FIG 2—Postage stamp celebrating 50th anniversary of award of Nobel prize to Professor William Bragg and his son, Sir Laurence Bragg (reproduced from reference 2 by permission)

anniversary of his original prize in 1915, and figure 2 shows a celebratory postage stamp.

Thus Röntgen's original discovery has borne fruit in medical fields far wider than the diagnostic techniques we now use.

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Anti-therapeutic community mental health law

EDITOR,—The defence by K C Calman, the chief medical officer, of the government's Mental Health (Patients in the Community) Bill seems to be based more on hope than on clinical argument.¹ It is also contradicted by the Department of Health's internal review of legal powers on the care of mentally ill people in the community, which preceded the drafting of the bill.² This stated that, although the department believed that wider use of guardianship might help some patients, "we cannot see guardianship offering a ready answer to the problems of the patients with whom we have been concerned." Aftercare under supervision, however, amounts merely to "guardianship, fortified with the power to convey."

Neither I nor Calman can support our expectations of the clinical impact of the bill by reference to clinical trials. This contrasts with the introduction of supervision registers, for which piloting would have been possible and should have been pursued. Calman offers no clinical argument, however, that influence over patients will be enhanced by enforced conveyance to a place "for medical treatment, occupation, education or training" in the absence of the power to treat. Is setting such a weak and confusing clinical boundary likely to enhance patients' compliance with treatment?

Calman rebuts my criticism of the bill—that it fails to offer resources in exchange for further restriction of civil liberties. Clause 1(1)25A(4)(c) of the bill says, "being subject to after-care under supervision is likely to help to secure that [the patient] receives the after-care services to be so provided." I would emphasise that adequate resources are required for this principle to be satisfied. Ordinary guardianship orders are often resisted by local authorities specifically because of their implications for resources, emphasising the frequent inadequacy of community resources. Ironically, some clinicians have suggested that the bill might allow adequate health and social service resources to be obtained by overtly showing unmet need. The doctor would simply record in the case notes, "I would have applied for aftercare under

supervision for this patient, but I was unable to legally do so because the aftercare services were inadequate."

Since forced conveyance is likely to be perceived as anti-therapeutic, and sometimes even as dangerous, aftercare under supervision will be reduced to a mechanism for encouraging proper case reviews. It must not be perceived as a means by which patients in the community can be directly controlled. There is a deep divide between legislating for care in hospital and in the community.⁴

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Telephony remains useful in medical informatics

EDITOR,—Enrico Coiera¹ and Paul McLaren and C J Ball² point out that even in the midst of recent technological advances the telephone remains a valuable tool for doctors. We have recently shown that, in north London at least, the telephone's potential for improving communication between consultants and general practitioners has not been realised.

We sent a questionnaire to 100 local general practitioners to determine the number of telephone calls from a consultant that each general practitioner had received in the preceding month and whether he or she would like to receive more such calls. We also determined how easy it was to contact general practitioners by studying the telephone calls that we made to general practitioners over nine months.

There was a 93% response rate to our questionnaire. Fifty eight general practitioners had received no telephone calls from a consultant in the previous month, and only 12 had received more than one such telephone call. Eighty three respondents wished to receive more calls, with 78 specifically stating that they did not mind being interrupted in a busy surgery about an important matter. General practitioners were generally easy to contact by telephone. Contact was made within five minutes in 49 of the 75 calls we made and within 24 hours in 63 calls.

We found that general practitioners appreciate telephone discussions with consultants when important or pressing matters about one of their patients arise. Although the general practitioners were usually easy to contact by telephone, they received few calls from consultants. We look forward to joining the Internet when the British Paediatric Association gets its home page. Nevertheless, we are confident that even when the Internet is established in medical practice the telephone will remain a powerful way for general practitioners and consultants to communicate with each other.

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Should older women be offered in vitro fertilisation?

Authors' premise is faulty

EDITOR,—In concluding that "it is not right to withhold fertility treatment on the grounds of the interests of the potential child" on the premise that existing will always be preferable to non-existing, Tony Hope and colleagues are guilty of false logic.¹ They wonder whether it is better never to have existed than to be born and have one's mother die while young. Their error is in attributing interests to a being that does not exist and then weighing these interests against the interests of a being—that is, the potential mother—who does exist.

