Evidence 17

Letter from Lord Winston Published in British Medical Journal Claiming He Had Nothing to Do With Cook Report's Treatment of Dr Jack Glatt

CORRESPONDENCE

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- *No letter should be more than 400 words.*
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Avoidable blindness

SIR,—In his editorial Dr Andrew R Potter states that blindness in about 80% of the 30 million affected is avoidable.[1] This is a concept much favoured by those concerned with public health aspects of eye disease. It is a clever semantic device whereby cataract, which is curable but not yet preventable and is by far the largest cause of blindness, is added to such potentially preventable causes as xerophthalmia, trachoma, and onchocerciasis to show that most blindness is avoidable. This has proved to be quite profitable for propaganda purposes for medical and relief agencies working to prevent blindness.

In other respects, however, how useful is it to talk of avoidable disease? Not at all, I suggest, and it can be misleading. The major killers are all avoidable to a considerable extent if people have a better lifestyle (coronary disease, cancer, stroke) or better living conditions (malnutrition, gastroenteritis). Labelling such diseases as avoidable would not help to bring about needed change.

As Dr Potter points out, "Unless things change the number of people who are blind will double by the year 2025." He is, of course, urging greater awareness and increased resources and personnel, but I suggest that the necessary change is conceptual rather than logistical.

From earliest times until only recently medicine has concerned itself with treating individual patients. With increasing complexity of knowledge and practice it was inevitable and fully justifiable that specialisation by systems should develop. This organ based approach so necessary for treating individual patients is, however, totally inappropriate for controlling disease in the community, where health interventions are broadly based. It is neither logical nor cost effective to hive off the relevant measures from the mainstream of primary health care just because these very dissimilar diseases have the same target organ. At the first international meeting on the prevention of blindness held by the World Health Organisation in 1976 xerophthalmia, trachoma, onchocerciasis, and cataract were officially identified as "the four giants," but unofficially they were described as "four uneasy bedfellows." They have very different aetiologies, risk groups, and global occurrences and require totally different approaches, as Dr Potter acknowledges.

This misconception has now become deeply institutionalised and will take some shifting. WHO has a prevention of blindness programme with numerous collaborating centres around the world; the International Association for the Prevention of Blindness has affiliated to it national prevention of blindness committees in 60 countries. Interestingly, non-governmental agencies supposedly dedicated to preventing blindness are increasingly supporting general health care—I suspect because the penny has dropped among those with the most practical experience.

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1 Potter AR. Avoidable blindness. *BMJ* 1991;302:922-3. (20 April.)

The Cook Report: assisted conception

SIR,—Mr Roger Neuberg's factually inaccurate letter carries innuendoes beneath comment.[1] However, I was in no way responsible for the treatment of Dr Jack Glatt or, indeed, anybody else mentioned in this programme. I neither wished for, nor had, any editorial input.

For the record, I made three short observations only. I gave the briefest history of a woman who had had 10 separate private attempts at embryo transfer unknowingly into a non-existent uterine cavity at a cost of nearly £30 000. I was put under great pressure to release her name, but this was refused, as was the identity of the clinic largely responsible for her mismanagement. Secondly, I said that "many private [in vitro fertilisation] clinics are, in the main, offering a single treatment for a multiplicity of causes." That this is true can be seen from last month at Hammersmith Hospital. Eleven patients in whom in vitro fertilisation had failed conceived after tuboplasty, correction of uterine disease, or induction of ovulation or simply spontaneously. All had previously had multiple private attempts at in vitro fertilisation without specific (and usually cheaper) treatment being offered first. Thirdly, I observed that "many [in vitro fertilisation doctors] have gone into the private sector because they have failed to make the grade sometimes in the NHS." This is substantiated by the numerous applicants from private clinics trying unsuccessfully to get back on to the career ladder. Mostly, they are not even shortlisted.

In our weekly clinics at Hammersmith Hospital we see perhaps six new patients who have been inexpertly or inadequately treated, mostly from various private in vitro fertilisation clinics. These patients in general are not dissatisfied customers, complaining about their previous doctor, but couples whose sad mismanagement would make sensitive doctors weep. We cannot encourage patients to sue their previous doctor, and most private communication simply induces a hostile response. These are not problems that could have been effectively policed by the excellent Interim Licensing Authority and there are occasions when, despite Professor Lesley Owen Drife's rather ill judged comments,[2] the medical profession needs to come clean. Often, we are reputed to close the shutters against criticism. In the case of in vitro fertilisation and related treatments patients are too frequently getting a raw deal from the NHS and often from private clinics. Of course I have no "contempt of clinics in the private sector"—there are many good ones—but our profession should do much more to protect the interests of these particularly desperate and vulnerable patients.

