back with persuasion. Where there were persistent and clear-cut demands to leave the hospital, civil rights were protected by appropriate use of the Mental Health Act.

Being selective, the device does not mean there is an all-seeing monitor such as CCTV, and there is the added advantage that no one has constantly to monitor a receiving screen. Some staff training is required so that nurses understand the attachment procedures, and *x*-ray and laundry staff are warned to watch for tags inadvertently leaving the ward.

The final test is whether people on the spot are convinced in practice and that is certainly so at the Hallett Clinic.

I am grateful to the following people at Exe Vale Hospital: Charge nurses S Braunton and R Adams, Sister Julie Bloom, and the nursing staff of the Hallett Clinic for their work with the patients and on the ratings; the engineering staff for help with the installation; Dr N N Bayatti for some of the analyses; Mrs Gill Meredith for typing the script and rating scales; and Mr Jack Brummitt, radiographer, for some of the photographs. I thank Mr Heinz Wolff of the Clinical Research Centre, Northwick Park Hospital (division of bioengineering), for his interest and for putting me in touch with Mr Karl Grossfield of the National Research Development Corporation, and Mr Sydney Pocock of the CRC, Northwick Park Hospital (division of bioengineering), who conducted the early engineering appraisal and advised on the most appropriate apparatus and its application in the hospital setting; Mr John Falck and Mr Geoff Pawsey of Tag Radionics Limited for the loan and installation of equipment; and Mr M Harman, inventor, and Commander Dr Rowe of the Rehabilitation and Medical Research Trust. Although they did not, in the end, supply the apparatus, their support was an important encouragement at a difficult period in the venture.

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USSR Letter

The anti-abortion campaign

MICHAEL RYAN

Early in September this year the Soviet Government announced a package of measures relating to social security payments and maternity leave.[1] Leaving aside the improvements in pensions (for old age, invalidity, and loss of the family breadwinner), these changes should be interpreted not so much as a move to alleviate family poverty but as one element in a developing demographic strategy. For some years now, official concern has been mounting over the low birth rates and rates of natural increase in European republics of the Union, a situation that is made more disturbing for the authorities by high levels of population growth in Soviet Central Asia, where predominantly Moslem traditions persist.

The current pronatalist policy also finds expression in propaganda levelled against abortion, which is widely resorted to as a form of family planning. For an indication of the broad approach and arguments deployed in the campaign it is helpful to turn to an article in the popular scientific journal *Nauki i Tekhnika* (*Science and Technology*).[2] As it happens, this journal is published in Latvia, where the birth rate and natural increase in 1979 were the lowest for the Soviet Union; they stood at 13·7 and 1·0 per 1000 population and may be compared with the highest rates of 37·8 for births and 30·1 for natural increase, which occurred in the Tadzhik republic

The article in question consists of an interview with a Dr K B Seglenietse, who holds a senior post at the Medical Institute in Riga. The title poses a question: "Induced abortion—is it murder by the skilled?", which might signal an attempt to identify the ethical implications and dilemmas confronting a doctor in this matter. The text, however, shows no interest in professional self-scrutiny; it is important for what one expert has to say about policies to combat the population crisis.

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Should abortion be banned?

Since 1955 women in all parts of the Soviet Union have enjoyed the right to abortion on demand, provided that the fetus has not reached viability, which is currently defined as around 1000 g. So Dr Seglenietse had no difficulty in dismissing a question that echoed the article's title; having referred to the legal position she made the tart comment: "to accuse women of murder when they are having an abortion is mere affectation."

More important from the viewpoint of policy analysis was her response to the interviewer's statement: "Some people recommend that abortion should be prohibited and contraceptive devices withdrawn from sale." In her reply the doctor cites what is evidently regarded as the deterrent example of Rumania.

The facts of recent population politics in that country are briefly as follows. In 1957 the Government legalised abortion with the object of curtailing the activity of backstreet abortionists and enhancing the health of mothers. By 1965 abortion had become the predominant method of birth control, despite widespread advocacy of contraceptives. The birth rate had fallen from 24·2 to 14·3 per 1000 population. Then in 1966 a law was passed authorising abortions only for women over 45, those with four or more children, those whose life and health were endangered by pregnancy (in the judgment of a medical commission), and for cases involving incest, rape, and mental subnormality. Fiscal measures such as family allowances were also used as collateral aids. Initially the birth rate responded with a sharp increase, but then fell back again as the pattern of small families became re-established.

A selective approach

The reference to Rumania's experience may well indicate that the balance of expert opinion has tilted against a radical change in the Soviet abortion law. In all probability Dr Seglenietse also echoes the majority view in favouring a differential approach that entails discouraging not abortion in general but abortion of the first pregnancy. There can be no doubting the importance she attached to this strategy; refusal to take a first pregnancy to full term, in the doctor's view, constitutes "a crime against morality."

A cautionary message

That vehement moral judgment is followed by a most revealing section, which seems to be intended as a stern warning to the journal's young female readership. To convey the sense of an unfolding argument, I will record the passage in unbroken translation.

