Gravesham district two candidates were rejected, and a similar situation repeats itself all over Britain.

The one factor that is common to all the people rejected is not that they are subversive, but that they are effective communicators, care passionately about the health service, and are earnest in their attempts to express the fears of the community about the decline in standards in many areas of the NHS.

In my own case the West Lambeth Health Authority chairman, John Garnett, declared openly that I was not acceptable to them, although the decision is taken legally by the regional health authority. District health authority members attempting to overturn the decision of the chairman were prevented from doing so by a procedural device.

A government that fears the influence of a single member on a district health authority must really be quite scared of public criticism and the ability of a few committed opponents to expose ministerial mendacity.

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SIR,—I am most concerned by the implications of signing the Department of Health and Social Security's new contract on the freedom to publish the findings of DHSS supported research and share the views of Sir Douglas Black (19-26 December, p 1582) and others (6 February, p 427).

If there is no wish to restrict publication I cannot understand the need to tamper with the current contract, which, as Dr R H L Cohen (6 February, p 427) points out, "guarantees the scientific independence of the researcher." The reason put forward by officials of the department, as well as by ministers, that the present contract does not satisfy current copyright law has not been vindicated by the opinions of independent legal experts. Why, if the department says that it has a case, could it not test or discuss the legal interpretations of the old and the new contracts with experts nominated by the researchers interested in this question?

Further, if the DHSS feels that it has right on its side why do the Home Office and the Scottish Home and Health Department operate different rules in negotiations with their researchers?

Researchers believe strongly that if there is any interference in the right to publish findings it will become increasingly difficult to obtain cooperation from colleagues (6 February, p 427). Even if research findings gave reason for concern, under the new contract there would undoubtedly be a certain reluctance to criticise public policy. Journals might be reluctant to publish "censored" work, and the credibility of the findings would be questioned and might do damage to the DHSS as well as to the researchers.

I have no doubt about the good faith of those concerned with the administration of research, but I have major reservations about their sensitivity.

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Obscure gastrointestinal bleeding

SIR,—We were surprised that Messrs A C Steger and J Spencer (2 January, p 3) made no reference to isotopic methods in diagnosing the site of obscure gastrointestinal haemorrhage. During the past three years we have gained considerable experience of in vivo technetium-99m labelled red

cell scintigraphy in the investigation of lower gastrointestinal haemorrhage and have been impressed by the results.

Over the period June 1984 to September 1987, 43 isotope scans were performed on 41 patients (22 men, 15 women, and 4 children aged 5 months to 91 years) who presented with lower gastrointestinal haemorrhage. In each case the accuracy of the scan in localising the bleeding site was checked either by independent investigations or at laparotomy. Bleeding was accurately localised in 29 out of 30 cases (sensitivity 97%), and in the 13 cases in which no definite bleeding site could be found there were only two false positive results (specificity 85%). The investigation had a high predictive value when both positive (94%) and negative (92%).

Two types of lesion which may frustrate even the most thorough investigation are those that bleed slowly and those that bleed intermittently. Successful angiography requires relatively high bleeding rates of 0.5-1.0 ml/min and this must be occurring at the time of contrast injection.¹ Red cell scintigraphy can detect bleeding rates as low as 0.05-0.1 ml/min,² and because labelled red cells have a long intravascular half life repeated scans can be performed over 36 hours without injection of further radioisotope.

The technique of in vivo red cell scintigraphy is simple and elegant, requiring only two intravenous injections.³ We believe that this investigation should be used more widely and has advantages which are especially relevant in cases of obscure gastrointestinal haemorrhage.

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Attitudes of a multiracial antenatal population to HIV screening

SIR,—The issue of consent to screening for antibodies to the human immunodeficiency virus (HIV) is crucial, yet consent should be fully informed and not simple acquiescence.

Like Dr Gisselbaek and^o others (23 January, p 288), we conducted a survey among our patients—a multiracial antenatal clinic population, a particularly important group in view of recent

suggestions that antenatal screening should be used to establish prevalence data.¹

Two hundred and ninety nine consecutive first time attenders to our antenatal clinic were asked to complete a simple questionnaire with the aid of an interpreter if necessary. The inquiry encompassed not only their knowledge of and attitudes to screening for HIV infection but also other aspects of screening in pregnancy and what action or actions should be taken should a test be positive (see table).

One hundred and seventy six (59%) completed questionnaires were returned, the response rate being 50% (53/107) among the Asian population and 65% (123/192) among the white and Afro-Caribbean population. Altogether 11% of responders thought that the clinic population should not be screened whereas 35% did not know; 34% said that they themselves would not wish to be screened and 29% did not know. If screening were to be introduced 85% of responders wanted to be informed and 87% wanted to know the result (see table). The prevalence of "don't know" answers throughout the questionnaire was significantly higher among the Asian sample.

We also noted that 59% of our responders stated that they would request a termination of pregnancy if they were found to be positive on testing and this were known to affect the fetus, while 16% would still request a termination if the fetal effect were uncertain.

