rise to any serious problems in Dr. Morrow Brown's hands, we would be extremely uneasy if his methods were adopted on a large scale in routine clinical practice.—We are, etc.,

I. W. B. GRANT
G. K. CROMPTON
D. N. S. MALONE
Y. F. J. CHOO-KANG

Respiratory Diseases Unit,
Northern General Hospital,
Edinburgh

¹ Landon, J., Wynn, V., and James, V. H. T., *Journal of Endocrinology*, 1963, 27, 183.

² Wood, J. B., Frankland, A. W., James, V. H. T., and Landon, J., *Lancet*, 1963, 1, 243.

The Doctor in Conflict

SIR,—In your leading article "The Doctor in Conflict" (25 March, p. 761) you say "there is no reason to suppose, and no shred of evidence, that any doctor in the recent troubles has departed from the ethical traditions that guide the profession" and you advance the argument that the attention of a doctor before interrogation is more humane than his absence "for presumably if the doctor pronounces the person to be medically unfit for interrogation it would not be carried out." You do not say, however, whether the attention of those doctors who pronounced many persons *medically fit* (my italics) was in your opinion humane, when those persons were found to be fit to be submitted to methods of interrogation which (in the words of an editorial in *The Times*, 3 March) "clearly involved a degree of physical ill-treatment which it is hard to distinguish from brutality."—I am, etc.,

P. HORGAN

Limerick, Eire

SIR,—I was sadly amused by the irony of your leading article "The Doctor in Conflict" (25 March, p. 761). Glancing through the journal my eye caught the World Medical Association's Declaration of 1946 "I will maintain the utmost respect for human life from the time of conception," and I thought that the B.M.A. must be raising one of its periodic squeaks about the Abortion Act. However, on reading it, I fully agreed with your views on the doctor's ethical problems in regard to interrogation, however humanely conducted.

It is, however, blatantly hypocritical to quote such an authority in one context when in another the medical profession of this country is passively and actively allowing abortions to proceed at the rate of 150,000 per annum, so that the medical ethical standards of this country fall far below most other countries. This illogical stand is emphasized by the reasonable proposition that the interrogation of internees might have prevented many more life-long deformities from bombing of civilians than all these abortions have prevented the birth of deformed babies.

Surely, to quote again, "even under threat" this country's doctors have long ago abandoned the Declaration of Geneva. So please don't quote it in a rather minute ethical problem when, from anyone's viewpoint, we are faced with a major social problem.—I am, etc.,

F. DIFFORD

Bristol

"Sorcerers' Apprentices"

SIR,—In your leading article (12 February, p. 391) you discussed the issues raised by the letter of Dr. J. A. D. Anderson and others on "Doctors and Overpopulation" (8 January, p. 108). You then gave your readers a lot of advice, which most of us would accept as sound, concerning the role of the doctor in limiting population growth. Because of the great importance at this time of the allied threats of overpopulation and pollution, the correspondence goes on.

Is there not some message for us in the account of sextuplet pregnancy (25 March, p. 787)—iatrogenically produced. Of course the events described occurred more than two years ago, before our great concern was aroused, but the dangers of overpopulation have been recognized for a very long time.

No one would wish to deny the childless marriage a natural child, if this can be safely achieved. But surely until we can precisely control what we do, doctors must "encourage young parents to think responsibly about the size of their families" (12 February, p. 391).

Dr. Gillian Lachelin and her colleagues say "Gonadotrophin therapy . . . should be undertaken . . . in a special centre where precaution can be taken to minimize the likelihood of hyperstimulation." ". . . and even with careful monitoring . . . it is not always possible to avoid . . . multiple conception" (p. 790). What the lawyers would call, I think, *res ipse loquitur*. If in a modern special centre using all known means of monitoring and precaution it is—as this case seems to imply—a toss up as to how many ova are produced and fertilized should we not cease to behave like so many sorcerers' apprentices, and leave well alone till we know what we are at.—I am, etc.,

DAVID GULLICK

Stevenage, Herts

Payment by Colour

SIR,—I should like to comment on Dr. Sue Dowling's letter "Payment by Colour" (11 March, p. 689). There are many good things to be said about the standards of medical care in South Africa, but visitors to that country should not allow themselves to be seduced by these without asking several important questions: Why is there so much malnutrition in a country of such affluence? Why do black people have such high infant mortality rates and low life expectancies? Why aren't there more black doctors and medical students? Why do black doctors get 70% of the pay their white colleagues get for doing the same job? And, above all, what is the medical profession doing, collectively or individually, to redress these wrongs? Medical and scientific visitors to South Africa who express interest in these problems lend strength to the few South Africans who still care about the discrepancies in health between whites and blacks, and they can cause others to adopt new more critical attitudes. But if they fail to raise these and other questions, privately or publicly, their silence is construed as acceptance or even approval of the system and, I believe, they would have done better not to have gone at all.

Dr. Dowling brings up another important point in her last paragraph. Regularly, the

B.M.J. carries advertisements for medical posts in South Africa without stating that they are open to whites only, or, if not, that discriminatory rates of pay will apply, based solely on the skin colour of the applicant. One might reasonably ask whether these advertisements should be carried at all. If they are, surely it is less than honest to publish them without making these points clear. I would urge the B.M.J. to reconsider its policy on this. The journal should at least insist that the advertiser indicates what restrictions and discriminations apply to each post, and this information should be clearly stated in each advertisement.—I am, etc.,

R. HOFFENBERG

Hemel Hempstead,
Herts

Contaminated Drip Fluid

SIR,—Your leading article "Contaminated Drip Fluid" (18 March, p. 707) suggests that only one fatality due to such contamination has been reported in recent years.¹ The Medical Protection Society reported a similar tragedy in its *Annual Report* of 1969.²

This case concerned a 27-year-old woman in whom labour was induced with a Syntocinon drip. The patient suffered a rigor 20 minutes after the infusion was commenced. It was immediately discontinued but the patient died approximately two-and-a-half hours later, having meanwhile given birth to healthy twins.

It was established that the fatal septicaemia was due to bacterial contamination of the 5% glucose solution used for the infusion. Inspection of the bottle by daylight showed a minor degree of opalescence but this was not apparent to the house officer who set up the infusion by artificial light on a winter's evening. The manufacturers of the solution accepted full legal liability for this tragedy.

This case underlines the advice given by Drs. J. Guy and E. W. Jenkins (27 August 1966, p. 523) in which the need for visual examination of all perfusion fluids before use was stressed.—I am, etc.,

P. G. T. FORD

Regional Secretary,
Medical Protection Society

Leeds, Yorks

¹ *British Medical Journal*, 1966, 2, 597.

² Medical Protection Society, *Annual Report*, 1969, 77, 23. London.

Interstitial Cystitis

SIR,—We read your recent leading article (11 March, p. 644) and are in agreement with most of the points that were made, particularly in relation to the problems of diagnosis. We would like to make two observations.

Firstly, at the time of the initial symptoms, the diagnosis of interstitial cystitis is only one of many conditions in the differential diagnosis. Having excluded the imitators histologically, it is usually possible to prove it on a time-proven basis before secondary bladder contracture has proceeded to a point at which the bladder can no longer be distended to a useful capacity under anaesthetic. Early diagnosis is important because treatment at this stage, albeit empirical, may be effective. We have