

Aggressive patients—what is the answer?

SIR,—Dr Lewin asks (19 January, p 183) if he has understood my earlier letter (8 December, p 1509). Yes, I think that general practitioners should now be expected to try to make sense of the patient's communication even if that communication is not in a form which is to the doctor's liking.

I am not criticising Dr K Raghu's (3 November, p 1147) feeling of indignation at being called out so rudely, but I am pointing out the importance of understanding the anxieties which have arisen in the patient's home and which provoke the aggressive behaviour. In particular, it is the anxieties of the intermediary which require attention as they initiate the request for a home visit. The doctor can choose other courses of action, such as a confrontation with the intermediary. This usually leads to a battle of wills over who is going to control the situation. I suggest that the former course is more satisfying for patients and doctor. It is then more likely that the doctor will be able to use the rapport established to modify the patient's "help-seeking behaviour."¹ It may be just as difficult for the doctor to change his behaviour as it is for the patient to change his.

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¹ Stott NCH, Davis RH. *J R Coll Gen Pract* 1979; 29:201-5.

Pregnancy order and reproductive loss

SIR,—The paper by Professor L S Bakketeig and Mr H J Hoffman (22 September, p 693) has elicited some comment. The two most recent letters (1 December, p 1436) conflict in their interpretations of the data: Dr Newcombe believes that these data indicate a negative birth order effect and Dr Golding believes that they do not. Since my own papers have been cited in this discussion, I should like to suggest that the problem will not be decided in regard to these data until they have been reanalysed.

Both Dr Newcombe and Dr Golding note that Professor Bakketeig and Mr Hoffman's analysis is susceptible to the objection that the probability of engaging in a further pregnancy may be affected by the outcome of the previous pregnancy (or pregnancies). Dr Newcombe, if I understand him, thinks that this objection may be overcome by the use of complete reproductive histories. If I am correct, this is an error: similar analyses of complete reproductive histories are equally susceptible to this objection.

Dr Golding notes that one can design a model which embodies equal probabilities of fetal mortality at each birth rate for each woman and yet which replicates the features of the data of Professor Bakketeig and Mr Hoffman. However, her model also embodies a degree of reproductive compensation (contingent on the appearance of a perinatal death). One may reasonably expect reproductive compensation to have occurred in Bakketeig and Hoffman's sample. But whether it occurred to the extent necessitated by Dr Golding's model cannot be established without reanalysing Bakketeig and Hoffman's data. So what she calls an "amusing artefact" may be just that, or it may reflect a real birth order effect. Reporting on other data and

making some attempt to take reproductive compensation into account, I have suggested that some sibships exemplify a positive birth order (or maternal age) effect and others a negative one. This was so in regard to still-birth,¹ perinatal death,² neonatal death,³ and spontaneous abortion.⁴

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¹ James WH. *Ann Hum Genet* 1968;32:151-62.
² James WH. *J R Statist Soc Ser C* 1969;18:276-81.
³ James WH. *Ann Hum Genet* 1970;33:385-94.
⁴ James WH. *J Biosoc Sci* 1974;6:23-41.

SIR,—The nature of the relationship between pregnancy order and the rate of fetal loss has recently been discussed in this journal by Professor L S Bakketeig and Mr H J Hoffman (22 September, p 693) and in subsequent correspondence (3 November, p 1147; 1 December, p 1436). It has long been known that the association between pregnancy order and fetal loss rates is J-shaped. The lowest rates are found in second pregnancies and the rates then increase successively in subsequent pregnancies. This pattern has generally been thought to reflect some biological process, directly related to pregnancy order. This belief has recently been questioned by Professor Bakketeig and Mr Hoffman and by ourselves in a previous publication.¹ This letter is an attempt to clarify some of the issues and implications involved.

The data presented here concern spontaneous abortions only, and come from a survey of women doctors which has been fully described in the past.^{1,2} The accompanying table shows the numbers of live births, spontaneous abortions, and spontaneous abortion rates arranged by the order of the pregnancy and the total numbers of pregnancies (gravidity) that the women had experienced at the time of the survey. When all women and pregnancies are combined the rate of loss (on the far right of the table) shows the classical J-shaped pattern. However, the spontaneous abortion rates within each gravidity group do not increase with increasing pregnancy order and fall to their lowest levels in the last pregnancy order. For example, among women of gravidity 4 the loss rates for the first, second, third, and fourth pregnancies are 21.4%, 18.3%, 16.1%, and 9.0% respectively. In addition, women of high gravidity—that is, those who have had the greater total number of pregnancies—have higher spontaneous abortion rates in every pregnancy order.

Both self-selection and biological factors probably contribute to these observations. In these data, with the exception of first pregnancies, a

woman who has a miscarriage is, in general, more likely to have a further pregnancy than a woman who has a live birth. In the table below this is reflected in the low spontaneous abortion rates in the last pregnancy order, for all gravidities. Self-selection also explains part of the variation between the gravidities. In the higher gravidity groups there are relatively fewer women who have had only live births, and relatively more who have had fetal losses. Self-selection processes indirectly explain why the combined rate increases with pregnancy order, while within gravidities it does not.

We believe that different women are subject to different risks of loss throughout their reproductive lives, as was suggested by James.³ The observed increase in spontaneous abortion rates with increasing pregnancy order is largely attributable to an increase in the proportion of relatively "high-risk" women in the higher gravidities and hence in the higher pregnancy orders. These "high risk" women will have been at an increased risk throughout their reproductive lives, not just in their later pregnancies.

Ideally we would wish to detect those women who have a relatively high risk of loss before they lose even their first pregnancy. But this will not be generally possible until we know more about the determinants of miscarriage and perinatal loss. Data analysis which takes no account of the biological and social variability between individual women will not extend our understanding of the aetiology of these pathological processes.

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¹ Roman E, et al. *Early Hum Dev* 1978;2:131-8.
² Pharoah POD, Alberman E, Doyle P. *Lancet* 1977; i: 34-6.
³ James W, *Am J Hum Genet* 1963;15:223-40.

SIR,—Professor L S Bakketeig and Mr H J Hoffman's paper (22 September, p 693) stimulated discussion on pregnancy order and fetal loss. In assessing how a particular variable affects the risk of fetal loss the general principle is to examine the changes in risk when that factor is allowed to vary while all other relevant variables are held constant. In the case of variables such as maternal age and social class, this may be extremely difficult in practice, because of the

Pregnancy histories classified by gravidity and pregnancy order

Pregnancy Order	Gravidity						All women and pregnancies combined
	1	2	3	4	5	6+	
1 LB	(459)	(922)	(654)	(279)	(91)	(51)	2456
SA	(61)	(43)	(88)	(76)	(35)	(27)	330
"	11.7	4.5	11.8	21.4	27.8	34.6	11.8
2 LB		(927)	(650)	(290)	(94)	(56)	2017
SA		(38)	(92)	(65)	(32)	(22)	249
"		3.9	12.4	18.3	25.4	28.2	11.0
3 LB			(694)	(298)	(93)	(54)	1139
SA			(48)	(57)	(33)	(24)	162
"			6.5	16.1	26.2	30.8	12.4
4 LB				(323)	(90)	(52)	465
SA				(32)	(36)	(26)	94
"				9.0	28.6	33.3	16.8
5 LB					(110)	(53)	163
SA					(16)	(25)	41
"					12.7	32.0	20.1
6 LB						(59)	59
SA						(19)	19
"						24.4	24.4

LB = live birth; SA = spontaneous abortion