables are standardised for age and sex and consequently draw attention to variations that should be examined.

Harry questions the assignment of patients to his trust. All trusts were treated in the same way—namely, by all hospitals constituting a trust on 1 August 1994 being included. The table shows results for Fife Healthcare NHS Trust. They include Milesmark Hospital (now closed), but it is clear that, during the period analysed, mortality for Fife Healthcare arose largely from admissions to the smaller community hospitals and the geriatric specialties in the Victoria Hospital. Particular care should be taken in interpreting results when any hospital is divided between trusts according to specialties. Thus reference to Queen Margaret Hospital NHS Trust is inappropriate.

Some medical directors continue to express anxiety about the exercise, but it was agreed, after detailed consultation with the Medical Directors' Group and other professional groups in Scotland, that professional practice and improved care would best be served by openness. The Scottish Association of Local Health Councils has reported

no public disquiet about the report. Unnecessary anxiety seems to have been restricted to Fife Healthcare Trust's sphere of influence.

Professional staff and the media have, overall, received the report seriously and constructively. Health boards have been asked to initiate local discussions about the variations, and my working group will be supporting that initiative and continuing to work on refining the existing indicators and developing new ones.

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- 1 Harry NW. Interpreting hospital death rates. *BMJ* 1994;310:599. (4 March.)

Applicants for senior medical positions in New Zealand

EDITOR.—The New Zealand public health service is going through a process of rapid restructuring, and the employers of salaried senior medical staff are now known as crown health enterprises. Coupled with this change is New Zealand's unique industrial law. For example, there is no longer the lawful ability to negotiate national terms and conditions of employment, and what right employees have to contract negotiation is nominal, lacking effective procedures or obligations. Negotiations now have to be conducted with each separate crown health enterprise (there are 23). The Association of Salaried Medical Specialists, which is affiliated to the New Zealand Medical Association, is responsible for the negotiation of collective contracts with these crown health enterprises.

If readers of the *BMJ* are considering applying for, or have been offered, positions in a New Zealand crown health enterprise they are strongly advised to seek the advice of the association. We can be contacted at PO Box 5251, Wellington, New Zealand (tel 0064 4 499 1271; fax 0064 4 499 4500). As the conditions of employment vary and there are different perspectives on the employment of senior medical staff among (in fact sometimes within) different crown health enterprises, professional industrial advice is strongly recommended. You can be materially disadvantaged without it.

There are at least two crown health enterprises with which particular care should be taken. One, contrary to the wishes of currently employed staff, is seeking to employ new senior medical staff on significantly different, inferior, and deceptive individual contracts. The other is refusing point blank to negotiate a collective contract and instead is offering disadvantageous individual contracts in opposition to senior medical staff. In all cases, applicants and those offered positions are encouraged to seek the advice of the association.

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Deaths occurring within 30 days of admission as percentage of all admissions with acute myocardial infarction, Fife Healthcare NHS Trust and Scotland overall, October 1990 to September 1993

| | Patients admitted | Died within 30 days | Mortality (%) | Standardised mortality rate (95% confidence interval) (%) |
|--|-------------------|---------------------|---------------|---|
| Patients assigned to Fife Healthcare NHS Trust | 885 | 292 | 32.99 | 29.56 (26.26 to 33.15) |
| Victoria Hospital, Kirkcaldy (geriatric specialties) | 88 | 59 | 67.05 | 37.59 (28.61 to 48.51) |
| Queen Margaret Hospital (geriatric specialties) | 2 | 1 | NA | NA |
| Milesmark Hospital | 652 | 155 | 23.77 | 25.42 (21.57 to 29.75) |
| Forth Park Hospital | 3 | 0 | NA | NA |
| Other hospitals in trust | 140 | 77 | 55.00 | 36.04 (28.44 to 45.06) |
| Rest of Scotland | 39 305 | 8240 | 20.96 | 21.02 (20.57 to 21.48) |
| Scotland | 40 190 | 8532 | 21.23 | 21.23 |

NA=Not applicable.