Genetic counselling to a traditional society

SIR,—I was puzzled by Dr Carmi's comment "Distressed by these consequences of our well-meant intervention, we decided to change . . ." (Feb 2, p 306). All of us have learnt that genetic counselling is a complex process requiring a team approach.[1] The well-planned studies to control and prevent Tay-Sachs disease in US Jewish communities showed the danger of stigmatisation, on individual, couple, or family when a carrier is identified.[2] Initial counselling could have included the screening of prospective couples. If that had been done, it probably would have avoided the personal tragedies subsequently noted. I strongly support the suggestion that genetic counsellors take into consideration societal factors in conducting premarital or preconceptional counselling not only in a traditional society but also in any society.

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SIR,—I have experienced severe censure for providing prenatal diagnosis to a culture that had learned of fetal sex determination at 12–14 weeks by ultrasonic inspection of external genitalia (fetal anatomical sex assignment). Indians of Sikh origin—with no encouragement from me since I am pro-life and anti-abortion and all patients are told that—wish to use this technique for their own specific family planning needs. Among these Sikhs, at least one male child is of paramount importance for social, religious, and other cultural reasons, and this view remains unaffected by the influences of western society. The only value that appears to have an impact on this culture is the economic pressure to have fewer children, who have to be clothed, educated, and raised in a western society that is imposing socioeconomic pressure on families with two or more children.

My experience has been that women who have two daughters and then have a history of termination of pregnancy for unexpected/unwanted pregnancies seek fetal sex assignment to limit the number of abortions and provide an opportunity of continuing a pregnancy if the fetal sex is the one wanted. Although most commonly male is the wanted sex, that is not always so and in other cultures of which I have had experience the reverse preference is expressed.

The Canadian Medical Association has recommended that physicians who associate themselves with termination of pregnancy on grounds of sex be made liable for disciplinary proceedings. Such intrusion is viewed by the Indian Sikh community as unacceptable. Members of this society in Canada cross the border to the United States, where there is a long tradition of the right of individuals to exercise freedom of choice.

If young families are given the option of using this technology early in their reproductive careers, they are more likely to have smaller families and families that are appropriately and traditionally balanced, thereby avoiding the tragedy of having many unwanted children while trying for a "wished for gender". I have seen one Sikh who was given permission by his first wife, it is alleged, to divorce her after five daughters to marry a younger woman; having had two more daughters by his second wife, the couple came to see me for two pregnancies both of which were diagnosed as female (and, presumably, terminated).

As Dr Carmi indicates "genetic counsellers" need to be sensitive to social and cultural factors. If fetal sex determination techniques are used, it is now possible to plan a family of one healthy wanted boy and one healthy girl and so avoid the socioeconomic deprivations that come from large families. My understanding is that when individuals are allowed freedom of choice they make decisions that, for the most part, benefit society at large and there are few abuses of modern technology.

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Primary health care in developing countries

SIR,—Dr Feksi and colleagues (Feb 16, p 406) ignore the basic principles of primary health care. The lively discussion about comprehensive versus selective primary health care[1–4] must have gone unnoticed by them. The programme Feksi and his colleagues describe is selective by nature, and definitely not comprehensive, because needs as perceived by the people and given priorities by them were not the starting point for this programme—needs as defined by health-care staff were. The difficulties of the inhabitants of the Rift Valley in south-west Kenya are reduced to biomedical symptoms. Moreover, entry criteria are used in this programme, creating even more selection. It might be more in the interest of these individuals to tackle other development difficulties, and not waste time and energy on troubles not identified by the inhabitants. A study to assess what epilepsy means to people in the community with such seizures and traditional ways of coping with the disease might have been more appropriate.

Primary health care is not merely a way to bring medical goods to the periphery; it makes possible the creation of a health-care system that caters for the people's needs and that suits their circumstances and financial possibilities. The World Health Organisation has emphasised comprehensive primary health care as the route to Health for All by the Year 2000.[5] The interests of patients can differ from those of doctors and pharmaceutical companies,[6] and selective primary health care can sometimes be in conflict with the needs and priorities of patients.

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Violent behaviour on psychiatric wards

SIR,—Violent behaviour on psychiatric wards may be correlated with nurse staffing,[1,2] although this finding was not replicated on a mental handicap ward.[3] To investigate this question further, I have studied a 30 bed high-dependency ward in the psychiatric wing of a London teaching hospital. Data were examined retrospectively for each of the 36 months from January, 1987, to December, 1989, with a previously validated methodology.[1,2] The number of incidents of physical violence was recorded by nurses (categorised as violence to staff, patients, or property), and the average weekly nursing provision was noted. The number of violent incidents for each month was then correlated with staffing by Kendall's rank correlation.

Over 36 months there were 432 violent incidents. Violence against staff ($n = 252$) and other patients ($n = 116$) ranged from biting to fighting. Violence to property ($n = 53$) included destruction of furniture and fittings. There was no significant correlation between number of violent incidents and total nursing, permanent nursing, and agency nursing provision. This result is in sharp contrast to previous findings.

There may be several explanations for this study's negative result. The amount of violence was high and the baseline provision of nursing staff comparatively low; any fluctuation in staffing might not be reflected in rates of violence.[3] Our study did not include incidents of self-harm, which may explain the lack of association. However, further analysis of Fineberg's data[1] showed that correlation between violent incidents and staffing persisted despite exclusion of incidents of self-harm. There have been reports of