Randomised clinical trials guard against over-optimism likely to arise from uncontrolled experiments, where bias is easily introduced. It is not true that no major advances have arisen from randomised trials in obstetrics. Two important examples are the use of corticosteroids to prevent the respiratory distress syndrome and the use of anti-D to prevent rhesus isoimmunisation. Furthermore, several disasters have occurred because randomised trials were not carried out, including the well known epidemic of retrolental fibroplasia.² More generally, the widespread use of inferior research designs leads to confusion in published medical reports. Of course, it is known that a few people cheat when carrying out randomised trials, but that is a reason for trying to design trials in such a way as to make such fiddling impossible, not for abandoning clinical trials completely.

Randomised clinical trials are just one way of doing research and constitute a small minority of all research carried out. No one would say that all research should be in the form of randomised trials, but not to perform one when it is both possible and desirable is foolish and arguably unethical.

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1 Sackett DL. Bias in analytic research. *J Chronic Dis* 1979;32: 51-63.

2 Silverman WA. *Human experimentation. A guided step into the unknown*. Oxford: University Press, 1985.

SIR,—Professor D F Hawkins is right in saying that the randomised clinical trial is not appropriate for all clinical circumstances in obstetrics (23 January, p 291). Indeed, the whole point of our article (21 November, p 1298) was to show that this method was of limited use because of considerations of sample size and ethics. Professor Hawkins is also right to suggest that when the results of a randomised trial are not available or when randomisation is undesirable we should rely on alternative methods such as multivariate analysis (and logistic regression). These methods, however, are not equivalent to randomisation; they can adjust only for known variables and cannot remove unknown sources of bias. The latter often have a greater influence than the former on clinical outcome.¹

Professor Hawkins is also correct to link the size of a proposed trial to the size of an effect that would influence clinical practice. An important point in our article, however, was the demonstration that the size of this difference is often very small indeed. We have shown this by the use of consumer questionnaires (involving the probability equivalence multiple gamble method), but this point must be obvious to almost all obstetricians, since the whole of our subject is now concerned with marginal increases in safety. For example, 50% of women would accept a doubling of the risk of miscarriage, from 1 in 200 to 1 in 100, to take advantage of early prenatal diagnosis by chorion biopsy.² Thus to produce results with confidence limits which would be useful to only half of our prospective patients a randomised trial would need to be large enough to show a difference of this size.

Professor Hawkins is right to say that randomisation can pose ethical dilemmas. Again he is wrong if he seeks to imply that this inevitably precludes the use of proper, rigorous clinical experiments. Equally wrong are those who say that there are no ethical concerns and insist on randomisation until doubt is eliminated. We are seldom completely certain or completely uncertain, and for this reason the concept of equipoise was introduced. The less the degree of equipoise—that

is, the more certain clinicians are about the advantages of one treatment over another—the less ethical does a trial become. If we stop a trial when p is less than 0.05 then we regard it as unethical to randomise patients when there is 95% probability that one treatment is better. Most randomised trials involve a trade off between optimising outcome for an individual (by following the line of treatment which is thought to have the greatest chance of success) and optimising outcome for society (thus providing the best possible unbiased data for future patients). It is inevitable, healthy, and appropriate that people will form different opinions on this trade off.

Detailed analysis of the ethics of randomisation, bearing in mind the sample size required, the outcomes involved, and the perceived strength of existing evidence, is preferable to the use of slogans and entrenched positions on this issue.

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1 Coronary Drug Project Research Group. Influence of adherence to treatment and response on cholesterol on mortality in the coronary drug project. *N Engl J Med* 1980;303:1038-41.

2 Thornton JG, Lilford RJ, Howel D. The safety of amniocentesis. *Lancet* 1986;ii:266.

Medical confidentiality in child sexual abuse

SIR,—A number of important issues were raised in Dr D T D Bulugahapitiya's letter (9 January, p 133) on the paper by Dr Roger Williams, myself, and other colleagues on child sexual abuse (21 November, p 1315).

