

extensive work already undertaken in measurement in chronic disabling conditions.<sup>8</sup> Most of this is now based on the World Health Organisation International Classification of Impairments, Disabilities, and Handicaps (WHO ICIDH) model, which offers a moderately coherent system for measuring outcome in disabling illness.

In the meantime doctors should strongly resist attempts to use QALYs as a means for allocating resources. Their use simply sanitises and provides pseudoscientific justification of decisions on resource allocation, and doctors should not be party to this particular deception. Instead health authorities should say to the affected patients, "We have decided that your disease cannot be treated because society judges that the personal distress caused to you does not warrant resources when compared with the distress caused by other diseases, even though we have not assessed your distress in any way."

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- 1 Carr-Hill RA, Morris J. Current practice in obtaining the "Q" in QALYs: a cautionary note. *BMJ* 1991;303:699-701. (21 September.)
- 2 Mor V, Guadagnoli E. Quality of life measurement: a psychometric tower of Babel. *J Clin Epidemiol* 1988;41:1055-8.
- 3 Wade DT. Measuring the quality of life in acute stroke. In: Amery WK, Boussier M, Rose FC, eds. *Clinical trial methodology in stroke*. London: Baillière Tindall, 1989:166-76.
- 4 Read JL, Quinn RJ, Hoefler MA. Measuring overall health: an evaluation of three important approaches. *J Chronic Dis* 1987;40(suppl 1):7-21S.
- 5 Rosser R, Kind P. A scale of valuations of states of illness: is there a social consensus? *Int J Epidemiol* 1978;7:347-58.
- 6 Sackett DL, Torrance GW. The utility of different health states as perceived by the general public. *J Chronic Dis* 1978;31:697-704.
- 7 Slevin ML, Plant H, Lynch D, Drinkwater J, Gregory WM. Who should measure the quality of life, the doctor or the patient? *Br J Cancer* 1988;57:109-12.
- 8 Wade DT. *Measurement in neurological rehabilitation*. Oxford: Oxford University Press (in press).

SIR,—In their cautionary note Roy A Carr-Hill and Jenny Morris draw attention to the use of measures of health status in the estimation of quality adjusted life years (QALYs) and express concern regarding the reliability and validity of measures used to make that quality adjustment.<sup>1</sup> Curiously, they have chosen to focus on the York health measurement questionnaire as an example of current practice. This questionnaire formed part of a continuity development programme, being first piloted in a survey by Carr-Hill himself,<sup>2</sup> and was originally published in a discussion paper some three years ago.<sup>3</sup> It is a useful means of collecting information on health related quality of life, though in the mean time many new developments and improvements have occurred.

The authors acknowledge the need for a single index measure of health related quality of life for use as the adjustment factor in estimating QALYs. In the past these data have been derived from the Rosser index<sup>4</sup>—the only measure of its type that incorporated valuations based on the United Kingdom. As the Rosser measure was originally intended as an instrument to be administered by an observer it had obvious limitations in any survey that relies on self rated procedures—hence the original impetus for the health measurement questionnaire. Analysis of data obtained with the questionnaire in the initial survey in 1985 has shown (a) significant positive correlation between the Rosser categories into which respondents are assigned and their scores on the Nottingham health profile and general health questionnaire and (b) that the Rosser scores show significant differences between people with different experiences of illness.<sup>5</sup> This evidence of convergent and discriminant validity suggests that in a practical context the health measurement questionnaire performs reasonably satisfactorily.

The concept of QALYs challenges clinicians and health economists alike. It exposes the paucity

of information on outcome in patients, at the same time focusing attention on the value judgments that underpin management and clinical practice. Thorough and systematic testing of new methods is obviously desirable, but the demand for the new technology is already here. Rather than strongly discouraging its use, as counselled by Carr-Hill and Morris, we should be carefully exploring its potential.

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- 2 Carr-Hill R, McIver S, Humphreys K. *Wolverhampton: a picture of health?* York: Centre for Health Economics, University of York, 1987.
- 3 Gudex C, Kind P. *The QALY toolkit*. York: Centre for Health Economics, University of York, 1988. (Discussion paper No 38.)
- 4 Kind P, Rosser R, Williams A. Valuation of quality of life: some psychometric evidence. In: Jones-Lee MW, ed. *The value of life and safety*. Amsterdam: North-Holland, 1982: 159-70.
- 5 Kind P, Gudex C. *The HMQ: measuring health status in the community*. York: Centre for Health Economics, University of York, 1991. (Discussion paper No 93.)

