

References

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7. Royal College of Obstetricians and Gynaecologists. *The report of the Royal College of Obstetricians and Gynaecologists Working Party on Ultrasound Examination in Pregnancy*. December 1984.
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Sir,

There are many points in Mrs Tew's letter (February *Journal*, pp. 84-85) with which we disagree, but we intend to concentrate solely on what we think is the most important point in her letter, the validity of the labour prediction score.

Mrs Tew agrees that the labour prediction score does not make sufficient allowance for pre-delivery risk. We believe that the clinical acumen of general practitioners, midwives, and obstetricians (who would, of course, take many of the factors in the labour prediction score into account as part of normal practice), is a better predictor. Every clinician has experience of cases where he/she has a sixth-sense of danger, but which could not be measured by statistical or epidemiological method. In denying the existence of this, Mrs Tew is in effect saying that if it cannot be measured by statistical or epidemiological methods, then it is not so, which is philosophical and scientific nonsense. For this reason, we do not accept that two women with the same labour prediction score are similar and that outcomes in them can therefore be directly compared.¹

Our original reason for writing was that after the extensive national and local publicity Mrs Tew's article received, one of us had to deal with telephone calls from very anxious heavily pregnant ladies asking if hospital deliveries really were dangerous. We believe that it is possible for any doctor, in any branch of medicine, to reassure such ladies that there is no such evidence.

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Reference

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Sir,

Marjorie Tew, in reply to my letter (December *Journal*, pp. 587-588) raises three main points, all of which are easily answered.

First, every part of Ms Tew's paper is affected by the presence of transfers in the hospital group, not just the parts dealing with standardization.

Secondly, the labour prediction score is dubious because it is, at least in part, a measure of outcome and can be affected by the place of booking or delivery.

Finally, her penultimate paragraph contains two errors. An unbiased procedure applied to a biased sample will produce biased results. And, in saying that transfers would have done better if left at home, she is assuming the truth of her own hypothesis and basing her tests on that assumption.

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Contraceptive care and family planning: a correction

Sir,

Please allow me to correct an error in my recent article (January *Journal*, p.13). In the same issue of the *Journal* a review of a recent publication¹ reported that 'Following the Abortion Act of 1967 the number of pregnancies therapeutically terminated in Britain rose to the present stable rate of 11-12 per 1000 women aged between 15 and 44 years per year'. The reviewer further noted that 'As a result increasing numbers of people — medical and other professionals and lay workers — are involved in counselling pregnant women, in providing an abortion service and in caring for women before, during and after an abortion'.

My own research, as published, appeared to refute my original hypothesis

that a high uptake of appropriate contraceptive care could effect a reduction in the rate of legal abortions. I had made the mistake, however, of comparing the rate of such abortions in the practice for the whole year of 1984 with that for England and Wales during only the June quarter of that year.² It was not until I looked back at my own paper that I recognized the simple need to have quadrupled the quarterly rate for England and Wales before making a comparison with the practice's annual rate. The annual rate for England and Wales of 11 per 1000 women of 'all ages' in 1984 has now been published.³

With nine terminations of pregnancy during 1984 among 1515 women of 'all ages' in the practice, the rate of legal abortions has now been found to be significantly *lower* than that for England and Wales during that year (chi-square = 4.00, 1 df, $P < 0.05$). The number of terminations of pregnancy in the younger age groups was too small for formal testing.

The practice records for 1985 are now available. During that year a further nine legal abortions were undertaken. By January 1986 there were 1559 women between the ages of 14 and 49 years under study. Reference to the *OPCS monitors* for both the March and June quarters of 1985 identified similar national rates to those of 1984 suggesting a similar annual rate of 11 per 1000 anticipated for the full year. That being so, the practice rate of legal abortions was again significantly *lower* than that expected for England and Wales (chi-square = 4.36, 1 df, $P < 0.05$). Again the number of terminations of pregnancy in the younger age groups was too small for formal testing.

Reverting back to my original hypothesis, although the numbers for comparison are small, it does confirm that during two consecutive years a high uptake of appropriate contraceptive care can effectively reduce the rate of legal abortions.

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