Fig 1—Twinning and triplet rates in Western Australia, 1960-94

Figure 1 shows twin and triplet rates in five year groups from 1960 to 1994 (complete data are available from us on request). The total numbers of singleton, twin, and triplet pregnancies in the period 1960-4 were 83 408, 825, and 5 respectively, while in 1990-4 the corresponding totals were 123 713, 1613, and 45. Triplet rates peaked in 1988 and 1989 (at 6.4 and 7.5 per 10 000 pregnancies; 95% confidence intervals 3.3 to 9.6 and 4.2 to 10.9 respectively), with a sharp drop to 1.6 (0.03 to 3.1) in 1990; they rose gradually to 5.6 (2.7 to 8.6) in 1993 and dropped back slightly in 1994 to 4.0 (1.5 to 6.5), which was still only about half the rate seen five years previously. Two quadruplet pregnancies and one quintuplet pregnancy occurred in 1989, with only one other quadruplet and one other quintuplet pregnancy occurring during 1985-94. The twinning rate followed a similar though less dramatic pattern to that of the triplet rate, being about the same in the most recent years as it had been at the end of the 1980s.

These patterns are of interest in the light of guidelines introduced by the Reproductive Technology Accreditation Committee in 1987, which included recommendations to limit the number of embryos or oocytes transferred in any one cycle of assisted conception treatment to three, or four in exceptional circumstances.⁵ Legislation adopting these guidelines was passed in 1993. The fall in the rate of triplet gestations is reassuring and suggests that fertility clinics, after an initial delay, have responded to the committee's recommendations in an effort to reduce multiple gestations and their associated risks.

It is important to continue to collect and monitor data on multiple births, including long term outcome, and we are interested to know if trends seen in Western Australia are occurring elsewhere.

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MYMOP, a patient generated measure of outcomes

Research into outcomes has moved away from symptom based assessments

EDITOR,—Charlotte Paterson's patient generated instrument to measure outcomes in primary care, the "measure yourself medical outcome profile" (MYMOP), seems to undermine most of the principles of psychometric theory and many of the purposes of research into outcomes as promoted recently.¹ The paper gives no account of how the measure was developed and does not provide a rationale for the selection of items or why it makes sense to sum them to provide an overall score. Much of the paper is either based on assertion (the use of the MYMOP "in chronic conditions might help the patient uncover patterns and influences on their behaviour") or unsupported by evidence ("practitioners gained new insights into the patient's view of the problem").

In defending the MYMOP Paterson claims that it is sensitive to change and can be used to inform medical practice and research. Its sensitivity, however, is largely due to the fact that it is primarily concerned with changes in symptoms. Two of the items ask patients to select symptoms and indicate their severity. Paterson then finds that these questions are more sensitive to change than the domains of the short form health profile, SF-36, a generic measure of outcomes. This seems to miss the point of research into outcomes. The current interest in patients' perceptions of health outcomes is due to a wish to get away from symptom based assessment and to gain a greater insight into overall self reported functioning and wellbeing. Indeed, some research indicates that the symptoms with which patients present to their general practitioner are often not the main reason for their attendance²; this was one of the primary findings of the developers of the COOP chart.³ A measure that is concerned primarily with symptoms is a step back to a more medicalised approach to the assessment of health outcomes.

Paterson's claim that measures generated by patients assess "only the domains that a patient wishes to change" is pure assertion. In the case of the MYMOP the domains measured are primarily related to symptoms, and we cannot know whether other aspects of life that are important are being tapped. Indeed, a conclusion that Paterson might reach is not so much that the SF-36 is insensitive to changes detected by the MYMOP but that, while many patients reported improvements in symptoms, their general health status hardly improved at all. Indeed, the well-being dimension on the MYMOP was found to be less responsive than other items. Surely this must be taken as evidence that improving symptomatology is not akin to truly improving wellbeing.

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Rate of completion of forms should have been analysed by age

EDITOR,—Charlotte Paterson compares her patient generated measure, the "measure yourself medical outcome profile" (MYMOP) with the short form health survey, the SF-36.¹ Although she states that 7% of the MYMOP forms were incomplete, she does not provide comparable data for the SF-36. We would be interested to know whether there was any correlation between age and completion of the forms as our recent experience suggests that the elderly population may have considerable difficulties when attempting to complete the SF-36 themselves. Poor completion rates in older age groups have also been reported elsewhere.²

With regard to responsiveness, it is not surprising that the SF-36 detected little change over time when the reference time frame used was one month and the period between administrations was four weeks. A version of the SF-36 that has a reference time frame of one week is available,³ and this may be more appropriate for comparisons over relatively short periods.

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Reliability of such instruments needs to be proved

EDITOR,—Charlotte Paterson should be commended for piloting her patient generated outcome measure in a primary care setting.¹ The "measure yourself medical outcome profile" (MYMOP) has potential for routine use, not least because it is simple to use. Also, the authors' tests of validity and responsiveness indicate that it correlates with health status and perceived improvements in health. Three important questions remain unanswered, however. Firstly, does the MYMOP really measure outcomes that matter to patients—that is, that have meaning and relevance in the context of their daily lives? Secondly, does it make sense to combine three quite distinct health dimensions—symptoms, activity, and wellbeing—to produce a single index? Thirdly, is the MYMOP reliable enough to be used in assessing individual patients?

The MYMOP is adapted from the patient generated index, which was designed to measure quality of life.² This index derives from Calman's definition of quality of life as "the extent to which our hopes and ambitions are matched by experience."³ Patients are asked to list the five most important areas of life that are affected by