Risks of Abortion

SIR,—May I agree with and commend the views put forward by Mr. John Frampton (4 May, p. 298)?

It was the risks attendant upon the termination of pregnancy—increased when carried out in relatively unskilled hands—that concerned me in my letter (28 January 1967, p. 237). The fact that the actual operation may lawfully be performed by doctors without specialized knowledge of the female pelvic organs thus represents a potential menace to the women involved.

Mr. Frampton has pointed out some of the technical operative risks. Trained obstetricians know that the operation of uterine evacuation calls for that knowledgeable tactile sense combined with controlled speed and clinical understanding—particularly when the pregnancy has exceeded the ninth week, and especially in a sick patient—which can only be acquired by training, experience, and continuing obstetric practice. The registrar who is assuming operative responsibility is carefully trained and supervised, and perhaps most consultants would agree that this operation, rare enough hitherto, should be undertaken only by those who have acquired this degree of experience.

Although the Royal College of Obstetricians and Gynaecologists considers that most cases will be referred to N.H.S. hospitals and will come under the care of consultant gynaecologists, it is nevertheless probable that some will be admitted to “a place approved for the purpose by the Ministry of Health or the Secretary of State,” and additionally may not come under the care of a trained and experienced obstetrician. Therein to my mind lies a danger to these women, as the numbers seeking abortion continues to increase and as hospital beds become so severely taxed as to necessitate delay in admission. The difference between the risks of the operation in the early weeks and in the weeks between the ninth and the fourteenth is considerable, and after this point an abdominal approach must be considered. The factor of time, therefore, is against the patient in this respect, and this factor, in my view, is likely to complicate the issue to an increasing extent as time goes on.

For these reasons, in my earlier letter I feared the possibility of panic measures leading to unethical surgery in inadequate surroundings (apart from authorized units) and stressed the need for the hospital consultant to be directly concerned in all cases. In this connexion the letter by Mr. Wilfrid Mills (30 December 1967, p. 802) points out the already existing difficulties facing the hospital consultants. These I feel could be mitigated by the recognition of responsibility for assessment, references, and even the operative treatment being delegated to the chief assistant or trained registrar. This would conform with the decision of the R.C.O.G. and B.M.A. that “it be made obligatory for the termination to be carried out by or under the supervision of a consultant.”

I emphasize the risks of induced termination of pregnancy, because, as Mr. Frampton says, hardly a word has been written on this aspect of the problem during the whole period of discussion of this Bill. He mentions some of the immediate risks. To these could be added the long-term risks consequent upon unskilled or handicapped treatment (retained

products, chronic pelvic infection, functional disorders, etc.) which come under the category of chronic pelvic disease and which have a permanent effect upon the physical and mental health of women.

I trust that the necessary thought and study will be given to this aspect by all in authority. It certainly has fascinated as well as terrified me that a Bill with such far-reaching influence upon the future health of young women can come into law without its inherent risks to them being thoroughly appreciated through adequate publicized discussion. This at least might have enabled the public to understand that—to put it bluntly—there is more to it than just “giving a woman an abortion.”—I am, etc.,

Manchester 3.

K. VERNON BAILEY.

Negligence and Doctors

SIR,—It is surely the essential privilege of the professions that their standards are set from within and not imposed from without. For this reason a professional man has been able to resist an allegation of negligence by showing through the evidence of his fellows that he acted in accordance with an accepted practice, and this despite proof that an equally accepted practice of which he knew or should have known would have avoided the injury on which the claim against him is founded. The courts have propounded, and indeed defended, this doctrine and the professions have flourished under their protection.

It would, however, appear from the report in *The Times* and your leader (18 May, p. 381) on the case of *Hucks v. Cole* and Another that a general-practitioner obstetrician has been convicted of negligence despite the evidence of a consultant obstetrician and two other general-practitioner obstetricians that Dr. Cole had done what they themselves might or would have done in the same circumstances. The report does not suggest that the evidence of these obstetricians was either prejudiced, discredited, or even formally rejected.

The evidence of the plaintiff seems to have come from a different level of practice altogether, and in particular the point on which the defence foundered appears to have been the evidence of a consultant bacteriologist. One would have expected that the plaintiff might have called at least one general practitioner to affirm that the view of a consultant bacteriologist of a London medical school was known to and shared by the average general practitioner in the less sophisticated medical atmosphere of rural Somerset.

As you say, no substantial departure from the accepted law has been made, but as a general practitioner in law as opposed to medicine I also find myself puzzled as to the advice I should give to the hospital authorities I serve on the evidence necessary to defend a charge of medical negligence when the principle stated in the first paragraph of this letter is so clearly enunciated in a judgement which, *prima facie*, appears to contradict it altogether.—I am, etc.,

P. W. H. REVINGTON,

Legal Adviser,
Manchester Regional Hospital Board.
Manchester 8.

