SIR,—We have noted with interest the findings of Dr G M Fraser and his colleagues (31 January, p 270) showing that the overall diagnostic rate in the 112 patients in their series was only 71%. A much higher diagnostic rate has been achieved in patients with upper gastrointestinal haemorrhage admitted to other units, and in a recent series we reported a rate of 91% using both methods of examination in each of 138 patients.¹ Similarly, we would like to point out that in most other published series a much higher diagnostic rate has been achieved by early endoscopy than the 57% found in Edinburgh. In two recent series from the USA^{2,3} the source of bleeding was identified on endoscopy in 92% and 97% of cases respectively and in our series we achieved a rate of 86%. The diagnostic rate with radiology from Edinburgh (61%) is in better agreement with other published work; in our series the rate was 51% but increased to 65% after review of the emergency barium films.

There is no mention by Dr Fraser and his colleagues of the time interval between the admission of patients and the investigations or whether the 112 patients were admitted consecutively. We and others⁴ have pointed out that it is imperative that investigations should be performed within 24 hours of patients being admitted, and most of our patients were examined by both methods within 12 hours. A delay may involve the missing of superficial lesions such as Mallory-Weiss tears, which account for 10-13%^{1,5} of all cases but did not feature as a diagnosis in the Edinburgh series. There is also no mention in their article of who did the endoscopic examinations. It would be interesting to know how experienced or interested these investigators were and why only 72 out of the 112 patients underwent endoscopy at all. We have pointed out that relatively junior, but admittedly highly motivated, endoscopists can achieve an extremely high diagnostic rate with great safety and surprising ease in the majority of patients with upper gastrointestinal haemorrhage so long as the investigation is performed within 12-24 hours of admission. In 150 patients, admitted consecutively to one hospital during a two-year period, there were only four failed endoscopic examinations.¹

In their letter in 1974 (15 June, p 609) Dr Fraser and his colleagues called for further controlled trials to establish the relative merits of radiology and endoscopy in the diagnosis of the source of bleeding in patients with upper gastrointestinal haemorrhage. Until they undertake a study similar to ours, when all patients admitted are subjected to both examinations within 12-24 hours of admission, they will not be able to elucidate the problem further. We believe that our final conclusion still applies: the two methods of investigation are complementary, but if a choice must lie between them then endoscopy should take precedence.

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¹ McGinn, F P, *et al*, *Gut*, 1975, **16**, 707.

² Katon, R M, and Smith, F W, *Gastroenterology*, 1973, **65**, 728.

³ Sugawa, C, *et al*, *Archives of Surgery*, 1973, **107**, 133.

⁴ Cotton, P B, *et al*, *British Medical Journal*, 1973, **2**, 505.

⁵ St John, D J B, *et al*, *British Medical Journal*, 1974, **1**, 140.

Cancer statistics

SIR,—Dr R F Mould in his brief article (10 January, p 86) omits to mention two important functions of cancer registers. These are (1) the

measurement and detection of trends in incidence and (2) the identification of the occurrence of cancer in groups of persons exposed to special risks. Both these require accurate ascertainment of as high a proportion of new cases as possible, but no clinical details apart from site and histology are needed. Fortunately, thanks to the painstaking work of the staff of registries, high-quality material is available in several regions and has already proved invaluable.¹

While in a perfect world it might be interesting to have large quantities of cancer morbidity data classified according to stage of disease and treatment, in practical terms the problems of comparability and completeness of records are so great in relation to such parameters that the useful yield would be small. Advances in treatment are more likely to be identified by the execution of carefully designed and controlled trials than by the use of routinely collected cancer register data.

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¹ Doll, R, Payne, P, and Waterhouse, J, *Cancer Incidence in Five Continents*. New York, Springer, 1966.

Hospitals for the developing world

SIR,—The recent announcement that the Social Services Secretary has made arrangements for the "export" of British doctors to Persian Gulf countries again emphasises the concern expressed in your leading article (8 November, p 309).

It may be unwise to comment on this decision without being acquainted with all the facts, but it appears that this was made without a great deal of discussion with the health professions. The question is a good deal more complicated than simply creaming off a small number of specialists from our own strained services. In the first place why is this service being offered only to the Persian Gulf countries? The needs for the development of health services are far greater in many other countries with which Britain has close ties. Some may even be in a position to offer a reasonable fee for services rendered.

A much more important question is why is the offer being made particularly for help in designing and equipping hospitals? It is now becoming increasingly accepted that the real answers to the improvement of the health of people in developing countries are improvements in the standard of living and the provision of simple rural health services. Large and prestigious hospitals are simply further monuments to the failure to provide for these needs. They provide a relatively sophisticated service for a small number of privileged people. Rather than encouraging the development of hospitals Britain should be taking a lead in providing for the overall development of the health services in these countries. Fortunately a number of agencies from Britain are already working in liaison with international agencies and the countries themselves towards these ends.

