SIR,—In your leading article (27 March, p 729) you state that doctors “must, whenever possible, ensure that our patients are made to feel that they have taken part in the decisions that affect their lives.”

The real need is that patients must actually take for themselves the basic decisions that affect their lives. To this end the doctor's role must be to provide the relevant information in a way that it can be understood and to support the patient with advice, short of actually taking the decision for them.

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SIR,—The new spirit of critical assessment which is now being applied to selected aspects of current childbirth management has not, it seems, yet been extended to include the all-important and generic question of the terms in which the medical profession views the relationship between patient and obstetrician. I refer particularly to your leading article “Induction of labour” (27 March, p 729). Your conclusion here is that recent media interest in obstetric practice may be evidence that “doctors were not adequately communicating their intentions to their patients and hence the public.” You go on to assert that “the modern woman still wishes to have faith in her doctor—to believe that she can hand over to him, without anxiety, the care of herself and, more important, of her baby.”

Such statements may very well describe what it is that pregnant women feel about the medical decision to induce labour. But on the other hand they may not. Surely these claims are in the nature of hypotheses about what it is that pregnant women want from their obstetrical management. (And they are thus analogous to the hypothesis, in the light of which many decisions to induce must have been taken, that induction is safer for baby and/or mother: a hypothesis which recent evidence questions.) Hypotheses need testing; they do not become convincing simply through repetition. But, more fundamentally, these particular hypotheses are derived from a basic model of the doctor-patient relationship in which patient dissatisfaction is due simply to non-communication by the doctor of his intentions. Is this model appropriate to the interaction which takes place between patients and their obstetricians today? Again, we do not really know until we have found out.

I write as a medical sociologist carrying out a three-year study of childbirth (financed by the Social Science Research Council) at one London hospital. My own data are still in the process of collection, but they clearly question the assumption that a prescription for more explanation on the doctor's part will succeed in curing the syndrome of patient dissatisfaction. Pregnancy and childbirth are not illnesses, and the criteria for induction, although sometimes clear cut, often are not. This is obvious to many women, who know that induction rates vary a good deal between different hospitals; they are thus aware that induction is to some extent a matter of “policy.” There are also differences within hospitals and between consultants in the criteria chosen. “Postmaturity” means different things to different doctors, and this fact can be gathered not only from perusal of a medical textbook but also simply by sitting in an antenatal clinic.

Of course there are some women who want to be induced; it is the articulate group who don't want to be whose voice is publicly heard, and there may be many women in between these two extremes who don't really mind. But I would argue that sensitivity to these differing outlooks is important and that it will emerge only when unproved assumptions about doctor-patient communication are regarded as hypotheses and are discarded and replaced where necessary. As Miss Margaret Stacey (27 March, p 771) rightly argues, more attention needs to be paid to sociological and psychological aspects of childbirth. The doctor's own interaction with patients is one such essential area of scrutiny.

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SIR,—Professor J Bonnar (13 March, p 652) suggests that induction of labour using oxytocin stimulation will increase the caesarean section rate, but there is little evidence to support this view. The national statistics for England and Wales showed an increase in the incidence of induction of labour from 15% in 1965 to 33% in 1972¹; during the same time the caesarean section rate showed virtually no change, being 5.0% in 1965 and 5.3% in 1972. Even the figures that Professor Bonnar quotes from the National Maternity Hospital in Dublin do not support his own case. At that hospital the induction rate in 1970 was 36% and fell to 21.2% in 1974, but despite this large fall the caesarean section rate rose from 4.2% to 5.0% and the forceps rate from 7.7% to 10.5%.

Professor Bonnar invites us to compare the caesarean section rates at the Glasgow Royal Maternity Hospital and the National Maternity Hospital in Dublin. We suggest that such a comparison would be of doubtful value without knowing whether the two have identical obstetric populations. The difficulties of comparing two separate maternity hospitals can be illustrated from Professor Bonnar's own data from Dublin and Oxford. In 1968 Oxford had an induction rate of 32% and a section rate of 8.3%. In 1971 Dublin had an almost identical induction rate of 31% but a section rate of only 5.0%. Clearly the section rate is dependent on many factors apart from the incidence of induction.

In 1973, the induction rate at the Glasgow Royal Maternity Hospital was 33% and the caesarean section rate 13.6% compared with an induction rate of 15% and a section rate of 7.4% in 1968. Increased use of caesarean section for fetal distress and a higher incidence of elective section in high-risk cases was responsible for the rise in the number of abdominal deliveries. It is noteworthy, however, that the number of deaths in babies over 2500 g associated with labour asphyxia fell from 3.9 per 1000 in 1968 to 1.9 per 1000 in 1973.² Following greater use of fetal blood sampling, as suggested by Edington and his colleagues,³ the incidence of section fell to 12% in 1975 despite a further increase in the induction rate to 42%. It would seem likely that the best results will be achieved by a combination of timely intervention and intensive fetal monitoring.

