prove most distressing to an already anxious, but innocent mother. Unnecessary skeletal radiography of the baby is to be deplored.

Even if the parents are exonerated, in the future the mother may still be too frightened to report the inevitable childhood injuries.—I am, etc.,

J. R. IVEY

Radiotherapy Department,
Singleton Hospital,
Sketty, Swansea

Library Services in Hospitals

SIR,—The Department of Health and Social Security circular H.M. (70)23 under the above title purports to give official guidance on planning hospital libraries. We therefore based our proposals for a new multi-disciplinary staff library strictly on H.M. (70)23.

We are now told by officers of the Regional Hospital Board that the people in the Department who control building projects had never heard of H.M. (70)23. When they were provided with a copy, by the Regional Hospital Board, they rejected the advice of their colleagues elsewhere in the Department out of hand and cut the floor area of our proposed new library by half.

The lesson of this absurd episode must surely be to discard H.M. circulars without bothering to look at them. If they only represent the individual opinions of their writers, and not the collective policy of the Department, they are so much waste paper.—I am, etc.,

MARK HUGHES

Chairman, Library Committee

Postgraduate Medical Centre,
Royal Hampshire County Hospital,
Winchester

Treatment of Hypothyroidism

SIR,—Dr. P. B. S. Fowler's letter (11 August, p. 352) about the paper by our colleagues and ourselves (21 July, p. 131) raises several points which merit a reply.

After adequate treatment of hypothyroidism the serum cholesterol and triglyceride levels of our patients were very similar to those of control subjects. Though the mean value of serum triglycerides in the treated patients was higher than that in the controls as Dr. Fowler points out, the standard deviation quoted in our table makes it evident that this difference is not statistically significant.

The raised serum triglyceride level after treatment refers to the four patients whose levels rose after treatment but within the normal range, a finding as yet unexplained. The two statements quoted by Dr. Fowler are not mutually contradictory if the paper is read fully, but we apologize if our meaning was not clear.—We are, etc.,

DAVID EVERED
R. HALL

Department of Medicine,
Royal Victoria Infirmary,
Newcastle upon Tyne

Cancer and the Patient

SIR,—This debate is important. May I make the following contributions?

(1) For most of my 30-odd years as a radiotherapist I could boast that I had

never told a patient that he or she had cancer—but many had told me their diagnosis. Times do change, public knowledge is increasing, and we are gradually moving nearer to the American situation. We know that the prognosis in some groups (skin, cervix, etc.) is often excellent, but the fact still remains that most cancers are still fatal, and the terminal stages in many cases—but by no means all—are very distressing.

(2) Last week a surgical colleague performed a mastectomy on an intelligent patient for an anaplastic growth. He prevaricated with the patient, who was tense and anxious and "knew too much," but told her husband the truth. The husband promptly passed it on to his wife. By the time I arrived the patient was composed and cheerful and willing to have any further treatment advised.

(3) My ward sisters tell me that patients told the whole truth tend to be the most "difficult." I have the greatest respect for, and pay great attention to, the opinions of experienced sisters.

(4) Suicide has been mentioned. I think most doctors know in their hearts that, on occasion, suicide can be sincerely rational and deeply charitable, but are naturally reluctant to say it aloud because of the obvious and admitted dangers of misuse.

(5) Since the correspondence began, I have asked the relatives in several hopeless cases whether they thought I should tell the patient the truth. In every instance they said "no;" they thought the patient suspected but would not like to be told outright. I am sure they were right.

(6) A final point which some may find surprising. It is not very rare for a patient or his family to be given the diagnosis and to insist later that they were never informed. Such is the (perhaps fortunate) capacity of the human mind to reject the unpleasant.

All this adds up to the not very original conclusion that there are no easy answers; we should move with the times but not force the pace. We must do the best for the individual patient as we see it—and that takes time.—I am, etc.,

J. WALTER

Weston Park Hospital,
Sheffield

Incomprehensible Explanations

SIR,—In order to inform the general public of the existence and function of the new Health Service Commissioner (or "Ombudsman") a leaflet¹ has been prepared by the commissioner's office and widely distributed. Several colleagues commented that they found the leaflet difficult to read and so it was decided to subject it to a measure of reading comprehensibility. Several methods are available to calculate the proportion or educational level of the population who might be expected fully to understand a given piece of writing.² Recently one such technique (that described by Flesch^{3,4}) was used by Ley *et al.*⁵ to measure the comprehensibility of various x-ray leaflets.

Using Flesch's formula a "reading ease score" is obtained which indicates that the commissioner's explanatory leaflet could be expected to be understood by 4.5% of the population and that its level of difficulty corresponds to that found in scientific journals. The score is derived from a consideration

of the average sentence length and the degree of polysyllabism. Whereas years of experience might well render members of the professions adept at pursuing a main verb through a maze of qualifying clauses, it is doubtless significant that the newspaper with the widest circulation are those with the simplest sentences.

Though reference has been made to the Health Service Commissioner's leaflet, similar remarks could have been made about many pamphlets which are believed to explain the nature of operations, investigations, or treatment procedures. It is, perhaps, particularly undesirable that a large proportion of patients might not fully understand a pamphlet that advises them how to lodge a complaint.—I am, etc.,

JOHN COUPER-SMARTT

Child and Family Psychiatry Clinic,
Cambridge

- ¹ *Health Service Commissioner for England, Functions and Scope*, London, H.S.C.E., 1973.
- ² Seels, B., and Dale, E., *Readability and Reading—an Annotated Bibliography*. New York, International Reading Association, 1966.
- ³ Flesch, R., *Journal of Applied Psychology*, 1948, 32, 221.
- ⁴ Ley, P., *Journal of the Institute of Health Education*, 1973, 11, 17.
- ⁵ Ley, P., Goldman, M., Bradshaw, P. W., Kinney, J. A., and Walker, C. M., *Journal of the Institute of Health Education*, 1972, 10, 47.

Spontaneous Abortion and Neural Tube Defects

SIR,—Dr. C. J. Roberts and Mrs. Setsuko Lloyd (6 October, p. 20) examined the spontaneous abortion rates among the previous sibs in cases of anencephaly and spina bifida (A.S.B.) and among the previous sibs of normal controls in an area of high A.S.B. rates (area A). They contrasted these two values with comparable estimates from sibships in an area of low A.S.B. rates (area B). They found that the rates of reported previous abortion in the high-risk area were lower than those in the low-risk area. To explain this, they offered the hypothesis that the overall A.S.B. rate at conception may be the same in the two areas, but that the survival of an A.S.B. fetus to term may be facilitated by some (presumably) environmental factor in the high-risk area.

Let us assume that the spontaneous abortion rates of non-A.S.B. fetuses in the two areas are equal. (I shall later suggest that this is a generous assumption.) Then if the authors' hypothesis is correct, the (total A.S.B. rate plus total spontaneous abortion rate) should be equal in the two areas. In fact, these two values are not equal but are about 13.96% in area A and 15.64% in area B. (Since the outcomes of the various pregnancies in a single sibship are not independent, I shall not cite a significant level for the difference between these values; but I shall assume that it is not due to chance.) What could cause this disparity? It seems there are two alternatives: either (1) the spontaneous abortion rate of non-A.S.B. fetuses in area B is higher than in area A, or (2) there is a reporting deficit of abortions in area A.

I shall treat these alternatives in order. (1) The mean social class level of area B is clearly higher than that of area A. Now women in the higher social classes are subject to lower stillbirth rates than women in the lower classes.^{1,2} One would suppose that