sometimes have chronic severe pain, disability, and mutilation. They are not helped by professionals who refuse to accept that there is a physical problem. Where surgery or physiotherapy brings improvement, mental state also benefits. The second group is women with post-traumatic stress disorder, usually following birth interventions, especially if attendants were not supportive. The third group consists of women who believe that they have cause to criticise the care they or their babies received.

Fortunately an increasing number of women report supportive general practitioners. But after many counterproductive referrals to obstetricians and psychiatrists we are reluctant to recommend specialist help in some areas and are afraid of overloading the most helpful and knowledgeable doctors by referrals from elsewhere. We suggest that:

(1) Obstetric services and procedures should be monitored for maternal morbidity—both physical and mental;

(2) Unnecessary intervention should be avoided: slow labours are not necessarily dysfunctional or distressing;

(3) Vacuum deliveries have been shown to cause less maternal injury than forceps deliveries.[2] The benefits may extend to postpartum mental state—this needs to be explored;

(4) We need specialists in treatment and repair of obstetric injury (if necessary in regional units) who can easily be located by general practitioners;

(5) Logue reported that postpartum haemorrhage rates correlate with the personality of the accoucheur.[3] We believe that some obstetric staff produce equivalent psychiatric iatrogenesis; they should be swiftly identified and removed or retrained;

(6) Diagnosis of postpartum psychosis should be emphasised in training;

(7) All parents of stillborn babies should receive sympathetic support—and honesty if there were elements of substandard treatment;

(8) Doctors and midwives need to accept that there are times when it is legitimate for patients to express anger about the quality of care they have received—for treatment of depression expression of anger is essential. It is not just fear of litigation that causes professionals to block these messages—some cannot cope emotionally, and institutions often suppress complaints rather than explore the real needs for staff support. Unless we deal with this problem the needs of some suicidal patients will not be met.

JEAN ROBINSON
BEVERLEY LAWRENCE BEECH

Association for Improvements in the Maternity Services,
Oxford OX2 7EP

1 Appleby L. Suicide during pregnancy and in the first postnatal year. *BMJ* 1991;**302**:137-40. (19 January.)
2 Chalmers I, Enkin M, Keirse MJNC. *Effective care in pregnancy and childbirth.* Vol 2. Oxford: Oxford University Press, 1989:1226-7.
3 Logue M. Management of the third stage of labour—a midwife's view. *J Obstet Gynaecol* 1990;**10** (suppl 2):S10-2.

SIR,—Dr Louis Appleby has, probably quite inadvertently, clouded the already murky issue of preventing of suicides by childbearing women by implying that simply drawing a suicidal woman's attention to her child related responsibilities might prevent her from carrying out any suicidal plans.[1]

Such concerns do deter some women from suicide, and there is some evidence to suggest that not only do they protect against self harm but also cause women to avoid consulting their general practitioners about depression.[2] This means that general practitioners involved with primary suicide prevention will not be aware of some depressed mothers at high risk, and specialist workers in secondary prevention such as myself may see a greater share of "failed suicides."

It is this group of failed suicides who present the challenge to suicide prevention services. It is not simply a case of treating their psychiatric disorder, as some patients may be suicidal but not clinically depressed. There is overwhelming evidence now to support the view that hopelessness is a far better predictor of eventual suicide than is depression.[1]

Hopelessness of course is a cognitive issue and the treatment of choice must be cognitive therapy.[4] One of many treatment techniques is the balance sheet approach to suicide, in which the patient is asked to list advantages and disadvantages of both suicide and staying alive. It is not just a question of providing the patient with a list of good reasons for staying alive but is a very sophisticated intervention.[5]

I see mothers who have tried to kill themselves because of—not despite—their concerns for their children. They have a remorseless suicidal logic about being bad mothers whose children would be better off without them. Readers of Dr Appleby's article might assume in error that merely reminding these women of their childcare responsibilities will bring them to their senses; instead, what it might do in unskilled hands is increase the cognitive dissonance between what they know they ought to be doing and how they have failed to do it, and thereby intensify the suicidal risk.

P W N GRIFFITH

Hospital Social Work Services,
Royal Cornwall Hospital (Treliske),
Truro TR1 3LJ

1 Appleby L. Suicide during pregnancy and in the first postnatal year. *BMJ* 1991;**302**:137-40. (19 January.)
2 Brown GW, Harris T. *Social origins of depression. A study of psychiatric disorder in women.* London: Tavistock, 1978:282.
3 Beck AT, Brown G, Berchick RJ, Stewart BL, Steer RA. Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. *Am J Psychiatry* 1990;**147**:190-5.
4 Rush AJ, Beck AT, Kovacs M, Weissenburger J, Hollon SD. Comparison of the effects of cognitive therapy and pharmacotherapy on hopelessness and self-concept. *Am J Psychiatry* 1982;**139**:862-6.
5 Williams JMG, Wells J. Suicidal patients. In: Scott J, Williams JMG, Beck AT, eds. *Cognitive therapy in clinical practice.* London: Routledge, 1989.

