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LEADING ARTICLES

Fulminant hepatic failure in childhood.....	823	BCG in Britain.....	825
The prognosis of multiple sclerosis.....	824	Community medicine: A second chance?.....	826

PAPERS AND ORIGINALS

Management of acute stroke in the elderly: follow-up of a controlled trial W M GARRAWAY, A J AKHTAR, L HOCKEY, R J PRESCOTT.....	827
Evaluation of single-dose hypnotic treatment before elective operation M R B KEIGHLEY, M GANNON, J WARLOW, C R M JENKINS, R J GAMMON.....	829
Effect of bile on vitamin B ₁₂ absorption N H TEO, J M SCOTT, G NEALE, D G WEIR.....	831
Breast-feeding and plasma oxytocin concentrations A LUCAS, R B DREWETT, M D MITCHELL.....	834
Relapses in Wegener's granulomatosis: the role of infection A J PINCHING, A J REES, B A PUSSELL, C M LOCKWOOD, R S MITCHISON, D K PETERS.....	836
Recurrent abdominal pain associated with digoxin in a patient undergoing maintenance haemodialysis MARTIN FEINROTH, MARY V FEINROTH, A PETER LUNDIN, ELI A FRIEDMAN, GEOFFREY M BERLYNE.....	838
Arthritis preceding fulminant ulcerative colitis and responding to colectomy DAVID K MCCULLOCH, DAVID M FRASER, ALLAN L TURNER.....	839
Successful pregnancy in severe chronic renal failure not requiring dialysis R A COWARD, N P MALLICK, D W WARRELL, D GRIMES, H KIRKPATRICK.....	839
Ionised calcium in rheumatoid arthritis: effect of non-steroidal anti-inflammatory drugs M G BRAMBLE, D R BLAKE, T WHITE, J SLY, D N S KERR.....	840
Gonorrhoea presenting as "sterile" pyuria B CHATTOPADHYAY, I HALL.....	841
Controlled trial of cromoglycate and slow-release aminophylline in perennial childhood asthma A T EDMUND, F CARSWELL, PAT ROBINSON, A O HUGHES.....	842
Admission rate of old people to Scottish psychiatric units IAN PULLEN.....	843
Malabsorption of prednisolone from enteric-coated tablets after ileostomy S AL-HABET, HELEN C KINSELLA, H J ROGERS, J R TROUNCE.....	843

MEDICAL PRACTICE

Listening and talking to patients: I—The problem CHARLES FLETCHER.....	845
Ethical problems in feeding patients with advanced dementia ASTRID NORBERG, BO NORBERG, GÖRAN BEXELL.....	847
The natural history of preventive medicine, or breaking the chains of causation LORD TAYLOR OF HARLOW.....	849
Lesson of the Week: Anaphylactic reaction to desensitisation for allergic rhinitis and asthma DAVID A RANDS.....	854
Does interferon cure cancer? KAROL SIKORA.....	855
Letter from Brisbane: A new Cecil: or assessment assessed DEREK MEYERS.....	859
Reading for Pleasure: An alfresco choice B G DUDLEY.....	860
Any Questions?.....	854, 858
Materia Non Medica—Contributions from WILLIAM THOMSON, JULIAN JESSOP.....	853
Words B J FREEDMAN.....	853
Medicine and Books.....	862
Medicine and the Media—Contributions from JANE SMITH, TONY SMITH.....	866
Personal View R N VILLAR.....	867

CORRESPONDENCE—List of Contents..... 868

OBITUARY..... 876

NEWS AND NOTES

Views.....	879
Medical News.....	880
BMA Notices.....	881

SUPPLEMENT

From the GMSC: Identifying underprivileged areas.....	882
Computers for general practice: feasibility study.....	884
Underprivileged areas: report of working group.....	884
Recruitment to community medicine.....	886
Staffing in thoracic medicine K M CITRON, D R LEWIS, A J NUNN	887
Community medicine in Scotland.....	888

CORRESPONDENCE

Perinatal practice and compensation for handicap	
P Mitchell, MA, and I G Chalmers, MRCOG	868
Ulcer healing, hospital admission and bed rest	
D W Piper, FRCP	869
Vomiting in association with cardiac pain	
D S Short, FRCP; O M P Jolobe, MRCP	869
Genital herpes	
M J O'Neill, MRCOG	869
High-risk groups and cervical cancer	
W J G Prendiville, MRCOG, and P N Bamford, MRCOG; Sylvia W Davies, FRCPATH	869
Work load produced by breast-cancer screening	
J Philip, FRCSED	870
Bladder cancer as a prescribed industrial disease	
F J Darby, MB	870
Site of action of intrathecal morphine	
P J W Knell, FFARCS; L Jacobson, MB	870
Pleural aspiration and biopsy	
W T Bertill, MRCP	870
Taking blood and putting up a drip in young children	
C G Peters, FFARCS	870
Intravenous urography	
G S M Harrison, FRCS	871
Dietary fibre and calcium excretion in diabetes	
A Aro, MD, and others	871
Managing extrapyramidal disorders	
C D Marsden, FRCP	871
Acupuncture and postherpetic neuralgia	
C R Jolly, FFARCS	871
Percutaneous central venous cannulation	
J Bancewicz, FRCSGLAS, and others	871
Familial hypercholesterolaemia and coronary disease in South Africa	
H D Tunstall Pedoe, MD	872
Mental Health Review Tribunals	
H R Rollin, FRCPSYCH	872
Prostatic biopsy	
M A Jones, FRCS	872
Two jubilees in psychotherapy	
P G McGrath, FRCPSYCH	872
Women in hospital medicine	
H R Vickers, FRCP	872
A better system for polio vaccination in developing countries?	
P E M Fine, PhD	873
Hormone receptors and human breast cancer	
C R Franks, MB	873
Tapping ascites	
A M Burke, FRCS	873
Hyperlipidaemia advances and retreats	
A Bloom, FRCP	873
Treatment of severe hypertension using chlorpromazine	
P E Nielsen, MD, and others	873
Bayes's theorem and the evaluation of tests	
G W Partridge, BM	874
The hospital practitioner grade	
S P Hall-Smith, FRCP	874
Physician's assistant in general practice	
K N Hambly, MRCOG	874
Physicians for Social Responsibility	
J Marrow, FRCS	874
Concern about "rickets" campaign	
T Rathwell, BA	874
Bad news for rheumatology	
A K Clarke, MRCP, and others	875
Medical audit	
F E Weale, FRCS	875
Points Taking blood and putting up a drip in young children (J Oldham; C S Ball); Laryngoscopy: stopping the mirror steaming up (P Huguenin); Why does cold weather cause frequency of micturition in some elderly people? (D Kohn and Edith Flatau; P E Jackson); Occupational hazards of anaesthesia (H V Corbett)	875

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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