"(Interviewer): But what about the difficulties resulting from the birth of a baby? Not everyone has the right conditions . . . for example, wouldn't it be more sensible for a student couple to wait?

(Doctor): And they do wait! There are data showing that women students who attend technical and higher educational establishments and live in hostels postpone the birth of the first child more frequently than others of their age. There are difficulties, indeed, but I consider that the difficulties should be preferred to a quiet life. But what happens? The years from 19 to 26 are the most favourable age for childbearing and up to 60% of abortions of the first pregnancy occur during this very age. The urge to postpone motherhood carries a danger of complete loss of ability to become a mother. In the first place a good many women are completely infertile even by the age of 30 and, in the second place, abortions can also lead to infertility. Think of a young woman who is not inclined to have children at the moment—it is not exceptional for the desire to do so to arise in her later on. Ask psychiatrists what mental disturbance is sometimes caused by the inability to satisfy a suddenly awakened maternal feeling."

After an interjection by the interviewer, Dr Seglenietse proceeds to quote hard data that could scarcely fail to create an alarming impression. "There is an investigation by A Shutskaya; it was undertaken in Belorussia; it lasted 13 years and studied 7550 women who aborted their first pregnancy. A fifth of these had acute or chronic inflammation of the sexual organs. Eight per cent—604 women—were infertile and, although they received treatment for 10 years, they still did not become pregnant. Furthermore . . . there are the data of T Federovna: after the first abortion 36% of the women in the survey suffered from chronic diseases. P Kasko and G Kniga call the first abortion a hormonal blow to the organism of a woman who has not yet reached full physical maturity. On what basis? They studied the longer-term (six months to two years) consequences of this operation and established hormonal insufficiency in almost half of the cases!"

A studied silence

At this point it is relevant to pause in order to consider the manner in which Dr Seglenietse perceived or at least presented the issue of the frequency and seriousness of complications. Arguably, she could have criticised the conditions that give rise to such unfortunate consequences and could have advocated a drive to improve standards—for instance, concerning asepsis—in those units where operations for abortion are performed. As it is, however, she says nothing to suggest that the Soviet hospital service bears any responsibility for the *sequelae*. Moreover, she says nothing to counter the inference that they are an unavoidable concomitant of aborting the first pregnancy or even a form of punishment for doing so.

A studied avoidance of criticism directed at the State may be found in another passage. The interviewer inquired: "Why are abortions far more popular than contraceptive devices?" He received the following reply. "Popular? They are forced on people! The use of contraceptives is not always possible and, besides, they are not 100% reliable. Many women know only by hearsay about the highly effective contraceptive pills and intrauterine coils; others are apprehensive about them—they are new and unfamiliar." Dr Seglenietse did not venture to emphasise the undoubted need to improve the quality, increase the supply, and extend the distribution of contraceptives. Nor would she have been reported had she drawn attention to a striking and fundamental contradiction. This is that the Soviet Union, despite giving its health service a strongly preventive orientation, has—either deliberately or by default—chosen to rely more on abortion than contraception as a method of family planning.

This substitution effect, if the phenomenon can be so termed, is especially prominent in the case of young, unmarried women. According to the article, on average four-fifths of the women who abort their first pregnancy are unmarried (to which area this figure applies is not clear). Among women under 20 who attended abortion units in Riga 41% were unmarried and 33% engaged in full-time studies.

Social policy implications

In view of the article's general drift and specific attempt to sustain a distinction between first and subsequent pregnancies, at least part of the conclusion will come as no surprise. Having heard about the Rumanian lesson, the interviewer asked: "But what should society do then about the huge number of abortions and the resulting increased frequency of premature births and complications of various kinds?" He recorded the following reply: "A range of limited restrictions suggest themselves as most advisable—for instance, directing women who wish to abort their first pregnancy to a medicolegal advice board."

It is only proper to add that this highly authoritarian proposal was qualified by the statement that effort should be directed mainly at improving the circumstances of families. In general terms Dr Seglenietse has in mind positive discrimination to favour families with more than one child in respect of "rights" and "social position." Earlier she listed specific practical measures which, if implemented, would clearly do much to make the life of a working mother more tolerable. These were: greater mechanisation of housework, more flexible hours of employment, greater opportunities for married couples to take holidays together, the right to an additional room on the birth of the second and each subsequent child, and the extension of the network of kindergartens and crèches.

References

1 *Pravda* 1981 Sep 6:1.
2 Seglenietse KB. Iskusstvenni abort-iskusnoe ubistvo? *Nauki i Tekhnika* 1980;**9**:27-30.

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After mitral valve replacement patients are often put on a long-term anticoagulant such as warfarin. If they have rheumatism, musculoskeletal aches, and joint pain what anti-rheumatic drugs can be given for relief?

A careful check should be kept on prothrombin levels when any drug is prescribed with warfarin. In the present context paracetamol is the safest but its analgesic effect is relatively weak; of the non-steroidal anti-inflammatory drugs ibuprofen, naproxen, and flurbiprofen do not alter prothrombin levels; salicylates, phenylbutazone, and indomethacin all potentiate the effect of warfarin.—ALEX PATON, postgraduate dean, North-east Thames region.