We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

PLAIN PICTURE/GORILLA

DECIDING ON CAESAREAN SECTION

Vaginal birth after a caesarean is not always beneficial

The study by Montgomery et al and the accompanying editorial are based on the premise that vaginal delivery after one caesarean section is necessarily a beneficial and desirable objective or outcome.[1 2] However, the box shows the risks and benefits as published in the recent RCOG (Royal College of Obstetricians and Gynaecologists) guidelines.[3]

Given that most women in developed countries are unlikely to have more than two to three babies, the value of promoting vaginal delivery after one caesarean section is highly questionable.

Women with a breech presentation are no longer offered a choice between vaginal delivery and caesarean section on the basis of the results of the term breech trial.[4] Must we wait for such a trial to recognise that vaginal delivery after one caesarean section costs lives and caesarean section saves lives? Women should have a choice, but this should not come before safety. To promote a process that is known to be associated with greater mortality and morbidity, or consider such a process as beneficial or desirable seems inappropriate irrespective of the reduction in women's anxiety.

Risks

- Uterine rupture 22–74/10 000
- 1% increase in risk of endometritis (289/10 000 versus 180/10 000)
- 1% increase in need for blood transfusion (170/10 000 versus 100/10 000)
- 2–3/10000 additional risk of birth-related perinatal death compared with planned caesarean section
- Increased risk of antepartum stillbirths after 39 weeks with an overall increase in perinatal mortality at term
- 8/10 000 risk of hypoxic ischaemic encephalopathy, which may have long term developmental implications.

Benefits

- Probable reduction in risk of neonatal respiratory problems: 2-3% with planned vaginal delivery after one caesarean section and 3-4% with caesarean section
- Caesarean section may increase the risk of serious complications in future pregnancies.

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Competing interests: None declared.

1 Montgomery AA, Emmett CL, Fahey T, Jones C, Ricketts I, Patel RR, et al. Two decision aids for mode of delivery among women with previous caesarean section: randomised controlled trial. *BMJ* 2007;334:1305-8. (23 June.)
2 Lauer AP, Betrán JA. Decision aids for women with a previous caesarean section. *BMJ* 2007;334:1281-2. (23 June.)
3 Royal College of Obstetricians and Gynaecologists. *Birth after previous caesarean birth. RCOG green-top guideline no 45*. London: RCOG, 2007.
4 Hannah ME, Hannah WJ, Hewson SA, Hodnett ED, Saigal S, Willan AR. Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. Term Breech Trial Collaborative Group. *Lancet* 2000;356:1375-83.

DRUG TRIALS IN GENERAL PRACTICE

Time for a quality check before recruiting patients

In Norway, through our work in a general practice research committee under the Norwegian Medical Association, we have been involved in a voluntary arrangement with pharmaceutical companies where we evaluate research projects initiated by the industry and recruit general practitioners to find patients.[1] Our committee makes recommendations to Norwegian general practitioners about whether a project is a real research project rather than marketing camouflaged as research.

However, after we criticised some projects in 2001, this arrangement has been largely boycotted by the industry. One objection in one particular project was that the protocol favoured the company's own drug. We also maintained that exaggerated demands for statistical power led to a grossly overestimated number of people participating. Research ethics should safeguard that type 2 error is prevented, but statistical power beyond reasonable limits (95% or greater power), leads to research where almost any difference reaches significance. According to our view, this also represents a violation of ethical demands in research. Apparently, it is not evident that research committees have expertise that takes such considerations into account. In correspondence in 2001 with the national research ethics committee in Norway, we recommended that ethics committees routinely should ask for and require a positive answer to these two questions:

- Is the project design a priori neutral and without favouring one or the other of intervention and control drugs?
- Are power calculations reasonable and realistic, so that neither too few nor unnecessarily many patients are recruited?

Our committee has a checklist for quality assurance of multicentre drug research in general practice. All questions require a positive answer. The most important demands for approval are:

- Is the objective of the study important and relevant for general practice?
- Are financial support and coverage clarified and openly communicated?
- Are methods and criteria for inclusion and exclusion specified?
- Is the size of the study groups sufficient and not exaggerated?
- Does the protocol safeguard that all participants and their outcomes will be registered and accounted for?
- Has the research committee behind the study full access to data and the entitlement to publish the results?
- Is external validity safeguarded and are possible causal interpretations plausible?
- Are the recommendations in the Helsinki Declaration satisfied?

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Competing interests: None declared.

1 Lenzer J. Nigeria files criminal charges against Pfizer. *BMJ* 2007;334:1181. (9 June.)

MTAS

We received over 100 responses to the articles on the Medical Training Application Service (MTAS) in the issue of 23 June. Go to bmj.com to read them.

BEFORE AND AFTER PICTURES

A time honoured way of oversimplifying problems

With its talk of an impending epidemic that will overwhelm services and its eye grabbing before and after photos of a woman after two and a half years of taking crystal meth, Coombes's article reminded us of an article published 80 years earlier, warning of yet another contemporary psychiatric epidemic.[1 2] As in the *BMJ* article, a first photo shows a relaxed and dignified man before the "habits of the secret vice began to show," while the second photo shows the same man, now haggard and furtive, "three years later, when he had become an inveterate victim of the vice." What was this vice that threatened to overwhelm the asylums of the day? "Self-pollution, the unnatural and degrading vice of producing venereal excitement by the hand."

