Restrictions of Medical Aid in Abortion

SIR,—If Mr. J. White's Abortion (Amendment) Bill is, as indeed he has represented it to be, an urgent demand to Parliament to control the present exploitation of pregnant women in distress with unwanted pregnancies, then no doctor concerned for the welfare of such women will wish to do other than fully support it. But if it contains measures designed to deprive women in need of access to medical aid in abortion, which it does, this is another matter.

Seeking to limit the legal right to abortion to 20 weeks and thus interfering with the accepted and established figure of 28 weeks for fetal viability is an unwarranted intrusion on medical assessment. Surely such matters are best left to doctors to decide? Again while certainly abortion for foreign women coming here for that purpose should be free only in exceptional circumstances, most medical men will feel that to forbid these women access to help is not only inhuman but introduce an unwelcome and uncongenial note of xenophobia.

But perhaps most importantly of all, Mr. White's Bill seeks also to discount social and emotional factors in medical grounds for termination. This would be a most retrograde step, not only in this field but in medicine generally, as deeply damaging to our present ethos and concept of whole-person care. When this measure comes before the Select Committee which is to be set up it is to be hoped that all those interested in the preservation of insight into the role of emotion and social factors in the aetiology of disease will be heard.—I am, etc.,

NORMAN CHISHOLM

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Community Health Specialists

SIR,—Dr. R. G. Dunning (22 February, p. 456) welcomes the inauguration of an Association of District Community Physicians but regrets that the formation of other special interest groups may tend to disintegrate the emerging specialty of community medicine and weaken its voice.

Any initiative aimed at developing our thinking and skills is welcome, and we are still free to organize ourselves (or not) as we please. The B.M.A., and the Faculty of Community Medicine through its appointed advisers in the English regions, Scotland, Wales, and Northern Ireland, have provided a framework for regional—and more local—meetings of almost any kind.

Dr. Dunning should be assured that the Faculty of Community Medicine is anxious to develop its peripheral and local as well as its central and national activities, but some of the impetus must come from our members. He suggests that the faculty might "act as a catalyst," and he will shortly read in the faculty newsletter that Dr. H. Binysh, of Cornwall, has kindly accepted the office of faculty adviser in Dr. Dunning's region.—I am, etc.,

T. MCL. GALLOWAY
Registrar,
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SIR,—I was dismayed and intrigued to read Dr. W. S. Parker's reply (22 February, p.

455) to my letter in that he obviously does not understand what a community health specialist is.

Dr. Parker is a district community physician, and I regard them with great sympathy as being immensely valuable members of the community and, even seen through a vaginal speculum, they are undoubtedly performing a thoroughly worthwhile task. Community health specialists, however, are a completely different entity and are area appointments with a much more dubious job description and bring, among other things, a proliferation of bureaucracy. They also are a drain on the limited medical resources for community medicine, as mentioned in Dr. Parker's letter. I regard them, moreover, as a threat to the autonomous position of consultants within the Health Service.

In reply to the remark made by Dr. H. Gordon that I should have spoken up before the N.H.S. reorganization was introduced, one assumed at the time that the procedure would be sensible and helpful. Time has shown it to be otherwise.—I am, etc.,

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Prolactin and Pre-eclampsia

SIR,—Dr. C. W. G. Redman and his colleagues in their interesting paper (8 February, p. 304) have omitted to mention much of the evidence supporting the concept that prolactin may be involved in the syndrome of pre-eclampsia. The idea was first proposed in 1971¹ and has been considerably developed since.^{2,3}

The main pieces of evidence are: (1) Prolactin can cause renal retention of sodium, potassium, and water in man.¹ (2) Prolactin can elevate arterial pressure in rabbits.⁴ (3) Prolactin in concentrations similar to those found in human pregnancy can potentiate the responses of rat arterioles to both noradrenaline and angiotensin.⁵ (4) Elevated levels of prolactin appear to be nephrotoxic in rats, causing a nephrotic-type syndrome.⁶ (5) The development in old rats of a nephrotic-type syndrome can be prevented by treatment with 2-bromo- α -ergocryptine, which suppresses prolactin secretion.⁷ (6) Prolactin can stimulate progesterone synthesis by human ovarian tissue.³ Govan and Mukherjee in 1950⁸ reported a study of the ovaries of stillborn infants from pre-eclamptic pregnancies and from pregnancies not complicated by pre-eclampsia. Of 33 non-pre-eclamptic cases there was no evidence at all of follicular maturation in 29; in the remaining four there was some maturation but without rupture or luteinization. Of 25 pre-eclamptic cases, 23 showed clear evidence of follicular maturation and in seven there was obvious luteinization. These forgotten observations strongly implicate some luteotrophic factor in pre-eclampsia. (7) Prolactin can have excitatory effects on the heart¹⁰ and vascular smooth muscle.⁵ If it acts on neuronal membranes in similar ways it could provoke epileptiform attacks. A number of drugs which have in common stimulation of prolactin secretion are known provokers of such attacks.²

There are therefore very strong reasons

for considering the possibility that prolactin may play a major role in pre-eclampsia.—I am, etc.,

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Wife Battering

SIR,—Dr. J. J. Gayford's study (25 January, p. 194) is most timely; let us hope, now that he has shown the need for places of refuge, that those of us who have been struggling to establish such places will begin to attain some recognition. Over 80 have been set up throughout the country, including one in Acton which I helped start and which has been running for eight months; we have helped about 110 women and their children and have met most of our expenses from jumble sales and charity shows. Most of the work has fallen upon a small nucleus of us (all mothers with small children but the advantages of sympathetic husbands, a stable home, and a reliable family income), but we have recently appointed a full-time "housemother" who sees to matters such as helping new arrivals find a solicitor, apply to social security, etc. Also we normally have a part-time play leader, though the last one was worked nearly into the ground by the demands of the children, who tend to be very disturbed as a result of their experiences.

We have rapidly come to the conclusion that we have undertaken a serious job of social work which we cannot continue to do unaided; to continue, we shall need the support and interest of the medical and social work professions and, most importantly, reliable funding to enable us to employ trained, skilled, and sympathetic people to work with us.

So please forget those tired old jokes about "battered brides" and "battered husbands" and take the women seriously for a change.—I am, etc.,

ANNE MARCOVITCH

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A New Service

SIR,—The following salient facts seem to emerge from our present confrontation with the Government. (1) The profession has never been so united. (2) The consultants will never return to their previous onerous working week. (3) The Government will move slowly, if at all, to resolve the impasse. (4) Waiting lists in most specialties will shortly reach unacceptable dimensions.

However, our patients will have to accept