epithelial elements as the result of drug metabolite toxicity rather than as malignant change.

Cyclophosphamide, in common with other cytotoxic agents, can under experimental conditions produce malignant change in laboratory animals. However, it is not one of those that has been known to produce malignancy in humans treated with cytotoxic drugs for non-malignant disease or for suppression of homograft rejection. However, one case of a second malignancy (myeloblastic leukaemia) occurring in a patient on long-term cyclophosphamide for a first malignancy (of the ovary) has been reported,³ and though this hazard may be less with cyclophosphamide than with certain other cytotoxic drugs, it should be borne in mind.—I am, etc.,

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¹ Liedberg, C.-F., Rausing, A., and Langeland, P., *Scandinavian Journal of Urology and Nephrology*, 1970, **4**, 183.

² Goldman, R. L., and Warner, N. E., *Cancer*, 1970, **25**, 7.

³ Smit, C. G. S., and Meyler, L., *Lancet*, 1970, **2**, 671.

Organ Donation—Valid Consent

SIR,—Reference was made in Council's Report (*Supplement*, 8 May, p. 62) to organ donation. Patients often ask how they can help medical science and others by donating an organ or their bodies. The following notes may be of assistance.

(1) A would-be donor must be at least 16 and mentally sound.

(2) If the deceased wished to leave his body or parts of it for medical purposes, this amounts in law only to a request to which his executor is not bound to give effect.

(3) If there was no mention of his wishes, surviving relatives have a right, so far as it is practicable to consult them, to object to the disposal of his body for medical purposes.

(4) The person "lawfully in possession" of a body has to dispose of it. This person is the owner of the premises until the executor or a relative claims the body, becoming the person "lawfully in possession."

(5) Even if the next-of-kin or a relative has indicated prior to the deceased's death that they do not object, the executor still has the power to decide against disposal of the body for medical purposes.

(6) If a person dies in an institution without relatives, the institution decides on disposal. Being intestate or having made no mention in a will is not crucial. The institution may bequeath the body only if it has no reason to suppose, after inquiry, objection by the deceased in his lifetime.

(7) An instrument of donation may not be so formal as a will. The would-be donor should leave with his papers a written statement of his desire to benefit medical education in this way.

(8) As soon as possible after death of the testator, the executors should telephone H.M. Inspector of Anatomy (01-407 5522) and post to him at the Department of Health and Social Security a notice (under the Anatomy Act) and medical certificate of cause of death.

(9) If the deceased wishes to leave an

organ under the Human Tissue Act, he should make an oral declaration before two witnesses in his final illness. Alternatively, a simple written declaration will meet this Act if the intention is clear.

(10) If no executor exists nor knowledge of the deceased's intention, relatives or the person "lawfully in possession" can authorize a bequest for medical purposes.

(11) As to transplants, the organs must be removed very soon after death; hence only a medical institution would be able to help in such cases.

(12) The Royal National Institute for the Blind, 224 Great Portland Street, London W.1, keeps a register for corneal grafting. Potential donors might carry on their persons a note of their wish to make such a bequest.—I am, etc.,

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General Practitioner Obstetrics

SIR,—Some complaints about long waiting times at antenatal clinics may well arise out of unnecessary attendances. Obstetric consultants have a tendency to take over perfectly straightforward antenatal work from the general practitioner merely because a statistically increased risk necessitates booking one of their hospital beds for the confinement. Delivery of a grand multipara or elderly primipara may be safer in the general hospital 20 miles (30 km) away than in the local maternity unit, but the overall advantage in some cases must become very doubtful if arranging this with a consultant is going to let her in for regular 40-mile journeys (60 km) to his antenatal clinics, with an hour or so waiting about to be seen by a variety of obstetric personnel.

Under present foreseeable circumstances the consultants must compromise, and clearly should do so in a logical manner that would also avoid the overcrowding of their antenatal clinics and unnecessary journeying and waiting by mothers. There might even emerge a case for every primipara having the benefit of a second opinion at 36 weeks' gestation, but surely it would be found that the hordes of mothers who regularly attend hospital for no better reason than that they have booked their confinement there could well revert to the care of their own doctors for at least the first seven or eight months of gestation.—I am, etc.,

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Fractured Femur and Fat Embolism

SIR,—Mr. P. A. Ring (3 July, p. 46) seems to give tacit acceptance to the fact that fat embolism is not a complication of the nailing operation for subcapital fractures, but his statement that this operation "commonly ends in disaster" is something less than half the truth.

Such a statement would be valid only if it were confined to trifin nailing for displaced fractures of Stage III and IV.¹ As emphasized by Barnes² and many other observers, trifin nailing is quite inadequate for these fractures for which more rigid fixation is necessary. Several methods of internal fix-

ation are in fact available³⁻⁵ which have been shown to achieve a consistent union rate of about 85% in displaced fractures, and those experienced in their use believe internal fixation to be a far safer and more dependable routine method of treatment for these elderly patients than primary prosthetic replacement. This view was confirmed by a recent comparison of two series of patients treated at the Radcliffe Infirmary, Oxford, by internal fixation and prosthesis respectively, in which the results came out strongly in favour of the former, both as to primary operative mortality and postoperative morbidity.⁶

In a series of cases to be published shortly from this centre, confined to fractures of Stage III and IV and to one method of fixation (triangle pinning), there has been no primary operative mortality, no recognizable case of fat embolism, and, in a minimum follow-up of two years, no patient has required replacement surgery for avascular necrosis. The union rate among these patients was 86% and the evidence suggests that the remaining 14% of failures were attributable in every instance to an error, in either reduction or fixation, on the part of the surgeon, rather than to any inherent biological or mechanical qualities conducive to non union in the fracture.—I am, etc.,

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¹ Garden, R. S., *Journal of Bone and Joint Surgery*, 1961, **43B**, 647.

² