returning to the use of complicated interview forms and then having the data from these forms entered into the computer by a skilled keyboard operator.

Only when the problems of a particular application have been resolved and the rewards of the application become clearly measurable will a microcomputer system be accepted, whether this be in an antenatal clinic or elsewhere in a hospital.

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Drug treatment of premature labour

SIR,—I read your leading article (8 August, p 395) on the drug treatment of premature labour with great interest. I suggest that mention should be made of the glucogenic effect of β-sympathomimetic drugs,[1] which makes the intravenous administration of these agents extremely hazardous in diabetic mothers.

Two important questions also remain unanswered. Firstly, for how long is it safe to continue a course of intravenous β-sympathomimetics; and, secondly, is there any restriction on the number of intravenous courses which may be administered to patients with recurrent premature labour?

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[1] Beard RW. *Preterm labour. Proceedings of the Fifth Study Group of the Royal College of Obstetricians and Gynaecologists.* London: Royal College of Obstetricians and Gynaecologists, 1977;203-11.

**Beta-sympathomimetic drugs can indeed induce hyperglycaemia and ketoacidosis in diabetic mothers. If they are given to pregnant diabetics blood glucose concentrations must be checked regularly and insulin dose adjusted accordingly.[1] We cannot be dogmatic about the maximum duration or number of courses of intravenous β-sympathomimetic drugs. If the uterus continues to contract persistently after β-sympathomimetics have been given, the cervix will usually dilate and delivery will follow. If contractions persist in the absence of cervical dilatation, the diagnosis of premature labour should be reviewed. The prolonged or recurrent use of intravenous β-sympathomimetics may cause unpleasant side effects sufficient to stop treatment.

[1] Steel JM, Parboosingh J. *BMJ* 1977;i:880.

The right to live and the right to die

SIR,—It is astonishing to see from the letter of Professor R S Illingworth (29 August, p 612) that he still believes in the myth that if you operate on spina bifida babies they live and if you do not operate they are "allowed to die." It has become increasingly apparent to doctors in this country and in the United States that the so-called policy of selecting out those babies who are going to die has a built-in insurance policy, guaranteeing the correctness of the forecast by giving the babies heavy doses of hypnotic drugs.

The reports of considerable numbers of cases from Liverpool and also from Queen Elizabeth's Hospital for Children, Hackney, of severely affected babies with 30-50% survival without neonatal operation and with simple ordinary good baby care simply serve to emphasise what happened in the unit of Dr Franc Ingraham in Boston, Massachusetts, over 30 years ago. None of those babies had neonatal surgery; after one or two weeks they were sent home to be looked after by their families and by the paediatrician in a simple way with normal baby management. I myself have seen many of these babies who attended once a month at the orthopaedic and neurosurgical clinics until the swelling on the back was removed at about 18 months or 2 years of age.

Professor Illingworth has consistently taught for many years that drug therapy, even in normally accepted doses, should not be started unless there are clear indications for it. Although I would regard excessive twitching or convulsions as indications for sedation these symptoms are unusual, and I have never known one of these babies unable to sleep. Moreover, these hypnotic drugs are usually started on the *first* day after the decision is made not to operate on the infant, and the dosage is often eight to 10 times that recommended in standard reference books. I am quite sure that Professor Illingworth is not taken in by the subterfuge that these hypnotic drugs are given to relieve pain, for in the neonatal period when this excessive sedation is given there is seldom any spontaneous pain.

The main purport of Professor Illingworth's letter, however, seems to be to cast doubt on the integrity of the organisation Life by mentioning it in the same breath as McCarthy and secret police. I have the honour to be a vice-president of Life, but long before it came into existence I held the view that it is wrong directly and on purpose to take the life of an innocent human being—in this case a child. That also happens to be the law of the country; and if either he or I were to see one of our colleagues clearly taking the life of an infant in this way we would be under an obligation to try to prevent it by remonstrating with the aggressor or reporting the matter to the authorities. If either of us saw a parent deliberately starving a baby so as to cause its death and kept quiet about it we would be open to severe criticism, and we are not entitled to assume that doctors are above the law.

It is unworthy of Professor Illingworth to trail the red herring that surgeons will be "spied on" and that the specialist in the intensive care unit will be reported if he decides that a patient with gross brain damage cannot benefit from a ventilator and switches it off. Life is rightly worried about those obvious, clear-cut actions which bring about, and are intended to bring about, the death of the infant; and, believe me, there are quite a number of these which continue today.

If we doctors will not put our house in order, we must not be surprised if others are prepared to report what seems to be a serious breach of the law.

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SIR,—Whatever might be one's ethical view of the issues in the recent case of the baby with Down's syndrome, discussed in your leading article (29 August, p 569) and correspondence columns (p 611), it is abundantly obvious that there is a lack of objective information about the quality of life of such children living at home and that of their families.

The Down's family project has now collected information on 1300 individuals with Down's syndrome living at home in Scotland under the care of their general practitioner. At present we are carrying out a prospective study comparing the morbidity of 200 children with Down's syndrome and their parents with that of 200 normal children and their parents controlled for age, sex, social class, and family size and on the list of the same family doctor.

Hopefully, this study may help to produce guidelines for those advising the parents of newborn infants with Down's syndrome about the kind of life which such families might expect and may help to modify advice that often dates from a view of Down's syndrome obtained not from living families but from undergraduate demonstrations.

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SIR,—With reference to your most informative leading article "The right to live and the right to die" (29 August, p 569) perhaps the present confusion of responsibility between patients, doctors, and courts could be resolved if guidelines were formulated by all the royal colleges on what are to be regarded as ordinary and extraordinary treatments in these distressing circumstances. The onccept has been with us for many years and we still have only very general rules for our guidance.

It may be that general agreement will not be possible, in which case the courts will have to decide, as in the case of the baby Alexandra.

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Audit in renal failure

SIR,—The Medical Services Study Group of the Royal College of Physicians in its report on deaths from chronic renal failure under the age of 50 (25 July, p 283) drew attention, among other things, to the large contribution made by diabetic kidney diseases to renal failure deaths. It also illustrated our apparent therapeutic impotence in dealing with the problem. Of 19 patients reported as dying from diabetic nephropathy, only two were offered renal support or treatment: "diabetic complications" (retinopathy ranking high among them) were the dominating cause for withholding dialysis and transplantation. The study group concluded that the lack of machines or facilities could not be held responsible for these and other deaths in renal failure, which were seen as an inevitable consequence of the underlying disease. Diabetes mellitus was cited as an example in support of this view.

Although this may have been true in the past—indeed, the early reports of renal physicians attempting to treat diabetic nephropathy made dismal reading[1]—we must take care *not* to be trapped in passive and fatalistic clinical attitudes to the diabetic in renal failure as conditions change. There is good reason for urging a more hopeful and active approach. For example, severe visual impairment due to diabetic retinopathy, often taken as a major contraindication to dialysis and transplantation can now be delayed or even prevented by timely treatment with retinal photocoagulation.[2] The number of diabetics in whom blindness complicates advanced renal disease can be expected to show a notable decline. Even a little residual vision