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

can be more convincing to a patient than the more callous approach of a seasoned practitioner who has seen it all before.

(2) The doctor should stress to the patient that the presence of a student may actually improve the care he is getting. The patient can be told that the melding of seasoned experience and up-to-date scientific knowledge that his physician and student when acting in concert bring to a clinical situation can work only to his advantage. This calls for an admission of humility on the part of the physician, but this too is a welcome thing to many patients.

(3) The patient should be informed that students have to learn and that medical education is only part book learning. The practice of medicine, and general medicine in particular, is something that must be learned in the field. A certain altruism on the part of the patient can and must be cultivated.

Finally, at the end of the interview a few minutes can be spent with the patient in a tactful way to determine if he held back on any information because of reluctance to be candid in the presence of a third party. Occasionally important facts come to light and the patient has been served.

Obviously what I am talking about cannot be done in an office which has a rapid turnover; but then perhaps those offices are not ideal for the training of medical students. If encouraged and made to feel a part of the health care team our students will grow into more sensitive and caring physicians.—I am, etc.,

DAVID ELPERN

Family Medicine Institute,
Augusta General Hospital,
Augusta, Maine

Isolation System for General Hospitals

SIR,—I suggest that some of the recommendations of the Control of Infection Group at Northwick Park Hospital (6 April, p. 41) seem to be examples of the first of Todd's¹ list of the main errors of medicine—basing treatment on theory. Or, as Chapin² might have put it, that the group do not always distinguish clearly between how diseases might be spread and how they are in fact spread.

As cubicle isolation is expensive in resources, it is important to record observations which indicate when it is not necessary. I therefore report that in the infectious disease unit at this hospital during the past 27 years patients with hepatitis (in its icteric stage), meningitis (of all forms), encephalitis, erysipelas, herpes zoster (in adults), leptospirosis, psittacosis, brucellosis, glandular fever, malaria, pneumonia, and non-infective disease have commonly been nursed together in open wards without evident ill effects. Though the Northwick Park group do not recommend isolation in the five last-mentioned conditions, I include them in the record because when treated in infectious disease units elsewhere the patients are commonly nursed in cubicles—for lack of any other accommodation.

These observations suggest the possibility of great saving in gowns, gloves, time, and other expenditure.—I am, etc.,

H. G. EASTON

Ruchill Hospital,
Glasgow

¹ Todd, J. W., *Lancet*, 1970, 1, 665.

² Chapin, C. V., *The Sources and Modes of Infection*. New York, Wiley, 1910, cited by Taylor, I., and Knowleden, J., in *Principles of Epidemiology*, 2nd edn., p. 117. London, Churchill, 1964.

SIR,—Those of us who have been concerned with the control of infectious diseases will have been impressed by the article on isolation in general hospitals (6 April, p. 41). The Control of Infection Group at Northwick Park Hospital are to be congratulated.

However, the implication that cases of suspected smallpox should ever be confined in such a unit is a cause for concern. Whenever smallpox is suspected direct admission to a special smallpox hospital should be the rule. Any attempt to contain the patient locally while the diagnosis is confirmed is to be deprecated since it can result in needlessly contaminating part or all of the general hospital, with grave disruption of general medical services during the subsequent inevitable closure.—I am, etc.,

M. F. H. BUSH

Ipswich

Accidental Poisoning in Children

SIR,—In the debate on the adjournment in the House of Commons on 18 March Dr. David Owen, Under Secretary of State for Health, said that medicines were chiefly responsible for hospital admissions in cases of poisoning in children under 5 and that aspirin was the largest single cause (30 March, p. 652). It seems likely that of the 16,000 children admitted to hospital for accidental poisoning each year about 5,000 are due to the specially flavoured "junior" aspirins.

A personal study of over 300 such cases has shown that these children practically invariably finish the opened packet which usually contains 50 tablets (total of 4 g). Dr. Owen says that he is prepared to examine anything which could reduce the risk of accidental poisoning. One of the simplest and most practical measures would be to forbid the sale of "junior" aspirin in packages of more than a dozen (1 g). This amount is very unlikely to give rise to toxic effects and would make the admission of the child to hospital unnecessary.—I am, etc.,

W. P. SWEETNAM

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Royal Infirmary,
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Rebound Migraine

SIR,—I would like to draw attention to a syndrome which can develop in patients taking ergotamine preparations for the relief of migraine and which can easily go unrecognized. Four patients were encountered personally over a six-month period in whom migraine or migrainous neuralgia had initially responded to ergotamine but who had then developed daily headaches while taking the drug every day. The headaches were similar to those for which they had first sought treatment, but there were often slight differences in their character, situation, or timing. They were improved for an hour or more by a dose of ergotamine, but as its effects wore

off they invariably recurred and were relieved again only by another dose. When all ergotamine preparations were stopped the headaches subsided within a few days.

Infrequent accounts of this situation have appeared before.¹⁻⁴ The terms "ergotamine tolerance," "ergotamine withdrawal headaches," and "ergotamine-induced headaches" have been used to describe it, but these are not satisfactory descriptions. Ergotamine tolerance has never been proved⁵ and it is misleading to call these "withdrawal" headaches since they are at their worst while the drug is being taken and disappear, sometimes immediately, when it is stopped. Though they are undoubtedly induced by ergotamine the situation is more complex than this, for they continue to be relieved by it as well. I suggest that the syndrome should be called "rebound migraine," which evokes the continuous fluctuation of symptoms in relation to ergotamine intake. The probable underlying mechanism is a recurring cycle of vasoconstriction → vasodilatation with headache → vasoconstriction,¹ based on a primary followed by a rebound response to each dose of ergotamine.

This syndrome may be much commoner than is generally realized. The diagnosis should be considered in any migrainous patient who has intractable headaches while taking substantial amounts of ergotamine every day; such headaches may be occurring because of rather than in spite of the drug. Withdrawing the ergotamine can lead to complete relief, but the patient must be given to understand that this may take several days and that the trial period of abstinence has therefore to last at least a fortnight.

A fuller account of this condition will be published elsewhere.—I am, etc.,

N. J. LEGG

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London W.C.1.

¹ Peters, G. A., and Horton, B. T., *Proceedings of the Staff Meetings of the Mayo Clinic*, 1951, 26, 153.

² Friedman, A. P., Brazil, P., and von Storch, T. J. C., *Journal of the American Medical Association*, 1955, 157, 881.

³ Lucas, R. N., and Falkowski, W., *British Journal of Psychiatry*, 1973, 122, 199.

⁴ Rowsell, A. R., Neylan, C., and Wilkinson, M., *Headache*, 1973, 13, 65.

⁵ Brazeeau, P., in *The Pharmacological Basis of Therapeutics*, ed. L. S. Goodman and A. Gilman, 4th edn., p. 893. London, Collier-Macmillan, 1970.

Polyarteritis after Influenza Vaccination

SIR,—We would like to draw attention to a patient who developed acute polyarteritis of a fulminating type following administration of a dose of inactivated influenza vaccine.

The patient, an Englishman aged 46 with a family history of diabetes mellitus but no family history of allergy or asthma had suffered from mild bronchitis for most of his life. In 1968 bronchial asthma was diagnosed and this required intermittent courses of steroids. In 1972 he was investigated and found to be sensitive to house dust and house dust mites. There was no history of any other allergy and in particular no intolerance to eggs. Respiratory function tests showed moderately severe airways obstruction with a reversible component. He was started on long-term steroids and was well controlled with disodium cromoglycate and 2.5 mg of