couples would conceive naturally while waiting and those who did not would be more mature and therefore able to provide a more appropriate environment for the child. These age bands could also be used to define who would be accepted for in vitro fertilisation programmes.

RACHEL JOYCE
Registrar in public health medicine
JONATHAN HILDEBRAND
Registrar in public health medicine

Merton, Sutton and Wandsworth Health Authority,
Wilson Hospital,
Mitcham,
Surrey CR4 4TP

1 Redgment CJ, Al-Shawaf T, Grudzinska JG, Craft IL. Gamete intrafallopian transfer in older women: effect of limiting numbers of gametes transferred. *BMJ* 1994;309:510-1.
2 Office of Population Censuses and Surveys. *Marriage and divorce statistics 1991*. London: HMSO, 1993.
3 Department of Health. *On the state of the public health: the annual report of the chief medical officer of the Department of Health for the year 1993*. London: HMSO, 1994.

Overseas adoption

EDITOR,—My wife and I recently adopted our daughter from China after deciding not to have our own children. We are not infertile. We recognise that many couples arrive at adoption as a last resort, having tried various forms of infertility treatment. We are also aware that a general practitioner is the first point of call of such a couple. While a general practitioner may consider that adoption is a matter for local social services, many citizens are not advised of their rights regarding overseas adoption when they ask their local social services about adoption, and they proceed with infertility treatments on the advice of their general practitioner.

We think that general practitioners should present such information and, indeed, counsel couples about the options open to them. Presenting such information would not only guarantee a higher success rate in turning childless couples into families but also result in lower costs relating to antenatal and postnatal treatments as well as to infertility treatments. The costs to the patient might also be considerably lower. We are concerned that the medical profession is offering technological solutions without the full range of alternative solutions being presented to infertile couples, at a cost to the NHS, the couples, the success rates, and, of course, the tens of thousands of orphans in countries such as China.

For information on overseas adoption general practitioners and their patients may call the Department of Health's overseas adoption helpline (071 954 5536); STORK, an overseas adoption charity (0792 844329); or me (0273 454692 or fax 0273 413355).

RUPERT ROBIN

Shoreham by Sea BN43 5RH

Young people's advice clinic in reproductive health

EDITOR,—It was disappointing that once again a new service—a young people's advice clinic in reproductive health[1]—has been introduced with no formal evaluation. The authors state that one of the specific aims of the clinic was to reduce teenage pregnancy rates, one of the government's current targets.[2] They also state that the clinic has been an outstanding success, but no formal outcome measures are considered in their report.

For instance, rates of attendance at the clinic are not compared with those at alternative sources of advice—for example, community family planning clinics or general practice surgeries. It is well recognised that teenagers find attending for health care difficult and that alternative and innovative provision of services may be needed.[3] The paper describes such a service, but such provision needs more thorough consideration in terms of resource effectiveness.

The key outcome indicator, a reduction in teenage pregnancy, is dismissed because of difficulties in obtaining the relevant data. Although any changes in teenage pregnancy rates are notoriously difficult to attribute to any particular intervention, proxy measures can be used for small geographical areas. Such measures include maternity claims by teenagers as a proportion of all maternity claims and rates of second pregnancy, which may be a sensitive early indicator of an intervention's effectiveness.[4,5]

The clinic seems, however, to be popular and provides an opportunity for a valuable and formal evaluation, which could also include an economic appraisal. Such evaluations are vital and should perhaps even be mandatory before innovative ideas and practices can be expanded across Britain.

SHARON HOPKINS
Senior registrar in public health medicine

South Glamorgan Health Authority,
Cardiff CF1 3NW

LIONEL JACOBSON
Research fellow

Department of General Practice,
University College of Medicine,
Cardiff CF4 4XN

1 Williams EC, Kirkman RJE, Elstein M. Profile of young people's advice clinic in reproductive health, 1988-93. *BMJ* 1994;309:786-8. (24 September.)
2 Secretary of State for Health. *The health of the nation*. London: HMSO, 1992.
3 Jacobson L, Wilkinson C. Review of teenage health: time for a new direction. *Br J Gen Pract* 1994;44:420-4.
4 Hudson F, Ineichen B. *Taking it lying down: sexuality and teenage motherhood*. Basingstoke: MacMillan, 1991.
5 Working Group on Teenage Pregnancy. *Report*. Cardiff: South Gamorgan Health Authority, 1994.