Picking up the tab for erythropoietin

SIR,—Dr Roger Gabriel's recent editorial[1] infers that erythropoietin was withdrawn in our study because of underfunding.[2] We hasten to clarify that our paper reported results from a randomised crossover trial to compare intravenous and subcutaneous administration of erythropoietin in patients receiving haemodialysis and to study potential concomitant changes in platelets and clotting factors. The patients were withdrawn from erythropoietin treatment for a short period on completion of the first phase of the study, and all were given erythropoietin in the second limb of the study when their haemoglobin concentration fell below 80 g/l.

All patients continued to receive erythropoietin after the end of the second maintenance phase of the study. The trial was conducted with prior approval of an ethics committee, well before a product licence was granted, and made erythropoietin available at no cost to all eligible patients (haemoglobin <80 g/l) when the study began.

On completion of the trial the patients were provided with erythropoietin by the pharmaceutical company until the product licence was obtained and thereafter erythropoietin was supplied by Tayside Health Board. We have encountered great difficulty, however, in securing funding for supplies of erythropoietin for patients who have been waiting to start treatment since the time entries to the trial ended. We agree with Dr Gabriel that the inadequate funding from the health boards for erythropoietin is unacceptable and that additional central funding is warranted for this treatment, which really works.

J E TAYLOR W K STEWART
R A MACTIER I S HENDERSON

Ninewells Hospital and Medical School,
Dundee DD1 9SY

1 Gabriel R. Picking up the tab for erythropoietin. *BMJ* 1991;**302**:248-9. (2 February.)
2 Taylor JE, Henderson IS, Mactier RA, Stewart WK. Effects of withdrawing erythropoietin. *BMJ* 1991;**302**:272-3. (2 February.)

SIR,—Dr Roger Gabriel's analysis of, and solution to, current difficulties regarding erythropoietin is not as simple as he makes out.[1] The argument does not involve erythropoietin alone; there are other drugs coming along fast on its heels.

In Lothian general practitioners are trying to deal with this issue rationally. A group under the aegis of the Lothian Local Medical Committee has recently been convened to determine which medicines should be prescribed by general practitioners and which by hospital consultants, based solely on clinical considerations. The group comprises general practitioners and members of the area drugs and therapeutics committee and will be under the chairmanship of the chief administrative pharmaceutical officer. The dialogue will be difficult, but it is long overdue.

MARGARET G ANDERSON

Lothian Local Medical Committee,
Edinburgh EH8 9DR

1 Gabriel R. Picking up the tab for erythropoietin. *BMJ* 1991;**302**:248-9. (2 February.)

SIR,—I would like to comment on the correspondence[1] arising from my recent editorial.[2]

Some general practitioners have anxieties that prescribing erythropoietin for selected patients would place them in breach of their contracts or perhaps risk litigation and hence are unwilling to prescribe this hormone. There are two courses available to these doctors' patients, who are in such an unenviable position. They can either accept their doctors' scruples and lose the chance of having their quality of life increased by 70-80% or go elsewhere. Many general practitioners are currently prescribing erythropoietin without difficulty.

I do not think that the points of the York group are directly relevant because their analysis would give answers about the consequences of providing or not providing erythropoietin and not about whether it should be used.[3] I will wager with them the cost of a year's treatment with erythropoietin that a proper trial of the clinical benefits of this hormone will never be completed because the placebo group (no active drug) would fare so badly that the study would have to be discontinued.

ROGER GABRIEL

St Mary's Hospital,
London W2 1NY

1 Correspondence. Picking up the tab for erythropoietin. *BMJ* 1991;**302**:407-8. (16 February.)
2 Gabriel R. Picking up the tab for erythropoietin. *BMJ* 1991;**302**:248-9. (2 February.)
3 Leese B, Hutton J, Maynard A. *The costs and benefits of the use of erythropoietin in the treatment of anaemia arising from chronic renal failure: a European study.* York: Centre for Health Economics, University of York, 1991.

Interleukin 2 denied on grounds of cost

SIR,—Dr Alison Walker identifies an issue that the providers and consumers of health care must confront and resolve if we are to maintain the