

colour and raised) tend to respond poorly to pulsed dye lasers: better and more rapid responses can often be achieved with alternative lasers such as the frequency doubled neodymium yttrium aluminium garnet laser in conjunction with an automated delivery system. Deeper cavernous areas or hypertrophic tissue may require more non-specifically destructive treatment such as neodymium yttrium aluminium garnet or carbon dioxide lasers to improve their appearance. None of these alternative treatments rule out subsequent treatment of residual port wine stain with a pulsed dye laser, and using several different lasers in combination often gives the best results.

Mathematical modelling can determine theoretically ideal laser variables for treating port wine stains. This work has made a great contribution to our understanding of the subject, although the structural diversity of port wine stains confounds the best attempts at mathematical modelling and there is no substitute for good clinical assessments and comparisons of different laser systems. Further research needs to be done before Van Gemert and colleagues can be confident in suggesting using pulsed dye lasers as first line treatment for all port wine stains.

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## Cardiovascular disease in developing countries

EDITOR,—Unfortunately, the emerging epidemic of cardiovascular disease in developing countries cannot be explained by selective quotation or wishful thinking. Uffe Ravnskov is sceptical about evidence from death certificates.<sup>1</sup> Of course, there is a particular problem with death certificate data in developing countries, but there is plenty of other evidence for the epidemic.<sup>2</sup> Ravnskov attributes the epidemic to the effects of westernisation.<sup>1</sup> Dietary change is a central component of this process, and there is a mass of evidence to support the role of a diet high in saturated fat in atherogenesis.<sup>3</sup> The epidemic is preventable and is being prevented in many industrialised countries.<sup>4</sup> Unfortunately, it is not yet being prevented in eastern European or developing countries.

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## Quality of life measures

EDITOR,—D J Spiegelhalter and colleagues discuss measuring the benefits of health care in terms of quality of life and describe using quality adjusted life years (QALYs) in resource allocation.<sup>1</sup> This measure may be of use to health care planners, but, even if it is eventually validated and accepted as an equitable way of allocating resources, it will be of little help to general practitioners, whose decisions

are mostly concerned with managing self limiting minor illnesses.

I suggest that general practitioners' decisions are generally what Spiegelhalter and colleagues call stage 1 decisions—that is, unaided intuitive judgments. I strongly support Tony Delamothe's view that evidence that treatments are actually efficacious is needed before we start rationing care.<sup>2</sup> General practitioners might be helped most, and would consequently help their patients most, by research defining the best way to manage these common, unexciting illnesses. Such research would be helped by the development of valid, reliable instruments to measure quality of life in common minor illnesses. Most of these minor illnesses last only a few days or weeks: what are needed, therefore, are the measures quality of life days or quality of life weeks.

Such instruments would have several advantages over QALYs. Firstly, they would be more reliable and valid. They could be constructed by random surveys of a general practitioner's practice population (culturally valid), most of whom would have had personal experience of common conditions. The responses could be analysed for differences in opinion depending on the time since the respondent had suffered from the illness or between those who had ever and those who had never suffered from the illness in question. Secondly, patients would not be asked to include death in the range of responses. Thirdly, the instruments would be used primarily to compare different management choices for one illness and not to make rationing choices between different illnesses.

The results of research with such instruments would enable general practitioners to provide scientific evidence to managers on why they may be using more expensive management options for a particular illness when the managers exert pressure on them to use the cheapest. Moreover, by choosing an option that has been shown to be the best in terms of quality of life days gained general practitioners would be more certain that they were acting with beneficence; at present, using simply their "unaided intuitive judgment" to make such decisions, they can only hope that this is the case.

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## Rationing

EDITOR,—Tony Delamothe writes that there was much common ground between two recent conferences on rationing, one sponsored by the Royal College of Physicians and the other by the Radical Statistics Health Group, Public Health Alliance, Critical Public Health, Socialist Health Association, National Union of Public Employees, National and Local Government Officers' Association, and Confederation of Health Service Employees.<sup>1</sup> His view was not shared by another reviewer.<sup>2</sup>

The "great and the good in serried ranks" at the Royal College of Physicians heard clinicians from different specialties confront managers with the problems of rationing at the clinical interface. This specialty focus could be perceived as "plea bargaining" and was taken as such by at least two chairpeople of health authorities. Many of the other presentations reduced rationing to an academic exercise which ignored the current impact of decreased resources on the provision of health care.

Focusing on effectiveness and outcomes as a basis for decisions on rationing is a desirable aim that cannot be achieved at present when so much of

health care is unevaluated. Health authorities have already begun to restrict services, most commonly removal of tattoos and cosmetic surgery.<sup>3</sup> These interventions are surgically effective, and their removal from the list of services has more to do with social judgments. Discussions of the Oregon experiment were repeated, although this debate has already been well rehearsed.<sup>4</sup> The Oregon experiment was introduced to ensure a basic level of health care for poor and elderly people. In contrast, in the NHS we now face reduced access to care in a system that once prided itself on its aim of universal accessibility.

Rudolf Klein, in a remarkable about turn, concluded at the meeting at the Royal College of Physicians that, since purchasers cannot make their decisions on rationing explicit, clinicians should make the decisions but make explicit whom they will not treat. Are the political constraints that prevent purchasers from making their decisions on rationing explicit any different from those facing clinicians? And are clinicians any more immune from social judgments?

Rationing should not be the exclusive domain of managers and professionals. Our conference, which Delamothe said was attended by "political activists and pensioners," was intended to open up the debate to the public and to inform people using the service. The proceedings of the meeting are to be published by Critical Public Health. If pensioners, with potentially the most to lose in the rationing process, do not participate in discussions about rationing who should? By holding an expensive meeting on a weekday the Royal College of Physicians denied a voice to the very groups that most need to participate in the debate. Could this have been the intention?

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## Working with adult survivors of child sexual abuse

EDITOR,—I was struck by the subtitle of Penelope Campling's editorial on working with adult survivors of child sexual abuse: "Much can be learnt from what goes wrong."<sup>1</sup> I would like to draw attention specifically to the trauma of vaginal and rectal examinations for adult survivors.

I am the daughter of a doctor and was sexually abused throughout my childhood. I have been through a long period of psychotherapy dealing with this abuse and continue to find internal examinations traumatic. In September 1989 I was taken into hospital with the classic symptoms of acute appendicitis. An understanding female house officer took a history and examined me. Then I saw the senior registrar, who had already been briefed by the house officer about my history of abuse. I also explained to him myself that I had been abused by my father, who was a doctor, and that I did not wish to be examined by a man. An argument of 45 minutes ensued, during which I became distraught. In his professional opinion this was overreaction on my part, and he was extremely inconvenienced by my insistence not to be examined internally by him.

Eventually my husband and the house officer managed (with great determination and much shouting) to persuade him that if it was absolutely necessary to examine me internally the house officer would do so. She did, and my appendix was