physician, in his present state of medical knowledge, is of the opinion that it is likely to make life more livable for a particular patient and his immediate associates.

Perhaps some practitioner will favour us with his views on, say, pan-hysterectomy, which, like leucotomy of course, is so frequently and irresponsibly advised.—I am, etc.,

Hull. A. S. ELLIS.

SIR,—I fail to see that there is any reasonable objection to leucotomy. Modern psychiatry indicates that "mental" diseases are physiological in nature and psychological only in their manifestations. Therefore, interfering with the physiological machinery subserving mental function is the logical and legitimate way to treat effectively—e.g., insulin, E.C.T., amphetamine, etc. There is no question of touching the soul, which is immaterial; but if its manifestations and operations are impeded, as in mental disease, and prevented from normal exercise it is right to use surgery when that is the only way to remove the physical impediment.

Physiology and medicine are materialistic and deterministic in scope and method, and so now is mental medicine, in which psychology will play an ever-diminishing part. Since amentia and dementia depend upon physical deficiencies and not on any "disorder of the soul" or mind *per se*, it is very likely that "acquired" mental disease is similarly determined—a psychosis is a sort of dementia. Psychiatric practice shows an ever-increasing reliance on somatic procedures, together with a progressive lessening of psychotherapy in line with these developments. Time will clarify the precise nature of these subtle organic disturbances, the so-called "mental" disorders; meanwhile physical techniques, including leucotomy, constitute reasonable empirical methods.—I am, etc.,

Bridgend, Glamorgan. H. M. FLANAGAN.

Family Planning

SIR,—As the full quota of pregnancies with which unfettered Nature would supply us is now practically never to be seen in professional *or* non-professional families, Dr. Joan Malleson (May 3, p. 970) can take it as an only too realistic starting-point that widespread contraceptive practices flourish—and are certainly no jealously guarded professional secret. One needs no persuasion to believe also that the less knowledgeable women who attend F.P. clinics will indeed gratefully accept the advice offered. Just as I have no doubt at all that the many women who tearfully ask us in our surgeries for advice on how to abort would call us blessed if we assisted them. But how often, in actual practice, does this much-unwanted pregnancy blossom forth at a later date in the form of a happy and well-accepted child, who in future years is both a physical and financial help to the mother: albeit that at one time she felt its arrival would cause her both physical and financial embarrassment. Had she "planned" more efficiently or had we been more "sympathetic," this help would have been denied her.

Is not the gradually increasing problem of there being insufficient young people to produce for and look after the old more acute than that of the unwanted child? Might it not, after all, be wiser to take a long-term and not too emotional view on these matters? *Our* duty must lie in giving advice, if asked, *on medical grounds only* (one took it that multiparity of four or five children could be reasonably classified as "medical grounds"). Beyond this we have no responsibility.

Voluntary lay help is a very precious commodity in these materialistic days. It was with no intent to scoff that I suggested (April 19, p. 868) we encourage the utilizing of such help in a constructive way—viz., in helping mothers so to organize that they can tend their reasonably sized families efficiently and without too much loss of personal leisure.

The unalterable fact remains that, while some women can (in only two rooms and with a rock-bottom income) efficiently rear a family of six or even more children and remain good companions, etc., to their husbands, others, with all material benefits to help, will make a poor job of their carefully planned one or two children. The tendency to look on the controlling of fertility as a way of altering human nature is a tempting but mistaken one. If, however, we must willy-nilly stomach the idea of lay-organized public clinics for planning and other purposes, we should most certainly try to omit two of the features at present incorporated with them: the advertisement in the press, and the sale of contraceptives on the spot. Both are distasteful accompaniments to the giving of professional advice.—I am, etc.,

Berwick-on-Tweed. AGNES R. S. SADLER.

Hypnosis in Childbirth

SIR,—I read with great interest the article on "Hypnosis in Childbirth" by Dr. A. M. Michael (April 5, p. 734). It was in 1949 that I personally stimulated the Department of Obstetrics and Gynaecology at St. Helier to investigate the question of hypnotherapy in childbirth, after my demonstration of several cases. Since that time I have come to the conclusion that hypnosis should be restricted to practice by only those physicians who have been trained in pyscho-analytically orientated psychiatry. My reasons for insisting on such embargoes are not because of any inherent dangers within the hypnotic process *per se*, but that such procedures in the presence of underlying morbidity may liberate psychopathological processes of a confusing and harmful nature to both patient and hypnotist. Therefore the indiscriminate practice of hypnosis in childbirth, without the benefits of persons qualified to deal with the possible complications, is a matter to be carefully considered by the administrative authorities concerned. Hypnosis should not be practised on ill-chosen persons for ill-thought-out reasons by ill-qualified hypnotists.—I am, etc.,

University of Texas, Galveston. NEVILLE MURRAY.

Period of Gestation

SIR,—The article by Professor Thomas McKeown and Dr. J. R. Gibson (May 3, p. 938) only attempts to indicate the upper limit of the period of gestation, but for medico-legal purposes is not the minimum period for the delivery of a full-term infant equally important? I suggest that the Birmingham data be further examined to indicate the shorter periods resulting in normal births, and also that the duration of amenorrhoea be compared in each case with the normal menstrual cycle. The authors show how greatly the period of gestation varies above the normally accepted period of 273–280 days, but the range is really very much greater, and may fall as far below the 280 days as they have indicated it may rise above—and so make 280 days a true average.

I wrote of one case of short duration (*British Medical Journal*, 1928, 1, 75) where pregnancy occurred after I had curetted and removed the fragments of a septic abortion. There was no sign of menstruation after this operation before the patient conceived again. The normal cycle was 21 days. The confinement took place 231 days after the curettage and 210 days after coitus and resulted in the birth of a baby with no sign of prematurity. To quote from my letter of 1928, "The child cried lustily at birth, had a good crop of hair, was well coated with vernix caseosa, measured 20 in. in length, and weighed 7 lb. The finger- and toe-nails were fully developed and the child sucked vigorously on being put on the breast. In every way it appeared to be a full-time child." This woman has had no other pregnancy, and as far as I am aware the "210-day daughter" is not married and I do not know whether her menstrual cycle is the same as that of her mother.

There seems to be considerable evidence that parturition occurs at a date approximately 10 times the length of the menstrual cycle after the first day of the last period, regardless of the precise date of fertilization. Many times I have acted on this assumption when calculating the probable date of confinement for women whose menstrual cycle was regular but always some days more or less than the average 28. I can recall many such accurate forecasts, but unfortunately my notes covering many