The recent information campaign has clearly not reached our ethnic minority groups to an extent where they and we can feel confident about introducing screening with informed consent, and our findings emphasise the need to develop information and counselling services.

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- 1 Doll R. A proposal for doing prevalence studies for AIDS. *Br Med J* 1987;294:244.

Defibrillation after near drowning

SIR,—My experience as an anaesthetist in Cornwall and now as an immediate care general practitioner leads me to differ substantially from the advice given by Dr Mark Harries (23 January, p 27).

There is now little doubt that the victims of near drowning should be resuscitated using generally accepted cardiac arrest techniques. The victim should be placed on a blanket, towels, or dry clothing to stop further cooling, and if he is pulseless and apnoeic cardiac compression and ventilation should be performed. A combined

Attitudes to screening in pregnancy with particular reference to AIDS. Results are numbers (and percentages)

Question	Yes	No	Don't know
Is syphilis tested for during pregnancy?	44 (25)	10 (6)	122 (69)
Would you request a termination if your baby was going to be severely abnormal?	68 (39)	37 (21)	71 (40)
Have you ever had an AIDS test?	4 (2)	164 (93)	8 (5)
Would you like to be tested?	60 (34)	65 (37)	51 (29)
Should all pregnant women be tested?	95 (54)	19 (11)	62 (35)
Should you be informed if you were tested?	150 (85)	6 (3)	20 (11)
If you were tested would you want to know the result?	153 (87)	8 (5)	15 (9)
Should your family doctor know the result?	151 (86)	8 (5)	17 (10)
Should your partner know the result?	147 (84)	13 (7)	16 (9)
If you were found to have the AIDS virus and it would affect your baby, would you request a termination?	104 (59)	16 (9)	56 (32)
If you were uncertain your baby would be affected, would you still request an abortion?	28 (16)	59 (34)	89 (51)

monitor-defibrillator allows a cardiac diagnosis to be made, and if the heart is in ventricular fibrillation it should be defibrillated. Children have been successfully defibrillated at temperatures of 27°C to 30°C, contrary to what has been previously thought.¹ If unsuccessful, further attempts should be made. Laying the patient on a dry blanket protects the operator; arcing does not seem to happen, even with a damp chest. If the heart is in asystole, cardiopulmonary resuscitation should be continued until the victim's temperature is higher than 32°C, the established technique for the management of cardiac arrest being followed.

Victims should never be certified dead until their body temperature and electrocardiogram can be monitored. Resuscitation should continue for however long this takes, for there are recorded cases of full neurological recovery after cardiopulmonary resuscitation for more than two hours.²

Although right heart bypass is an extremely valuable technique in warming the victim, I have seen many who have survived after peritoneal dialysis and continued cardiopulmonary resuscitation, a technique available in every district general hospital.

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1 Simcock AD. Treatment of near drowning—a review of 130 cases. *Anaesthesia* 1986;41:643-8.

2 Orłowski JP. Drowning, near-drowning, and ice-water submersion. *Pediatr Clin North Am* 1987;34:75-92.

Child abuse and osteogenesis imperfecta

SIR,—In reference to the letters of Dr L S Taitz and of Drs Helen Carty and Donald G Shaw (23 January, p 292), I confirm that the 13 patients mentioned in our letter (12 December, p 1561) were all ones in whom there is now no doubt about the diagnosis of osteogenesis imperfecta. We deliberately excluded those, such as those mentioned by Dr Taitz, over whom some doubt may persist. These patients form a worrying group.

I can also reassure Drs Carty and Shaw that the patients we reported on in our recent paper on osteogenesis imperfecta type IVA¹ were collected after patients in whom the diagnosis of osteogenesis imperfecta was doubtful had been excluded, as had been all patients whom we could not, with confidence, allocate to the type IVA variant. Of this group, 64 had been seen personally and 45 had a clearly positive family history. In each case osteogenesis imperfecta had been diagnosed by local paediatricians or orthopaedic surgeons before we carried out our investigations. Skull fractures do occur in this group of patients, as in all other types of osteogenesis imperfecta. In any individual there are of course many more limb fractures than skull fractures, but our figures indicated the proportion of patients who had had at least one skull fracture at any time.

It is not true that osteogenesis imperfecta type IVA is always a mild disease; in our study the mean fracture rate was about twice that of IA disease at all ages. There is even more variation in the severity of the condition than is true of type I disease.

In all the cases I reviewed there were substantial reasons for doubt about the diagnosis of non-accidental injury before I was asked to investigate. Indeed about half were referred not by the parents' solicitors but by the guardians ad litem. The diagnosis in a child with unexplained fractures is seldom easy, and at least four bone disorders—osteogenesis imperfecta, copper deficiency, rickets, and hyperphosphatasia—can cause difficulty. It is incumbent on all of us who are concerned in

these difficult cases to ensure that an incorrect diagnosis of child abuse is not reached and equally that genuine cases of child abuse are identified to protect the patient and any siblings.

