LETTERS

Assisted conception on the NHS

EDITOR,—David T Baird wonders why governments have reservations about assisted conception techniques for managing infertility.[1] Surely one of the reasons is the poor quality of evidence for the effectiveness of some treatments, which we review in the most recent issue of *Effective Health Care*.[2]

Many subfertility treatments have not been evaluated by randomised controlled trials. For example, there is no published report of a randomised controlled trial comparing in vitro fertilisation and embryo transfer with an untreated control group (for example, subjects in whom treatment is delayed). Similarly, the view that medical treatment of amenorrhoea is highly effective is based entirely on retrospective reviews. Estimating the increase in pregnancy rate over the often appreciable spontaneous pregnancy rate that would have occurred in the absence of treatment is often difficult.[3]

The relative effectiveness of in vitro fertilisation and embryo transfer and other assisted conception techniques is not clear for various reasons. For severe bilateral occlusion of the fallopian tubes in vitro fertilisation and embryo transfer is the only possible treatment, but for women with at least one patent and healthy fallopian tube there is controversy over which technique is best. Well designed randomised controlled trials are needed to answer questions about the best technique for particular indications and patient characteristics.[4]

Different treatments may have different effects on the monthly fecundity and cumulative pregnancy rates. For example, prednisolone treatment of antibodies to sperm may need longer follow up before improvement in male fertility is observed. With assisted conception the effects are more rapid. Therefore, to compare treatments time must be incorporated into the analysis. Many studies, however, do not report the duration of follow up or number of cycles of treatment. Often life table analysis cannot be used appropriately because of the lack of information about non-random drop out of patients.

Small studies cannot reliably answer questions of efficacy and may result in potentially effective interventions being dismissed prematurely. To increase the size of their study some authors group together patients with various causes of infertility, but this makes interpreting the results difficult. Another approach is to use meta-analysis to pool the results of small studies. Variability in the selection of patients, treatment, and measurement of outcomes is so great among studies, however, that aggregating results can be misleading.

Lack of good quality evidence on the effectiveness of treatment for subfertility has contributed to health authorities' often sceptical stance.[5] These treatments must be evaluated thoroughly before they become generally available on the NHS.

TREVOR A SHELDON
FUJIAN SONG
NICK FREEMANTLE

School of Public Health,
Leeds University,
Leeds LS2 9LN

1 Baird DT. Assisted conception on the NHS? *BMJ* 1992;**305**: 204-5. (25 July.)
2 *The management of subfertility.* Leeds: School of Public Health, Leeds University, 1992. (*Effective Health Care* bulletin No 3.)
3 Collins JA, Wrixon W, Janes LB, Wilson EH. Treatment independent pregnancy among infertile couples. *N Engl J Med* 1983;**309**:1201-6.
4 Hershlag A, Kaplan EH, Loy RA, DeCherney AH, Lavy G. Selection bias in in vitro fertilization programs. *Am J Obstet Gynecol* 1992;**166**:1-13.
5 Harrison S, Wistow G. The purchaser/provider split in English health care: towards explicit rationing? *Policy and Politics* 1992;**20**:123-30.

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

Screening, ethics, and the law

EDITOR,—P J Edwards and D M B Hall apply sceptical and humane intelligence to the ethical problems of health screening.[1] I hope that this heralds a backlash against the uncritical zeal that has been a hallmark of the less responsible advocates of health promotion. But I offer one modification. When Edwards and Hall say that "by offering to screen . . . the doctor assumes the same duty of care as if the patient had initiated the contact" I believe that they understate the case. By offering to screen a healthy patient the doctor, I suggest, assumes not the same but a greater duty of care than if the patient had initiated the contact.

To put it crudely: when patients ask a doctor for help because they feel ill they can expect the doctor to do only his or her best. Responsibility is, in a sense, shared between the patient and the doctor so long as the doctor is acting in good faith. But the ethics that govern preventive medicine must be different.[2] When a doctor initiates contact with a person who is not ill then doing his or her best is not good enough, as the later part of the editorial makes clear.

Before screening the doctor ought to have objective, scientific evidence that screening will benefit the patient—good intentions are not enough. Though screening may have uncertain benefit, it results in certain harm: wasteful cost, needless anxiety, accidental complications, predictable inconvenience, and unnecessary procedures. If there is no strong evidence of benefit the doctor should leave the patient alone. To do otherwise is, it seems to me, unethical and against the patient's interest.

BRUCE G CHARLTON

Department of Anatomy,
Glasgow University,
Glasgow G12 8QQ

1 Edwards PJ, Hall DMB. Screening, ethics, and the law. *BMJ* 1992;**305**:267-8. (1 August.)
2 Charlton BG. Public health medicine: a different kind of ethics? *J R Soc Med* (in press).

EDITOR,—Specialists, general practitioners, and clinical medical officers should consider carefully the points that P J Edwards and D M B Hall make in their editorial on screening, ethics, and the law because of the implications not only for new screening procedures but also for established screening programmes.[1] It is always difficult to stop a screening programme once it has started.

Screening for congenital dislocation of the hip has been almost universal in Britain since the mid-1960s. It has depended on the reliability of subjective clinical tests—the Ortolani test and the Barlow test. Though when some people perform these tests they are reliable,[2] in Britain as a whole screening has not reduced the incidence of missed diagnoses.[3,4] It is therefore essential for each area to audit its results.[5] These results, which will vary by area, could then be included in a handout on informed consent and screening for the condition, which could be given to the parents of every newborn baby. The wording of such a leaflet must, however, be considered carefully because the vast majority of babies (99·8%) have normal hips.

This problem is further complicated medico-legally by the fact that many believe that the disease is not always detectable clinically at birth.[6] Edwards and Hall are correct to emphasise the importance of knowing the natural course of a disease before screening is started. Also, in the case of congenital dislocation of the hip, the Barlow test might possibly be harmful,[7] causing a further ethical dilemma.

Screening for congenital dislocation of the hip illustrates so many of the problems associated with screening. It started on a wave of enthusiasm, with no attempt being made to measure the specificity, sensitivity, or predictive value of the tests. The clinical tests used do not strictly qualify as screening tests. In West Glamorgan the division of child health has recently addressed this problem and agreed the wording of an information leaflet that will be given to parents of all newborn babies. The leaflet will reassure them but also make them aware that the babies' hips will need further screening after the neonatal stage. It will also explain which babies have an increased risk and therefore (in this area) qualify for an ultrasound scan.

D A JONES

Morriston Hospital,
Morriston,
Swansea SA6 6NL

1 Edwards PJ, Hall DMB. Screening, ethics, and the law. *BMJ* 1992;**305**:267-8. (1 August.)
2 Dunn PM, Evans RE, Thearle MJ, Griffiths HED, Witherow PJ. Congenital dislocation of the hip: early and late diagnosis and management compared. *Arch Dis Child* 1985;**60**:407-14.
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6 Berman L, Klenerman L. Ultrasound screening for hip abnormalities: preliminary findings in 1001 neonates. *BMJ* 1986; **293**:719-22.
7 Moore FH. Examining infants' hips—can it do harm? *J Bone Joint Surg [Br]* 1989;**71**:4-5.

Motivating people to attend screening for osteoporosis

EDITOR,—M J Garton and colleagues obtained response rates of 54-75% for community screening for osteoporosis.[1] Repeated health screenings in Busselton, Western Australia, since 1966 have shown that response rates depend to a large extent on the potential advantages offered to those invited to attend.[2] The lowest rate of attendance was for Papanicolaou smear testing (57%) and the highest for general health screening (91%).