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Swedish pregnant women accept voluntary HIV testing

Screening for HIV infection in pregnant women is a useful indicator of the spread of the virus in the heterosexual population. Knowledge of their infection early in pregnancy enables women to make informed decisions. In 1987 Sweden started to offer HIV testing to all women visiting antenatal clinics and in some abortion clinics. In the first five years Lindgren *et al* report that most women accepted the test, and 54 HIV positive women were identified in 510 000 tests (p 1447). About a third of these would not have been identified if screening had been confined to women at risk.

Relation between birth weight and blood pressure is not linear

As part of the continuing investigations into the association between events in early life and disease in adult life Launer *et al* (p 1451) examined the relation between birth weight and systolic blood pressure at birth, 3 months, and 4 years in 392 Dutch children. They found that both low and high birthweight infants have raised systolic blood pressure at 4 years. Differences in blood pressure, weight, and weight gain in early infancy that may be related to birth weight suggest that the mechanisms regulating increases in blood pressure may differ by birthweight group. The authors suggest that future investigations of correlates of disease in adult life should examine low and high birthweight infants separately.

Rural children are taller

Variations in birth weight and height are sensitive indicators of social inequalities in the health of a population. On p 1458 Reading *et al* compare rates of low birth weight and the mean height of primary school children between affluent and deprived areas in rural and urban settings. They found the expected increase in rates of low birth weight and reduction in height in more deprived areas regardless of the rural or urban nature of the area; but there were also consistently poorer measures in increasingly urban settings. This urban disadvantage was unrelated to levels of material deprivation and possibly reflected environmental or lifestyle differences, the effects of selective migration, or the legacy of poorer health in previous generations of urban mothers.

Prenatal screening could be introduced for trisomy 18

Biochemical screening for trisomy 21 has been greatly refined since the original observation that a low maternal serum α fetoprotein concentration was associated with fetal trisomies. Many health authorities and organisations, however, have still not introduced screening programmes despite reported detection rates of 50-70% for trisomy 21. The first index case in the original study concerned trisomy 18. On p 1455 Spencer *et al* report the world's largest series of trisomy 18 cases in an attempt to develop a screening programme for this defect. Their findings suggest that by using the concentrations of α fetoprotein and free β human chorionic gondatrophin as biochemical markers some 50% of trisomy 18 cases could be identified at a cost of subjecting only 1% of the pregnant population to amniocentesis and karyotyping. With a birth incidence of one in 7000, trisomy 18 is the second most frequently found autosomal trisomy (after trisomy 21).

Referral guidelines are unlikely to reduce numbers

Is the wide variation among general practitioners in rates of referral to hospital due to some doctors referring patients unnecessarily? According to Fertig *et al* (p 1467), the answer is no. They examined specialists' views about referrals they received and also reviewed the referrals with reference to locally developed guidelines. They found that unnecessary referral could explain only a small part of the local variation in rates of referral, and referral guidelines were unlikely to reduce the numbers of patients referred. There may be room for improvement in the quality of referrals, but the place of guidelines is likely to be in improving the quality rather than the quantity of referrals.

GPs find feedback on their referral rates unhelpful

Since 1990 general practitioners have been required to collect details of their referrals to hospital. de Marco *et al* (p 1465) visited general practitioners in East Anglian practices to see how they could use feedback from family health services authorities which showed how their rates of referral compared with other practices. Results were disappointing. Doctors were sceptical about the quality of the data, perceived no link between rates of referral and quality of care, and did not find the rates a useful stimulus to perform detailed audit of clinical cases. Doctors identified access to specialist care, the skill of individual general practitioners, responses to patient demand, and fear of litigation as important influences on referral decisions.

Litigation does not promote good clinical practice

Few medical mishaps in hospital practice result in a claim and even fewer in compensation. The cost, however, is considerable. On p 1483 Neale examined 100 claims of negligence against hospital doctors. In 56 cases errors could be clearly defined, and in 34 there were doubts about the overall standard of practice. The medicolegal process takes several years to determine the cause of medical mishaps, and many cases remain unresolved. Thus, the system is unlikely to affect clinical practice. Reform should be aimed at providing a means of improving medical practice and overcoming the frustration and dissatisfaction expressed by claimants.