## Preventing coronary heart disease in primary care

SIR,—The working group of the Coronary Prevention Group and the British Heart Foundation describe an action plan for preventing coronary heart disease in primary care.<sup>1</sup> Unfortunately, the working group has perpetuated a falsehood in its worked example. It is not true that "under the new general practitioner contract the practice needs to offer health checks to all its patients aged 18-74 every three years. . . ." The rule applies to patients aged 16-74 who have not been seen by a general practitioner in the past three years.

In practice, for my list of 1500 patients, in 1990-1 there were only 44 such patients. This is a drastic reduction on the figures suggested in the paper. All 44 patients were sent a letter. Twenty two did not reply, nine refused, two were seen because they were ill, and 11 came as a result of my letter. Three of those who attended merited special preventive care as proposed by the group.

The action plan is a useful paper, albeit it looks through the other end of the telescope to me. As so high a proportion of the population is seen in three years (97%), and as I offered health promotion integrated in ordinary consultations before the new regulations were introduced, the care was already being given. Since April 1990 I have set up a healthy heart clinic (10 patients a week) for the work that the group suggests, and the risk-disk is on order to help.<sup>2</sup>

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- 2 Tunstall-Pedoe H. The Dundee coronary risk-disk for management of change in risk factors. *BMJ* 1991;303:744-7. (28 September.)

## Animal experimentation

SIR,—Hart, writing on the use of animals in medical research and the problems with the Home Office's official statistics, raises several points of interest.<sup>1</sup> The British Union for the Abolition of Vivisection agrees entirely that the *Statistics of Scientific Procedures on Living Animals Great Britain 1990*<sup>2</sup> is wholly inadequate. In a subject as

controversial as this the public is surely best served by the availability of the facts. Hiding the details of this sort of medical research, both behind locked laboratory doors and behind inadequate statistics, makes serious debate on these issues difficult. This serves neither medicine, the public, nor the animals.

We do, however, take issue with Hart's claims that "defending the past is easy." Sir Walter Bodmer, and others, are well known for claiming all great breakthroughs as the result of animal experimentation. For example, the Research for Health Charities Group claims the discovery of penicillin as "depending on animal research" when of course Fleming actually discovered it in vitro.<sup>3</sup> It was later tested in vivo, but fortunately not in guinea pigs, to which it is poisonous. This is not an isolated case.

Hart also assumes that all doctors automatically support vivisection. That this is not the case can be seen by the growing membership of Doctors in Britain Against Animal Experiments. But even if many doctors do support some animal experimentation, Hart himself points out circumstances in which it is not justifiable. Yet he wants to defend all 3.2 million experiments regardless of their purpose. This blind defence is both inhumane and unscientific. The debate on animal experimentation must acknowledge this.

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- 1 The week. *BMJ* 1991;303:670. (21 September.)
- 2 Home Office. *Statistics of scientific procedures on living animals Great Britain 1990*. London: HMSO, 1991.
- 3 Research for Health Charities Group. *The need for animal research in medicine*. London: Research for Health Charities Group, 1991.

SIR,—Hart's comment on vivisection<sup>1</sup> failed to mention that over 600 doctors have now joined the Ligue Internationale Médecins pour l'Abolition de la Vivisection. All believe that animal experiments are so misleading as to be dangerous to human patients. In a recent survey of 500 British doctors organised by the international league 88% of them agreed that "laboratory experiments performed on animals can be misleading because of anatomical and physiological differences between animals and humans."

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- 1 The week. *BMJ* 1991;303:670. (21 September.)

## Your child is dead

SIR,—As the parent of a child who died suddenly I welcomed Dr Ilora Finlay and Ms Doris Dallimore's article.<sup>1</sup> It highlighted the need to train medical professionals in informing parents when a child dies and how subsequently to approach parents about organ donation. Seeking parental consent to use organs is far from easy at a time when parents are overwhelmed by grief, but the medical profession should recognise that it has a duty to ask. Parents who are not asked can suffer the additional burden of regret that nothing positive came from their child's death, and those awaiting transplant surgery may miss the chance of suitable donor organs. Even when parents seem likely to refuse permission for their child's organs to be used they still have the right to be asked because the choice should be theirs.

According to transplant coordinators, doctors are often deeply saddened at the death of a child in their care and may not wish to add to parents' grief by asking for consent to use organs. Others are