CORRESPONDENCE

Correspondents are asked to be brief

The Doctor in Conflict

SIR,—Your leading article (25 March, p. 761) is timely, welcome, and in the highest traditions of our profession. It is a fact that thousands of doctors of all denominations in these islands are deeply worried about the doctor's position with regard to abortions, euthanasia, and now the questioning of prisoners and detainees. Your editorial has stated the case with regard to one of these —namely, the questioning of detainees and prisoners—and eloquently voiced our disquiet but has not really attempted an answer.

May I say, with all humility but also with conviction, that there can be only one answer? A doctor must at all times refuse to certify that a prisoner or detainee is fit for questioning, or to be present at such questioning. This rule should apply even though the doctor may be requested by the prisoner to give a certificate of his or her condition. A moment's reflection will make it clear that surrender of the rule on this seemingly reasonable point could lead to abuse and the giving away of the whole position.

A doctor should reserve the right to give a certificate of unfitness. Otherwise, the refusal to certify in a particular case could reasonably be interpreted as considering that particular person fit for questioning.

The principle that should guide us in the matter can, I think, be stated as follows: Action directed at the deliberate infliction of mental or physical injury on a human being is totally opposed to the fundamental function of the doctor, and the doctor can therefore take no part in such action either directly or indirectly. Physical or mental injury resulting as a secondary effect of legitimate and necessary therapeutic measures does not break this rule.—I am, etc.,

SEAN F. O BEIRN

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Sabbatical Year

SIR,—Most of my colleagues who have been consultants for 15 to 20 years wish to retire at 60 years of age if it is financially possible. They state that the "pressures" of medicine today are so great that they wish to leave it at the earliest possible moment. A few have indeed broken down with diseases which are said to be stress invoked.

On investigation one finds that these are all extremely busy clinicians who are happy in their practical work. The pressures they refer to are those of keeping up with their academic reading and of attending meeting after meeting, administrative and medical, at many of which they are expected to speak. The real stress appears to be their feeling of academic inadequacy owing to not being able to read all the outpourings of the medical journals. They feel unable to keep up with advances in their own subject, let alone medicine as a whole.

If the National Health Service is not to lose five years of work from their most experienced clinicians it should initiate some method to help them keep abreast of advances in medicine. While a sabbatical year may be too much—I would suggest six months' leave with pay every ten years should be given to them to allow three months' complete holiday and three months' work in a medical library. Their clinical work during this time could be done by senior registrars in their third year as part of their training under the general supervision of other consultants.—I am, etc.,

R. E. LODER

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Herpes Encephalitis

SIR,—In view of the severe morbidity and mortality of herpes simplex encephalitis I would like to question some statements on idoxuridine, cytaribine, and dexamethasone treatment of this disorder in your leading article (4 March, p. 582).

The table shows some of the results of treatment of herpes simplex encephalitis with idoxuridine and steroids. As surgical decompression has been used in so many of the cases these results do not allow statistical analysis but it is clearly too early to dismiss the use of steroids.

All authors note the toxic effect of idoxuridine. Meyer *et al.*[1] noted "serious toxic effects" but Rappel[2] stated that toxic effects were "rarely severe and always transient" in 10 patients treated with the drug. However, Breeden *et al.*[3] noted jaundice in their patient and Dayan and Lewis[4] reported severe hepatotoxicity in a fatal case. Those cases of Meyer *et al.*[1] who recovered exhibited stomatitis, bone marrow depression (leucopenia and thrombocytopenia), and alopecia. Secondary infection occurred in three out of four cases during the granulocytopenia, and platelet transfusions were necessary. I have seen two cases which showed granulocytopenia and jaundice without clinical improvement and these results correlate with the lack of improvement and death seen in two cases of