

this criterion. Firstly, the more challenging cases, such as cases of bilateral clefts, occur so rarely that surgeons seeing five or 10 cases of cleft lip annually might operate on this subtype only once every two years. Secondly, occasional operators tend to be supported by an incomplete network of other inexperienced professionals.¹ Thirdly, cleft lip and palate is expressed with considerable heterogeneity, and the homogeneity of 40 unilateral cases is necessary for statistical discrimination of clinically relevant variation in surgical performance.³ For surgeons seeing only five new patients annually, 28 years would have to elapse before audit could be performed. Finally, previous research has been hindered by small samples and dependence on weak design.⁴ Peter Ward Booth refers to a form of repair whose early results "show great promise,"² but such hopes litter the history of care in cleft lip and palate, and systematic reviewing according to the protocols of the Cochrane Collaboration shows that randomised trials have been used rarely (J F C Tulloch, American Cleft Palate Association meeting, Tampa, Florida, April 1995). Thus rationalisation of services is a prerequisite for worthwhile research.

The steering group has not assumed that surgeons from any particular discipline have a natural right to perform primary surgery, bone grafting, or osteotomy of the jaw and will consider instead training pathways for future specialists. It also proposes the instigation of national audit and accreditation of centres by peer review.

Concentration of cases into the hands of high volume operators provides no guarantees but establishes the optimum conditions for best practice and monitoring. Given the overhaul of services now required, the heroes of the hour may be not the clinicians who step forward but those who step back.

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Health care rationing

Implicit rationing should take place within a framework

EDITOR,—Though I agree with David Mechanic that all health care systems should use a mixture of rationing mechanisms, I have some reservations about placing too much reliance on the discretion of professionals to determine the clinical allocation of services.¹ I have no doubt that many carry out this function in a rational and well informed manner with due regard for budgetary restraint, and as a result the NHS is an efficient health care system. Unbridled implicit rationing, however, allows clinical freedom to foster vested interests and to breed inefficiency. For example, the drug treatment of intermittent claudication costs the health service over £25m a year, but the consensus is that this form of treatment is ineffective.²

Professionals have a clear responsibility of virtue and duty to individual patients, which will often

conflict with a broader social ethic. The nettle of explicit allocation of resources has to be grasped by central government and purchasing authorities to allow professionals to practise implicit rationing within a well defined framework.

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Implicit rationing is not open to public scrutiny

EDITOR,—David Mechanic invokes the Royal Bank of Sweden's prize in economics given in memory of Alfred Nobel to underpin Herbert Simon's apparent favouring of implicit as opposed to explicit rationing.¹ Other well known recipients of this prize (endowed in 1968) include F A Hayek and M Friedman. At about the same time as Simon was writing, Hayek identified rationing as a problem that would face nationalised health care systems and concluded that the most dangerous aspect of this was that "a system that gives the indispensable helper of the individual, who is at the same time an agent of the state, an insight into the other's most intimate concerns and creates conditions in which he must reveal this knowledge to a superior and use it for the purposes determined by authority opens frightening prospects."²

Explicit rationing is a form of open government. As Mechanic points out, it runs the risk of being buffeted by conflicting pressure groups. Implicit rationing is ruling in secrecy. It requires government inquiries and commissions to police it. Mechanic cannot really believe that his sentence "I suspect that the rich and powerful if sufficiently motivated will always find ways to circumvent explicit criteria" does not apply to implicit rationing too: it applies even more so. Likewise, had the investigation into how to dispose of the Brent Spar oil platform been done openly, the platform would probably now be resting on the seabed rather than being dismantled. Indeed, the strength of open decisions is that it is easier to take remedial action, as illustrated in Sweden, where all 14 directors of its Medical Research Council were recently made to resign.

In 1863 Lincoln expounded the United States constitution for all time.³ He finished with the phrase "that government of the people, by the people, for the people, should not perish from the earth." Surely it is in this spirit of responsibility and accountability that we should reform the NHS.

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Muddling through leaves matters to chance

EDITOR,—David Mechanic concludes his article on rationing in health care services by saying that at the micro level this must be "left for doctors and patients to work out among themselves" and that "once the boundaries are set, more is gained by muddling through rather than by trying to establish all the rules beforehand."¹ He uses the example of access to haemodialysis, for which

acceptance rates in the United Kingdom have lagged behind those in most of western Europe and in North America over the past two decades, particularly among elderly people and those with diabetes.² Unfortunately, there is considerable evidence of inequitable distribution of dialysis resources in the United Kingdom.³

Extremely difficult life or death decisions have too often depended on individuality and chance; there has been minimal medical training on how to discuss these issues with the patient openly and honestly. Is the current structure for this sort of decision making appropriate? Use should be made of multidisciplinary teams to reduce individual bias, particularly because increased caseloads mean that modern renal physicians are unlikely to know their patients as well as in previous decades. Guidelines on the process of the decision making would be useful to ensure that all aspects are considered and to protect patients' autonomy. Careful documentation of that process would facilitate audit.

However health care is funded, it will not be possible to provide all the care available to all those who might benefit. Those responsible for making decisions about the allocation of scarce resources must be publicly accountable and sensitive to the ethical dimensions of their judgments. We can do better than muddle through.

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Bone densitometry in clinical practice

Clinical uses of densitometry are not yet proved

EDITOR,—J E Compston and colleagues review the indications for bone densitometry in clinical practice.¹ They agree with the conclusions of the *Effective Health Care* bulletin that there is insufficient evidence to justify screening women at the menopause.² Several of their other recommendations, however, do not seem to be supported by the evidence.

The authors propose that bone densitometry should be used, for example, for people with strong clinical risk factors. This is justified only if the information provided by the test can influence decision making in a way that improves the effectiveness or cost effectiveness of treatment.³ However, no evidence is cited to show that decision making is improved as a result of bone densitometry in people at increased risk of fracture due to accelerated bone loss. Since the presence of multiple risk factors is more important than the result of bone densitometry in predicting hip fracture in older white women⁴ it is important to show the extra value of densitometry. No data are presented to support the view that management decisions that take into account the results of densitometry improve outcomes or reduce costs when compared with decisions that do not take into account these results.

This lack of evidence also applies to other recommended uses, such as the monitoring of treatment. The precision of measurements of bone density in routine settings is not well documented and is likely to be lower even than that reported by the manufacturers. On the basis of the figures