proportion (55/932) of all cases of cerebral palsy in that period. The aetiology of cerebral palsy in low birthweight infants in multiple births is probably similar to that in singletons.

In a few cases a cotwin died antenatally, with resulting brain damage in the surviving twin. This is seen in our data and has been known for many years.² As rates of multiple births are rising it is important to keep monitoring the rates of cerebral palsy in these births.

We agree with Judith Glynn and David Leon's comments. It is impossible from our epidemiological data to ascertain when brain damage occurred. We agree that in infants of 1500 g who develop cerebral palsy the sequence could have started antenatally, perinatally, or postnatally and the epidemiological picture would be similar. We recently reviewed this.³

In normal birthweight infants it is also likely that there has been a shift from deaths to survivors with cerebral palsy, and possibly from survivors with cerebral palsy to non-handicapped survivors. We still believe that our data, in conjunction with other data to which we referred in our paper, can be interpreted as suggesting that birth asphyxia is not the main cause of cerebral palsy.

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Juvenile myoclonic epilepsy

EDITOR,—In their editorial P L Timmings and A Richens state that juvenile myoclonic epilepsy occurs in 10 of all cases of epilepsy.¹ This is a gross overestimate. Community based studies have shown a frequency of no more than 2%,^{2,4} and the paper that Timmings and Richens quote in support of their figure of one in 10 actually gives a figure of 4-6%.³ This is not an insignificant issue, as misdiagnosis is rife and may lead to incorrect treatment.

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AUTHORS' REPLY,—Discussion about the incidence and prevalence of juvenile myoclonic epilepsy is important. In our original draft we observed that "interest in juvenile myoclonic epilepsy has increased steadily and the reported incidence of 2-1%¹ among all epilepsy (1957) has risen to 11-9%² (1984)." This was reduced to "accounts for about 1 in 10 cases of epilepsy" in the final version. As S D Shorvon and J W A S Sander observe these figures are derived from hospital based groups, and the figures in unselected community based services may be lower. We also note, however, that

(a) physicians unfamiliar with a condition are less likely to diagnose it, and this clearly applies to juvenile myoclonic epilepsy as the mean time from presentation to correct diagnosis is measured in years^{3,6}; and (b) including paediatric patients in any survey of the prevalence of juvenile myoclonic epilepsy will tend to dilute the figure (the figure of 11-9% is based on an "almost exclusively adult population").

In a review Penry *et al* stated that juvenile myoclonic epilepsy represents 4-6% of all epilepsy³ but did not give any original figures, preferring to refer to Janz and Christian.^{1,2} In another review of juvenile myoclonic epilepsy Dreifuss stated that it affects about 7% of all adolescents and adults with epilepsy, but, again, no new data are cited.⁷ Interestingly, in a recently reported series of 180 patients referred over 21 months to a "new epilepsy" clinic in Britain the prevalence was 8-3%.⁶

We believe that juvenile myoclonic epilepsy makes up 5-10% of all epilepsy in adolescents and adults and that the papers referred to by Shorvon and Sander (with prevalences of around 2%) may be underestimating its frequency because of underrecognition and inclusion of paediatric data.⁸⁻¹⁰

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Selective serotonin reuptake inhibitors

EDITOR,—The correspondence^{1,2} on J Guy Edwards's editorial on selective serotonin reuptake inhibitors³ requires comment. Debbie Harrison chides Edwards for mentioning single reports of adverse reactions,¹ but such reports are vital as postmarketing surveillance and require attention. Harrison and S O Fradd² criticise Edwards for mentioning cost. This is not surprising from Harrison, who is an employee of the main pharmaceutical company in this field, and it is inappropriate for her to reprimand Edwards for having made up his mind already about the role of selective serotonin reuptake inhibitors—no more so than Harrison and her company have.

Fradd's outlook is particularly disappointing. Fradd oversimplifies the problem, implying that selective serotonin reuptake inhibitors are without serious side effects while tricyclic antidepressants, with which we have long experience, are highly toxic. To suggest that doctors should not consider the economic consequences of their prescribing to society as well as to individual patients is an outmoded concept that doctors should abandon. A professional decision to prescribe only selective serotonin reuptake inhibitors would cost £100-150

million a year, with inevitable consequences for other NHS services.

