

The median hospital stay was 5 (range 3-99) days. Neither the hospital stay (children, $p=0.63$; adults, $p=0.08$ (Kruskal-Wallis test)) nor the frequency of postoperative complications (children, $p=0.82$; adults, $p=0.5$) increased significantly with the interval between admission and surgery.

Though the conclusions of both of these studies are clinically important, the danger is that they may be used by surgeons, anaesthetists, or hospital managers as an excuse to delay surgery when the condition of a patient clearly indicates otherwise.

With regard to complications, careful follow up (to 18 months 95%; to eight years 63%) showed that nearly half (49.6%) of our patients claimed to have suffered one or more postoperative problems. Despite all patients receiving a metronidazole suppository preoperatively the rate of wound infection diagnosed in hospital was 11.7% (29/248 cases) and the rate of wound infection first occurring after discharge was 10.9% (26/239). Although our results are possibly higher because of the inclusion of factors such as wound pain and changes in gastrointestinal, urological, or gynaecological function and the fact that most of the operations were performed by junior surgeons, we believe that the true morbidity of appendicectomy is greater than the <5% quoted by the authors.

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1 Surana R, Quinn F, Puri P. Is it necessary to perform appendicectomy in the middle of the night in children? *BMJ* 1993;306:1168. (1 May.)

Bleeding complications after thrombolysis

EDITOR,—In addition to the lessons mentioned in Nick J M London and colleagues' report of systemic thrombolysis causing haemorrhage around a prosthetic abdominal aortic graft there is another.¹ The fact that the patient had chronic renal failure and had been receiving haemodialysis should have prompted the clinicians to be more vigilant with regard to potential problems of coagulation.

Patients with chronic renal failure are known to have a tendency to bleeding. The exact mechanism of this is not fully known but is thought to be due to abnormalities of platelet function.² Dialysis contributes to the haemostatic abnormalities of uraemic patients because the interaction between the blood and artificial surface may induce chronic activation of platelets, leading to their dysfunction.³ It has been suggested that reduced adhesiveness of platelets and prolonged bleeding time are constantly observed in uraemic patients and that there is a direct correlation between prolonged bleeding time and clinical bleeding in uraemic patients.³ Gimple *et al* observed that the prolongation of bleeding time seemed to be the first recognised, potentially useful index identifying and possibly measuring the bleeding tendency associated with thrombolytic treatment.⁴

It may therefore be useful to measure bleeding time before giving thrombolytic treatment to patients at increased risk of bleeding, thus avoiding the potentially fatal complication seen in the patient reported on by London and colleagues. The haemorrhagic tendency of uraemic patients is influenced by anaemia, which has a negative effect on the rheological components of the interaction between platelets and the vessel wall.⁵ If the initial haemoglobin concentration of the patient was

90 g/l this may well have contributed to the severe haemorrhagic complications that occurred.

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- 1 London NJM, Williams B, Stein A. Systemic thrombolysis causing haemorrhage around a prosthetic abdominal aortic graft. *BMJ* 1993;306:1530-1. (5 June.)
- 2 Vignano G, Remuzzi G. Coagulation abnormalities of patients with chronic renal failure. In: Cameron S, Davison A, Grunfeld JP, Ritz E, eds. *Oxford textbook of clinical nephrology*. Oxford: Oxford University Press, 1992:1361-4.
- 3 Steiner RW, Coggins C, Carvalho ACA. Bleeding in uremia: a useful test to assess clinical bleeding. *Am J Hematol* 1979;7:107-17.
- 4 Gimple LW, Gold HK, Leinback RC, Collar BS, Warner W, Yasuda T, *et al*. Correlation between template bleeding time and spontaneous bleeding time during treatment of acute myocardial infarction with recombinant tissue-type plasminogen activator. *Circulation* 1989;80:581.
- 5 Livio M, Marchesi D, Ramuzzi G, Goth E, Mecca G, de Gaetano G. Uraemic bleeding: role of anaemia and beneficial effect of red cell transfusions. *Lancet* 1982;ii:1013-5.

Health visitors should assess jaundice in babies

EDITOR,—Gordon A Mackinlay is right to highlight the need for doctors to be aware of the importance of early diagnosis of liver disease in babies.¹ I question his logic, however, in bringing forward the 6 week "well baby review" to 4 weeks of age.