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1 Paterson CR, McAllion SJ, Shaw JW. Clinical and radiological features of osteogenesis imperfecta type IVA. *Acta Paediatr Scand* 1987;76:548-52.

**This correspondence is now closed.—Ed, *BMJ*.

Clumsy children

SIR,—I agree with Dr D M B Hall (6 February, p 375) that clumsiness in childhood has many causes but suggest that within the overall group it is possible to identify a specific syndrome of difficulty in learning motor skills (and sometimes cognitive skills as well) for which no structural abnormality in the brain can be shown.^{1,2} At its most severe this syndrome probably represents one end of a spectrum of severity, since minor degrees of difficulty are common when detailed psychological assessment is carried out in school-children.³

I wondered, however, why Dr Hall did not refer specifically to psychometric testing of such children and whether he would agree that the use of the Wechsler intelligence scale for children can be a useful screening test; in most cases where a specific learning defect causes defective acquisition of motor skills it shows a discrepancy between a relatively high verbal IQ and a low performance IQ. I agree with Dr Hall that many of these problems are at least partially overcome in the teen years and that clumsiness of this nature is a talent deficit which, like other learning disabilities, demands specialised and skilled educational requirements for these children.

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1 Walton JN, Ellis E, Court SDM. Clumsy children: a study of developmental apraxia and agnosia. *Brain* 1962;85:603-12.

2 Gubbay SS, Walton JN, Court SDM. Clumsy children: a study of apraxic and agnosic defects in 21 children. *Brain* 1965;88:295.

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AUTHORS' REPLY.—Sir John suggests that clumsy children represent one end of a spectrum. He does not specify whether he means a spectrum of normal function, as I proposed in my article, or of some as yet uncharacterised pathological process.

Clumsiness may, of course, occasionally be the functional manifestation of several distinct pathological processes. For example, it may follow encephalitis or neonatal hypoglycaemia. Perhaps some localised cerebral malformation might be responsible; such lesions have been associated with dyslexia⁴ (though they do not necessarily cause it). In my experience cases with evidence of pathology are rare, whereas some authors claim that clumsiness affects 3-15% of children. It is difficult to believe that they all have damaged or maldeveloped brains.

Since there is no radiological or biochemical marker for clumsiness the condition can be defined only clinically. Sir John implies that clumsy children can be identified through a verbal-performance discrepancy on IQ testing.

There are undoubtedly children of normal or superior verbal ability who not only are clumsy but

also have difficulties with constructional tasks, attention control, and so on. This apparent clustering, which gave rise to the concept of the "clumsy child syndrome" and the closely related idea of "minimal brain dysfunction," has been shown to be largely artefactual.² Each of the many subskills which make up psychological functioning can vary independently and is to some extent under separate genetic control.³ The unfortunate child who has a statistically improbable mix of talents and deficits is not well tolerated by parents, peers, or educationists. If he is referred for medical evaluation he is likely to be diagnosed as a "typical" clumsy child. Clumsiness is a pejorative term and is best avoided altogether, but the concept may have some value if it is applied specifically to motor disabilities. Any associated problems should be assessed and described on their merits.

Some children are undoubtedly helped by recognition that they have real difficulties with particular tasks, but there are also dangers in the medicalisation of normal human variation: "An entire generation has been conditioned to regard its deviation from the narrowing standards of approved norms as sickness."⁴

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1 Galaburda AM, Kempner TL. Cytoarchitectonic abnormalities in development dyslexia: a case study. *Ann Neurol* 1978;6:94-100.

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Treatment of prostatic cancer

SIR,—Dr Jonathan Waxman (30 January, p 356) discusses the relative merits of subcapsular orchidectomy and gonadotrophin releasing hormone analogues for treating prostatic cancer.

In Bristol we have had extensive experience over the past three years with depot gonadotrophin hormone releasing hormone analogues. Undoubtedly when we discuss the treatment options most men will select a monthly (or three monthly) depot injection in preference to orchidectomy. Some men, however, do prefer the "once and for all" surgical option. Perhaps more men would choose it if we explained to them that while both provide effective treatment they both have the same physiological effects—impotence, flushes, and reduction in size of scrotal contents. The apparent advantages of avoiding a "mutilating" surgical procedure may well be outweighed for some by the need for regular outpatient attendance and therefore a monthly (or three monthly) reminder of their condition. This has been particularly noticeable in our unit, where patients are reviewed in a specific prostate cancer clinic. Some patients find the obvious deterioration of others, who may have been attending the same clinic on the same day for several months, disturbing.

There is no evidence that men with prostatic cancer necessarily view orchidectomy as mutilating, and we know of no studies into the psychological effects of this procedure in this group of patients. Recent studies in patients with breast cancer have actually shown no difference in psychological morbidity between those undergoing mutilating surgery (mastectomy) and those undergoing conservative surgery.¹ Unless similar studies of attitudes to orchidectomy are undertaken it cannot