In reality, neither tricyclic antidepressants nor selective serotonin reuptake inhibitors are ideal for depression: both are slow to produce a benefit, and neither is effective in more than about 80% of cases. The selective serotonin reuptake inhibitors are a relatively new class of antidepressant whose full pharmacology and role in treatment are not yet known.^{4,5} To advocate a wholesale move to using them as first choice antidepressant treatment⁶ rather than more established and less expensive drugs, solely because of their safety in overdose, is unreasonable on medical, ethical, and economic grounds.

Should a doctor treat a depressed patient with a tried and trusted remedy or with a less established drug? The family of a patient who commits suicide by any means (and not just drug overdose) might well have a better case if the doctor prescribed the less established treatment; of course, a doctor should weigh each case on its own merits. In a court case the gold standard would probably be what the doctor's peers would reasonably do in the circumstances.

Edward's conclusion that selective serotonin reuptake inhibitors should be reserved for selected patients represents a balanced view of the current state of knowledge, and Harrison's contention that these drugs are an enormous advance in the treatment of depression is unwarranted.

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Value of Dundee coronary risk-disk

EDITOR,—Tony Randall and colleagues report that when they used the Dundee coronary risk-disk on the population of south Bedfordshire it failed to detect high risk subjects.¹ According to the registrar general's figures, the coronary risk for south Bedfordshire makes it, on the basis of crude death rates, the eighth safest health district in the land: Milton Keynes, west Berkshire, Huntingdon, Oxfordshire, west Surrey, Parkside, and north west Surrey have lower crude death rates. Tayside, on the other hand, is 15th from the top of Britain's 220 health districts in terms of coronary risk and is far more typical of the country as a whole.

Of the seven low risk areas, only three (including south Bedfordshire) have low age standardised rates—that is, the populations are untypically young. Thus a schedule for assessing risk such as the Dundee score will miss more of the single risk factors in a young population than in a population of average age distribution because one of the variables contributing to the score is age; in south Bedfordshire this is artificially low. Other factors must operate in Parkside, Berkshire, Oxford, and Cambridge: all have age standardised coronary death rates 63% of Tayside's rate.

A series of cholesterol concentrations measured in this practice gave an average of 6.1 mmol/l, so other factors in southern England must operate to reduce the coronary risk and the Dundee disk does

not reflect these. From Randall and colleagues' paper we can tell that the risk due to smoking in south Bedfordshire is in line with the British average though the proportion with high blood pressure is lower owing to the lower age range.

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DNA fingerprinting and contact tracing

EDITOR, —DNA fingerprinting of human material has given great service in securing conviction in several trials for rape and murder. DNA fingerprinting of bacteria and viruses in a case in which A is alleged to have infected B can, however, strengthen the case for the defence—that is, if the strain infecting A differs from that infecting B. As Peter Godfrey-Faussett and colleagues point out, it is always possible that another infected person, C, is the common source for A and B.¹ DNA and other methods of fingerprinting bacteria and viruses are likely to become evidence for the prosecution only when A is alleged to have infected several people whose only common factor is a link with A and each is infected with a bacterium or virus with a fingerprint identical with that infecting A. This was the case when a dentist and several of his patients were found to be infected with the same strain of HIV.²

Contact tracing, which we carried out in the case reported by Godfrey-Faussett and colleagues, has limitations, being a descriptive exercise rather than one that tests a hypothesis. It can determine only time-space relationships and the possibility of transmission from A to B, not whether transmission is likely.

Godfrey-Faussett and colleagues' paper raises an additional issue in that, although it does not identify the subjects reported on, the case is well known and the local newspaper swiftly carried an article on it under the subheading "Genetic testing backs theory that neighbour was source of infection which killed toddler"; the article contained photographs and names.³ Should patients have the option to oppose the publication of their history even though they are not identified in the report and publication is in the interest of science?

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Patient's charter in outpatient services

EDITOR, —The letters¹⁻⁵ published in response to my editorial on implementing the patient's charter in outpatient services⁶ indicate the varying requirements in outpatient clinics in different specialties

in different parts of the country. Some specialties require continuing care from a specialist team.¹ Others can maintain satisfactory contact with patients by telephone,² and some deal with urgent rather than elective referrals, so that any delay in consultation could be detrimental.⁴ The 13 week limit between referral and the first outpatient appointment would not be appropriate for such services; it is, however, a regional standard for all specialties in the South Western region for 1993-4 and is an unattainable target for many. Non-urgent referrals in specialties such as plastic surgery, orthopaedics, ophthalmology, and, in many district general hospitals, ear, nose, and throat surgery, general surgery, oral surgery, dermatology, and neurology may have to wait six to 12 months. This is clearly unsatisfactory.

