of grade 3 appearances in those whose placental grading was known by the clinician (about a quarter of all inductions in women with a grade 3 placenta) was balanced by more inductions for post term pregnancy in those whose grading was not known by the clinician (about 40% of inductions in women with a grade 3 placenta). This partly, but not totally, explained the observed difference between the total trial groups in the gestation at delivery. We recognise that there are other mechanisms by which knowledge of placental grading might have had an effect on gestation at delivery, but we believe that those proposed by Mr Fitzpatrick are unlikely to have been the cause.

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Comparisons between written and computerised patient histories

SIR,—Dr Martien J Quaak and colleagues compared written and computerised patient histories in many different ways and found that doctors preferred the written history and came to different conclusions when assessing information provided by computer and by the conventional written history. It seems to me that their programme was designed to cover practically all presenting symptoms in a medical outpatient clinic and that this explains the fairly poor performance of the computerised history system. We found that computerised history taking for specialist applications (antenatal care, termination of pregnancy, and infertility) was successful and widely acclaimed by doctors and patients.^{1,2} These systems provided not only more information but more pertinent and relevant information, as assessed by independent experts.^{3,5} Our findings were much less positive, however, when we expanded our infertility system to cover all gynaecology outpatients.⁶ We too had a complex branching programme of over 400 questions, and when this was extended to cover the whole of gynaecology we also found that patients often could not express all of their complaints. Doctors were also less happy with the history because of overreporting of less important symptoms.

The conclusion I have reached as a result of my work with Professor Chard, which this paper reinforces, is that computerised data entry systems work best when covering a fairly well defined subject, with a limited (albeit large) and fairly well organised information set. Extension of such systems to deal with the almost infinite complexity and subtlety of a general outpatient department is less successful and may represent an excessive attempt to codify a largely intuitive process. This is not to say that computer interviewing systems do not have a useful place in medicine but mainly to draw attention to the limits of these applications, which are beautifully discussed by Dreyfus and Dreyfus in their recent book.⁷

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A shocking American report with lessons for all

SIR,—Professor T J Hamblin (11 July, p 73) correctly draws attention to the need to inform subjects fully before their consent is obtained to take part in any sort of clinical study. This is particularly important when the study offers no benefit to the subject.

We agree entirely with his concern that clinical studies should be conducted properly, and we also support the Royal College of Physicians' report *Research on Healthy Volunteers*,¹ which is concerned with protecting the interests of the healthy volunteer. These interests and those of patients are the same wherever the study takes place.

There is a tendency, both in the report and in Professor Hamblin's article, to suggest that studies may be acceptable in academic institutions but not in commercial institutions. Provided the interests of the subject or patient are adequately safeguarded, with the provision of adequate facilities, then a study is just as justified in a commercial institution as in an academic environment. It is dangerous to perpetuate the myth that subjects' interests are automatically protected in an academic environment and exploited in a commercial one. Our experience is that the contrary might be the case.

We would argue that it is quite reasonable to use as subjects employees of the firm performing the experiment as the firm has a particular interest in maintaining their wellbeing. Any mishap would make it more difficult for the firm to obtain other volunteers. The firm can maintain a panel of volunteers, the employee's health record is known to the company, the company is able adequately to supervise long term follow up (except in the case of staff who leave), and it is possible to get access to the volunteers' general practitioners for their consent. This is surely preferable to recruiting from a transitory population. It is suggested that undue pressure may be put on staff to take part. In our company the reverse is true as managers are most reluctant to release their staff as volunteers as this prejudices the normal work of research programmes and production schedules.

In the interests of the volunteer we believe that the same standards should be applied to both academic and commercial establishments carrying out volunteer studies.

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1 Royal College of Physicians. *Research on healthy volunteers*. *J R Coll Physicians Lond* 1986;20:4.

Setting standards

SIR,—It is most encouraging to see Mr R C L Feneley's concern about the cost effectiveness of medical products (25 July, p 267).

There are now 240 published British standards for medical products, and a further 400 are being

developed under the auspices of the health care standards committee of the British Standards Institution. Many of these standards are generally applicable, and there are now few products that are not covered by a standard of some kind. Most of the standards are concerned with safety, and compliance with them should be a prerequisite of any product being considered for purchase. This message has been signalled to the National Health Service for many years and is being pressed home even more forcefully today.

The choice of the best value for money from all of the products that comply with the standards is one that only the user can make, and he can make a better choice if he is well informed. The Department of Health and Social Security spends about £2m each year on evaluating medical products, and the results are published in *Health Equipment Information* and in the "blue cover" series of reports. This programme can, of course, cover only a small proportion of the items on offer, and it concentrates on those on which most money is spent, high priced items, and new devices. For the rest, the user must inform himself as best he can, which generally means cooperating with his technical and commercial colleagues in the National Health Service to set his requirements realistically and to assess how well the competing devices match his requirements.

The National Health Service Management Board is acutely conscious of the £1 billion spent each year on medical products. Its desire to see this money used to full advantage is clear from the formation of the procurement directorate and the appointment of the director of procurement to the board. One of the important tasks now being done by the procurement directorate is the production of an option appraisal manual for medical equipment purchases, which will be published before the end of this year.

The procurement directorate is particularly concerned to promote closer cooperation between supplies officers and clinicians to obtain best value for money, and I hope that Dr Feneley's letter will help to promote that cooperation.

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Points

Tower Hamlets' health

Professor J G GRUDZINSKAS (The London Hospital Medical College, London E1 1BB) writes: Your Medical News report (13 June, p 1554) quoted the *Tower Hamlets Health Inquiry* as stating that perinatal and infant mortality rates are high in Tower Hamlets and that those for Bengalis are twice the national average. The *Tower Hamlets Health Inquiry* does indeed give these figures, but they refer to the country as a whole. In the Tower Hamlets district, as the report states, the "perinatal mortality rate declined to 9.7 per 1000, which compares favourably with the average of 9.8 for England and Wales in 1985." This is the first time in at least a decade that the perinatal mortality rate has been at, or below, the figure for England and Wales. This low figure has been sustained throughout 1986 and 1987, and the perinatal mortality rate for our immigrant Bengali patients, who constitute about half of our obstetric population, has been lower than that in our indigenous population in recent years. These figures are the result of the changes that have occurred in the maternity service in recent years, which may well provide a model for other services with large immigrant populations. They include the appointment of more midwives with greater flexibility for deployment into the community and Bengali speaking maternity aides. Nevertheless, the energy and skill of the midwives and young doctors who have succeeded in achieving an excellent standard of