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Abortion without the woman's consent is unlikely to improve her depression

EDITOR,—As a general practitioner and trained counsellor, I was horrified to learn that a consultant gynaecologist could legally remove a woman's 11 week old fetus without her consent.[1] Anyone who has studied the psychological origins of depression will be aware that loss is a major factor.[2,3] For Reginald Dixon to justify ending his patient's pregnancy on the grounds that it would benefit her mental state suggests great ignorance of the aetiology of mental health problems. Creating further loss cannot improve depression, only exacerbate it.

My research into the psychological effects of obstetric and gynaecological procedures showed that risk factors for the development of post-traumatic stress disorder include lack of consent for the procedures, lack of information, the women's lack of control over their bodies, and an unsympathetic attitude on the part of the doctor.[4] In my view, removing a woman's fetus without her knowledge or consent fulfils all of these criteria.

The public places its trust in the medical profession to act in the best interests of the patient. Aborting a fetus without obtaining the woman's consent in my view betrays that trust. If the law fails to protect that trust women will, rightly, stop having confidence in their carers.

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Cost effectiveness of antenatal screening for cystic fibrosis

Realistic cost must be established for genetic counselling in two step screening

EDITOR,—The paper by H S Cuckle and colleagues reaches an extraordinary conclusion—namely, that couple screening is more expensive than two step (sequential) screening per affected pregnancy detected.[1] This is contrary to the conclusion of the recent detailed analysis by Morris and Oppenheimer[2] and to the conclusions that colleagues and I reached after substantial field trials of both types of screening.[3,4]

The problem seems to lie primarily in establishing a realistic cost for the genetic counselling component of two step screening. In Cuckle and colleagues' paper this element seems to have been ignored. In our two step trial a trained genetic nurse managed to cope with 200 carriers a year, generated from the 5000 women accepting the offer of screening. At a salary of £20 000 this added £10 000 per affected pregnancy detected, making two step screening considerably more expensive than couple screening. I concede that it is theoretically possible for a genetic nurse to cope with up to 400 carriers a year, provided that they are being counselled in the antenatal clinics of the same hospital. I do not believe that it is practical to dispense with skilled genetic counselling in two step screening.

Herein lies a crucial issue for any form of screening for cystic fibrosis. If the objective of screening is to "give information to families who want it," as Angus Clarke suggests in his commentary on Cuckle and colleagues' paper,[1] then the counselling element will make it a prohibitively expensive programme. It is no surprise that all screening programmes in the non-pregnant population have ended after research funds were exhausted. If, on the other hand, the purpose of screening is to allow parents to reduce the risk of having affected children then the minimal counselling of the couple screening programmes will probably suffice. The ultimate test of any screening initiative is whether it can move from the protected environment of a research trial to the hurlyburly of the NHS internal market. Couple screening for cystic fibrosis has managed to do just that.[5]

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Counsellors do not have to be genetic nurse specialists

EDITOR,—It is interesting that authors of papers on screening for cystic fibrosis and other genetic disorders take it for granted that carriers should be counselled by genetic nurse specialists.[1] The implication is that only a genetic nurse specialist will, or even could, have the required understanding and knowledge. It also seems to be unquestioningly accepted that all genetic nurse specialists are trained counsellors. I wonder if I am alone in questioning this received wisdom.

About 280 children are born with cystic fibrosis each year.[2] In 1995 my staff at the Cystic Fibrosis Trust received telephone calls from 277 parents of newly diagnosed children and 78 other relatives. Not all required counselling, but a number did—as do members of the public who are concerned, and sometimes anxious, about their carrier status. None of my staff is a genetic nurse, but all of them have received recognised training in counselling and all are knowledgeable about cystic fibrosis. When, rarely, a person is particularly anxious or is having exceptional difficulty in understanding and making personal sense of the situation then he or she is referred to an appropriate specialist, which may include a genetic nurse specialist.

While it is understandable that people working in clinical settings automatically consider clinical colleagues when establishing a multidisciplinary service, it does not follow that this is the most effective method of delivering a service or the optimum use of resources. The cost of £25 per couple quoted by H S Cuckle and colleagues is much higher than the cost of our service, for example.[1]

The consensus is that counselling skills are an essential component of a screening programme. People with such skills and recognised training can, however, obtain the knowledge and understanding of a genetic disorder required to counsel carriers successfully without training to be genetic nurse specialists.

