

PROVHILO clearly answers Futier's question "positive end-expiratory pressure in surgery: good or bad?"² in the patient group being studied. When a low tidal volume strategy is used, a low PEEP level without recruitment manoeuvres does not increase the incidence of postoperative pulmonary complications and is associated with less haemodynamic impairment compared with high PEEP with recruitment manoeuvres. These results need to be confirmed in morbidly obese patients and in patients undergoing thoracic surgery. We hope that beliefs and myths regarding PEEP during general anaesthesia will soon give place to the evidence of large randomised controlled trials.

We declare no competing interests.

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Primary care research

In his Comment (Sept 20, 2014)¹ about primary care research, Richard Horton described exciting new developments in Sweden. We applaud the leadership of Lars Lindholm and would like to raise awareness of primary health-care research capacity building on a broader scale because some important developments since the family medicine research meeting² hosted by WONCA (World Organization of Family Doctors) might have been missed.

The first reassurance comes from the Kingston Conference² itself that resulted in an extensive review of the priorities of primary health-care research and recommendations to build the research capacity to approach these priorities, and which has served as a template for WONCA and its member organisations in 131 nations to advocate and support research in primary care in all regions of the world. The WONCA guidebook³ has an excellent section on the way each nation can support primary care research. WONCA has a thriving Working Party on Research and active regional groups, including the South Asia Primary Care Research Network, the North America Primary Care Research Group, and the European GP Research Network, which hold regular workshops to support and encourage those working in family practice to take part in primary care research. WONCA has also supported the Brisbane

Initiative for International Leadership, which holds yearly meetings in Oxford, UK.⁴

One of the recommendations of the Kingston Conference² was the establishment of multidisciplinary research training programmes. In addition to Sweden, these initiatives have since been developed in Scotland, England, The Netherlands, and USA, each resulting in thriving primary health-care research outputs.^{5,6} The Netherlands School of Primary Care Research, for example, produced more than 100 PhD theses in 2013. Family doctors around the world take research seriously and promote and engage in research in primary care. WONCA regional and special interest conferences every year provide evidence of these efforts for all to see, and for all to critically appraise.

Finally, we are sorry that Richard Horton had such a wretched time in Kingston, Canada, all those years ago.¹ Family doctors are held responsible for many things, but even we cannot be blamed for the weather.

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For the Netherlands School of Primary Care Research see <http://www.researchschoolcare.nl/>

For the WONCA conferences see www.globalfamilydoctor.com/conferences.aspx



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Stillbirth in France

Between 1901 and 2001, stillbirth rates in France decreased from 35 stillbirths per 1000 births to 4.8 stillbirths per 1000.¹ However, in 2002, this rate increased to 8.2 stillbirths per 1000 births, probably because of the use of WHO thresholds for civil registration, switching from a gestational age of 28 weeks of gestation to 22 weeks in November, 2001. In 2010, stillbirth rate in France (9.2 per 1000 births) was deemed to be the highest in Europe.² Nevertheless, gestational age and birthweight are not included in civil registration, and registering stillbirths from 15 weeks of gestation, depending on parents' requests, since August, 2008, might explain why reliable stillbirth rates could not be calculated from civil registration data.

To overcome this difficulty, French authorities stated that stillbirths must be registered through the hospital discharge data system. From March, 2011, a gestational age of 22 weeks or more, or a birthweight of 500 grams or more, are the criteria for stillbirth inclusion.³

The NéMoSI project was launched in 2010–11 to improve stillbirth recording. Analyses of stillbirths recording throughout hospital discharge data started at Trousseau Hospital, Paris, in 2010, and in Academic Hospitals of eastern Paris, and pointed out that the 2011 recording stillbirth guidelines³ did not seem sufficient for stakeholders to distinguish stillbirth registration for epidemiology purposes from voluntary civil registration for

families' right purposes (ie, family register, burial). Good quality and exhaustive data were not systematically integrated into practices.⁴

The NéMoSI project was later extended around Paris (eastern Paris in 2011, all Assistance Publique-Hôpitaux de Paris birth sites in 2012, Seine Saint Denis in 2012–13, and Val d'Oise in 2014). It covers about 85 000 births and 900 stillbirths per year, and contributed to reclassify as stillbirths mis-recorded births, register unrecorded stillbirths, type of pregnancy (eg, medical termination), and specify fetal death circumstances.

These observations, and *The Lancet* stillbirth Series, point out that computing stillbirth rates remains a challenge for clear international comparison.^{4,5} Reliable data are essential to estimate health risks. To raise awareness about these issues among families, health professionals, and authorities, and consider regulations related to stillbirth, livebirths, and voluntary or medical interruptions of pregnancy are necessary to improve data quality for international comparisons.

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Public health—the bigger picture

I agree with Richard Horton's Offline (Sept 27, p 1171)¹ that England needs a strong faculty and public health service. I do not think anyone would claim that there has ever been a golden age when public health advice was leading the debate, and we should retain humility about this. Incidentally, I made this point to the Health Select Committee almost a year ago when they observed that, 7 months into the existence of Public Health England, we had yet to find our voice. As I explained at the time, our first priority was to find our feet without dropping the ball, and they acknowledged that we had done this well.

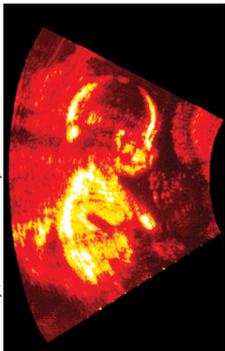
Looking forward, the seven improvement priorities of Public Health England² that I have outlined are all rooted in the evidence and we are free to speak to this and regularly do; for example, with standardised packaging and minimum unit pricing. We will of course continue to respond flexibly to the immediate priorities of the day, just as we are doing with the outbreak of Ebola.

I am Chief Executive of Public Health England.

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For *The Lancet* stillbirth Series see <http://www.thelancet.com/series/stillbirth>

For the NéMoSI project see <http://www.perinat-ars-idf.org/nemosi.php>