

Harwood replies:

Goonetilleke raises some interesting and important points about the validation of new measurement scales.

In comparing characteristics for responders with non-responders the aim is to judge the representatives of the study population. The important point is whether the characteristics are quantitatively different, not whether the difference arose by chance (which is what a p value tells you). In this case the magnitude of differences were all quite small. A response rate of 67% to a single mailed questionnaire is good. This can often be boosted to about 80% with follow up questionnaires, and to about 90% by telephone calls and personal visits. We opted to use no more than one mailing as the subjects had already been extensively surveyed for other parts of the study.

The World Health Organisation's *International Classification of Impairments, Disabilities, and Handicaps* (ICIDH) handicap dimensions were chosen by a Manchester rheumatologist, Professor Phillip Wood, on the basis of professional experience. His aim was to be able to classify disadvantage with a comprehensive yet simple schema. We adopted the classification as we believe it to have excellent face validity. Factor analysis is a technique for classifying items into a smaller number of dimensions and would not be helpful here unless we had a huge pool of items which had been judged to represent handicap that we wished to sort into groups. We have performed factor analysis on London handicap scale responses in two separate datasets (patients with stroke and patients with rheumatoid arthritis) and found only one factor to have an eigenvalue greater than one. This factor accounted for 55–60% of the variance. Labelling of factors is up to the analyst, and we suggest that this factor represents underlying handicap. Moreover, a single dominant factor is what one would require for a scale with a simple additive structure.

Disability and handicap have been defined throughout with reference to the

ICIDH. Disability is the inability to perform tasks or activities in a normal manner. Problems have arisen because these words were in use before the ICIDH attempted to clarify the consequences of chronic disease by offering precise definitions. Conceptually and in rehabilitation practice there is a distinction between the abstract ability to perform isolated tasks such as walking, dressing, or reading, and whether problems with these have an impact on everyday functioning given the usual physical environment, available help and resources, volition, culture, and so on. Thus the inability to climb stairs may or may not be handicapping depending on the requirement to climb stairs to lead a normal life.

The definitive validation of scales measuring abstract and intangible concepts such as mood or handicap is impossible. Much depends on face validity; what the scale contains and how it sets about quantification. Construct validation is merely confirmatory. A perfect correlation implies that no new information is gained by using the new scale. If a scale fails to show a relation with another measurement where one is expected, either of the scales may be invalid or the assumption of a relation may be wrong.

Given the vast number of scales available, new scales need careful justification. Unfortunately almost all the existing scales are either incomplete descriptors of what we want to measure or inadequate because of their metric properties. A recent MRC review of research on the health of elderly people reiterated this point.¹ I agree that further application will be the final arbiter of the London handicap scale's usefulness.

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¹ Medical Research Council. *Topic review: The health of the UK's elderly people*. London: MRC, 1994.

Neurological stamp: Marie François Xavier Bichat (1771–1802)

I would like to point out some small errors of spelling and fact in *J Neurol Neurosurg Psychiatry* 1994;57:263.

The name of the gentleman whose name is associated with the guillotine is spelled Joseph Ignace Guillotin. He did not invent the guillotine but recommended its use on humanitarian grounds. He was Professor of Anatomy in Paris.

After Maastricht such minor details may be important. Your French readers may be too polite to point out such mistakes.

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NOTICES

Fifth meeting of the European Neurological Society (ENS '95)

This meeting will be held on 17–21 June 1995 in Munich, Germany (teaching courses 17–18 June, scientific programme 19–21 June). Deadline for submission of abstracts: 15 January 1995. For further information contact ENS '95, c/o AKM Congress Service, Clarastrasse 57, PO Box CH-4005 Basel. Telephone 41-61-691 51 11; fax 41-61-691 81 89.

The winter meeting of the **British Neuropsychiatric Association** will take place in the Conference Theatre London Zoo, on 20 January 1995. The subject will be *the neuropsychiatry of vascular disease*. For further information please contact Sue Garrett, Administrative Assistant BNPA, 17 Clocktower Mews, London N1 7VV, UK. Telephone/fax 071-226 5949.

CORRECTION

Chen R, Sahipaul R, Del Maestro R F, Assis L, Young G B. Initial enlargement of the opposite pupil as a false localising sign in intraparenchymal frontal haemorrhage. *J Neurol Neurosurg Psychiatry* 1994;57:1126–1128.

During production, the fourth and fifth rows in the table (p 1127) were moved to the left. The correct table is presented here.

Summary of clinical course

	Day 1 2300	Day 2 0720	1500	1530	1600	1645	1800	Day 3 0800	Day 4 0800	Day 29 0800	Day 60 0800
Event	CT		Angiogram		Mannitol	CT	ET,HV,OR				
Right pupil	4 mm R	4 mm R	3 mm R	6 mm NR	6 mm NR	7 mm NR	6 mm NR	4 mm NR	4 mm R	4 mm R	3 mm R
Left pupil	4 mm R	4 mm R	3 mm R	4 mm R	4 mm R	7 mm NR	3 mm NR	2 mm MR	2 mm R	3 mm R	3 mm R
Eyelids	Normal			Right ptosis		Unable to assess			Right ptosis	Mild right ptosis	Normal
EOM	Full				Abducted right eye *				Full		
Limbs	Normal power			Normal power		Bilateral extensor posturing		Left: semi-purposeful movement	Right hemiplegia		Mild right hemiplegia
	Right hyper-reflexia			Restless				Right: extend to pain			

* Absent vertical and horizontal eye movements with oculoccephalic manoeuvre. EOM = extraocular eye movements, ET = endotracheal intubation; HV = hyper-ventilation, MR = minimally reactive; NR = non-reactive; OR = operating room; R = reactive.