taken part in discussions with fundholders over contracts has varied widely, depending on local relationships between consultants and general practitioners, relationships between consultants and managers, and, most importantly, the participation of consultants in clinical directorates or equivalent structures. Often consultants have been presented by managers with an ultimatum: "Either we sign up to these specifications or the fundholder will take his business elsewhere and our gynaecology/ENT/rheumatology service will no longer be viable, with all the knock on effects that that entails for recognition of training posts and integration of services." The dilemma for consultants was that sometimes the fundholders' specifications were unrealistic in terms of the level of service provided by the department as a whole or would place consultants in a professionally improper position by asking them to give preferential treatment to one group of NHS patients over another.

The issues resolved themselves into two main conflicts. The first is conflict between an individual consultant's clinical judgment and the content of contracts: can a consultant override clauses in contracts when faced with a patient whose clinical needs dictate something different? Consultants would of course argue that they must or their ultimate clinical responsibility becomes meaningless. The second conflict is between the content of different contracts covering the same service: when the contract for the patients of a particular fundholder specifies a normal waiting time for admission of six weeks and the contract for other patients from the same district specifies six months (or does not specify at all) is it ethical to advance the fundholders' patients up the waiting list, thus delaying admission for the other patients? Again, consultants would wish to resist being part of such a system.

The guidance that has now been drawn up by the Joint Consultants Committee and the department should go a long way towards resolving the most acute problems. Perhaps more importantly, when contracts are renegotiated for next year the existence of agreed principles will help consultants, general practitioners, and managers to prevent the problems from arising at all. The guidelines deal with the fundholding

scheme in some detail (p 1486), but several important principles are worth highlighting.

Firstly, the guidelines emphasise the need for consultants to participate in all discussions leading up to contract agreements, as this above all will prevent the inclusion of unreasonable or impracticable stipulations. Secondly, the timing of consultations or treatment for individual patients must be based on clinical need, and judgment on the relativities of clinical need must rest with individual consultants. Provider units should offer waiting times that take these relativities into account. Thirdly, provider units are not to offer contracts to one purchaser that would disadvantage the patients of other purchasers.

Finally, the guidelines cover the situation where a fundholder may want to make contractual arrangements that benefit his or her patients by creating additional capacity in the hospital—for example, by providing finance that would enable the establishment of a new outpatient clinic or the reopening of a closed theatre. This is permissible, but it would also bring advantages to other purchasers' patients by offering faster throughput. Again, the basis on which patients would be seen or treated in such circumstances would be clinical need.

The Joint Consultants Committee has been encouraged by the department's willingness to discuss these issues and welcomes the guidelines as a constructive attempt to face some of the problems that have arisen. It will continue to monitor the impact of fundholding on hospital medicine and will consider issuing further guidance if necessary. In the mean time consultants who believe that the principles embodied in these guidelines are not being adhered to should notify the secretariat of the Joint Consultants Committee.

A P J ROSS

Chairman,
Joint Consultants Committee,
London WC1H 9JP

1 NHS Management Executive/Joint Consultants Committee. *Joint guidance to hospital consultants on GP fundholding*. London: NHS Management Executive, June 1991.

2 Department of Health. *Funding general practice*. London: DoH, December 1989.

3 Department of Health. *Guidance on contracting by fundholders*. London: DoH, September 1990.

Baby stealing

Too little known about diagnosis and treatment

Stealing a baby, one of the most distressing crimes, is rare. Of all "violent offences against the person" recorded by the Home Office, only about 0.08%—about 120 a year—come under the category of child abduction.¹ This term also covers two other offences: abduction by a parent—as in a custody dispute—and abduction of an older child, often by a man with a sexual motive.² Compared with other offences, the stealing of young children is unusual in that those who carry it out are almost always women who show evidence of mental disturbance.^{3,4} Despite this psychiatric context and the attention that each case attracts,⁵ the subject is virtually untouched by research. Little is therefore known about the mental state of those who commit the offence and less about the crucial medicolegal questions of disposal, outcome, and repetition.

D'Orban divided women who had stolen babies into three categories according to diagnosis and motive after interviewing them on their arrival in prison.⁴ In his "comforting offence" the woman abducts a baby or young child to satisfy her own emotional need. Her background is one of delinquency and emotional deprivation, her diagnosis is often personality

disorder, and hysterical or immature personality traits are prominent. In the "manipulative offence" the offender also has a personality disorder, but previous social adjustment is better and the baby is stolen for a specific purpose—for example, to keep a boyfriend by claiming that the child is his. The "impulsive psychotic" offence is carried out during an acute relapse of psychotic illness, usually schizophrenia.

But the presumed aetiology and the need for treatment based on it are less clear than such a typology implies. Categories based on a combination of diagnosis and motive are bound to overlap—as these do—and are therefore of low validity. And personality disorder itself has been criticised for lacking precision⁶ and for leading to rejection from treatment even when superimposed disorders, such as depression, are present.⁷⁻⁹

Accordingly, among d'Orban's women those with a diagnosis of psychosis or subnormality would receive treatment, some as a result of treatment orders, while those considered to have a disordered personality could find themselves either in hospital or in prison. The latter group

and their emotional needs are analogous to women with pseudocyesis — there is one reported case of both pseudocyesis and baby stealing.¹⁰ Yet though women with pseudocyesis might receive psychotherapy or treatment for concurrent depression,¹¹ non-psychotic women who abduct infants are as likely to be given a punitive sentence.

