question of the partner not undergoing the procedure having the right of veto.

The Department of Health took the decision not to include reference to the patient's partner on the consent form as a result of the representations received following a consultation exercise. There was a clear feeling that respondents did not consider it correct to include such a "reminder" on the form. Among those making that point were medical and nursing professional bodies plus consumer groups. As the consultation for any medical treatment is a private one between health professional and patient we felt able to agree that the consent form was not the right place to require consideration of the partner's interest.

The department has of course issued detailed guidance on family planning services, which includes advice on the need for full counselling for both partners before deciding on the operation. This guidance is still current.[1] Although it is not a legal requirement and the form therefore makes no specific provision for obtaining a partner's consent, the department's view is that doctors may still, as a matter of good practice, seek the partner's agreement if the patient accepts that this should be done and record this locally if desired.

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Trials of homoeopathy

SIR,—We would like to reply to several letters that have commented on our meta-analysis of clinical trials of homoeopathy.[1]

Dr Peter Fisher and colleagues address the problem of evaluating research for which the report does not include full details of the characteristics of the patients or methodology, etc.[2] We believe that sufficient details must be present to enable the reader to judge the evidence. It would surely be very complicated if every reader had to go after the necessary information. They say that the journal did not allow them to put more information in their report of homoeopathic treatment. A subsequent letter,[3] however, did not contain information that would increase our methodological score, nor did a duplicate publication of the same trial.[4]

Dr Fisher and colleagues also oppose our view on crossover trials. We have doubts about the prognostic comparability at the start of the second period of these trials unless the treatment does not work. This will especially be the case when subjective symptoms are most important. If the results of only the first period are valid they must be presented separately. One of the goals of homoeopathy is long lasting treatment effects, preferably after short treatment. Therefore we think that crossover designs (including studies of one patient) do not make much sense despite the fewer patients needed. In the extreme, the optimum number of patients in such trials is zero.

In checks on blinding (before treatment effects are expected) the subjects' answers must be compared between the treatment and control groups. Breaking of blinding is suspected if there are differences in the distribution of the answers between the groups. The influence of leading questions might be a problem only if almost all the patients answered "don't know." In practice many patients will guess that they are receiving placebo or active treatment.[5]

Dr Marc Girard rightly states that the evidence available is less impressive if each homoeopathic remedy is considered separately for each new medication.[6] Before assessing the effects of all these therapies and variations of homoeopathy it should be established whether homoeopathy has a specific effect in at least some cases. It is not surprising that opinions differ over whether the existing evidence is sufficient for such efforts, which is illustrated by the remarks of Dr Michael Baum[7] and Sir Michael Drury and colleagues.[8]

We had extensive discussions about how further evidence should be obtained. The results of our review would probably be interpreted differently if laboratory studies showed convincing evidence that there is some action of high potencies. Two of us (PK, GtR) thought that this kind of evidence has priority. On the other hand, if laboratory studies show no effects homoeopaths will say that homoeopathy works only in humans. In that case only rigorously performed randomised trials will confirm or refute the existing state of affairs (JK). Meanwhile, reports of new controlled trials are being published.

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Incidence of insulin dependent diabetes in children aged under 15

SIR,—Ms M Alison Metcalfe and Professor J David Baum used a one year register of newly diagnosed cases of insulin dependent diabetes in children resident in the British Isles to ascertain incidence.[1] Regional variations in rates were observed, with Scotland having the highest rate and Northern Ireland one of the lowest. Validation of ascertainment was attempted in two regions by contacting consultants to check on potential extra cases identified from hospital admission data. As a result the case ascertainment was estimated as 90%.

Examination of the data provided in the appendix, however, led us to different estimates of ascertainment. Assuming that the pick up rate of valid extra cases by consultants who did not respond was the same as that by consultants who did, we estimate that there were 20 valid extra cases in the admission data supplied by the Northern Regional Health Authority and 17 valid extra cases in the data supplied by the South Western Regional Health Authority. These numbers suggest that the estimate of the ascertainment rate should be revised to 82% (90 out of 110) in the Northern region and to 82% (77 out of 94) in the South Western region. These revised estimates, however, do not take into account the fact that some cases will have been missed by both the national register and hospital admission data. Assuming that these two sources of ascertainment are independent, estimates of ascertainment rate of 72% and 77% may be obtained for the Northern and South Western regions, respectively.[2]

Using notifications from paediatricians, diabetologists, and diabetic nurses and school health records, we have been maintaining a register of new cases in Northern Ireland since 1 January 1989, based on identical ascertainment criteria. We identified 58 cases in 1989 and 59 cases in 1990, compared with 43 reported by Dr Metcalfe and Professor Baum in 1988. Validation against an independent secondary source of cases indicated that our rate of ascertainment was in excess of 90%. Even if we assume that we did not miss any cases in 1989-90, the best estimate of completeness of Dr Metcalfe and Professor Baum's figure for Northern Ireland is 74%.

Underascertainment may therefore account for the low incidence reported for Northern Ireland. Interestingly, the highest incidence was obtained in Scotland, where there has been a determined, coordinated effort to register new cases for some years.[3]

The results from the Northern Ireland register will be published with data from over 20 other European centres that are participating in EURODIAB subarea A, a study of the epidemiology and aetiopathogenesis of insulin dependent diabetes in children. To ensure that observed geographical variations in registration rate can be interpreted meaningfully each centre is validating its completeness of ascertainment.

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AUTHORS' REPLY,—No national survey of childhood diabetes can achieve absolute ascertainment, but we believe the active reporting procedure of the British Paediatric Surveillance Unit to be the best available. It is possible that there were several valid extra new cases under the care of consultants who did not respond during the validation exercise, and we are willing to agree with Dr Patterson and Professor Hadden's revised rates of 82% for both regional health authorities. As paediatricians are responsible both for the diagnosis of a case and for reporting that case to the British Paediatric Surveillance Unit, however, the two sources are not independent, and we do not accept that our ascertainment was much less than 82%.

There are other problems with Dr Patterson and Professor Hadden's critique. Their estimation of an ascertainment of 74% for Northern Ireland assumes that our record of 43 confirmed cases in 1988 compares strictly with theirs of 58 and 59 cases. In Patterson *et al*'s study of childhood diabetes in Scotland[1] considerable annual fluctuations in the numbers of cases were described. We therefore remain unpersuaded by their estimate for Northern Ireland.

It is true that in Scotland doctors have been encouraged for some years to register new cases of childhood diabetes: we were allowed access to information on their cases diagnosed during 1988. However, we informed them of 10 cases (out of 190) that were unknown to them. Where does that leave us in the ascertainment stakes? Within the remaining regions we have no reason to believe that reporting by paediatricians was different across the health authorities: ascertainment rates would have been similar and regional differences maintained.

We would emphasise that if our study did