Number of psychiatric beds needed

EDITOR,—The editorial by Graham Thornicroft and Geraldine Strathdee about the number of psychiatric beds that are needed has a misleading subtitle: "the debate shouldn't be swayed by moral and political considerations."[1] The authors' argument for a broad range of services is moral, because they rightly believe that "the community" should provide good quality care for severely disabled people. It is political because such care cannot be paid for by those in greatest need. Enoch Powell's account of the development of the health and welfare plan for community mental health care in 1963 shows the central importance of moral and political motivation as well as the paucity of evidence on which the judgments were based.[2]

In an editorial with the same title but without the subtitle, published 23 years ago, precisely the same conclusion was reached about the wide range of alternative facilities that would be necessary if most hospital beds were to be closed.[3] The evidence then available was summarised. The moral issues have remained the same over the years, but the opportunity for a planned and gradual transfer of resources from predominantly hospital care to predominantly non-hospital care, supported by bridging funds, informed by continuing health services research, and fine tuned to allow for differing patterns of community need, has been missed.

Apart from lack of funds, the problems hindering achievement of the sort of service recommended by Thornicroft and Strathdee now include poor joint working between the various agencies involved; restrictive criteria for entry to non-NHS residential care; difficulties in providing safe 24 hour cover in a dispersed service; poor sustainability of community based multidisciplinary teams; and the increasing influence of those general practice fundholders for whom severely mentally ill patients are not a high priority.

The evidence provided by the authors that these obstacles can be surmounted comes from experimental services whose ability to survive the burn out of staff and the loss of committed leaders has yet to be shown. Their appreciation of the scarcity of family, occupational, and residential aids that help preserve the dignity, functioning, and wellbeing of people with longer lasting psychosocial disabilities is, by contrast, well documented.

JOHN WING
Emeritus professor of social psychiatry
PAUL LELLIOTT
Director

Royal College of Psychiatrists Research Unit,
London SW1X 7EE

1 Thornicroft G, Strathdee G. How many psychiatric beds? *BMJ* 1994;309:970-1. (15 October.)
2 Powell E. In conversation with Enoch Powell. *Psychiatric Bulletin* 1988;12:402-6.
3 Wing JK. How many psychiatric beds? *Psychol Med* 1971;1:188-90.

Aircraft cabin pressure and parkinsonian symptoms

EDITOR,—Gerald Stern's reservations about the relation between flying and improved symptoms in Parkinson's disease should be directed at decreased cabin pressure and not at increased cabin pressure as he states.[1] Although people refer to a pressurised cabin, it is pressurised only with respect to outside air pressure at a given flight altitude. In fact, internal cabin pressure in most commercial aircraft at cruising altitude approximates to an altitude of 1520-2440 m,[2] with oxygen concentrations ranging from 15·2% to 17·6%.[3] The question should be why decreased air pressure may improve parkinsonian symptoms.

JEREMY BROWN
Intern

Department of Medicine,
St Elizabeth's Medical Center of Boston,
Boston, MA 02135, USA

1 Stern G. Any questions. *BMJ* 1994;309:785. (24 September.)
2 Commission on Emergency Medical Services, American Medical Association. Medical aspects of transportation aboard commercial aircraft. *JAMA* 1986;247:1007-11.
3 Cottrell JJ. Altitude exposures during aircraft flight. *Chest* 1988;92:81.

Judicial punishments in Iraq

EDITOR,—Reports in the *BMJ* have drawn attention to a series of recent decrees of the Iraqi Revolutionary Command Council introducing amputation of the right hand as judicial punishment for theft, with amputation of the left foot for a second offence.[1,2] Amputation of one ear is decreed as punishment for evasion of the draft, military desertion, or harbouring deserters. Amputation of the other pinna is the penalty for a second offence, and the death penalty is decreed for a third. In addition, an X is branded on to the forehead. It seems that these sentences are carried out in hospitals and that doctors are being forced to perform the operations. Similar punishment is ordered for those who attempt to remove the brand or conduct plastic surgery on the amputated limbs.

Amnesty International has received reports of 14 people who have had one ear severed since the introduction of Decree No 115, 12 of whom were subjected to the procedure at the Adnan Khairallah Hospital in Baghdad on 26 September this year. At least one of these men was branded on the forehead. Press reports have suggested that up to 800 men have had ears severed and their foreheads