I assume that the review he refers to is the 6 week developmental surveillance by the general practitioner; doing this before 6 weeks would be inappropriate. In practice it is often done by the general practitioner at 8 weeks to coincide with the first course of primary immunisation.

A large group of health professionals, not mentioned in Mackinlay's article, are in regular contact with mothers and babies in the early weeks of life—namely, community midwives and, more specifically, health visitors. Both these groups of staff need to be aware of the importance of investigating jaundice that persists beyond 14 days of age.

In this district this message has been inserted into the parent held child health record so that when the health visitor visits at 10 days she should note the presence or absence of jaundice and record this in the notes. If jaundice is present at 10 days she should review the situation a few days later and refer the baby for investigations if the jaundice persists at 14 days.

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1 Mackinlay GA. Jaundice persisting beyond 14 days after birth. *BMJ* 1993;306:1426-7. (29 May.)

Children's consent to treatment

Legal advice often unnecessary

EDITOR,—In their article on whether children can withhold consent to treatment J A Devereux and colleagues conclude that if there is doubt, legal advice should be sought.¹ This conclusion must be challenged before it gains the status of expected practice. Doctors have responsibly to provide appropriate treatment for children in their care; to consult colleagues when they, the child, or carers have doubts; and to use the law when an impasse occurs. The suggestion that this is something for which legal advice may often be required could be seen as further legal infiltration of medical practice.

The problem is partly the high cost of the legal process. There can be little doubt that the private business of law has targeted medicine. Perinatal medicine is becoming increasingly more difficult

because of legal activity, and I doubt that we can afford to let lawyers, however eminent, leave the issues of consent in such a vague and evenly balanced manner as the article proposes. This could be seen as creating uncertainty, which could then be exploited. There is a particular risk that social services departments would think that many more medical decisions about children in their care needed to be referred to court, whereas obtaining second opinions and agreement might be more sensible, quicker, and all that could be afforded.

The limited budgets of health and social services cannot be allowed to be spent on legal fees without some sort of control. Legal costs and practice have to be kept to agreed and sensible levels. The article is silent on such issues. The medical profession should not accept that the involvement of lawyers at the more difficult margins of practice is inevitable. I doubt, for example, if society would lose much sleep over an adolescent having her life saved, apparently against her wishes, even if her rights had not been argued in court. The reference to a single medical practitioner in an adversarial position with a patient and family caricatures the situation because medical practice involves several doctors, and often other professionals, advising in difficult clinical situations. Doctors' practices should be open to public discussion and scrutiny, but the adversarial approach to single cases is a different matter. There will always be doubts in medicine that relate to ethics, resources, and science, but the notion that the law is commonly helpful and cost effective is unproved.

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1 Devereux JA, Jones DPH, Dickenson DL. Can children withhold consent to treatment? *BMJ* 1993;306:1459-61. (29 May.)

Abstract debate is unhelpful

EDITOR,—The article by J A Devereux and colleagues¹ continues a long tradition. A single, extreme example of an older adolescent's seemingly irrational, life threatening decision is cited. General opinions from psychiatry, law, and ethics are discussed, concluding with advice on practising defensive medicine. The title's question is not actually addressed, nor are integral secondary ones.

These questions include: When are children considered old enough to make informed, wise decisions about proposed treatment? How is competence defined and assessed? Is age the most salient factor? How are children involved in making decisions across the whole spectrum of current clinical practice? How complex, serious, risky, urgent, irrevocable, life changing, or life extending are these decisions? How do decisions make sense within the context of the child's life?

Apart from these empirical questions, there are important theoretical ones. When do claims about children's "best interests" serve adults' convenience or power? How have recent changes in medicine and society, and in respecting children's and patients' rights, affected children's consent? Until quite recently, women were dismissed as irrational for reasons which are still advanced against children; how valid are these reasons? What personal characteristics affecting competence distinguish teenagers from adults? How do myths about childhood colour professional judgment?

During recent research interviews with children having surgery and the adults caring for them,² most interviewees held markedly different views from Lord Donaldson's. Far more salient to assessed competence than age are the child's experience and the assessor's personal beliefs. Of