On the question of service abroad by British doctors it is a pity that the majority go for only a short period at a time when they are still young and inexperienced. All developing countries need doctors—a few clinicians but many "generalists" with a

community health orientation. Unfortunately the specialist career system in Britain seldom encourages service abroad unless closely attached to a secondment scheme. Family responsibilities, lack of security, poor living conditions, and loss of seniority and pension rights are all deterrents to service abroad. There is still a good case for the setting up of a system of regular secondment or rotation abroad. But credit should be given for this and career opportunities, if anything, enhanced. There is, incidentally, in many countries an even greater need for nurses and other medical staff, especially for those capable of teaching.

Finally, by all means let us train medical staff from the Middle East in Britain. But if we do this let us charge a full economic rate (that is, £20 000 per annum for a doctor). Let us make sure that they get the real community orientation that will allow them to be of most beneficial service to their countries. For those who genuinely cannot afford the economic fees, then subsidising an education is a far better form of aid than building hospitals.

If we are to sell our medical expertise abroad let this be for the creation of health and not for the perpetuation of sickness that our own service so regrettably encourages.

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Long-term postinfarction treatment with practolol

SIR,—We note with interest the comments by Drs J A Vedin and C E Wilhelmsson (6 December, p 579) on our findings of a reduction in mortality in postinfarction patients treated with practolol (27 September, p 735).

We accept that our 3038 patients were a selected population not fully "representative of the general population of infarct patients." This is an inevitable consequence of using β -adrenoceptor blocking agents, for we had to pay due regard to the risks that would be inherent in using practolol for patients with uncompensated heart failure, conduction disorders, and asthma. We believe that our results are entirely relevant to the great majority of patients for whom β -adrenoceptor antagonists are not contraindicated in the convalescent stage after infarction.

The Swedish workers note that 39% of patients who died did so after withdrawal from the trial and question our definition of end points. The criteria for reinfarction were as defined for infarction at entry. Because therapeutic activity was expected to have worn off deaths occurring later than 24 hours after the onset of a new event were counted as deaths after withdrawal unless medication had been continued, which was unusual. These conditions were laid down in the original protocol for the trial. Any other design would have seriously distorted the results. It is of importance to note that no excess of deaths occurred in the withdrawn patients who had been taking the active drug.

Some criticism was implied of our retrospective analysis of the data to investigate the possibility that some subgroups gained more than others from treatment with practolol. Surely in a trial of this size which demonstrated a striking overall reduction in mortality the use of discriminant analysis was not only

permissible but obligatory? This technique identified factors which *each independently* was associated with special benefit—namely, a pre-entry history of anterior infarction and below-average blood pressure at entry. In our paper we discussed collateral evidence, and adduced reasons, for believing that patients with anterior infarction are at special risk from late serious arrhythmias. We understand less well the apparent importance of β -blockade to patients with lower diastolic blood pressures, but it would not be justifiable to ignore statistically significant trial results.

Finally, we are puzzled by the authors' reluctance in their last paragraph to accept the arguments that the life-saving effects were due to β -adrenoceptor blockade rather than to any property peculiar to practolol. Indeed, in the first sentences of their second paragraph they claim that the results obtained using practolol confirm the results of their own small-scale trial with alprenolol.¹ With this we agree.

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¹ Wilhelmsson, C E, *et al*, *Lancet*, 1974, 2, 1157.

A place to be born

SIR,—In their haste to do battle with the medical establishment in the form of those (still) anonymous leader writers (10 January, p 55) the members of the Study Group on Home Confinement of the National Childbirth Trust (31 January, p 279) ignore our article (10 January, p 84) and imply that the choice for mothers is either a "nasty" hospital birth or a "nice" if slightly risky home confinement. The acceptance by this well-meaning pressure group that there are only two possible alternatives does mothers a dangerous disservice.

Although we consider the physical safety of mother and baby to be of paramount importance, as paediatricians and mothers we know that the important social and emotional aspects of childbirth are frequently neglected, especially in hospitals. We would like to see a change in the relationship between hospitals and mothers and agree that the latter should be directly involved in decisions concerning childbirth. One essential component of this change is that mothers must have access to knowledge currently the prerogative of the professionals, among whom we number ourselves and the study group signatories. We must be wary of the ways in which such knowledge is interpreted, as evidence can be presented to make either option attractive. For example, the signatories point out that Sweden has the lowest perinatal mortality rate, closely followed by Holland, but omit to mention that Sweden also has the lowest maternal mortality, for which several other

countries return better rates than Holland.^{1 2} If decision-making is the critical question how much real control does a mother have at home where, as we have shown in our paper, she is clearly subject to the whims and current opinions of the individual practitioner?

Finally, the National Childbirth Trust should consider the prospect that they may in the not too distant future acquire some unlikely allies in their campaign. In the present economic climate bureaucrats whose first thought is "cost-effectiveness" may decide that neither physical safety nor emotional satisfaction is the overriding consideration.

Although we do not underestimate the difficulties we believe that the aim must be a maternity service which combines the safety of hospital with the personal qualities possible in home confinement.