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1 Neuberg R. The Cook Report: assisted conception. *BMJ* 1991;302:1078. (4 May.)
2 Drife JO. Overcooked. *BMJ* 1991;302:1028-9. (27 April.)

Supply of blood products

SIR,—In response to Mr R B Christie's recen letter,[1] I regret that I was unable to comment on th potential difficulties of national self sufficiency i my earlier letter,[2] but editorial consideration necessitated substantial reductions in the final tex and, in any event, I have addressed this topi before.[3] Mr Christie is right to emphasise the commercial sources of plasma products have i the past provided an important buffer again shortages, but European politicians have decide that this buffer has hitherto been too large and h brought with it needless devastation in the form transmission of viral disease. There is nothir unique in the concept of self sufficiency: t European Commission has simply implement recommendations made by the World Heal Organisation in 1975.[4]

Mr Christie's statement that the safety of plasr is not a function of payment or non-payment donors is frankly astonishing. Many scienti publications refute this statement, and I know none in support of it. Publications on this to started in the 1930s with syphilis and continu with hepatitis B virus, cytomegalovirus, HIV HIV-II, human T cell leukaemia/lymphoma vi type 1, and hepatitis C virus. On the other ha we should support Mr Christie's exhortations t we must concentrate more effort on ensuring t the plasma collected from both paid and unp donors meets high standards of safety. Doct will be interested to note that those collect plasma from paid donors in the United St have recently considered it necessary to prop that it should be assayed for contamination v heroin.

Mr Christie suggests that I proposed that European Commission's directive on self ficiency is legally binding (mandatory). This is so, and I have specifically emphasised this p previously.[3] But a definition of self sufficienc the *Oxford English Dictionary* is "able to meet o

Licensed Victuallers' Association has openly condemned the proposals.

It is difficult to see, therefore, how our recommendations could be regarded as biased by a concern for the sensitivity of our sponsors. Though we have not exactly bitten the hand that feeds us, we have probably given it something of a nip.

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1 Dillner L. Alcohol abuse. *BMJ* 1991;302:859-60. (13 April.)

The Cook Report: assisted conception

SIR,—I must strongly protest at the treatment of Dr Jack Glatt, medical director of the Infertility Advisory Centre, by Central Television's *The Cook Report* recently.[1] The declared aim of this programme is to be "on the trail of those with something to hide on behalf of people with something to lose." Sadly, there will always be losers in infertility.

However, the Infertility Advisory Centre's excellent results and "take home baby" rates compare very well with those of the most successful units in the United Kingdom, a fact that was omitted from the programme. The registered charity BABIe was severely criticised by Roger Cook, which is sure to distress and anger the many satisfied patients who are members of the BABIe support group.

Professor Robert Winston has yet again made clear his contempt of clinics in the private sector and of the people who work in them. The perspective of the spokeswoman for CHILD would have been easier to judge had the viewers been informed that the chief medical trustee of CHILD is Professor Winston. The programme also failed to mention that for the eight years up to 1988 Dr Glatt was the medical adviser to CHILD. Dr Glatt left that organisation at the same time as its founder, and together they set up BABIe as an alternative support group for infertility patients. It would be interesting to know how the disgruntled former patients of the Infertility Advisory Centre were recruited to the programme.

Dr Glatt's determination to provide a relatively low cost private service rather than continue to struggle in an underfunded NHS cannot by any stretch of the imagination label him as a "failed" doctor. He is an excellent medical director of an excellent infertility establishment. He is doubly qualified with both an MRCP and an MRCOG. Had his clinics been NHS clinics they would have been deemed exemplary.

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1 Drife JO. Overcooked. *BMJ* 1991;302:1028-9. (27 April.)

SIR,—Recently, Central Television's *The Cook Report* focused its attention on private clinics for assisted conception.[1] In particular it chose to attack the medical director of the Infertility Advisory Centre, Dr Jack Glatt. The ethics committee of the advisory centre wishes to make the following comments in protest:

(1) The committee is fully satisfied that the Infertility Advisory Centre is complying with all the guidelines of the Interim Licensing Authority.

(2) The committee finds it highly reprehensible that no mention was made of the advisory centre's commendable success, which is significantly higher than the national average for assisted conception units with regard to "take home baby" rates.

(3) The committee applauds Dr Glatt's belief and practice that assisted conception techniques should be within the reach of the general public by setting some of the lowest fees in the private sector.

(4) The committee has carefully examined the case records of the patients who appeared on the programme and can find no fault in their management.

(5) The committee has every confidence in Dr Glatt's ability both as a highly qualified, conscientious infertility specialist and as medical director of the Infertility Advisory Centre. We unanimously congratulate him and his team at the centre's three units on the high standard of care and the excellence of their results.

