

limits of the confidence interval for the predicted rate. This strongly suggests a major role for severity at admission in predicting mortality. Since no apparent differences were detected, this would argue for stopping the quality analysis at this screening level. Despite the fact that a test based on the combination of the ratios of actual to predicted deaths across three disease conditions achieved statistical significance, only further research can determine whether the difference that remains is due to unmodeled severity or a difference in quality. Our fear is that others may misinterpret these findings and pay insufficient attention to the authors' caveat that their findings could still be consistent with a disproportionate number of severely ill patients in the high-outlier hospitals.

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The above letters were referred to the authors of the article in question, who offer the following reply:

To the Editor: We appreciate the foregoing comments and would like to provide the following technical response. Drs. Brett and Roberts inquired about the definition of preventable death. In making a judgment about preventability, physicians considered a death preventable if the patient had received poor care that led to death. The physicians were instructed to ignore all events that occurred before hospitalization. Additional (ongoing) analyses indicate that a terminally ill patient (e.g., one with metastatic cancer) was not judged to have had a preventable death.

In response to Drs. Ruderman and Levin, first of all we agree that interrater reliability for preventable deaths involving pneumonia was low. However, low reliability makes it more difficult to detect differences in quality according to the type of hospital outlier. With a more reliable measure, the observed differences could have been larger. Secondly, as a measure of intrarater reliability we used the percentage of agreement instead of a correlation coefficient, because in our setting (small samples and the need to aggregate data across three diseases and nine raters), it is more stable and interpretable.

Drs. Pine and Smith suggest that the disparity between observed and expected death rates could have been produced by misclassification of cases. In general, this could be correct. However, to avoid this possibility, we first excluded from our model for predicted death rates all patients who did not meet medical criteria for having the disease.

We agree with Brewster et al. that adjustment for severity explained most of the difference in death rates according to the type of outlier hospital (high or low). However, a statistically significant difference in mortality remained. When this result is coupled with our finding of differences in preventable deaths, the finding of a disparity in quality according to type of hospital is supported.

It should be noted that our original death-rate model that identified the hospital outliers was based on only four variables and data aggregated to the level of the hospital. The recent model of the Health Care Financing Administration uses patient-level data and more variables, among which are measures of comorbidity. It may classify hospitals in regard to quality better than our model did. Thus, our hospital death-rate model may represent a lower boundary in terms of discriminating high-quality from low-quality hospitals. Models incorporating measures of severity may do even better, and need to be tested.

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ACADEMIC SANCTIONS AGAINST SOUTH AFRICAN PSYCHIATRISTS BY THE ROYAL COLLEGE OF PSYCHIATRISTS

To the Editor: Physicians in the United States should recognize and respond to the academic sanctions invoked against South African psychiatrists by the Royal College of Psychiatrists (United Kingdom). At a business meeting on January 28, 1987, the Royal College, an organization with 6000 members, committed itself to the Commonwealth Nassau Accord, which includes academic and cultural sanctions against psychiatrists in South Africa. The vote was 72 in favor, 4 against, and 9 abstaining.

Because psychiatrists in South Africa live in a country with a wholly unacceptable, racist national policy of apartheid, which no South African psychiatrist or medical organization has ever condoned, they are no longer permitted collegial communication with British psychiatrists. They are refused subscriptions to medical journals (with the curious exception of the College's own journal), and books from British university presses are no longer forwarded to them. Their scientific papers are not accepted for publication in British psychiatric journals. They are considered *personae non gratae* at international psychiatry meetings, and physicians everywhere are discouraged from having collegial exchanges or visits with South African psychiatrists.

These actions have been taken against 450 earnest physicians who are struggling to serve the victims of apartheid at direct risk to their careers, persons, and families' safety. These physicians are in danger of being banned and detained, yet have repeatedly assisted Amnesty International in identifying and making public the names of South African prisoners (black, "colored," and white) whose situation would otherwise remain unreported, under South Africa's stringent and unappealable "emergency" laws.

The situation of South African psychiatrists should not be compared with that of psychiatrists in the Soviet Union, where the Soviet Psychiatric Association, as well as individual members of the Soviet medical profession, endorse national policies that scientists in other nations find morally unacceptable, if not reprehensible. However, a historical parallel with the irrationality and inhumanity of the Royal College of Psychiatrists' policy of medical sanctions can be found in the ancient Roman law that considered the children of criminals as guilty as their parents, so that not only were murderers routinely executed but their children as well.

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BOOK REVIEWS

GYNECOLOGY: PRINCIPLES AND PRACTICE

Edited by Zev Rosenwaks, Fred Benjamin, and Martin L. Stone. 668 pp., illustrated. New York, Macmillan, 1987. \$75.

As the end of the 20th century nears, gynecology has evolved, although somewhat reluctantly, into a socially responsible scientific discipline. Women are now the primary health care consumers and decision makers in the family. This may be due to consumerism, feminism, their role as mothers, or merely the expected ritual of the annual Papanicolaou screening (no such routine cancer test yet exists for men). Women participate more actively than men in family care, and they express a greater desire for better information and