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G.M.C. and Abortion Act, 1967

SIR,—The shift in emphasis in the General Medical Council's recent review of the paragraph referring to abortion (20 April, p. 185) raises important questions. Before revision, a breach of the law of this land was not the sole consideration, for a doctor "who improperly procures . . . abortion or miscarriage overseas" could be charged with infamous conduct. Now it is "a serious matter . . . if done in circumstances which contravene the law." A charge will require a criminal conviction.

It is difficult for the ordinary doctor like myself to understand the role of the G.M.C. as regards medical ethics. Its change in attitude over abortion would suggest that the law of the land takes precedence over medical ethics, for the present law permits abortion for non-medical reasons. Does this mean that the G.M.C. will maintain only those medical ethics which do not conflict with the law, and that laws permitting euthanasia and

sterilization of the unfit would receive similar sanction?

There is surely a conflict here not only between the G.M.C. and individual doctors but between the G.M.C. and those medical ethics which have international recognition.

If the G.M.C. abrogated its responsibility for the preservation of medical ethics the medical profession would be in a position to organize itself to ensure that proper standards were maintained. At present the body which has the statutory power has opted, in the face of declared opposition by the British Medical Association and the Royal College of Obstetricians and Gynaecologists, for Government control of these standards. With less grave issues the G.M.C.'s attitude would cause serious concern; under present circumstances it could spell disaster.—I am, etc.,

Edgbaston,
Birmingham.

MYRE SIM.

Abortion Regulations

SIR,—In the first draft (1966) of the Abortion Bill, Section 1(1) provided that termination would be lawful if "(a) the continuance of the pregnancy would involve *serious* risk to the life or *grave* injury to the health whether physical or mental of the pregnant woman whether before at or after the birth of the child."

This was amended in committee by removing the words "serious" and "grave," and adding "risk . . . to the future well-being of herself and/or the child or her other children" to the grounds for termination.

The newly issued *Abortion Regulations, 1968*,¹ make clear the full implications of these changes, since the two registered medical practitioners, before treatment for termination is commenced, are now required only to certify that they "are of the opinion, formed in good faith, that . . . the continuance of

the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated."

Since the almost nonexistent risk to the life of a healthy woman in an abortion properly performed early on in pregnancy is indeed likely to be less than the present very low, but not wholly negligible, risk in normal childbirth, it is hard to see how any doctor could justify a refusal to give such a certificate. Whatever Parliament may have intended, this is in effect abortion on demand, subject only to a doctor's right to refuse to participate if he can prove a genuine conscientious objection.—I am, etc.,

C. B. GOODHART.

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Cambridge.

REFERENCE

- ¹ *Abortion Regulations* (Statutory Instrument 1968), No. 390. H.M.S.O.

Risks of Abortion

SIR,—The Abortion Law is here, and argument and discussion on the subject will certainly continue for many months to come.

The actual operation may lawfully be performed by doctors without specialized knowledge of the female pelvic organs, yet hardly a word has been written about the risks and dangers of the procedure to the mother. No one is suggesting that termination of pregnancy is a major operation, but neither should it be regarded as a "simple D. and C." For example, anaesthetists readily appreciate that there are distinct problems associated with a pregnant patient. The surgeon may produce damage to the cervix during dilatation, with subsequent long-term ill effects. Severe haemorrhage will occasionally occur regardless of the operator's skill. It is not difficult to perforate the wall of the pregnant uterus.

There are other considerations to be faced by the abortionist. Is the pregnancy too far advanced for vaginal termination via the cervical canal to be either safe or feasible? Has the uterus been completely emptied, or, conversely, has the uterine cavity been so enthusiastically curetted that permanent loss of the endometrium results? Is it logical in the majority of patients to terminate a pregnancy without performing sterilization?

This letter is not written by an alarmist. It just seems that much that has been published recently on the subject of lawful abortion has emanated from the philosophical armchair rather than from the practical operating-theatre stool.—I am, etc.,

Leamington Spa,
Warwick.

JOHN FRAMPTON.

Familial Mediterranean Fever

SIR,—Several points in your leading article (23 March, p. 724) invite comment. Except for the frequency of heritable amyloidosis, familial Mediterranean fever in Sephardic Israeli patients is no different clinically or pathologically from periodic peritonitis¹ as occurs in persons of other religious or ethnic origin.² The limiting geographic adjective is

undesirable: brucellosis, leptospirosis, and boutonneuse fever also are known as Mediterranean fevers, and abdominal pain, not fever, is the outstanding feature. Episodes are not always unpredictable as stated, but recur regularly for years in some Israeli victims¹ and in many others.² Periodic precision can be demonstrated if events are registered continuously.

Periodic fever is a separate entity. It does occur in Jewish people, in Aryans, Japanese, and Negroes. Amyloidosis has ensued.³ Periodic fever, like periodic polyserositis,

is rarely influenced by corticosteroid therapy. Aetiocolanone has no causal relation to either disorder.⁴—I am, etc.,

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- ² Reimann, H. A., *Periodic Diseases*, 1963. Oxford.
- ³ Ehrenfeld, E. N., Ellakim, M., and Rachmilewitz, M., *Amer. J. Med.*, 1961, **31**, 107.
- ⁴ Wolff, S. M., Kimball, H. R., Perry, S., Root, R., and Kappas, A., *Ann. intern. Med.*, 1967, **67**, 1268.

