

termination. Significant reduction of renal function has been reported by some⁴⁻⁶ but not all⁷⁻⁸ authors. Again, termination may be necessary. There is no evidence that pregnancy increases the likelihood of graft rejection. Viral and bacterial infections, which are common in transplant recipients, present a potential hazard, though anaemia is not usually a problem. The ideal outcome is a full-term vaginal delivery, but obstruction of the pelvis by the transplanted kidney may necessitate caesarean section,⁹ and premature labour is common.¹⁰ There is no evidence of an increased risk of fetal abnormality despite the fact that steroid and immunosuppressive treatment must be continued during pregnancy. The paediatrician must be aware of the potential problem of adrenocortical insufficiency in the infant, and paediatric intensive care should be available at delivery.

The number of terminations that have been carried out in these women suggests a medical failure to advise patients having dialysis or after transplantation of their potential fertility. Patients of childbearing age who do not want to become pregnant need advice about contraception and sterilisation. Should all these patients be advised against pregnancy altogether? The risks to the patient, the reduced likelihood of a successful outcome, and the possibility that the patient may not survive to bring up the child provide substantial arguments against pregnancy and valid indications for termination. Once informed, however, the patient must make the final decision. A successful outcome depends upon painstaking follow-up and co-operation among patient, husband, renal physician, obstetrician, and paediatrician. In an over-populated world Ivan Illich might regard this as a misuse of scarce resources and manpower. But Illich does not have to deal with the individual woman who wants a baby.

¹ Computer files of the European Dialysis and Transplant Association Registry containing data on questionnaires returned to 31 December 1974. Pregnancies quoted are those in which the outcome is known.

² Goodwin, N J, *et al*, *American Journal of Obstetrics and Gynecology*, 1968, **100**, 528.

³ Ackrill, P, *et al*, *British Medical Journal*, 1975, **2**, 172.

⁴ Board, J A, *et al*, *Obstetrics and Gynecology*, 1967, **29**, 318.

⁵ Caplan, R M, Dossetor, J B, and Maughan, G B, *American Journal of Obstetrics and Gynecology*, 1970, **106**, 644.

⁶ Moore, T C, and Hume, D M, *Annals of Surgery*, 1699, **170**, 12.

⁷ Merkatz, I R, *et al*, *Journal of the American Medical Association*, 1971, **216**, 1749.

⁸ Penn, I, *et al*, *Journal of the American Medical Association*, 1971, **216**, 1755.

⁹ Nolan, G H, *et al*, *Obstetrics and Gynecology*, 1974, **43**, 732.

¹⁰ Sciarra, J J, *et al*, *American Journal of Obstetrics and Gynecology*, 1975, **123**, 411.

Consultation or action?

The re-examination of health priorities forced upon us by economic circumstances¹ has stimulated interest in preventive medicine, and last week the Departments of Health issued a consultative document titled *Prevention and health: everybody's business*.² Welcome though the initiative may be, the report is a disappointment. Most of its pages are concerned with a review of historical and epidemiological data on the effects of environment and life-style on health, but it lacks any positive proposals. Indeed it "deliberately poses more questions than answers." Health authorities should, says the report, develop the preventive aspects of their work and it recognises the force

of the argument that, in the long term, money diverted from the expensive curative services to preventive medicine is likely to effect savings. In practice, of course, it is much more difficult for a health authority to cut hospital beds or reduce the number of nurses than to cancel health education campaigns and close screening clinics. Patients in need of treatment are individuals—identifiable and newsworthy—but illnesses prevented are necessarily anonymous.

Two years ago the Canadian Federal Government published a broadly similar document,³ which covered the same historical ground but put forward detailed plans for dealing with the problems. Five strategies were proposed: health promotion by informing and influencing individuals and organisations; regulations to control hazards to health from environmental pollution, food and drugs, and the effects of alcohol on driving; research to identify risk factors and to analyse accident and disease statistics and evaluate screening programmes; a health care audit to assess the cost-effectiveness and overall efficiency of the medical services in current use; and a goal-setting strategy through which a rational set of objectives would be agreed with the health professions, including specific reductions in mortality and morbidity to be accomplished by specific dates. This programme has been widely accepted in Canada, and, more important, the proportion of its health expenditure (already at 7% of the GNP or \$300 a year per head, well ahead of Britain) spent on preventive measures is to be raised progressively over the coming years.

In the last year the experts interviewed in our series *Medicine in the 'Seventies*⁴⁻⁷ have agreed on the need for action on prevention. A private member's Bill seems likely to achieve the much-needed legal requirement on drivers and front seat passengers to wear seat belts, but many other aspects of road safety such as the lack of legal control over jay-walking have been ignored by the Government despite advice from its experts. It seems unwilling to act firmly on fluoridation; it has rejected the use of financial pressures to discourage smoking; and there is a real possibility that it will accede to pressures to extend licensing hours and lower the age at which alcohol can be bought. Yet these are the four really clear-cut issues where Government action—with the authority of Government and the force of law—could have immediate and substantial effects on mortality and morbidity. The consultative document asks why Britain's health statistics are so far behind countries such as Sweden. Without doubt the gap could be narrowed by application of the knowledge we already have.

Furthermore, a determined effort by the Government on these aspects of health (where the arguments are so familiar that most people accept them) could spearhead a campaign in schools, factories, on television and radio, on the other, less well known aspects of health education such as the hazards of a diet high in animal fat. What is needed is not consultation but action.

¹ *British Medical Journal*, 1975, **3**, 64.

² *Prevention and health: everybody's business. A reassessment of public and personal health*. London, HMSO, 1976. Price 50p.

³ Lalonde, M, *A new perspective on the health of Canadians*. Ottawa, Government of Canada, 1974.

⁴ An interview with Mr Robert Maxwell, *British Medical Journal*, 1975, **3**, 424.

⁵ An interview with Professor C T Dollery, *British Medical Journal*, 1975, **4**, 750.

⁶ An interview with Dr David Owen, *British Medical Journal*, 1976, **1**, 513.

⁷ An interview with Sir George Godber, *British Medical Journal*, 1976, **1**, 638.