The National Vocational Qualifications currently being established in advice, guidance, counselling, and psychotherapy will allow many more health professionals to obtain nationally recognised qualifications. It is surely time, therefore, for more questions to be asked and fewer assumptions made about who is best equipped to deliver the counselling component of a screening programme. If a genetic nurse specialist is the best person then let that be shown empirically; surely our goal should be to find the most effective way of meeting the needs of clients.

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Couple screening should be preferred for medical reasons

EDITOR,—Oppenheimer and I recently concluded that the cost per detected fetus with cystic fibrosis was about £143 000 for couple screening and £147 000 for sequential (two step) screening,[1] whereas H S Cuckle and colleagues conclude that the cost is about £46 000-104 000 for couple screening and £40 000-90 000 for sequential screening.[2] Our costs are higher as we assumed that each person or couple would be retested for each pregnancy. Cuckle and colleagues assume that results would be reliably retained from previous pregnancies, and, if this was so, retesting would be unnecessary. Nevertheless, we still disagree with Cuckle and colleagues' conclusion that sequential screening is less expensive than couple screening.

Firstly, the cost of counselling mothers who are found to be carriers in sequential screening is not included. Such counselling would involve ensuring that the mothers are aware of the next steps in screening and the consequences if their partner's result is negative (an increased (though in absolute terms low) risk of having an affected fetus). Each woman would also have to be advised that any new partner would need to be tested. If the cost of such counselling was about £10 a session the cost of sequential screening would be about £1000 higher per fetus detected. In couple screening, individuals are not identified as being positive so this initial counselling is not required.

Secondly, the conclusion that sequential screening is cheaper than couple screening depends on the assumption about the proportion of women who will change partners. Cuckle and colleagues assume that 10-30% of women change partners between pregnancies, but the Office of Population

Censuses and Surveys' omnibus survey shows that only 2·1% of families with children contain children from both a previous and the current partner.[3] This proportion is low because, although many people change partners, they tend to do so after they have had most of their children. An unknown proportion of families with lone mothers contain two or more children of different fathers; if this proportion were half it would represent an extra 4% of all families with children. This would make the cost of the two screening methods similar.

The main reason, however, for preferring couple screening is not economic but medical.[4] In sequential screening 97% of women who are positive on screening will have a partner who is negative, some of whom will carry a mutation for cystic fibrosis that cannot be detected. These women may resent the anxiety generated by being identified as a carrier, with the resultant increased risk of an affected pregnancy but no diagnostic test available to resolve the uncertainty. This problem is avoided in couple screening, as carriers with non-carrier partners are regarded as being negative on screening.

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Couple screening would be easier for many centres

EDITOR,—H S Cuckle and colleagues provide further economic evidence supporting antenatal screening for cystic fibrosis.[1] The couple model is estimated to cost more than the sequential model, largely because of retesting in subsequent pregnancies if the woman's partner has changed. However, the estimate takes into account neither the cost nor the complexity of counselling and other contact with the patients in the sequential model. The cost of counselling would be modest, but locating each woman who was a carrier, explaining the need for and obtaining a sample from her partner, and subsequently explaining the results of the test would add complexity in decentralised health care settings. Furthermore, counselling 3% of couples, only one member of whom is a carrier, can raise anxiety with no prospect of definitive resolution by prenatal diagnosis. Some investigators report anxiety to be a continuing problem in the sequential model.

Besides avoiding these problems, the couple model requires that both the pregnant woman and the father agree to screening and submit samples at the outset. This simplifies the overall process, minimises further contact, and adds assurance that the decision to be screened is neither casual nor due to coercion. Genetic counselling is required for only the 0·1% of all couples (carrier woman with carrier partner) to whom definitive prenatal diagnosis can be offered.

Between June 1994 and December 1995 our group carried out a pilot study to evaluate antenatal screening for cystic fibrosis.[2] Enrolled couples lived in a sparsely populated region (Maine) and received antenatal care from 68 physicians at 38 health care sites. Before initiating the pilot study we determined that these sites could, without difficulty, provide initial printed information and material for collecting samples, obtain informed consent, and answer general questions. The staff could not, however, offer the more sophisticated counselling necessary for people found to be carriers. The sequential model would require that the physician's office recontact each carrier woman, obtain her partner's sample for analysis, explain the need for counselling, and arrange it. This was viewed as burdensome. Particularly in the case of couples in which the woman was a carrier but her partner was not, geographic barriers and work schedules could restrict access to timely genetic counselling. These considerations led us to select the couple model for the pilot study.

