foetal abnormality, is praiseworthy. But who can delude himself that these will be the main problems? The majority will consist of perfectly healthy women who are pregnant, in or out of wedlock, and who want to be rid of the baby. It is piously stated that "a doctor–patient relationship will be created and the doctor will then advise." What in fact will happen in these cases is that the woman will tell the doctor what she wants —an abortion, with the threat that if not she will go out of her mind and possibly kill herself. I have, indeed, already had a request on these lines from a woman who believed the Act was already in force. She did not get her request, but I was told that she knew of others in similar circumstances, but nearer London, whose doctors had been more obliging.

It must be admitted that without the word "grave" there is more strain and risk mentally and physically in bearing a child and caring for it, but I am sure the Act was not originated to relieve people of their responsibilities. If it was the idea that abortion is preferable to an unwanted child, then go ahead, abort, but do not be under any misconception that it is the doctor's decision. It is the woman's decision, and the doctor merely helps her carry it out. Abortion on demand? Certainly, and without payment. —I am, etc.,

H. A. ROBINSON.

South Shields,
County Durham.

Prescription Charges and Tuberculosis

SIR,—I am extremely disturbed to note that pulmonary tuberculosis is not included in the list of conditions for which drugs will be prescribed without a prescription charge.

I understand that it is, however, included in the list of conditions where an appropriate charge for a period of three months or a year might be made. I consider, however, that any charge to a patient on chemotherapy for pulmonary tuberculosis will discourage many patients from taking chemotherapy, which is in all conscience difficult enough to administer to patients at home as it is. The end result of this, of course, will be relapse, further admission of patients to hospital, recurrence of positive sputum, and the spread of the disease with increasing cost to the National Health Service.

I make a strong plea, therefore, for every chest physician to write to his Member of Parliament to protest about this before it is too late.—I am, etc.,

WILLIAM D. GRAY.

North Chest Clinic,
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SIR,—There is one very important aspect of the discussion about prescription charges to which I would like to draw attention.

Whether tuberculosis is a chronic disease or not, everyone would agree that chemotherapy benefits not only the patient but the community. It should therefore be made as easy as possible. We must try to persuade the Minister of Health that treatment of this disease should be free of prescription charges. —I am, etc.,

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Chest Clinic,
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Vocational Training for General Practice

SIR,—The Royal Commission on Medical Education[1] recommends that general practitioners and other doctors who will treat patients unsupervised should have six years' special training and experience after graduation leading to registration in their chosen specialty (see *B.M.J.*, 13 April, p. 109).

I trust that the British Medical Association will endorse this recommendation. I cannot see general practice ever rising from the low state to which it has sunk until doctors do a compulsory course of vocational training. At the moment any doctor, after completing his year of preregistration posts, can step into a practice as an equal partner. In fact overworked principals are only too thankful for anyone they can get, because applicants for general practice are so scarce.

In no other branch of the profession can a medical man become fully established with so little training. If he wants to become a surgeon, a dermatologist, or a medical officer of health he has to submit to a rigorous course of training; but any Tom, Dick, or Harry can enter general practice, and if the practice happens to be in a densely populated area supported by a good hospital service he can get by with very little effort on his part.

It has been argued that a compulsory vocational course will increase the shortage of general practitioners. This may well be, but at least the profession will know that once compulsory vocational training is accepted those doctors who then apply to become a partner or principal in general practice will be of the right calibre, and the standard of general practice in this country will inevitably rise.—I am, etc.,

BERNARD TAYLOR,
Hon. Secretary and Treasurer,
Tower Hamlets Division,
British Medical Association.

London E.3.

REFERENCE

1 *Royal Commission on Medical Education*, Cmnd. 3569, 1968. H.M.S.O., London.

"Normal" Temperature

SIR,—In view of the national change from degrees Fahrenheit to degrees Centigrade it seems likely that the clinical thermometer will receive a new scale. Would not this be a good opportunity to get rid, once and for all, of that little red line which suggests that temperatures above or below it are abnormal?

There has long been good evidence that this arbitrary "normal" temperature is misleading.[1] Ivy in 1944 reported on 276 American medical students whose temperatures were taken in class between 8 and 9 a.m. The mean temperature was 98.1° F. (36.7° C.), and the range containing two standard deviations was 97.3–98.9° F. (36.3–37.2° C.). The total range for the 276 presumably normal students was 96.6–99.4° F. (35.9–37.4° C.).

I have analysed the temperatures of 50 Belfast medical students taken in class between 2 and 3 p.m. Results were slightly higher than those of Ivy, as might be expected at this time of day. The mean temperature was 98.4° F. (36.9° C.), and the range containing two standard deviations was 97.6–99.2° F. (36.4–37.3° C.). The absolute range was 97.5–99.4° F. (36.4–37.4° C.).

DuBois,[2] in a review of the literature on normal temperature, suggested a normal range of 35.8–37.4° C. oral and 36.2–37.8° C. rectal. For simplicity I would suggest a normal range of 36.0–37.5° C. (96.8–99.5° F.), marked perhaps by green colouring, which would include most normal temperatures and exclude most abnormal temperatures, whether taken orally or rectally or in the axilla. Finally, a clinical thermometer which reads as low as about 30° C. (86° F.) might be useful to general practitioners in detecting accidental hypothermia.—I am, etc.,

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REFERENCES

1 Ivy, A. C., *Quart. Bull. Northw. Univ. med. School*, 1944, 18, 22.
2 DuBois, E. F., *Fever and the Regulation of Body Temperature*, Illinois, 1948.

Price of Blood

SIR,—A document by Cooper and Culyer,[1] of the University of Exeter, setting out the arguments for the purchase of blood for transfusion, has recently been published (see also leading article, p. 129). The simple economic law of supply and demand cannot, of course, be denied (although the same argument can be extended to the supply of kidneys for transplantation). However, the authors of this lengthy paper have completely ignored the outstanding hazard of commercially supplied blood—namely, the risk of post-transfusion hepatitis. Thus while it is easy to dismiss emotional and altruistic motives for blood donation by healthy adults, it would be a mistake to accept that purchased blood would achieve the same criteria of probable low infectivity so far as the virus of hepatitis is concerned. Experience elsewhere indicates that the risk of post-transfusion hepatitis is very much greater when commercial sources are used, the reason being that complete reliance must be placed on the verbal history of past infections and current health of the donor. No satisfactory laboratory tests are available at present for the detection of asymptomatic and chronic carriers of the hepatitis virus. The integrity of the potential purveyor of blood must therefore be assumed. Payment for blood has been known to attract sometimes an undesirable section of the population, notably narcotic addicts (whose risk of serum hepatitis is notoriously high), chronic alcoholics, and others. Furthermore, experience has shown that when potential donors were turned down by some blood banks on health grounds they soon managed to sell their blood elsewhere. Consequently as long as the blood bank must rely upon accurate medical history and the truthfulness of the potential donor this risk must be taken into consideration.

The figures for post-transfusion hepatitis, both in the icteric and anicteric form, published from some centres in the United States, Germany, and Japan, are remarkably high. In a recent study the overall attack rate of post-transfusion hepatitis was found to be 14%,[2] but a very much higher incidence has also been reported.[3] The overall mortality rate can be as high as 28%.[4] In 1963, in the United States, about 1.8 million patients were transfused, and it has been estimated that the incidence of clinical transfusion