example, pregnancy) in the order of one in 200. The result could be an ectopic pregnancy, a leading cause of maternal death in pregnancy. Despite the gravity of this potential adverse event, the benefits of contraception are thought by many to outweigh the rare chance of failure and maternal death. Pregnancy and childbirth are inherently risky, with perinatal death rates ranging from 2.3 per 1000 to 192.5 per 1000 internationally, and reaching 4.8/1000 in Canada, 5.2/1000 in the United Kingdom, and 6.6/1000 in the United States.[9] Modern technology and superior medical care cannot remove all risk completely. As international attention focuses on harms, rare threats to global health, and reduction of risk, we need to be mindful of our consistency and thoughtfulness in evaluating risks as the language we choose affects public perception and our clinical and research environment. Thus to decide on thresholds for risk for vaginal delivery and repeat caesarean section we need to look at rates for harms such as uterine rupture and benefits, and also ensure consistency with other issues when we interpret the thresholds.

Jeanne-Marie Guise *associate professor*

Oregon Health and Science University Department of Obstetrics and Gynecology, UHN-50, 3181 SW Sam Jackson Park Road, Portland, OR 97239-3098, USA
(guisej@ohsu.edu)

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What is intermediate care?

An international consensus on what constitutes intermediate care is needed

Intermediate care is an emerging concept in health care, which may offer attractive alternatives to hospital care for elderly patients. As little scientific evidence exists on the benefits of intermediate care, research is especially important.[1–3] A prerequisite for research is agreement on the definition of a concept, which is lacking for intermediate care. The term intermediate care is often used as if its meaning is clear, but it conveys little meaning other than being about care that is "in between." Commonly used definitions of intermediate care do not help much, and several very different definitions are in use. What is needed at the outset is a consensus on what constitutes intermediate care. Until this is agreed on, the concept of intermediate care will remain a mirage and its possibilities unknown.

The term intermediate care was introduced in the United Kingdom's *NHS Plan* and refined in the national service framework for older people.[4 5] The concept seems to arise out of a policy imperative, rather than an analysis of the scientific evidence about effective models of care. Objectives such as "promotion of independence" and "prevention of unnecessary hospital admission" were to be achieved through providing a new range of services between hospital and home. Specific targets (for example, the number of service users, prevented admissions) accompanied these objectives. However, no particular models of service delivery were defined.

Professional statements of good practice followed the political decision that reconfiguration of the health service would include investment in intermediate forms of care. The British Geriatrics Society listed three definitions in its statement on intermediate care.[1] The broadest definition is the one shared with the Royal College of Physicians of London, according to which intermediate care is delivered by those health services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team.[2]

Recently, Andrea Steiner published as many as eight definitions of intermediate care.[6] Five of them (partly) focused on facilitating the transition from hospital to home. Other aims include avoidance of admission and improvement of pre-acute and post-acute care. A systematic review on the best place of care for older people after acute illness concluded that service models were best described in terms of the objectives of care.[7]

Definitions from the databases Medline and CINAHL narrow intermediate care in the direction of nursing home care. For example, in Medline "intermediate care facilities" are institutions that provide health related care and services to individuals who do not require the degree of care which hospitals or skilled nursing facilities provide, but require care and services above the level of room and board. This probably results from the existence of intermediate care facilities in the United States and Japan, which closely resemble nursing homes. Further difficulty arises because individual authors also use the term intermediate care when describing a less advanced type of intensive care medicine.[8]

This inventory of definitions shows that the term intermediate care currently does not present imply a specific, well defined type of health care (box). This worrying conclusion has important consequences. To compare results of research projects will be difficult if not impossible, as will be identifying gaps in our current knowledge or critically appraising the benefits attributed to intermediate care. These difficulties will only increase because of the growing popularity of

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Definitions of intermediate care

British Geriatrics Society[1]

- An approach to health care intended to facilitate patients' transitions from illness to recovery, or to prevent their transition from home managed chronic impairment to institution-based dependence, or to help terminally ill people be as comfortable as possible at the end of their lives
- That range of services designed to facilitate transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patients' discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired
- Those services that do not require the resources of a general hospital, but are beyond the scope of the traditional primary care team. These can include "substitutional care" and "care for people with complex needs"
- (The last definition is the same as the one the Royal College of Physicians uses in its statement[2])

Medical subject heading (MeSH)[9]

- Intermediate care facilities are institutions that provide health related care and services to individuals who do not require the degree of care that hospitals or skilled nursing facilities provide, but because of their physical or mental condition require care and services above the level of room and board

CINAHL subject headings

- Intermediate care (see subacute care) is care provided to acute care patients who are medically stable but too unstable to be treated in alternative healthcare settings such as home, ambulatory, or traditional skilled long term care
- Intermediate care facilities: entered here are materials on nursing home facilities. For care given in a nursing home, see long term care

alternatives to hospital inpatient care across Europe and the rest of the world.

To deal with this Babel of voices we suggest a formal process to develop a consensus of the key elements of intermediate care. The aim of this debate should not be to arrive at a uniform definition of intermediate care, for our inventory on the definitions of intermediate care has shown that it is impossible to define intermediate care unequivocally at the highest conceptual level. For reasons of simplicity, this debate should be limited to defining intermediate care for the purpose of scientific appraisal. It would also be helpful if bibliographers were able to establish a consensus for terminology, such as medical subheadings.[9] For the time being we believe that intermediate care models can be best classified according to their objectives of care and not by their names. If we do not clearly define key elements of the concept of intermediate care, then it will remain a concept with unfulfilled promise.

René J F Melis *researcher*
Marcel G M Olde Rikkert *professor in geriatrics*

Department of Geriatric Medicine, Internal Postal Code 318, University Medical Centre Nijmegen PO Box 9101, NL-6500 HB Nijmegen, Netherlands
(r.melis@ger.umcn.nl)

Stuart G Parker *professor in geriatrics*

Sheffield Institute for Studies on Ageing, Barnsley District General Hospital, University of Sheffield, Sheffield S10 2TU

Monique I J van Eijken *researcher*

Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, Geert Grooteplein 21, NL-6525 EZ, Nijmegen, Netherlands

Competing interests: None declared.

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Guidelines for chronic obstructive pulmonary disease

NICE guidelines are evidence based but will need regular updating

Faced with a plethora of guidelines, doctors in primary and secondary care may well ask, why another guideline and particularly a guideline for chronic obstructive pulmonary disease and how is it going to affect practice?

Guidelines from the Global Initiative in Obstructive Lung Disease were updated in 2003.[1] The National Institute for Clinical Excellence (NICE) published a guideline earlier this year.[2] New guidelines from the European Respiratory Society and American Thoracic Society appeared recently (www.thoracic.org/copd). The existence of so many guidelines reflects the increasing recognition of the burden of chronic obstructive pulmonary disease both on patients and on healthcare resources. Whereas the condition was considered to have few therapeutic options previously, it is now considered treatable, and over the past five years increasing evidence supports pharmacological and non-pharmacological treatments. This article discusses the guideline published for NICE by the National Collaborating Centre for Chronic Conditions and many members of the British Thoracic Society and makes some comparisons with other guidelines. The 1997 British Thoracic Society guidelines needed updating,[3] which is what the NICE guideline does. It is truly evidence based, wide ranging, and deals with diagnosis, assessment of severity, and treatment of chronic obstructive pulmonary disease.

The evidence on which the recommendations in the NICE guideline are based is presented in a standard format for each section, indicating which studies were reviewed, with evidence based statements

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