Trimethoprim

SIR,—The excellent review of the bacteriology of trimethoprim by Darrell, Garrod, and Waterworth¹ no doubt prompted your leading article (18 May, p. 380) as a summary for your readers with clinical interests. You succeeded admirably except in one small but important detail. The efficacy of trimethoprim and sulphamethoxazole was extended to *Pseudomonas aeruginosa*, but Darrell *et al.* actually wrote that “the synergic effects on *Ps. aeruginosa* is presumably only of academic interest, since high concentrations of both drugs are required.” This laboratory confirms that synergy only occurs at impracticable concentrations of the drug against *Pseudomonas*. Out of 384 strains of 27 bacterial species freshly isolated here only the 10 strains of *Ps. aeruginosa* showed no enhanced susceptibility.² In a more general report of the properties of trimethoprim Bushby and Hitchings³ also showed that *Mycobacterium tuberculosis* and *Clostridium welchii* were similarly resistant. I would not therefore recommend treatment of infections due to *Pseudomonas* with trimethoprim and sulphamethoxazole. Eradication of *Pseudomonas* has so far been reported only for patients who were also infected with other organisms. Possibly in such cases *Ps. aeruginosa* has not been the important pathogen, or the antibacterial treatment has allowed the natural defences to concentrate successfully on a single pathogen.

The cause of the resistance of *Pseudomonas* to trimethoprim is known and has important practical implications. My colleague, J. J. Burchall, showed that trimethoprim binds just as firmly to the enzyme dihydrofolate reductase from *Pseudomonas* as it does to the enzyme of sensitive bacteria, but enters the intact *Pseudomonas* much less readily than it does other intact bacteria. Indeed, penetration can be improved without damage to the anti-enzyme properties of trimethoprim by altering the physical environment by such agents as Tweens.

I therefore expect that modifications of the molecule will provide a more useful way of penetrating the membrane of *Pseudomonas* without altering its fascinating property of inactivating bacterial enzyme, yet not influencing appreciably the enzyme of the human host.—I am, etc.,

A. S. E. FOWLE.

Wellcome Research Laboratories,
Beckenham, Kent.

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E.E.G. Signs of Death

SIR,—Your timely leading article (11 May, p. 318) draws attention to two main points that might need amplification. The first, already extensively publicized in the lay press, is the lack of a modern set of rules to help in defining the time of death when some of the patient's “vital” functions are assisted by artificial means. A working group to reconsider our present knowledge in the borderland between life and death is badly needed in this country, while modernization of the law has already evolved abroad.

The second point in your leader draws attention to "the national dearth of properly trained clinical neurophysiologists." This is particularly obvious in the field of electroencephalography, and it seems probable that the increasing interest in organ transplantation will add to the requests for neurophysiological investigations in "resuscitated" patients as well as in the "dying" ones. The implications of some E.E.G. findings may become of crucial importance to the subsequent actions of the resuscitation teams. Whoever is responsible for E.E.G. studies after resuscitation should be medically qualified, able to carry out personally such investigations, master the many technical pitfalls peculiar to intensive care units, and have specific knowledge of an intricate field which requires prolonged work at the bedside with mobile equipment. This kind of responsibility should never be left to E.E.G. technicians whatever their training and skills, nor to a physiologist or a neurologist without the appropriate training and specific experience.

The proper study of resuscitated patients is a very interesting but time-consuming job. Over the last ten years I have been called to one or another hospital in the London area many times but often had to decline because of lack of time. The establishment of an independent mobile E.E.G. unit run by fully trained personnel to study resuscitated patients in various London hospitals has been proposed in order to gain information and

save both time and money. However, such proposals were not supported and a decentralized scheme was favoured, overlooking the fact that portable E.E.G. equipment is scarce even in London teaching hospitals, and that appropriately trained clinical neurophysiologists are even scarcer.

A little more knowledge than your leader indicates has been reached in Britain in understanding the contribution of electroencephalography in the study of the result of cardiac arrest and cerebral anoxia: even the bibliography is rather more extensive than your leader implies, since the early contribution of Millar¹ in 1951 and some of our preliminary studies²⁻⁴ in 1958, 1960, and 1962. In the last few years the world literature (particularly from France⁵⁻⁷) has already covered many of the relevant aspects.—I am, etc.,

London N.1.

G. PAMPIGLIONE.

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Too Ill for Cardiac Surgery?