Even when women receive treatment this does not mean that their behaviour has been understood or that their treatment has been rationally based. The relation between treatment and outcome, and even what the treatment should be, is unknown. Furthermore, women who commit unusual offences may be recommended for psychiatric care without much exploration of their motives and therapeutic needs, a practice that has been called “playing the labels” to provide a “ticket to the psychiatrist.”¹²

A humane recommendation by the courts is not the same as understanding an offence. If better awareness of the causes of baby stealing and the most suitable legal outcomes are to be achieved a precise study of outcome, the impact of hospital treatment, and the prediction of repetition and persistent vulnerability is necessary, extending previous work beyond the point of the court’s initial recommendation.

There is also a more delicate, perhaps controversial, use for such information—to help detect the offender¹³ and to reassure the parents of the stolen child, who are the real victims of the offence. They can take comfort from the

knowledge that most abducted babies are found quickly as there is often no attempt to conceal them. And, although there are dramatic exceptions,¹⁴ the babies are almost always well cared for by the women who are desperate and disturbed enough to steal them.⁴

LOUIS APPLEBY

Senior Lecturer, Department of Psychiatry,
University Hospital of South Manchester,
Manchester M20 8LR

TONY MADEN

Research Worker, Department of Forensic Psychiatry,
Institute of Psychiatry,
London SE5 8AF

- 1 Home Office. *Criminal statistics, England and Wales, 1985-89*. London: HMSO, 1986-90.
- 2 D’Orban P, Haydn-Smith P. Men who steal children. *BMJ* 1985;290:1784.
- 3 D’Orban PT. Baby stealing. *BMJ* 1972;iii:635-9.
- 4 D’Orban PT. Child stealing: a typology of female offenders. *British Journal of Criminology* 1976;16:275-81.
- 5 Mother’s plea for her kidnapped baby. *The Times* 1990 Jan 13;3(cols 2-6).
- 6 Walton HJ, Presly AJ. Use of a category system in the diagnosis of personality disorder. *Br J Psychiatry* 1973;122:259-68.
- 7 Gunn J, Robertson G. Psychopathic personality: a conceptual problem. *Psychol Med* 1976;6:631-4.
- 8 Lewis G, Appleby L. Personality disorder: the patients psychiatrists dislike. *Br J Psychiatry* 1988;153:44-9.
- 9 Slavney P, McHugh PR. The hysterical personality: a controlled study. *Arch Gen Psychiatry* 1974;30:325-9.
- 10 D’Orban PT. Child stealing and pseudocyesis. *Br J Psychiatry* 1982;141:196-8.
- 11 Bargon P, Brown E. Pseudocyesis. In: Howells JG, ed. *Modern perspectives in psycho-obstetrics*. Edinburgh: Oliver and Boyd, 1972:53-67.
- 12 Allen H. *Justice unbalanced. Gender, psychiatry and judicial decisions*. Milton Keynes: Open University Press, 1987:69.
- 13 Hunter J. The problem of baby stealing. *Social Work Today* 1973;4:266-8.
- 14 Patients who can kill [editorial]. *BMJ* 1973;iii:241-2.

Randomisation

Essential for reducing bias

In the past year the *BMJ* has rejected several otherwise satisfactory studies for publication because of faulty randomisation. How can researchers avoid this fate for their papers?

Randomisation is one of many statistical ideas that have permeated medical research but are imperfectly understood. Its use is most familiar in controlled trials, where patients are given one of two or more treatments chosen at random. The purpose is to eliminate possible biases that may lead to systematic differences between the treatment groups—in particular to eliminate any influence on the allocation of treatment by the investigator (either subconscious or deliberate).

Random does not mean the same as haphazard: random allocation in a clinical trial means that all patients have the same chance of receiving any particular treatment (and in most cases each treatment is equally likely). Patients should be entered into a trial before their allocation to a particular treatment is known. A common misconception exists that allocation based on, for example, odd or even dates of birth or hospital numbers is random. These systematic allocation methods, however, clearly violate the requirement that all patients have the same chance of receiving each treatment. Alternate allocation does not in principle suffer from such problems, but there is a risk of abuse because the investigator’s knowledge of the next treatment may lead to some patients being excluded from the trial¹—making this method inadvisable. Trials using these inferior methods of allocation are not acceptable to the *BMJ*.

Even with proper randomisation a risk of bias exists when the investigators are aware of the treatment awaiting the next patient to be entered into the trial. Better to use a method of allocation that aims to remove the problems of bias—such as by telephone to a randomisation centre, by the pharmacy, or

by a secure system of sequentially numbered opaque sealed envelopes. These are the considerations that underlie the requirement to provide information about the method of randomisation in the statistical checklist used by the *BMJ*’s statistical referees.²

Exclusion of some of the randomised patients from the analysis of a controlled trial, for whatever reason, will destroy the unbiased comparison of treatments. This is the reason for the recommendation to analyse all randomised patients in the groups they were allocated to, even if some did not receive the intended treatment (an “intention to treat” analysis). For controlled trials, it is desirable for the groups receiving each treatment to be as similar as possible. Simple randomisation does not guarantee this for any particular trial, especially if the sample is small.³ Imbalance may be greatly reduced by using stratified randomisation.¹

In some circumstances randomisation is not possible, either for ethical reasons or because few patients are willing to be randomised. An unrandomised study of concurrent groups treated differently on the basis of clinical judgment or patient preference, or both, will need careful analysis to take account of differing characteristics of the patients and may still be of doubtful value. Failure to use randomisation when it could be used may fatally compromise the credibility of research, as happened in a study of periconceptional vitamin supplementation.⁴

Randomisation is also valuable in other types of research. In surveys it may not be practicable to contact the whole target population. A representative subset can be chosen by random sampling, whereby each person is equally likely to be selected. A low response rate will negate the advantage of random selection because of the strong possibility that those who respond are a biased subset. Thus it is more sensible to