If their argument holds, then all parents of whatever age are under a moral obligation to have as many children as possible by whatever means medical science can provide and to turn thousands of hypothetical babies into real babies on the grounds that it is better to be real than hypothetical. This conclusion is logical given their premise, but their premise is faulty. Anyone who saw a television documentary on the "dying rooms" in China's orphanages (*Secret Asia*, "The Dying Rooms," C4, 14 June 1995) might consider that humanity might have been served better if those wretched and unwanted babies had been left as hypothetical ones.

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Counselling may be a better use of resources

EDITOR,—The ethical debate on in vitro fertilisation for older women and the interests of the potential child¹ attracted considerable attention in the media, although the media failed to report that age cut offs have primarily been instituted on the basis of effectiveness. We agree that if the take home baby rate after in vitro fertilisation among older women were to improve then there would be a case for re-evaluating guidelines. We accept that if the interests of the child are important then the age of the father and comorbidity affecting the parents' life expectancy or ability to care for the child should also be considered. Age cut offs may become less of an issue as the current cohort of infertile couples requesting in vitro fertilisation either receives treatment or gives up the attempt to have children. In the future, the backlog of couples requesting treatment will have been cleared and referral will mainly be for incident cases of infertility, although some older women in second marriages may request treatment.

Tony Hope and colleagues point out that criteria for adoption are strict, although they argue that the case for in vitro fertilisation is different from that for adoption since the infertile couple are the only potential parents for the as yet unconceived child. We see no reason why strict though rational criteria should not be in place for in vitro fertilisation. If health authorities allocate resources to assist in the birth of a finite number of children then couples have to compete for one of these limited courses of treatment. Couples need to justify why they should have assistance to conceive their potential child in preference to other couples. Effectiveness and ability to care for the child in its formative years may be among the factors to be considered. The suggestion that we might "choose between 'competing' couples, on the basis of seeking to maximise the number of happy children made per pound spent," is actually an argument for investment

in better paediatric care, education, or social environment, which are more likely than in vitro fertilisation to maximise utility. When resources for health care are scarce we need to consider the opportunity costs of any investment. While infertility can cause psychological distress, a better use of resources may be to offer counselling to allow couples to accept their condition, or to attempt to alter the expectations of relatives and friends.

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Existing children are treated differently from embryos

EDITOR,—Tony Hope and colleagues rightly point out that the analogy drawn between assisted conception and adoption is false since in the case of adoption the child already exists.¹ They themselves, however, go on to draw a similar analogy when they quote society's reluctance to take children into care except under the most dire circumstances. But again, the child already exists. Does society usually consider that "the level of parenting would have to be very low for it to be preferable not to exist at all rather than exist as a child of those parents"¹ when it comes to the ethics of aborting potential children?

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Lowering patients' cholesterol

Excluding patients from trials increases uncertainty

EDITOR,—In their editorial Michael Oliver and colleagues rightly emphasise the important results of the Scandinavian simvastatin survival study,¹ which shows that overall mortality can be reduced by simvastatin in patients with existing coronary artery disease.² They do not, however, mention the problem of patients with heart failure, who were specifically excluded from the study, presumably on the premise that the mortality in such patients was likely to be determined more by their ventricular function than their serum lipid profile.

Coronary artery bypass grafting produces a similar relative reduction in mortality in patients with normal and abnormal ventricular function.³ Since mortality is higher in those with impaired left ventricular function, the absolute benefit of revascularisation is higher in this group. By analogy, lipid lowering treatment may also confer greater absolute benefit on those with heart failure, making the exclusion of this group from the Scandinavian simvastatin survival study particularly unfortunate.

Thus, according to the principles of evidence based medicine, treatment to reduce mortality after myocardial infarction should be selected according to left ventricular function. If the ventricle is normal

we should treat raised cholesterol concentrations with simvastatin. If it is impaired we should use an angiotensin converting enzyme inhibitor, but should we apply the study strictly and ignore the lipids?