Although the writer talks about Asian families, our experience is that these issues occur in every family we see. Many young people around the age of 14 manage to speak to a teacher they trust but ask that confidentiality should not be broken. This means that the professional confided in has a responsibility for that young person's welfare, and in my view the teacher quite rightly informed the doctor when the girl was admitted to hospital. The complaints were of abdominal pain—which can be associated with continuing traumatic experiences—and the teacher must have been relieved to share confidentiality. There should then perhaps have been a preliminary meeting as advised by the DHSS draft guidelines on interprofessional management so that those concerned could discuss the matter rapidly and decide how to proceed.

The psychiatrist's view that there should be no discussion of the abuse because of a risk of suicide was unhelpful because the opportunity to talk to the young person in detail was lost. It is entirely appropriate for a professional to say to a 14 year old that because of the magnitude of the problem he or she cannot maintain confidentiality and that the information must be shared with people who can ensure that she can be protected. It is a measure of the girl's desperation, perhaps her wish to draw further attention to the abuse, that she took an overdose of the very antidepressants that she had been prescribed. There is no information about a detailed interview with the girl to ascertain the extent of the abusive experiences or their effect on her. The fact that there are other young people living with the alleged abuser is of great concern. It is possible to examine even extremely shy young people if sufficient time is taken to sort out the young person's anxieties about inappropriate early sexual experiences.

Although the parents insisted on confidentiality and that the girl should not be seen by any other doctor except the psychiatrist and general practitioner, there is a question whether it is possible to

grant such confidentiality, given the fact that other children in the community might be at risk. If medical staff take on the task of accepting strict confidentiality in these cases this may run counter to agreements about the management of abuse between professionals in the community, and this means that they are now protective agents to this child. This is a heavy responsibility.

Of course, there are concerns about professionals carrying out their tasks in an insensitive and uncaring way, but it is essential that professionals should educate each other and devise proper management strategies. Abuse occurs in every community and it is our responsibility to ensure that children are protected and that we learn to understand each community in enough detail to be able to provide proper protection and proper treatment.

This is another case where there could have been a tragedy if the overdose had been successful. The management of this case resembles the management that was prevalent for many years before people began to recognise abuse and its long term effects. It is sad when avoidance and secrecy are practised rather than openness and a willingness to learn how to manage these extremely difficult and worrying cases.

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Should colonoscopy be the first investigation for colonic disease?

SIR,—While one would not necessarily argue with the primary conclusion of the paper by Drs D C Lindsay and others that radiological examination of the colon is not a necessary prerequisite for colonoscopy, it is unfortunate that those who read the article will come to the conclusion that radiology is seriously inferior to colonoscopy, even though the authors declare that this is not the intention.

The methods in the paper leave serious doubts about the validity of their comparison of colonoscopy and radiology. For example, colonoscopy was performed by four experienced and enthusiastic endoscopists, whereas radiology was performed by any one of a number of radiologists. Agreed, this is normal clinical practice, but we are not told whether the radiologists were informed that their investigations were being scrutinised for a prospective study or whether the protocol was discussed with the radiologists at the outset. The colonoscopists would undoubtedly have been aware that their patients were being prospectively assessed, and we can assume therefore that they made particular attempts to examine the colon as fully as possible and to give an adequate report. Unless the radiologist was also being given the same advantage the comparison becomes open to the influence of bias. Secondly, who scored the radiographs in an attempt to assess adequacy of examination? It takes some time to become experienced in interpreting the nuances of the barium enema examination, and scoring by a non-radiologist is quite unacceptable particularly if the same non-radiologist scores the colonoscopy examinations. Scoring by a clinician who is also a colonoscopist is open to considerable risk of bias, even though the clinician may make a particular attempt to avoid this. If the protocol was discussed with radiologists before the study, and if a radiologist did take part in the assessment of films, why is there no radiologist among the authors?

If a group of radiologists from the Royal Victoria Infirmary in Newcastle were to examine the films and reports of the barium enemas and the colonos-