The staff at the sites where antenatal care was given and a random subset of patients were surveyed at the end of the study to identify problems. Both patients and staff reported a high level of satisfaction. The couple model could thus more realistically be implemented in our setting.

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Authors should have used marginal analysis

EDITOR,—The paper by H S Cuckle and colleagues should aid purchasing decisions regarding screening for cystic fibrosis on the basis of only a single genetic marker.[1] The evaluation is, however, seriously flawed with respect to screening for multimutations because the authors have fallen into the classic error of using average rather than marginal analysis.[2]

In table 1 the authors show that screening for a single mutation, with uptake of 75% and a detection rate of 80%, detects 384 affected pregnancies for a total cost of £17 758 000, giving a cost effectiveness ratio of roughly £46 000 per pregnancy detected. The authors go on to show, however, that if a multimutation test is used then this results in an average cost effectiveness ratio of about £70 000. The authors should have used marginal analysis,[2] which is done as follows.

The single mutation test detects 80% (that is, 384) of affected pregnancies. If it is assumed that the multimutation test increases the detection rate by 10% to 90%, this would result in 432 affected pregnancies being detected (that is, $(384/0{\cdot}8)\times 0{\cdot}9$). What the authors have done is to take the total cost of screening with the multimutation test and divide it by the total number of affected pregnancies, which produces an average cost effectiveness ratio of £70 000, thus implying a total cost of £30 240 000 (that is, 432×£70 000—although there seems to be an error in the authors' calculations as substituting £33 for £16 in the figure leads to a total cost of £33 697 556).

What the authors should have done is take the incremental cost of multimutation screening, which is £15 939 566 (that is, £33 697 566–£17 758 000) and divide this by the extra 48 affected pregnancies detected (that is, 432–384), which results in a marginal cost effectiveness ratio of £332 074. This marginal ratio is nearly five times greater than the average ratio and is more likely to influence purchasers to buy the single mutation test rather than the more expensive multimutation test.

Purchasers might still have considered the multimutation test on the basis of evidence contained in the present paper, as £70 000 is still less than the 25 year discounted (at 6%) excess NHS cost of treating a person with cystic fibrosis (assumed to be £8000 a year[1]), which is £104 026. If purchasers realised that they would actually be paying £332 074 per extra affected pregnancy detected, however, they would be less likely to fund the extra costs of multimutation testing.

Inappropriate use of average rather than marginal analysis is all too common in published economic evaluations, particularly screening studies.[2]

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Study might be better described as a cost description of screening

EDITOR,—H S Cuckle and colleagues' paper on the cost effectiveness of antenatal screening for cystic fibrosis raises several important questions.[1] Firstly, their choice of cost effectiveness analysis rather than cost-benefit analysis makes an implicit assumption that the goal of a screening programme is to reduce births of affected infants and thus reduce health expenditure. This can be achieved only by introducing screening into a situation where there is high uptake (that is, antenatal clinics) and maximisation of the rate of subsequent termination of affected pregnancies. This is not the only model of screening. Indeed, it is one that explicitly limits reproductive choice in those women and couples who would not consider termination but might consider preimplantation diagnosis or artificial insemination by donor.

We know that a proportion of women in Britain would not consider termination of an affected pregnancy.[2] In their cost effectiveness analysis Lieu *et al* found that the proportion of women accepting termination of an affected pregnancy had a large effect on costs, particularly when it fell below 50%.[3] In Cuckle and colleagues' example the cost per affected birth avoided would increase to £92 000 if therapeutic abortion was accepted in only half of the cases.

Lieu *et al* also showed that increasing costs of lifetime medical care for a patient with cystic fibrosis had a large effect on the cost effectiveness of a screening programme. Unfortunately, Cuckle and colleagues quote a single annual figure for medical care derived from a single unit treating adult patients. This does not account for the fact that care may be cheaper for children, who tend to be in better health than adults with cystic fibrosis, nor does it use discounting over the current median life expectancy of 28 years.[4] Indeed, their study might be better described as a cost description of screening for cystic fibrosis, since effectiveness is not considered in great depth and factors known to affect cost effectiveness have been omitted from the sensitivity analysis.

This study makes other important assumptions, not the least of which is that a disease for which the life expectancy for the current birth cohort is probably at least 40 years should be prevented. The study shows what a programme that maximises termination of affected pregnancies might cost the NHS, but not that it is cost effective. It does not address the moral and ethical issues that such