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Few eligible patients currently receive treatment

EDITOR,—Michael Oliver and colleagues' editorial states that there is no longer any controversy over the treatment of patients with hypercholesterolaemia and coronary heart disease.¹ Since few published data exist on current practice with regard to treatment of hypercholesterolaemia in patients with coronary heart disease, we wish to report our findings derived from a computerised patient database and from health authorities' records.

After the benefits of lowering cholesterol concentrations had been proved convincingly we started a project to optimise the treatment of hypercholesterolaemia in patients with coronary heart disease at the health centre in Kuusankoski in southeastern Finland. The health centre is responsible for the primary care of 22 000 people. In the first phase of the project we analysed current practice. Our objective was to find out, firstly, how many patients visited a physician at the health centre during 1994 for suspected or diagnosed coronary heart disease; secondly, how many of these patients had their cholesterol concentration measured during 1994; and, thirdly, how many of these patients were receiving cholesterol lowering drugs at the end of 1994. The table shows the preliminary results.

In addition to showing gross undertreatment, the analysis showed insufficient measurement of the patients' cholesterol concentrations. Even though we suspected that the treatment might be inadequate, the true degree of undertreatment was disquietingly high. Unfortunately, we believe that the situation is no better in other municipal primary open care units in Finland.

Interestingly, the statistics of the Social Insurance Institution of Finland indicate that in Kuusankoski there are 621 patients who are entitled to preferential reimbursement for drugs used to treat coronary heart disease (including

Number of patients visiting physician at Kuusankoski Health Centre because of suspected or diagnosed coronary heart disease in 1994 and number (percentage) of these patients who had their cholesterol concentration measured in 1994 and who received cholesterol lowering drugs by end of 1994

	Age (years)			
	Total	< 65	65-	≥ 75
Patients visiting physician	631	132	240	259
Cholesterol measured	147 (23.3)	68 (51.5)	60 (25.0)	19 (7.3)
Cholesterol lowering drugs prescribed	NA	13 (9.8)	NA	NA

NA=Not available as analysis not yet completed.

nitrate, β blockers, and calcium antagonists). The health centre's database on patients thus seems to provide a relatively comprehensive record of coronary heart disease in the municipality.

As the second phase of our project we have started a structured intervention to improve the inadequate treatment. We urge all primary care units and hospitals to do the same because treatment of hypercholesterolaemia in patients with coronary heart disease saves lives and reduces clinical events, revascularisation, and admission to hospital.²

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Extrapolating results of trial of simvastatin gives room for doubt

EDITOR,—In their editorial Michael Oliver and colleagues clearly state the case for cholesterol lowering treatments in the secondary prevention of coronary heart disease.¹ From the information presented there indeed seems "little justification for inertia" or room for "controversy." Are there some important unanswered questions, not addressed in the editorial, that will inevitably lead to delay in the implementation of the research findings discussed?

Firstly, as a three to six month trial of diet is recommended, most patients requiring cholesterol lowering drugs after infarction will probably have the treatment initiated by their general practitioner. There is limited evidence on how results from randomised controlled trials in highly selected patients in secondary care translate to unselected patients in primary care.

Secondly, how well can the results of the Scandinavian simvastatin survival study be extrapolated to women? Although simvastatin reduced the risk of major coronary events in women, it failed to reduce mortality, the primary outcome measure. There was a 6% mortality in women taking placebo compared with a 7% mortality in those taking active treatment. The only definite conclusion from this has to be that the study lacked sufficient power to detect a significant difference in mortality in women.

Thirdly, about 40% of subjects were ineligible for inclusion in the Scandinavian simvastatin survival study because they had arrhythmias, heart failure, previous strokes, etc—all common accompaniments to established cardiovascular disease. Randomised controlled trials require a reasonably homogeneous population so that hypotheses can be adequately tested. How far can these results then be extrapolated to patients who would not have met the strict criteria for entry to the study? Do we need to validate the results of the controlled trials by studies of a heterogeneous unselected population in primary care or can we assume that it does not matter?

Finally, "number needed to treat" analysis is becoming increasingly popular. Ferner and Neill estimate that 162 patients need to be treated for one year at a cost of £60 500 for one life to be saved.² This analysis does not affect the optimum treatment recommended but is a factor that of necessity will determine the implementation of cholesterol lowering treatments into everyday practice.

The results of the trials discussed in the editorial