Contrary arguments always tend to be "shrill"; when the basic concern is with violation of human life the arguments have an inevitable and entirely proper "emotional" component—in fact, it might be argued that they have no other.

You suggest that while a conscience clause was "manifestly essential" seven years ago, now "the situation has changed." In what way? The extermination chambers of the Third Reich were no less of an affront to civilization at the end than they were at the beginning of their existence; the few who continued to speak against them were every bit as right ultimately as initially. Lest it be said that this is quite remote from the British abortion situation, I record that I have been faced with a healthy and affluent young woman demanding abortion "because the father is a Jew." That the abortion was carried out, though not by me, may give some of your readers pause for thought. Many other abortion requests come for the "simple" reason that the father is Indian or African and the child would be coloured; that abortion should be done for such reasons is clearly the most flagrant breach possible of the enlightened spirit of the Race Relations Act.

As the Lane Report says, "the quality of life which has become possible and is desired by this society" has changed; the increasing opposition to mass abortion as it can be perpetrated under the present legal situation is a manifestation of that same sympathetic humanitarianism which achieves improvement in the quality of living and keeps human dignity alive.

You ultimately say that there are some hospitals in which "therapeutic abortion is almost unknown, and *this situation will have to change*" (my italics). This is ominously like an advocacy of the end of clinical freedom. There are very few conditions for which abortion can be considered "therapeutic" in 1974; surely the aim must be to achieve the situation where induced abortion will be "almost unknown" throughout the land.—I am, etc.,

J. S. SCOTT

Department of Obstetrics and Gynaecology,
University of Leeds

¹ Report of the Committee on the Working of the Abortion Act, Cmnd 5538. London, H.M.S.O., 1974.

SIR,—It is hardly surprising that the Lane Committee found regional disparities in the number of abortions carried out within the N.H.S. The number of abortions in any individual centre must be inversely proportional to the number of doctors with conscientious objections to performing the procedure.

The alternative situation is not pleasant to contemplate—abortions evenly spread throughout the country at the present rates, or even higher, and any doctor with ethical objections suppressing his desire to practise obstetrics and the rest of gynaecology and leaving the specialty or the country.—I am, etc.,

ITA M. MILLER

Wigan

SIR,—In your leading article (13 April, p. 69) you state that "a conscience clause was manifestly essential when the Act came in, since many gynaecologists had sincere moral

or ethical objections to abortion on some of the grounds introduced by the new Act. Seven years later the situation has changed."

How has the situation changed? Men and women do not easily give up firmly held moral and ethical convictions. An action that they consider morally wrong remains morally wrong to them, no matter what the law says. A gynaecologist who sees the extinction of an innocent human life as wrong will maintain that attitude in his practice.

The solution to this problem will take a few years, depending as it does on the ages of the doctors who hold these unpopular views. As they retire they will be replaced by other doctors who will be prepared to kill fetuses for the social convenience of their mothers. This is what is implied in the Lane Committee's statement that "it is inevitable that the health authorities should prefer for appointment to certain posts those who see abortion as properly part of clinical gynaecological practice."

The implication of this attitude, as you clearly point out, is that Catholics and others who have a moral objection to abortion will be ineligible for appointment as gynaecologists (and possibly as anaesthetists) in the N.H.S. This seems to me to be an instance of discrimination on religious grounds and to be at variance with the resolution of the 27th World Medical Assembly, which met at Munich in October 1973. The resolution, endorsed by the B.M.A., reads: "Be it resolved . . . that the W.M.A. vehemently condemns discrimination on grounds of religion, race, colour, or politics of any form in the training of medical practitioners and in the practice of medicine and in the provision of health services to the peoples of the world."—I am, etc.,

J. R. NOLAN

Glenrothes, Fife

SIR,—As a member of the Society for the Protection of the Unborn Child I wish to declare my disappointment at the findings and recommendations of the Lane Committee and to register my protest at the recommendation for increasing the facilities for the immoral Abortion Act in the N.H.S.—I am, etc.,

HONORA J. TWOMEY

St. Annes-on-Sea,
Lancs

SIR,—In your leading article (13 April, p. 69) you report that the Lane Committee "clearly understood the dislike felt by many doctors and nurses for abortion procedures and sympathized with it" and you continue "abortion is indeed distasteful to many people." However, you feel that though "a conscience clause was manifestly essential when the Act came in . . . seven years later the situation has changed." You do not consider it important to ask why this antipathy exists.

The reason that doctors, nurses, and patients find abortion "distasteful" has not changed. The report, you say, calls for a fundamental change in attitude. You are right. Some of us, however, still young and free from the influence of any factor—financial, political, or sectarian—will be hesitant to comply. The rights of the individual in utero have been ignored. Some of us will not pretend for reasons of con-

venience that this is not so. I have little doubt that people who find abortion "distasteful" will now not go into gynaecology. The consequence will be that a specialty never very rich in grey matter will become deficient in character as well. And who will suffer?

Your implication that we gynaecologists are unsympathetic to our patients is just untrue. Neither are we susceptible to the temptations of courting easy popularity.—I am, etc.,

DAVID M. JENKINS

Leeds

The Nurse in Group Practice

SIR,—The two articles by Dr. G. N. Marsh and Mr. R. A. McNay (23 February, pp. 315 and 319) present an admirable picture of teamwork in a group practice. They highlight the changing role of the nurse in the primary care team and emphasize the need for training courses in unfamiliar aspects of the work to meet the new demands which are being made on her skills.

The Joint Board of Clinical Nursing Studies was set up four years ago to establish a national system of post-basic education and training for nurses in clinical specialties. Originally the joint board's terms of reference confined its sphere of activity to the needs of hospital-based nurses, but last year the terms of reference were extended to include nurses working in the community. As a result a panel of doctors and nurses has recently been convened to prepare a syllabus of training for a nurse working in a primary care team. When this is published it is anticipated that courses based on the syllabus and approved by the Joint Board of Clinical Nursing Studies will be offered by health authorities. A nationally recognized certificate will be given to successful students.—I am, etc.,

MARJORIE G. GARDENER

Principal Officer,
Joint Board of Clinical Nursing Studies

London W.1

Patients' Attitudes to Medical Students in General Practice

SIR,—Dr. H. J. Wright's article (2 March, p. 372) was interesting but discouraging. Unless commented on, I fear it will do more harm than good. I do not quarrel with the data, but the conclusions drawn appear to me somewhat limited.

As a resident in family practice in Maine I have a "private practice" and occasionally have medical students present. Though I routinely ask patients if they mind a third party being present, they invariably indicate that they do not. Still, I feel that they can hardly be candid with me, so I have adopted certain rules which I try to follow when medical students are present and which, I hope, improve the situation for all concerned. Perhaps I am deluding myself, but they seem to be of value.

(1) Rather than being "impartial observers," the students should be encouraged to contribute, to interview, and to show interest. This is extremely important to the patient, for he feels that even in the learning situation his interests are being served, and the sympathy and concern of a student