Michael P Corlett suggests one way of dealing with large numbers of elective referrals requiring straightforward operative care,⁵ and many specialties could develop their own mechanisms for getting the best out of the limited time available in outpatient clinics. When all this "efficiency" has been achieved the shortfall in staff in several specialties in hospitals throughout Britain will be obvious. To calculate the magnitude of that shortfall the finite capacity of the consultants and their teams will have to be clearly stated rather than the present unrecognised compromises in the quality of consultations be perpetuated. It is to enable such calculation to be made that the Royal College of Surgeons issued its guidance notes on the general surgical workload in the provider-purchaser contract.⁷

Quality measures based on the patient's charter and on regional and more local standards are now being incorporated in contracts for work between purchaser and provider units. Such measures are often added to historical workloads that entail the compromises in the quality of consultation that inevitably result from the standard practice of squeezing in more referrals than can be properly accommodated within the time available. There seems to be little understanding of the finite capacity of the clinicians who are the subject of such contracts. Moreover, because outpatient activity is common to almost all specialties it is likely to be in this that the gap between the level of service required by purchasers and that which providers can offer is made explicit.

It has been calculated that in England and Wales one consultant general surgeon is needed per 30 000 people, as is currently achieved in both Scotland and Northern Ireland; currently there is one per 50 000 people.

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Disintegration of civilian life in Myanmar

EDITOR, —The article about Burmese women refugees prompts me to write about the daily hardships suffered by ordinary citizens of Myanmar (formerly Burma) under the current military regime.¹

Basic commodities are available only from black

marketeers at highly inflated prices. This is the result of economic mismanagement by the military junta; every spare pyas (the money of Myanmar) is spent on developing and maintaining the military. The Democratic leader, Daw Aung San Su Kyi, who won the Nobel peace prize last year, is still under house arrest. The country has declared itself the poorest country in the world in order to exempt itself from interest payments on its debts. The country's rubies, emeralds, teak, and oil are no longer in the hands of the people of Myanmar but sold to meet the costs of the military's excesses. There is no social policy. Families are separated because they have had to flee to escape the military's atrocities. Those who remain in the country are barely surviving. Orphans and elderly people, who would normally fit into extended families, are cared for by distant relatives and neighbours. There are no social services to care for the needy, and the health service provision is completely inadequate.

The general hospital, with its Victorian architecture, in the centre of Rangoon has outlived its useful life and, owing to lack of investment and maintenance, is on the verge of collapse. Wards are overcrowded, and patients have to take their own medicine for treatment. These medicines are bought from black marketeers; they are usually out of date and adulterated and have not been kept at recommended temperatures. Hospital doctors employed by the military junta are poorly paid. Their salaries are similar to those in prewar days and do not keep up with inflation. In order to survive most doctors carry out private practice during unsocial hours. In contrast to services provided for ordinary citizens, military hospitals are well funded.

The education system has collapsed. Schools, colleges, and universities were closed during the period of mass protest by the population in 1989. They remain closed since the whole system has disintegrated, with buildings in ruin, facilities and equipment in need of replacement, and the disappearance of lecturers, tutors, and teachers who spoke defiantly against the military.

Doctors, whether civilian or military, are starved of knowledge. All post arriving in Myanmar is censored unless approval from a higher authority has been obtained in advance. Doctors in Myanmar are pleading to their medical colleagues outside the country to send any medical journals, newspapers, books, and magazines by any means available to enlighten and update their medical knowledge. This would be some small consolation in their otherwise miserable lives.

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**The author's name has been withheld to protect friends and relatives. —ED, *BMJ*.

BMA policy and fundholding

EDITOR, —The BMA has been bruised by the recent years of agonising over the introduction of market forces into the delivery of health care and its unsuccessful attempts to modify what were perceived to be potentially damaging and divisive changes to the NHS. Many doctors believe that the most controversial of the changes is the introduction of fundholding. At the recent annual representative meeting in Nottingham the representatives were denied an opportunity to debate the current policy on fundholding, although clearly this continues to cause great anxiety across the breadth of the profession, as evidenced by the motions on the agenda.

The leadership of the General Medical Services Committee clearly has a difficult path to tread. As fundholding is now established, for the immediate