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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Perinatal practice and compensation for handicap

SIR,—We have been concerned to learn of an increasing number of malpractice suits lodged by parents of children who have either died during the perinatal period or survived with some form of handicap. This trend may reflect the widely publicised opinions of those who believe that considerable scope exists for preventing perinatal deaths and handicaps by intensifying and centralising perinatal care. Although firm evidence to support these views has been difficult to find,[1-5] it should come as no surprise if the publicity they have attracted results in parents using litigation to seek compensation for the death or handicap of their children.

The effects of these developments on clinical practice in Britain were predicted some time ago.[6-8] As O'Driscoll has observed,[9] "there is a subtle influence in obstetrics that operates to absolve a doctor who intervenes in the course of a normal pregnancy and which, by implication, exposes a colleague to censure when an infant is born dead. This places a premium on intervention as a form of personal insurance for the doctor." Such considerations appear to explain, at least partly, the explosive growth in the use of caesarean section in the United States.[10]

In Britain we still have an opportunity to prevent a spiralling growth of defensive perinatal practice fuelled by increased litigation; but there are preconditions. Firstly, there must be greater willingness to audit clinical practice by reference to well-designed research from which it is possible to estimate the likely beneficial and harmful effects of medical interventions, and not by applying norms based solely on fashionable practice.[11] Secondly, there is an urgent need to abolish any requirement that those who seek compensation for death or handicap should have to establish that negligence was involved.

In making these suggestions we do not wish to deny handicapped children the financial help they desperately need; but litigation only benefits a tiny minority, and then usually only after years of additional strain. Current arrangements are also exceedingly wasteful: for every £1000 awarded in compensation £870 is spent on "administration."[12] What is urgently required is a comprehensive disablement benefit for both children and adults paid according to the severity of the handicap regardless of its cause. We would be interested to know the views of others who wish both to reduce the mounting pressures to practise perinatal medicine defensively and to support moves to provide prompt, effective, and equitable compensation for handicapped people.

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