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¹ United Nations Statistical Yearbook, 1973. New York, 1975.

² Wallace, H M, in *Health Care of Mothers and Children in National Health Services*, ed H M Wallace. Cambridge, Mass, Ballinger Publishing Co, 1975.

SIR,—Your leading article (10 January, p 55) produced a wave of controversial correspondence that has given only a passing reference to the important observations made by our colleagues Drs C A Cox and P M Zinkin and ourselves in the same issue (p 84). As the obstetricians concerned with this article we would like to comment on the emotive, negative, and statistical arguments raised by your correspondents both in favour of and against domiciliary delivery.

The emotive factors were well illustrated by Dr C K Hudson (24 January, p 216) and Professor J Ashford and others (31 January, p 279)—the security of husband, home, and familiar surroundings; the continuity of care and the 80% preference for home confinement by women who have had experience of both home and hospital. The negative factors were equally well represented and directed, predictably, against the large, impersonal maternity unit with its "increasingly technological environment." An attempt was made to restore the balance by Professor A G M Campbell (31 January, p 279) and the medical correspondent of *The Times* (9 January, p 16). The former noted that the wishes of the mother and her attendants may be given precedence over the safety of the child and the latter pointed out the shattering effect of a home confinement resulting in a complication leading to loss of life or damage to the future welfare of mother or child.

No one can ignore the abundant statistics in favour of hospital confinement that were ably summarised in your leading article, yet it would seem that disproportionate publicity is given to diminutive studies that use inadequate statistics to show that the home is as safe as, or even safer than, the hospital for confinement. Dr Hudson refers to just such a publication.¹ Examining the original article more closely, it is apparent that perinatal mortality rates were used as the main supportive argument. His series of 671 cases was broken down into three categories, the smallest of which included 32 cases, from which a perinatal mortality rate per 1000 live births was derived! Discounting this particular example, it is our opinion that the perinatal mortality rate is a very crude measure of the quality of obstetric care, as it records only the ultimate catastrophe of death in a group of human beings renowned for their ability to survive extremes of anoxia and clumsy obstetric manipulations. Applying these criteria to the series reported in our paper we should congratulate the doctors and midwives on a perinatal mortality rate

of 0 per 1000. Nevertheless the study in depth revealed some 20% of babies who had been exposed to unreasonable hazards. The National Perinatal Mortality Survey emphasised the importance of social class and geographical location. In Dr Hudson's series no figures were produced for the former, and the influence of the latter could be deduced only from his address in Tadley, Hants. No grounds were given for the original selection of cases, but it was noted that 82 changed to a hospital booking before the onset of labour. This left a final highly selected group of 589.

We now quote his own observations on this group, not as a criticism of a person keen enough to publish his figures but only to illustrate the size of the gap that still exists between the factors that alarm the consultant as opposed to the general practitioner obstetrician. The series included one pair of undiagnosed twins, two forceps deliveries, and four retained placentas. In addition there were 32 cases "transferred in labour due to delay in the first or second stage or for fetal distress," and 24 patients who had a post-partum haemorrhage, though "only five of these gave rise to sufficient anxiety to call a flying squad." Unfortunately, no observations were made on the condition of the babies at birth and there was no reference to resuscitative measures. The actual number of these cases at risk was not recorded and some may well have had two problems. However, if we take a reduced figure of 60 cases this represents roughly a 10% risk to mother or child. It must surely be questionable whether this risk is balanced by the emotional advantages of the home environment.

In our paper, in criticising the selection of cases for home confinement, we emphasised the fact that strict application of accepted "risk" criteria would not have reduced the hazards to the baby. Professor Ashford and his 18 colleagues from the National Childbirth Trust suggest that demands for 100% hospital confinement remove the mother's freedom of choice. May we respectfully suggest that it is our professional inadequacy in the field of prediction rather than our dictatorial personalities that prompts us to recommend this course? Every advance in obstetric and neonatal management leads us further from the home. However, there is no reason why the benefits of the home should not be introduced into the hospital.

It is interesting to reflect on the reasons why an article attacking domiciliary deliveries should provoke such controversy when two months previously the same unit published an article² outlining a community obstetric project which answered almost all the criticisms made by your correspondents, yet, despite its free distribution to every member of the medical profession, it was received with almost universal disinterest. It outlined a hospital service which combines continuity of care, homely surroundings, and family participation with all the technology and expertise of the large maternity unit and without even interfering with the contract between general practitioner and patient.

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¹ Hudson, C K, *Practitioner*, 1968, 201, 816.

² Matthews, A E B, Shearman, W H, and Steffens, E M, *Health Trends*, 1975, 7, 69.

SIR,—I read with increasing annoyance the letter from the members of the Study Group on Home Confinement (31 January, p 279). I would take issue with them on two points.

Firstly, they misquoted references in your leading article (10 January, p 55), inferring that a 50% domiciliary confinement rate in Holland did not adversely contribute to their