Unfilled Posts in the North

SIR,—The reluctance of senior registrars to apply for consultant posts in the north of England is not difficult to explain. The standards of medical and surgical care regarded as normal in undergraduate and postgraduate teaching institutions require elaborate laboratory and radiological investigation, together with facilities for consultation with other clinicians. "Adequate" laboratory facilities involve at least three consultants and a biochemist, but these are scarce and cannot be fully employed by populations much fewer than 150,000, who are estimated to require about 450 acute beds. Laboratory consultants require numerous staff and expensive apparatus, and must therefore work mainly in one place—they cannot effectively distribute their labours among a number of small units. It follows that modern standards of medical care can be attained economically only in hospitals of 450 beds and upwards, containing laboratories which have facilities for the four separate "disciplines" of pathology recognized by the College of Pathologists.

Such facilities are rarer in the north of England than in the south. To illustrate this

TABLE I.—Distribution of Beds According to Size of Hospital

No. of Beds	Newcastle		Wessex	
	No. of Hospitals	No. of Beds in these Hospitals	No. of Hospitals	No. of Beds in these Hospitals
Over 1,000	1	1,030	—	—
500-999	2	1,054	4	2,644
400-499	3	1,362	—	—
300-399	11	3,615	4	1,415
200-299	4	1,090	3	793
100-199	24	3,210	5	588
50-99	18	1,204	6	448
Under 50	53	1,225	19	517
Total	116	13,790	41	6,605

TABLE II.—Number of Hospitals (N) Served by Each Specialist

(a) Radiology (Diagnostic)

Region	No. of Radiologists	N.										Beds per Radiologist
		1	2	3	4	5	6	7	8	9	10	
Newcastle	35*	12*	7	8	2	1	1	1	1	0	2	394
Wessex	23	7	10	6	0	0	0	0	0	0	0	327

* 6 of these are attached to one hospital.

(b) Pathology

Region	No. of Pathologists	N.				Beds per Pathologist
		1	2	3	4	
Newcastle	36*	22	7	6	1	383
Wessex	30†	24†	5	1	0	220
A London hospital group	4	1	2	1	0	284

* 8 are attached to one hospital. † 7 are attached to one group laboratory and 5 to another.

argument I have compared information about "acute" and "mainly acute" hospitals in the Newcastle and Wessex regions. The data have been extracted from the 1966 *Hospitals Year Book, National Costing Returns*, (H.M.S.O.), and the *Medical Directory*.

Thus in Wessex 40% of beds are in hospitals of over 400 beds; in Newcastle 25%.

This excess of small hospitals implies that specialist consultants have to visit many hospitals, wasting travelling time and providing only an intermittent service. Even so, each radiologist or pathologist has to serve more beds in the north. Table II illustrates this. The London hospital quoted for comparison in Tables II and III is a regional hospital with responsibility for undergraduate and postgraduate teaching and two research units.

Expenditure on these services tells the same story. To save space I give figures only for laboratory services.

These figures show that some northern regions have inadequate basic services in radiology and pathology, and that the size distribution of hospitals makes it difficult to establish centres at which adequate services can be provided (or "centres of excellence"). This is one reason, and perhaps the most important, which discourages senior registrars in the clinical specialties from applying for posts in the north. Senior registrars in

TABLE III.—Cost of Laboratory Services

	Newcastle	Wessex	A London Hospital
Requests	1,388,400	811,900	131,700
Beds	13,790	6,605	900
Expenditure	£787,523	£586,523	£73,725
Medical salaries	£180,979	£142,026	£27,784
Requests/bed	99	121	146
Expenditure/bed	£57	£89	£82
Medical salaries of lab. specialists per bed	£13	£21	£31

laboratory disciplines will also be discouraged, because the College of Pathologists' training provides for excellence in one "discipline" only, whereas in small laboratories consultants have to undertake responsibility for two or more. There is also the fact that some established consultants consider that the first duty of a laboratory is to provide an exhaustive service in morbid anatomy and histopathology, and therefore veto the appointment of any pathologist, however skilled in another discipline, who is not able and willing to spend much of his time in the section of morbid anatomy.

The conclusions seem obvious. Young consultants are likely to avoid the northern regions until they can work in hospitals large enough to require the attendance of most clinical consultants on several days of the week, and to ensure the provision of proper laboratory and radiological facilities. Probably the easiest way of achieving this aim would be to modernize and expand the hospitals with 300-400 beds; were this done both Newcastle and Wessex could have more than half their beds in properly served units. Even then there remains the problem of persuading enough young men to start training as pathologists and radiologists. This is not a purely British problem: even in the People's Republics they are so difficult to find that they are paid "danger money."—I am, etc.,

GEORGE DISCOMBE,

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Psychotic Reactions During Travel

SIR,—I read with interest your leading article on psychotic reactions during travel (20 April, p. 132). When considering such reactions in travellers the role of drugs used against motion sickness must not be forgotten. Most of the drugs are anticholine in action and their effectiveness depends upon their action on the central nervous system. Hyoscine, one of the most popular and effective of these drugs, is a well-known producer of toxic psychoses.

These drugs are usually freely available to travellers, and an excessive dose may easily be taken. The traveller or his companions take such drugs for granted, and their use by the patient is often forgotten, unless the doctor specifically asks about them. —I am, etc.,

C. P. W. WARREN.

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London S.W.17.

Overcrowding in Psychiatric Hospitals

SIR,—Dr. C. Entwistle (13 April, p. 116) made a good point in advocating the discharge of long-stay patients to alleviate overcrowding in mental hospitals. It is, however, legitimate to ask what is happening to these discharged patients, what burden to their relatives do they constitute, and what community services are supporting them? With an ideal community service it is theoretically possible to transfer and diffuse the good mental hospital through the community. The problem then will only be diluted, not resolved. We might again think it would be more economical and more effective to treat