Our previous study on induced labour⁴ is quoted by Professor Bonnar as showing a section rate of 6.1%, but he made no mention of the essentially comparative nature of this

trial. In this study prospective random allocation was used to select two strictly comparable groups of patients—an approach we strongly recommend—and we found a lower incidence of caesarean section in the group with the higher incidence of induction.

Finally, we disagree with Professor Bonnar when he says that intervention by induction cannot be expected to improve results. In the two years 1966-7 the Glasgow Royal Maternity Hospital had an induction rate of 13% and 40 unexplained perinatal deaths in mature babies (a rate of 3.2 per 1000). The great majority of these deaths were antepartum stillbirths after more than 40 weeks' gestation and were therefore potentially preventable by timely induction of labour. In the two years 1974-5 the induction rate was 42% and the unexplained deaths in mature babies had fallen to three (a rate of 0.37 per 1000).² This difference is highly significant ($P < 0.001$). We hope that more units will undertake controlled prospective studies because only in this way shall we have information on which to evaluate critically the benefits and dangers of induced labour.

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¹ *Annual Report of the Chief Medical Officer of the Department of Health and Social Security for the Year 1973*, p 79. London, HMSO, 1974.

² McIlwaine, G M, et al. To be published.

³ Edington, P, Sibanda, J, and Beard, R W, *British Medical Journal*, 1975, **3**, 341.

⁴ Cole, R A, Howie, P W, and Macnaughton, M C, *Lancet*, 1975, **1**, 767.

Help for families of severely handicapped children

SIR,—The parents and siblings of a child who is severely mentally and physically handicapped suffer a variety of stresses and social inconveniences. The recent policy of managing these children in the community and of phasing out the big institutions for the subnormal have increased these stresses. Social service departments have not been able to cope with the new demands made on them. We are attempting to provide some help at weekends and during the school holidays, at no extra cost, using hospital beds in a large children's unit. Children are selected for admission with the help of social workers working with these families on the following criteria: (1) severity of handicaps; (2) the home situation; and (3) absence of any harmful effects of separation on the child.

The children's surgical ward is partially emptied at weekends by the early discharge of children operated on during the week. As the ward has to be kept staffed for the few remaining patients I felt we could use these empty beds more effectively. Two or three handicapped children are admitted on Friday afternoon from the special day school by prior arrangement with the parents and school. They bring with them any drugs in labelled containers, a favourite toy, any special items of clothing (for example, large-size plastic pants), callipers, wheelchairs, and a list of likes and dislikes and idiosyncrasies. Over the weekend they are cared for and played with by the paediatric nursing staff. On Monday

morning they are picked up by their usual transport which takes them to school. The parents are specifically asked not to visit and are told that they and the other siblings must use this time to do the things they could not do ordinarily as a family group with the handicapped sibling. The admissions are on a rota basis to give the family a break once in 6-8 weekends. The rota has to be flexible to some degree and also has to be planned well ahead. During the school holiday months of July and August the weekend rota is discontinued and we have these children in for 1-2-week periods in the surgical and medical wards of the children's unit.

This service is greatly appreciated by the families. I feel sure that the marriage breakdown rate, which is so high in these families, will be lessened. The cost to the NHS in staffing, food, laundry, and transport is negligible. The view that this type of service is the responsibility of the social service department is, in my view, wrong. The co-operation of our major caring professions is essential to provide a better service for these families by utilising to the maximum those facilities that exist, wherever they may be. I would like to encourage other district hospitals to try this scheme.

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International units and standards in immunology

SIR,—Until the value and importance of using international standards have become generally accepted it seems necessary from time to time to remind the scientific community of their purpose and even, perhaps, of their existence. A number of international standards and reference preparations relevant to immunologists have already been established by the World Health Organisation (WHO), and others are currently being prepared on the advice of and in collaboration with the Standardisation Committee of the International Union of Immunological Societies or of other interested bodies such as the International Agency for Research on Cancer. A list of these substances is given below. They cover materials and reagents of which the activity cannot normally be measured by physical or chemical means alone and their purpose is to serve as standards containing an accurately defined amount of a stable preparation of the material in question with which samples containing unknown amounts of similar material (with the same activity) can be compared.

For the very reason that the quantity of material cannot be measured except in terms of its activity in a given test the standards are assigned a value in units. The value of a unit is arbitrary but is chosen to be convenient for the purpose and to take account of any already accepted units—for example, the standards for human immunoglobulins IgG, IgA, and IgM, which consists of ampoules containing freeze-dried serum from a pool of many normal adult human sera, has been assigned values of 100 U of each activity per ampoule. Comparisons of this standard by immunochemical means with purified preparations of the various immunoglobulins have indicated that units of IgG, IgA, and IgM are approximately equivalent to 80.4, 14.2, 8.47 μ g respectively (*J Immunol.*, 113, 428 (1974)). Although it might seem that

accurate equivalents for such units could readily be assigned, in practice their value is found to depend on the purity, homogeneity, and physical state of the preparations of isolated Ig used for comparison. The unit provides, therefore, the one invariable quantity against which unknown materials can be evaluated using different tests in different laboratories.