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1 Drife JO. Overcooked. *BMJ* 1991;302:1028-9. (27 April.)

Recurrent miscarriage

SIR,—Ms Lesley Regan's editorial on recurrent miscarriage[1] fails to mention an important factor. The risk of spontaneous miscarriage is 30-70% higher among women who smoke and increases with the number of cigarettes smoked each day.[2] Smoking must therefore surely be the single most important identifiable (and avoidable) risk factor in recurrent miscarriage. Attention should be paid to this before women embark on costly, unproved treatment regimens.

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1 Regan L. Recurrent miscarriage. *BMJ* 1991;302:543-4. (9 March.)
2 Queensland Department of Health, Queensland Cancer Fund, and National Health Foundation (Queensland Division). *Smoking. The facts: the risks.* Brisbane: Queensland Department of Health, 1991.

Management of bleeding in early pregnancy

SIR,—Messrs M A Bigrigg and M D Read's study of the management of women referred to an early pregnancy assessment unit[1] was conducted in a district general hospital in Gloucester, which obviously has a close working relationship with the local general practitioners. No mention was made of those patients who present to their local accident and emergency department.

We undertook a study in the accident and emergency department at St Mary's Hospital, London, that has some similarities with the study in Gloucester. Over the six months February to July 1987 we saw 179 patients complaining of bleeding in pregnancies of less than 20 weeks' gestation. This was 0·7% of our workload (26 837 new patients were seen during that period). These were patients presenting de novo to the accident department and were not patients who had been referred to our department of gynaecology, who would have been seen directly at the Samaritan Hospital half a mile from the accident department. (One hundred and seventy nine patients is roughly half the number seen during a similar period in the department of gynaecology in Gloucester.) We monitored the effect of introducing new guidelines on management, which emphasised the importance of vaginal examination and the use of ultrasound to determine the viability of pregnancy, and of giving patients an advice sheet on miscarriage.

Admissions fell from 15 out of 53 women to seven out of 58; referrals to the gynaecologist on call fell from 23 out of 53 to 13 out of 58; and the reattendance rate fell from 11 out of 53 to four out of 58 (all changes $p<0·05$).[2] The work practice of the department of gynaecology was made more efficient at no extra cost and with no reorganisation. We did not calculate the financial savings.

A considerable number of patients with bleeding in early pregnancy present to accident and emergency departments in inner cities. There is much that such departments can do to improve their standards of care for such patients, as our study shows.

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1 Bigrigg MA, Read MD. Management of women referred to early pregnancy assessment unit: care and cost effectiveness. *BMJ* 1991;302:577-9. (9 March.)
2 Gilling-Smith C, Zelen J, Touquet R, Steer P. Management of early pregnancy bleeding in the accident and emergency department. *Arch Emerg Med* 1988;5:133-8.

Controversy breeds ignorance

SIR,—It was sad to read in a Personal View that the author was unable to have an epidural to help her deliver her dead fetus.[1] In the circumstances she was probably wise to decline the hesitant offer of an epidural even though her results of blood clotting studies were only "marginally abnormal." (Epidurals are contraindicated in patients with significantly abnormal clotting because of the risk of a haematoma forming in the epidural space, with consequent paraplegia.)

Clearly, some anaesthetists still use intrauterine death as a pretext for advising against epidural analgesia. Though it is true that intrauterine death is associated with hypofibrogenaemia, this coagulopathy rarely occurs until four weeks have elapsed since the death of the fetus. Women whose fetus has been dead for only a day or two are no more at risk of abnormal clotting than any other pregnant woman. In cases of doubt, clotting studies can be performed swiftly by most laboratories.

I hope that the author's comments on how she was failed by her anaesthetist will stimulate other anaesthetists into taking a more positive attitude towards giving epidural analgesia in cases of intrauterine death, especially if the fetus has been dead for only a short time. Though a pain free labour will never compensate for a dead child, it is a welcome comfort in a moment of sorrow.

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1 Anonymous. Controversy breeds ignorance. *BMJ* 1991;302:973-4. (20 April.)

SIR,—I was saddened and disturbed by the sequence of events described by the mother who lost her baby after attempted cordocentesis for investigation of toxoplasmosis.[1]

It is well established that congenital toxoplasmic infection results from a primary infection acquired by the mother during gestation.[2] Only one case has been reported in which the immunocompetent mother had been infected before she conceived. The author of the Personal View apparently had evidence for toxoplasmosis (presumably specific IgM) at the time of her miscarriage in March 1989. Depending on the laboratory method used specific IgM may be detectable for one year or longer after the infection is contracted.[3] It is therefore not surprising that IgM might have been detectable at the time of conception in November 1989.

Avidity studies on specific IgG antibody are likely to have shown the presence of high avidity