adaptive process—a catharsis—which enables the patient to adjust to his experience ; or the distorted, fragmentary, and purposeless appearance of recent memories which emerge when repression is in abeyance during sleep ; or the result of a subtle organic disturbance, with their content derived from recent experience. Neurotic reactions were found in almost all the patients with grave heart disease whether or not they had suffered cardiac arrest, but as the criteria of abnormality were not clearly defined any comparison with the incidence found in other studies is difficult.

These problems are likely to become more common as apparatus is developed which can take over other vital functions in patients who are seriously ill. Victims of accidents can be maintained alive by respirators[3] until it becomes clear whether or not the brain is going to recover. In these cases the borderline between life and death is becoming blurred.

The atmosphere of an intensive care unit heightens suggestibility. The patient is anxious, and he is in the presence of others, both staff and fellow patients, who are also likely to be anxious. He is surrounded by equipment to which contemporary mythology attributes magical powers. Druss and Kornfeld advise that patients should be allowed as much privacy as is feasible, that monitoring equipment should be placed inconspicuously, and that patients should not be aware of the monitor signal. Patients gain relief from talking about their worries and they should be given the opportunity to do this while they are in hospital and their experiences are still fresh. Druss and Kornfeld also advocate that : " the patients should be told that their bodies were alive during the time their hearts had stopped." Many would disagree with this advice. The fantasy of having been dead may arise spontaneously, but it may also be suggested by the doctor's attitudes and by this type of comment. Confronting the patient with the information that his heart stopped beating or that he stopped breathing could do harm. The physician's detailed understanding of the emergency has served its purpose if it has helped the patient to get better ; it is not part of treatment that this knowledge should be shared.

Doctors in Court

The protection of a doctor's professional confidence must sometimes conflict with the interest of justice in discovering the truth. The law resolves that conflict in all except a few special cases by giving the trial judge power to use the ultimate deterrent of committal for contempt to enforce disclosure of the confidence, while enjoining the judge to be sparing in the use of that deterrent.

In a report published last week the Law Reform Committee recommended[1] no change in the law so far as it affects doctors in civil cases. The Criminal Law Revision Committee is apparently thinking along similar lines in its consideration of the criminal law. The only change at present envisaged might arise out of the deliberations of Lord Justice Winn's Committee on Personal Injury Litigation, which is considering whether the " privilege in aid of litigation " should continue to apply to certain classes of hospital and other medical reports. At present a medical report prepared at the request of the legal advisers of a litigant for the purpose of litigation need not be disclosed to the court.

Much can be said in favour of the present state of the law.[2] Difficulties of definition alone make it almost impossible to set out the cases in which the professional man should be permitted to refuse to answer questions. The Committee's report shows how difficult it is to describe broad principles to cover this point. When considering how the court should exercise its discretion on the issue of compelling medical witnesses the Committee states:

" Where a doctor is called, not in his capacity as a medical adviser to testify as to the physical or mental condition of his patient, but as a witness of another fact not related to the health of his patient, we are confident that any judge would protect him from being questioned upon information obtained by him from his patient in his capacity of medical adviser."

The Committee suggests, for example, that a doctor should not be compelled to give evidence of an admission of adultery if the admission had no bearing on the patient's mental or physical health. The reverse of this proposition is probably more attractive to doctors. One can see the public interest in preserving secrecy about disclosures which are of assistance to a doctor in his care of his patient. There is much less (if any) public interest in protecting those disclosures made as incidental conversation at the time the patient sought treatment.

What is plain is that if the law is to remain in its present fluid state some better system of appeals from the ruling of the court should be considered. Since the right of confidence belongs to the patient and not to the doctor, the medical witness cannot be sure of his position until the patient's absence of consent to disclosure and the mood of the judge are revealed when the doctor is in the witness-box. It is not until the witness is in contempt of court by refusing to comply with an order to answer that he acquires any standing before the court to test the ruling on appeal. An adjournment for an immediate application to the Court of Appeal for a second ruling could probably be obtained even under the present Rules of Court, but it would require a firm advocate to persuade most judges to accede to such a course in the middle of a trial. It is a pity that the Law Reform Committee did not consider the procedural problems of ensuring that there are adequate means of appeal from the exercise of the existing wide judicial discretion.

Foot-and-mouth Disease

Few can fail to be shocked at the slaughter of nearly 300,000 animals in the current outbreak of foot-and-mouth disease. But this is the price that must be paid to keep Britain free from endemic infection with it. The disease is endemic in most countries of the world, and though Australia, New Zealand, North America, and Britain are normally free from it[1] the most rigorous measures of control must be employed to prevent the introduction and establishment of infection.

Foot-and-mouth disease is an extremely infectious viral disease of animals. Very rarely it also attacks man.[2 3] It has a high attack rate in susceptible animals and a capacity for rapid spread comparable to human influenza. It affects cloven-footed animals such as cattle, sheep, pigs, and goats The incubation period is from three to eight days, and the main route of infection is the respiratory tract. The virus causes a generalized infection, with vesicles on the tongue, mouth, and hooves, so that affected animals have increased salivation and lameness. Virus is excreted in large quantities in the saliva, and is present—though not in such large amounts

[1] *Sixteenth Report of Law Reform Committee*, 1967, Cmnd. 3472. H.M.S.O., London.
[2] *Brit. med. J.*, 1964, 2, 955.