completed four weeks later. This rate of perforation of 0·4% compares with a rate of 3% reported in a series treated by electroresection (A L Magos, third international symposium on gynaecological endoscopy, Oxford, 1990). Some of this resectoscope group required laparotomy for this complication, and this may reflect a real difference in the safety of the techniques.

Four women developed an infection after endometrial laser ablation, of whom only one seemed to have an important pelvic infection. There were no cases of haemorrhage, no blood transfusions were required, no laparotomies were needed, and there were no cases of haematometra.

Of the 517 women, 288 were followed up for more than six months, of whom 177 developed amenorrhoea and 80 reported acceptable reduction in still regular menstruation. Of the 26 patients who had no improvement, 16 responded to a second laser ablation, with the treatment failing completely in only 10 women, who required a hysterectomy. Overall, 267 had a satisfactory response to laser ablation.

We agree with Dr Magos that laser ablation and electrodiathermy seem to give similar, satisfactory clinical results. There may, however, be a different incidence of major complications associated with the procedures, and these potentially important differences need to be investigated in prospective trials before either procedure is widely adopted. This large study would suggest, however, that Nd-YAG laser ablation may be a safe, effective, and popular alternative to hysterectomy in the treatment of menorrhagia.

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Politicians and scientists

SIR,—I was somewhat surprised by Dr Nicholas Edwards's view in his letter on politicians and scientists that it is futile to continue the arguments for experiments and pilot demonstrations as part of health service reforms.[1] If there are a growing number of doctors who are in favour of and understand the reforms I have not met them.

The health authority that I work for was earmarked to become one of the first self governing trusts. The whole of the consultant staff was opposed to this and went public on the issue about a year ago. Only recently, however, has the district manager's application been withdrawn.

If Dr Edwards really believes that NHS trusts will have any genuine local control either by the general public or by those who work in the hospitals he really ought to read the government document again. The power will rest directly with the minister and those whom he chooses to appoint.

The idea that health care will in any way be better suited to local circumstances by these reforms is totally unrealistic. How are we expected to provide a better service when at least 10% of our revenue will be diverted into resource management?

Given that neither this government nor indeed the Labour party has any intention of channelling realistic sums of money to fund the service, we certainly do need careful scientific assessment of any proposed changes. That is the way the health service has evolved for the past 40 years, and to a large extent that has been due to the medical profession rather than managers and politicians. The health service has flourished despite, not because of, changes in management structure.

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GPs say no to self governing trusts

SIR,—In his news article on consultants' opinions on their hospitals becoming self governing Dr Tony Delamothe gives the result of Dr Raymond Pietroni's ballot of local general practitioners about the possibility of Guy's Hospital becoming self governing. This result is interesting but not surprising.

In Maidstone, where our local hospital has "expressed an interest," the local medical committee surveyed 103 general practitioners a year ago about the possibility of the hospital becoming self governing. Here, too, the results showed an overwhelming rejection of the idea. Among the 73 who replied (a response rate of 71%) 69 disagreed, two agreed, and two did not know—that is, 97% of those who expressed a preference disagreed with the idea.

We are about to repeat this ballot, and if the result is duplicated we will then discuss as a group of general practitioners what action to take if our local health authority ignores our wishes.

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People cause pollution

SIR,—The United Nations Population Fund report is at pains to qualify the assumption that effective contraception is the principal solution to the problem of increasing populations.[1] Dr Tony Smith in his news article[2] oversimplifies the argument.

Birth control does away with the need for abstinence if people want to choose when and whether to have children. For women it means a previously undreamt of control over their lives. It also prevents debility from constant child bearing, decreases the toll of deaths from back street abortions, and, because families can be spaced, is an important factor in the health of young children. But birth control by itself does not lead to demographic transition. The overwhelming evidence is that birth rates decrease after social and economic change, especially when it brings improvement in women's education and outside work opportunities, as well as in child survival. In Europe falling birth rates preceded the availability of modern contraception. Even now the less effective natural and barrier methods together make up 51·8% of methods used in developed countries compared with 15·1% in developing countries.[1] By contrast, after the coercive population programme in India during the late 1970s, the decline in fertility predicted from earlier trends failed to take place and rates had still not recovered in 1985.[1] The hostility aroused at the time was such that even now development workers dare not broach the subject in many communities. People will limit their families when it makes sense to them economically and socially, not when their governments or the international community tell them to.

Priorities for population planners and those concerned with environmental degradation should be education and health services; yet in poor countries social spending has decreased from already low levels over recent years, notably where governments struggle with the burden of foreign debt. It does a disservice to governments and population planners to promote birth control as a short cut towards lower birth rates when it can at best be an accessory. It also does a disservice to women because programmes designed by population planners tend to degenerate into an obsession with rates and figures.

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Goitre in northern Pakistan

SIR,—Dr Alex G Stewart has provided valuable data on the prevalence of goitre caused by iodine deficiency in Baltistan.[1] His observations of an increased prevalence of goitre north of the geological suture line (the Karakoram Thrust) lend strong support to the hypothesis that the high prevalence of goitre in this part of the world is related to the geological features of the region.

It is well known that there are considerable *local* differences in the prevalence of goitre. In the early years of this century Sir Robert McCarrison studied the prevalence of goitre among the inhabitants of hamlets situated on an alluvial fan who shared a common water supply; he found that the prevalence increased as he travelled downstream.[2] Later studies confirmed his observations but showed that the increase cannot be attributed to bacterial contamination of the water (as McCarrison thought) or to organic fixing of iodine.[3] We are not aware of any evidence that this small scale distribution of goitre can be explained by unequal local abundances of inorganic goitrogens of geological origin at the bottom of the alluvial fan.

An alternative explanation is that the salts containing iodine that are present in the water are progressively adsorbed on silt and clay particles in the heavily silt laden glacial meltwater during its passage down the irrigation channels. This explanation is supported by studies of uptake of radioactively labelled iodide by mineral particles.[3] Such adsorption would render what little iodine there is unavailable to the people and animals living on the fan.

The same explanation could account for the large scale spatial distribution of goitre described by Dr Stewart. The region north of the Karakoram Thrust in Baltistan is heavily glaciated, and, with its low rainfall, irrigation is largely by glacial meltwater. Adsorption of iodine compounds on waterborne mineral particles rather than the presence of goitrogens could be the principal factor responsible for the widespread prevalence of goitre in this region.

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