WELLCOME PHOTO LIBRARY

Self-pollution: the final stage

A recent nationwide electronic survey of psychiatrists by the national director for mental health found no evidence of an increased prevalence of psychiatric disorder related to methylamphetamine (L Appleby, personal communication). The prevalence of methylamphetamine use may be increasing (but probably remains less than the prevalence of masturbation), and the argument for vigilance to its adverse effects does seem reasonable. However, a common theme runs through both of these stories. Despite knowledge that mental health problems are almost always caused by a complex interplay of biological, psychological, and social factors, a simple culprit, and a simple solution, will always be attractive to the public, the media, and policy makers.[3]

Public health measures, such as banning nasal decongestants, legitimise the concept of a simple solution and give the false impression that something useful is being done. Such measures misdirect attention and free all of us from the moral and rational obligation to tackle more ubiquitous social problems that adversely affect the mental health of our communities. They encourage us to withdraw from uncertainty and seek a safe haven in false truth, as in the words of Bertrand Russell, "what men really want is not knowledge but certainty."[4]

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Competing interests: None declared.

1 Coombes R. Cold turkey. *BMJ* 2007;334:1190-2. (9 June.)
2 Ruddock E. *Vitalogy: an encyclopaedia of health and home*. Chicago: Vitalogy Press, 1927.
3 Goldacre B. Given the choice, I'd rather have the miracle pill story. *Observer* 2007 May 6.
4 Russell B. *History of western philosophy*. London: Allen and Unwin, 1979.

TACKLING HEALTH INEQUALITY

Let's get tough on politicians

Heath's message is that there must be a political remedy for the social injustice of health inequality.[1] It is no surprise to ordinary observers of our health service that our politicians (some of the current lot in power even claim to be socialists) have to be reminded that, as Chadwick pointed out, violence, alcohol, and opium abuse, are consequences rather than causes of poverty. Engels' and others' observations of the ghastly condition of the poor gave birth to modern socialism which spawned not only communism but our own Labour party.

That party is now so "off message" that, for example, it has attempted (and signally failed) to deal with the UK's drug problems with slogan led strategies such as "Tackling Drugs to Build a Better Britain."[2] The £17bn spent annually on criminalising drugs and stopping them coming into the country would be better used to help communities and individuals out of poverty and allow them to bring up their children with the hope of better opportunities to escape the poverty trap in which Britain (after the US) leads the developed world.[3]

Let's get really tough on politicians and, as Heath urges us, speak to the powerful on behalf of the powerless. The only way of eliminating health inequalities is by diminishing massive wealth inequalities.

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Competing interests: RLW runs a clinic for heroin addiction in primary care in London SW14.

1 Heath I. Let's get tough on the causes of health inequality. *BMJ* 2007;334:1301. (23 June.)
2 *Tackling drugs to build a better Britain—the government's ten-year strategy for tackling drugs misuse*. London: Stationery Office, 1998.
3 Godfrey C, Eaton G, McDougall C, Culyer A. *The economic and social costs of class A drug use in England and Wales, 2000*. Home Office Research Study 249. London: Home Office, 2002.

Let's ask them to curb choice

We have seen some paradigm shifts in managing health inequalities[1] in the past decade, which coincided with the Labour government taking power in 1997. However, the recent publication of England's health profile still shows marked inequalities in health between the north and south.[2] Despite the government's commitment to public health, financial resources that were earmarked for Choosing Health initiatives went into balancing primary care trusts' budgets. This is in parallel with unprecedented financial and political investments in the "choice" agenda despite evidence from a national research programme that it maintains the inequality divide and does nothing to address quality of health services and health outcomes.[3] In fact, when it comes to "choice," less is more.[4]

It is about time that we challenged politicians on the shameful waste of recourses on initiatives of dubious value such as Choose and Book and walk-in centres, which increase health inequalities even further, as the well informed and middle classes seem to benefit the most.

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Competing interests: None declared.

1 Heath I. Let's get tough on the causes of health inequality. *BMJ* 2007;334:1301. (23 June.)
2 Department of Health. Choosing health. www.communityhealthprofiles.info/index.php
3 Fotaki M, Boyd A, Smith L, McDonald R, Roland M, Sheaff R, et al. *Patient choice and the organisation and delivery of health services: scoping review*. National Co-ordinating Centre for NHS Service Delivery and Organisation R&D. www.sdo.lshtm.ac.uk/files/project/80-final-report.pdf
4 Bate P, Robert G. Choice. *BMJ* 2005;331:1488-9.

What are the causes?

Heath seems to imply that health inequality is a rich-poor thing, a widening of the gap between haves and have-nots.[1]

But why is the United Kingdom 21st out of the 27 European Union countries? Is it because we are increasingly embracing privatised health? Is it because we have an archaic feudal society? Well, I don't know, and my guess is that none of us does and so if we choose, as Heath suggests, to "pursue political answers alongside technical ones" we are reduced at best to nibbling around the edges of something so large that it has neither form nor shape.

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Competing interests: None declared.

1 Heath I. Let's get tough on the causes of health inequality. *BMJ* 2007;334:1301. (23 June.)