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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

SUPPLEMENT

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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 should be typed with double spacing between lines and 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.

Birth asphyxia and no-fault compensation

SIR,—The risk of permanent disabling neurological damage to a child as a result of birth asphyxia referred to in the leading article by Dr D P Addy (1 May, p 1288) seems to us to provide an example par excellence of the possible usefulness of no-fault medical insurance discussed by Dr Richard Smith (1 May, p 1323). Clearly a child with such damage needs and deserves financial support for a disability which is not only incapacitating but also due to no act or omission by the child itself. The alternative to providing such financial support without reference whatsoever to blame for possible medical mismanagement of the perinatal asphyxia is legal recourse which must decide: (*a*) if malpractice caused the disability (leading to a large financial recompence); or (*b*) if the precipitating event occurred without malpractice (no financial award whatsoever).

The shortcomings of this approach were discussed in your correspondence columns in 1980.[1] Litigation helps only a minority; the needs of those who receive no compensation are as great as those who do; the process is slow and wasteful; and a climate of defensive interventionist perinatal practice is fostered.

In the case of perinatal asphyxia, the scientific "truths" underlying its relation to neurological damage are so imprecise in our present state of knowledge that any legal decision must of necessity be largely arbitrary. Dr Addy's conclusion is similar to that reached by one of us in 1978[2] that even severe perinatal asphyxia which does not result in death rarely leaves the neonate permanently damaged. If the underlying cause of the asphyxia is unknown (as is often the case) there is a temptation to attribute it to events occurring during labour, with an implicit assumption that different clinical management would have altered the outcome. Such assumptions are dangerously simplistic. It is clear that perinatal asphyxia may be the result rather than the cause of neurological abnormality.[3,4]

Dr Smith has presented the shortcomings of the no-fault accident insurance system now functioning in New Zealand but says ultimately that it works well. He refers to the chaos in America. Settlement or judgments in excess of $1m are now commonplace there, and there are signs that Britain is moving in the same direction. We strongly support Dr Smith's conviction that progress towards a no-fault system would be much preferable.

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[1] Mitchell P, Chalmers I. *Br Med J* 1980;**281**:868.
[2] Niswander K. *Amer J Obstet Gynecol* 1979;**133**:358.
[3] Cross H, Jellinger K, Kaltenbäck E, Rett A. *J Neurol Sci* 1968;**7**:551-64.
[4] Chiswick ML, D'Souza SW, Occleshaw JV. *Early Human Development* 1977;**1(2)**:171-80.

SIR,—The leading article by Dr D P Addey (1 May, p 1289) was long overdue. One major problem in relation to this subject is definition of asphyxia at birth and subsequent neonatal behaviour. Cord pH, Apgar scores, and duration of resuscitation, while helpful in relating to subsequent behaviour and development, are not specific. Neither is there agreement on assessment of neurological signs during the first week. It is, therefore, difficult to compare results from different units. How does one define apathy, let alone cerebral cry, and relate such behaviour to subsequent development?

We have defined cerebral dysfunction in the first week (in term infants, those of 37 weeks' or more gestation, and those with normal growth weighing more than 2·5 kg) as a syndrome where tone and primitive reflexes are altered from the norm, using the method of assessment described by Prechtl. In many cases there is associated cerebral irritation manifested by irritability, altered cry, and more especially motor seizures.[1] There is little doubt that convulsions occurring in