BRITISH MEDICAL JOURNAL

SATURDAY 24 APRIL 1976

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO 6016 BRITISH MEDICAL JOURNAL 1976 VOLUME 1 975-1028 ASTM CODEN: BMJOAE 1 (6016) 975-1028 (1976)
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR. SECOND CLASS POSTAGE PAID AT NEW YORK NY WEEKLY 80p

CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Priorities for health and social services

SIR,—Experience of reading medical journals had convinced us that leader writers are fallible. We had hoped that there was a change for the better, because recently there appeared to be less subjective judgment in them, more objectivity, and more respect for, and understanding of, evidence of a statistical nature. That is, we believed this until we read your leading article "A policy of despair" (3 April, p 787). Let us examine some of its statements.

"Obstetrics is one of the few areas . . . in which in the last decade technological innovation has not only been rapid but has been proved to be effective." This we would claim to be misleading. The paper quoted[1] makes no such claims of proof in respect of fetal monitoring. The authors realised the difficulty of proof in a multifactorial situation and entered a caveat—"The assessment of the value of any new technique is always complicated by the difficulty of controlling the many variables that may influence the final outcome." Unfortunately they did not discuss why a randomised controlled trial of fetal monitoring could not be undertaken in their unit. In Cardiff[2] during the period 1965-73 there was rapid technological innovation in obstetrics, but for some reason the perinatal mortality fell more slowly here during these years than in other areas of England and Wales.

"Perinatal mortality is a good guide to the incidence of birth handicap, and every drop of even 0·1% in the national figure should mean a drop in the numbers of babies surviving with physical or mental defects." This is a most surprising statement, particularly when given without references and it is of interest to compare it with the findings of the Peel Committee[3]—"Infants suffering from mental and physical handicaps who would have died 20 years ago are now surviving in increasing numbers and a substantial proportion of them have multiple defects." Here we challenge you to quote the published evidence.

"The EMI scanner . . . is revolutionising the management of strokes and head injuries." We know of no evidence to support such a statement and again challenge you to produce it. We think that for strokes it is more probable that the EMI scanner will add to the costs of diagnosis without altering case fatality.

Surely if "by cutting through to the cause of the disease [rhesus haemolytic disease—a disease of genetic origin], the problem has been solved" means the prophylactic treatment of all rhesus-negative primiparous mothers so as to suppress the establishment of antibodies, then much less expenditure will be required in departments of obstetrics, paediatrics, haematology, and radiology than formerly.

We agree that a new strategy is required; we agree that this should concentrate on prevention and especially on the prevention of birth handicap. But we in the medical profession, too, need a new strategy; we need to be aware that our patients and our paymasters are questioning both the efficiency of our utilisation of the huge resources entrusted to our charge and the effectiveness of treatments "agreed to be most effective by orthodox medical opinion." Our policy should be based upon the prevention of unsupported assertions and the establishment of many more controlled trials to test the validity of orthodox medical opinion. It is unfortunate that at a time when a royal commission is being established such a false impression of the scientific standards of the profession should be given by this misleading article.

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[1] Edington, P T, Sibanda, J, and Beard, R W, *British Medical Journal*, 1975, **3**, 341.
[2] Chalmers, I, *et al*, *British Medical Journal*, 1976, **1**, 735.
[3] Department of Health and Social Security. *Report of the Subcommittee on Domiciliary Midwifery and Maternity Bed Needs*. London, HMSO 1970.

SIR,—There are many points raised by your leading article "A policy of despair" (3 April, p 787), but one in particular seems doubtful. No one would quarrel with the assertion that priority should be given to prevention, but there are two weaknesses in the argument as it relates to handicapped children.

The first is that the prevalence of handicap is remarkably stable among many different populations and over several decades, despite wide differences in perinatal mortality. Abramowicz and Richardson,[1] reviewing 27 studies from nine nations between 1925 and 1969, found an almost universal prevalence rate in children of 4 per 1000. The earliest study, conducted between 1926 and 1929 in England,[2] give a maximum prevalence rate of 4·2 per 1000 children. This finding offers little hope that a reduction in perinatal mortality will change the incidence of handicap, though it remains a possibility. Presumably a reduction in perinatal mortality is accompanied by the survival of damaged children who might otherwise have died and by reductions in later mortality among the severely handicapped. Though the reduction of morbidity among neonates after fetal monitoring[3] is hopeful, only long-term follow-up on a very