*Some international and national standards and reference preparations already established and available to all or freely available**

Human IgG, IgA, IgM
Human IgE
Human IgD
Rheumatoid arthritis serum (for rheumatoid factor)
Anti-nuclear-factor serum (homogeneous)
 α_1 -fetoprotein
Streptokinase-streptodornase
Tuberculin PPD
Carcinoembryonic antigen

*For a complete list see *Biological Substances, International Standards and Reference Preparations*. Geneva, WHO, 1975.

Further standards in preparation

Human serum proteins (for measurement by any method including nephelometric techniques)
Complement components (functional assay)
Candida antigens
Allergens (various)
Human fetal proteins (additional to α_1 -fetoprotein)
Fluorescein-conjugated anti-human Ig
Fluorescein-conjugated anti-human IgM
Fluorescein-conjugated anti-human IgG
Double-stranded DNA
Immune complexes

Similar considerations apply to other materials such as α_1 -fetoprotein, the standard for which consists of accurately measured amounts of pooled cord blood (in which it is assumed that the α_1 -fetoprotein is similar to that in blood samples from pregnant women or patients with suspected liver cancer, for example, on which estimations are required to be made). In the case of some reagents, such as fluorescein-labelled anti-human Ig or IgM, the standards permit comparison of the performance in a variety of immunofluorescence assays of other preparations intended for similar purposes.

Every standard material has been evaluated by recognised expert laboratories in several countries, and no standard is established unless there is agreement about both its suitability and usefulness. Standard materials are available from national control authorities in countries where these exist, free of charge (in the UK this is the National Institute of Biological Standards and Control, Holly Hill, London NW3 6RB), or directly from the Division of Biological Standards of the WHO in Geneva. In order to conserve these standards (which in terms of work done on them are worth their weight in gold) they should in general be used to calibrate local working standards. We hope that any investigators who do not already make use of them will do so, and that editors of journals should insist that where standards exist any measurements which are reported should have been made by comparison with such standards and the results recorded in international units.

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Iron deficiency and restless legs

SIR,—I am writing to draw attention to the surprising lack of general awareness of the association between iron deficiency and the distressing condition of restless legs. Sixteen years ago Ekbom¹ reported that 25% of affected patients have a low serum iron and that 24% of those with iron deficiency anaemia have restless legs. Even earlier Nordlander² had shown that in these circumstances iron therapy cured the symptoms.

A rapid survey of textbooks of medicine and haematology shows that while all dutifully mention pica as a symptom of iron deficiency, the common restless legs syndrome is virtually ignored or is confused with the paraesthesiae of peripheral neuropathy. Recent examples of this association in my own experience include a doctor's wife who, among other disabilities, had been unable to visit the theatre for 15 years because she could not sit still; a man of 28 in whom restless legs was the only symptom of iron deficiency due to blood loss; and a woman being treated for malignant disease whose symptoms had been misinterpreted as those of carcinomatous neuropathy. All obtained rapid relief of symptoms with oral iron. The majority of patients with restless legs are, unfortunately, not iron deficient, but those that are can be cured of this miserable condition.

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¹ Ekbom, K, *Neurology*, 1960, **10**, 868.

² Nordlander, N B, *Acta Medica Scandinavica*, 1953, **145**, 453.

Specialties within community medicine

SIR,—Dr A St Leger (20 March, p 709) raises the question of the form of specialist training that may be required for epidemiologists wishing to practise as recognised specialists in the member countries of the EEC. Epidemiology is not listed in article 5 of the second directive (75/363/EEC) regulating the nature and length of specialist training. Community medicine is listed in the second group and it is stated that the minimum length of specialised training must be not less than four years. However, at present the specialty is recognised only in the UK and Eire. A number of bodies (among them the General Medical Council, the Councils for Postgraduate Medical Education, and the Joint Committee on Higher Medical Training) are currently considering the relationships between the standards of specialist training required by the EEC directives and the standards already accepted by the joint committees on higher training. The question of the formal recognition of specialties within community medicine will have to be kept under review in the light of developments.

Unfortunately much of Dr St Leger's letter conveys a misleading account of the examination¹ and training requirements² of the Faculty of Community Medicine (this is the correct title, not Faculty of Community Physicians). The faculty does encourage the development of special interests within the practice of community medicine; a very wide range of subjects has been accepted in relation to Part II of the examination; experience and responsibility in areas of special interest are readily