and placenta are identified in the four hours after the administration of the prostaglandin, it provides an opportunity for counselling and contraceptive advice as well as ensuring that the abortion has been completed. Ultrasound scanning is necessary only in those women in whom there is doubt as to whether the abortion is complete (<5%).

Thus the number of clinic visits is no more than should be offered to a woman who has chosen vacuum aspiration. Unlike after vacuum aspiration, access to medical theatre and skilled medical and paramedical staff is required for only a small percentage (about 5%) of women after medical abortion.

Though it is prudent to ensure that medical abortion is both safe and effective, it would be a pity if this choice was not made available to women because the estimates of the cost have been based on overelaborate facilities.

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EDITOR,—J G Duddington discusses possible legal action by a child born with an abnormality after his or her mother changed her mind about abortion after receiving mifepristone.¹

If a fetus is damaged as a result of a mother changing her mind about abortion after receiving mifepristone the fetus will have a right of action in tort against the treating physician only if the mother has been negligently advised or treated, and against the drug company only if there has been negligence in connection with the drug's manufacture or advice on giving the drug. If the mother is not the victim of negligence of any kind but changes her mind while fully aware of the possible consequences to the fetus the fetus will have a cause of action against the mother.

Damages for wrongful life are not available in Britain and are unlikely to be in the foreseeable future. This does not obviate the award of damages for pain, suffering, and loss of amenity.

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- 1 Duddington JG. Medical abortion. *BMJ* 1992;304:1693. (27 June.)

Grieving women

EDITOR,—I am sorry that Lucy Grafen, who reviewed "A Different Kind of Love" in the Channel 4 series *Female Parts*, needed a happy ending. I would have supposed that a child psychiatrist more than most health professionals would understand that the real world does not have happy endings. I speak as someone who has experienced three miscarriages and a cot death. The programme was well done: in a journalistic world it is rare to watch such a programme about real feelings.

I now have two apparently healthy children and a career, and for the most part I am happy. Unfortunately, when a child dies he or she is never forgotten. Grafen may wish to reread Freud's

letters: he wrote to a friend whose son had died, "Although we know that after such a loss the acute stage of mourning will subside, we also know that we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else."² Hobson, in his "conversational model" of psychotherapy, describes the value of "staying with the feeling" rather than escaping its intensity.³ I am sorry that the reviewer found it too painful to "be with" the anguish of bereavement for the hour for which this programme was screened.

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Health and education in developing countries

EDITOR,—Donald Acheson's editorial on the health of our planet¹ revives the theory espoused by Malthus in 1798 that human populations increase geometrically while available resources increase arithmetically.² Malthus's paper was first published at around the beginning of the industrial revolution, since when the human population has grown exponentially while depletion of resources and environmental pollution have escalated dramatically, largely as a result of the waste economies of the military-industrial complex.

The widening gap between the rich industrialised nations and poor nations, patronisingly referred to by the World Bank as the Third World, is unlikely to be reversed solely by cancelling debts. The road ahead must surely lie in a paradigm shift of economic goals from militarism to education and health.

A chink of light in an otherwise gloomy scene may be found in the work of the Australian demographer Caldwell, who compared per capita incomes with infant mortality and life expectancy in selected developing countries.³ Thus people in Kerala (in India), Sri Lanka, and China enjoy a life expectancy in the high 60s with a per capita income of around \$300 a year. Costa Rica does even better, with a life expectancy of 74 and a per capita income of \$1400 (with the added advantage of having no standing army). These figures compare with a life expectancy in the mid-50s and a per capita income of around \$7600 for oil producing countries in the Middle East and a life expectancy of 75 and a per capita income of over \$11000 for the industrial market economies (1985 figures).

Caldwell found that differences in health achievement among poor countries were strongly correlated with the proportion of girls attending primary school. Countries with a high life expectancy devoted a disproportionately high percentage of resources to education and health through a combination of social and political will. Women enjoyed a high degree of autonomy in these countries, in contrast to the situation in Middle Eastern nations. The message is that low mortality for all will not come as a spin off from economic growth but will depend on pressures towards more egalitarian societies. Even the World Bank advocates spending money on educating girls and women.⁴

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- 1 Acheson D. The road to Rio. *BMJ* 1992;304:1391-2. (30 May.)
- 2 Malthus T. *An essay on the principle of population; or a view of its past and present effects on human happiness; with an enquiry into*

our prospects respecting the future removal or mitigation of the evils which it occasions. 6th ed. London: J Murray, 1826.

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Compensation for cancelled operations

EDITOR,—It is admirable that Odstock Hospital should voluntarily pay compensation for loss of a patient's earnings in connection with a cancelled operation.¹ I am sure that this will happen far more often in the future, as the article suggests.

In the present climate of careful budget control perhaps hospital managers should also be looking at the other side of the equation: those patients who do not bother to attend outpatient appointments or, worse still, do not turn up on the day of admission for surgery. Should hospitals start initiating compensatory claims for the wasted operating time, staff salaries, and accommodation that could otherwise have been used to treat someone else on the waiting list?

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- 1 Dyer C. Hospital pays for lost earnings. *BMJ* 1992;304:1400. (30 May.)

Polenta publications

EDITOR,—Recent correspondence has shown that there is disagreement about the desirability of slicing up a single piece of research into numerous similar "salami" publications.^{1,3} Presumably there is widespread support for the opposite process of combining two or more studies to create one large paper. Certain authors have tried including up to four different studies in a single article.^{4,5} This has the advantage, in the long term, of saving time, and in these days of computerised reference searches the work will probably be as influential as if it was spread over various journals.

To my knowledge there is no name for this process. May I suggest that large multistudy papers should be called polenta publications? Polenta is a kind of super-thick porridge made from maize flour. It is sometimes rather difficult to digest, but you know it is good for you.

If various committees follow through plans to concentrate on only a few choice publications during academic assessment perhaps a new feature of medical competition will emerge, in which everyone tries to have polenta publications published in general journals. Perhaps the *BMJ* could encourage this.

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Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.