

A question of conscience

SIR,—The article by Mr R Walley (12 June, p 1456) is of the very greatest importance to the public and to the medical profession. The account which Mr Walley gave of the pressure put on him to agree to carry out abortion against his conscience is a more fully explained example of this method of appointing consultant gynaecologists than others recorded before. The Department of Health must make sure that women know how and where they can obtain, at the right time, an abortion if they wish to have one, and if the Department requires more abortions than its gynaecologists are able and willing to supply it must supplement them by the appointment of regional or area medical abortionists.

Whether a candidate believes that abortions should be on demand or restricted, he should answer the questions put to Mr Walley by saying, "I shall do what I think is right and best for each patient." Further, it is time that physicians and surgeons made a similar declaration of conscience, for they should not leave their patients and themselves open to the risk that doctors could be threatened, by bureaucratic directive, to maltreat people in the way that has already happened in some other countries. The royal colleges should give a strong lead on this before the vandalism of the relation between the public and the medical profession goes a step further.

In the meantime it would be valuable to know the outlook of the members of the appointment committees who advised Mr Walley to go to work abroad. Was it cynicism or despair? At any rate, it could cause many other doctors and nurses to shun the NHS. Can the Department convince anyone that it will suppress dragooning of the kind that Mr Walley and others have experienced, or should the Minister be taken to court for making a directive which takes away the benefit to Mr Walley and others of the conscientious objection clause of the 1967 Abortion Act?

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SIR,—Mr R Walley's "Personal Paper" (12 June, p 1456) shocked me profoundly. Those of us who recall the policy of appointing to mental institutions in Nazi Germany only those doctors prepared to take part in "euthanasia" of mentally defectives must recoil from the implications of the policy he encountered. At the exit of the commemorative exhibition at Dachau concentration camp a wall bears the legend, "Those who do not remember history may well repeat it."

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Management of eclampsia

SIR,—Your leading article on eclampsia (19 June, p 1485) gave an informative summary of the therapeutic management of this condition. It is a pity that the place of caesarean section was dismissed with the perfunctory sentence, "There is no strong evidence in favour of routine caesarean section." Perhaps there is not, but one can say with equal truth that there is no strong evidence in favour of routine conservative management either. My opinion is that, provided an experienced

anaesthetist is available, caesarean section is an absolutely marvellous treatment, not only for eclampsia but also for severe pre-eclampsia, for these reasons: (1) while the patient is anaesthetised there is no possibility of a fit occurring; (2) it is the quickest way to empty the uterus and reverse the basic pathology, whatever that may be, and incidentally to halt the progress of the coagulation defect; (3) it is the most rapid method of rescuing the fetus which, if it has survived the first fit, is in constant peril; (4) furthermore, should the patient have inhaled vomit, nobody is in a better position thoroughly to clear the bronchi of secretions and give the patient oxygen than an anaesthetist. I therefore believe that caesarean section is the treatment of choice except when a vaginal delivery can be expected very soon (within an hour or so)—that is, when labour is well established, the presenting part is low, and the cervix nearly fully dilated.

An important feature of this disease not mentioned in your article is that a proportion of fits occur after delivery—and this is a very dangerous period as vigilance tends to relax.

It is perhaps worth a passing mention that convulsions due to causes other than eclampsia can occur in pregnancy and in labour; they are probably more common in the subtropics than in a temperate climate. Epilepsy, of course, springs to mind, but also parasitic diseases can be a cause, of which malaria is one. I have seen a case of cerebral malaria (malignant tertian) present as convulsions in a woman 39 weeks pregnant.

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"Practical Medicine"

SIR,—We should be grateful for an opportunity to comment on your review of our book *Practical Medicine* (15 May, p 1218). Your reviewer states that the aims of the book have not been achieved. However, from the examples given, he seems to have so far misunderstood the aims of the book as to give his comments little relevance. The book is intended as a problem-orientated approach to general medical outpatient work for junior physicians recently trained in diagnostic methods and clinical pharmacology. To have included, as your reviewer suggests, paediatrics, dermatology, ophthalmology, psychiatry, and therapeutics would have enlarged the book into a comprehensive compendium more suited to the reference library than to the practising clinician's pocket. Similarly, the reviewer cannot be serious in suggesting that the management of acute myocardial infarction has a place in a book on outpatient care.

It is disappointing that the reviewer resorts to the well-known journalistic trick of quoting out of context. We are accused of a dangerous error of fact—namely, "the statement that oxprenolol is cardioselective, with little effect on asthma." The book in fact states, in the section on *drug intolerance in asthma*, that oxprenolol has "relatively little effect on asthma (as compared with propranolol) but that it should still be suspect in any case of asthma that is difficult to control."

We fully accept that details of clinical pharmacology are omitted and that some of the most commonly used drugs have not been indexed. This was intentional but may well

have been misjudged, and we are grateful for the reviewer's opinion.

We never intended to write a fully comprehensive medical textbook; there are already a large number available. We hope that our book will help the junior physician and others to make safe and sensible decisions in the medical outpatient setting. Your review has not tried to assess the book in this light and consequently can be of little use to prospective readers.

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Age of menarche

SIR,—May I correct Dr P H W Rayner (5 June, p 1385)? The age of menarche has *not* decreased progressively since records were first kept. Dr D F Roberts and I have published two papers^{1,2} showing that the downward trend in the age of menarche stopped over 10 years ago. The mean age of menarche is now stable at about 13.2 years. It is perhaps significant that Dr Rayner's only quoted reference is to a book published 14 years ago. The author of this book is in fact one of several people both here and abroad who have supported our observations.

Since Dr Roberts and I published our first paper we have had to point out to apparently authoritative authors in various respected medical journals that the secular trend towards earlier menarche is no longer continuing. I have written to gynaecologists and endocrinologists and now I must add a paediatrician to the list. When, sir, will they ever learn?

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¹ Dann, T C, and Roberts, D F, *British Medical Journal*, 1973, **3**, 265.

² Roberts, D F, and Dann, T C, *British Journal of Preventive and Social Medicine*, 1975, **29**, 31.

Treatment of dermatomyositis

SIR,—We would like to amplify your expert's reply (13 March, p 637) and the comment by Dr W F Durward (29 May, p 1341) on this topic as a consequence of a survey recently undertaken in this unit¹ on the prognosis and response to treatment in 118 cases of polymyositis.

Most of the patients had been treated with high doses of corticosteroids, though a few had also received immunosuppressive therapy. The mortality in patients with polymyositis as a whole was about four times that of the general population. With high doses of corticosteroids 66% of the survivors with polymyositis had no significant functional disability three years after presentation, and the prognosis for recovery was even better in survivors with dermatomyositis. Though we have not carried out a controlled trial, our experience agrees with that of Benson and Aldo² that oral azathioprine leads to a higher rate and extent of recovery than corticosteroids alone. We find oral azathioprine much easier and safer to use than the intravenous schedule of methotrexate recommended by Metzger *et al.*³

Our suggested treatment regimen is to begin with prednisone 50-100 mg daily,