SIR,—Dr. R. Emanuel's paper (18 May, p. 400) pays deserved tribute to the skill of his surgical colleagues at the National Heart Hospital. But it is astonishing that he makes no mention of the crucial contribution that skilled anaesthesia must have made to the success of operations on patients so extremely ill.

Come to think of it, although the world's press has resounded for months with praise for surgeons who transplant hearts, lungs, and livers, there has been—to my recollection—no blowing of trumpets for their anaesthetists.

I do not suggest for a moment that the anaesthetists concerned would wish to be involved in the sort of ballyhoo which surrounded Professor Barnard: but it would be nice to hear of some public acknowledgement of the debt which modern surgery owes to modern anaesthesia.

It is not so many years ago that "Too Ill for Anaesthesia" would have been the limiting factor in decisions to operate.—I am, etc.,

West Runton,
Norfolk.

LUCY TURNER.

SIR,—Permit me through your columns to congratulate Dr. Richard Emanuel on the timeliness of his paper "Too Ill For Cardiac Surgery?" (18 May, p. 400).

As a general practitioner who is a frequent visitor to the National Heart Hospital, I am encouraged, nay heartened, by the evidence that I see there of patients with architectural structural defects who are restored to health

with correction of their valvular deformities. The more I see the more I realize that the heart muscle is a resilient tissue which even in failure will pick up if the architecture is made good, and if the management of the patient both operatively and postoperatively measures up to the physiological requirements.

My regret is that similar facilities with similar mortality and morbidity figures are not available in provincial centres. It is my good fortune that I am able to refer to the National Heart Hospital my cases for cardiac surgery.

Having been in the Heart Hospital at all times of day and night, I am satisfied that my patients will have the best of preoperative assessment and of operative and post-operative care available not only in this country but in the world.

I deprecate the adverse comments made in the *B.M.J.* regarding publicity given the team who carried out the first British heart transplant. I would point out to the critics that the team made history for British cardiovascular surgery and I am certain that the operation was not carried out as an experiment, nor for that matter to keep up with the rest of the world, but for success as a clinical operation on a patient in need.

I hope that Dr. Emanuel's paper encourages other general practitioners to put up their valvular heart disease patients, even in extremis, for operation, for I am sure that neither they nor their patients will be disappointed.—I am, etc.,

Congleton,
Cheshire.

W. ERIC LEATHEM.

Heart Transplant Publicity

SIR,—The great majority of the profession will surely find themselves in complete agreement with the views expressed so admirably in the letters from Mr. Malcolm Donaldson and Dr. C. J. Massey Dawkins (18 May, p. 433). What has happened to professional decency?

It is true that in recent years bad examples have been set in respect of the publication of intimate clinical details about patients, and this may partially explain, but does not excuse, the prevailing fashion of "blatant publicity" which has become a reproach to medicine in this country.

When in May 1925 Sir Henry Souttar performed, at the London Hospital, the first successful transauricular valvotomy on a girl of 15 with severe mitral stenosis no reference to it at all appeared in the press, though it was of course a landmark in the history of surgery. Mr. Souttar, as he then was, gave a full account of the operation in the *B.M.J.* some months later.¹

It is to be hoped that the dignified reticence shown recently by the Edinburgh surgical team may have a salutary effect in checking a deplorable tendency which threatens the good name of a great profession.—I am, etc.,

London N.W.7.

A. H. MORLEY.

REFERENCE

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SIR,—The whole world has been excited and deeply moved by the recent breakthrough in heart transplant surgery. In the case of our own first operation we felt proud of our effort and delighted to know the patient was doing well. These operations have brought the peoples of the world closer together in a common humanity.

In the case of this historic transplant we like to know the personal details of the patient, names of the surgeons, and so forth. We are interested in another man's fate—as we should be. The world was deeply moved by the real life drama of the accidental death of a fine young donor giving hopes of a much happier life to an older man he never knew. The press conference on television was worthy of the occasion: anything less would have been unworthy of a great event.—I am, etc.,

Shrewsbury.

ALBERT E. NICHOLLS.

SIR,—Is it really necessary to jump on the international bandwagon of transplant surgery with such a flourish of trumpets? It would be difficult to imagine a more undignified, vulgar, and tasteless display than that given by the medical personnel concerned with Britain's first heart transplant operation. Rows of smiling faces lined up for full publicity, team ties, Union Jacks and all (some Sunday papers, 5 May).

Words almost fail us to register our shock and dismay at this evidence of abandonment of the traditional code of professional conduct which has so long been part of British medicine. One dreads to think what abuses may result from this approach to what is undoubtedly a great surgical feat.—We are, etc.,

J. KENNEDY HARPER.
HELEN M. HARPER.

London W.1.