age of 70 where histological diagnosis may occasionally be difficult, for in the eighth to tenth decades many senile plaques without neurofibrillary tangles may occasionally be present in demented subjects, and this finding, though uncommon, is found in some non-demented individuals. At any age, however, numerous neurofibrillary tangles in the neocortex are restricted to the demented population, so the biopsy diagnosis of Alzheimer's disease is possible in the great majority of cases at any age.

Cerebral biopsy is not justified in this disorder more because of ethical reasons and lack of effective therapy rather than difficulties with interpreting the neuropathology.

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Authors of the world, unite . . .

SIR,—We would like to take up the suggestion of your leading article (12 June, p 1726) and urge both authors and readers to unite—against the Vancouver style of referencing. As readers and authors we find the Harvard system, giving authors and date in the text rather than a number, more informative, a great deal easier to organise, particularly when revising drafts, and altogether preferable. An alternative is to permit authors to submit references according to their own preferences, and then for the subeditors to redesign them for publication in their house style. This would afford maximum freedom to both parties. Obviously there are advantages in journals adopting a uniform system—but if journals try to inflict on authors a system with so many disadvantages and difficulties then they will find resistance and delays in acceptance.

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SIR,—In your leading article boost for the Vancouver style (12 June, p 1726) you say readers prefer the numbering system to the Harvard style of giving references by author's name and year. This is not true of serious readers, who are recurrently maddened by the errors of the numbering system which foil their attempts to trace specialised information. Mistakes of year and page number or volume number, and even the wrong paper, creep into every published list of references, through typing errors, rewriting errors, subediting errors, and so on. Scientific papers go through several drafts, are altered to please specialist advisers, processed, and references change order, are excised, or reinserted. With the Harvard system one can crosscheck author's name and year between text and reference list at every stage, but with only an index number in the text anything can happen and not infrequently does. With a wrong number one can go no further, but with a wrong name or year—that is, not squaring with the references—one can at least try the *Index Medicus* for ultimate enlightenment.

About a dozen of us, the editors of *British Journal of Psychiatry*, all serious readers and mostly serious authors of scientific papers and books too, some time ago discussed the numbering system when you were earlier urging us all to adopt the Vancouver style. We could see that it suits editors, keeps the page clean, and reads smoothly, but as readers who sometimes study a subject in depth we were unanimous in finding the Harvard style far preferable. Fewer exasperating errors, and, in spite of what you say, having the author's name and year before one's eye instead of having continually to flip 10 or 15 pages on to glance at the references, and back again, is also an advantage.

Do we really have to accept an inferior system just because a group of American journals have already adopted it? What authors want is simply an agreed system. What serious readers want is the most helpful and accurate system. Is Vancouver immutable, for all time? How about remembering the readers at your next international editors' meeting and going over to Harvard?

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***Some (though certainly not most) authors and readers may prefer the Harvard style of references to the numbering system, but has Dr Crammer any evidence that in articles submitted to journals references in the Harvard style are noticeably more accurate than numbered references? We can only repeat that, intelligently used, the numbered system is just as informative as the Harvard (even when the references have gone wrong); and the benefits of uniformity for journals, authors, and readers, outweigh the difficulties—many errors in references creep in because references have to be reordered for different journals. Finally, the American journals had the foresight to start the move towards uniformity, and it is less than helpful for Dr Crammer to criticise them: what all editors should be doing is to abandon their chauvinistic prejudices and accept a universal system willingly and soon rather than grudgingly and belatedly.—ED, *BMJ*.

SIR,—What a relief to read that there is hope for uniformity in manuscripts for journals—"Authors of the world, unite . . ." leading article (12 June, p 1726) by Dr Stephen Lock. Imagine my further pleasure: "Uniform requirements for manuscripts submitted to biomedical journals" (12 June, p 1766). I quote from the summary of requirements: "Type the manuscripts double spaced . . ." But then, oh calamity, on turning to "Instructions to Authors" in the self-same edition of the *Journal*: "Manuscripts should be typed treble spaced. . . ."

Alas, there is apparently still total confusion despite the well-meaning words—perfidious *Brit Med J*, *BMJ*, *British Medical Journal*, *Br Med J*, etc.

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***There are minor differences between the Vancouver style and our own Instructions to Authors, but the documents serve slightly different functions. As our leading article pointed out, the Vancouver style was designed not to standardise the format for editors but to make life easier for authors. Authors who may need to submit their paper to more than one journal should find the Vancouver style particularly useful because they will not have to retype it or change its format to conform with the requirements of different journals. Authors who intend to submit an article solely to the *BMJ*, or who have been commissioned to do so, may prefer to follow our own instructions. In short, though we may prefer treble spacing, we will happily consider a paper that conforms to the Vancouver style and has only double spacing.—ED, *BMJ*.

Review of maternity patients suitable for home delivery

SIR,—The statistics in Dr E A Dixon's article (12 June, p 1753) are very interesting and bear closer inspection. Of his 278 patients originally suitable for home delivery, 41 developed antenatal complications and would have been transferred to hospital management before the onset of labour. Two patients went into premature labour and would have also been transferred. This leaves 235 patients whose labour would have been managed at home.

Safe intrapartum transfer would have been possible for the seven patients requiring intervention for prolonged labour (five forceps deliveries and two caesarean sections), though the five requiring forceps could have probably been delivered safely at home by the flying squad. Forceps were also used for the five infants who developed heart abnormalities during the second stage of labour, which might have been missed if continuous monitoring had not been used. In the event only two of these required resuscitation, and the supervising GP should be able to intubate infants needing it (13 altogether in this study). In fact, in many isolated consultant units this skill is not immediately available. The other three infants who demonstrated fetal heart "abnormalities" were quite probably not distressed. Five patients received postpartum transfusion; for them transfer to hospital of mother and baby would have been non-traumatic.

Serious differences of outcome between hospital and good home management might have occurred in only three cases. Two are the infants with heart trace abnormalities who would seem to have been in distress. At home without fetal monitoring these might have been at risk. The third is the patient developing spontaneous rupture of the membranes and prolapse of the cord, who might have done so at home wherever she was booked. If the prolapse actually occurs in the hospital the prognosis is, of course, much better.

Thus seven patients in 235 "home deliveries" would probably have been safely transferred intrapartum, although five of these might have been delivered at home by the flying squad. Five patients would have been transferred postpartum for blood transfusion. This leaves three patients for whom home management might have had serious consequences—a complication rate of 1·28%.

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What's wrong with the funding of cancer research?

SIR,—I appreciate the trouble that Mr D I Williams and his colleagues of the Imperial Cancer Research Fund (ICRF) took to explain their reasons for restricting the use of the large amount of money available to the fund to long-term projects for its own workers (15 May, p 1471), but I would like to make some comments. I would have done this earlier,

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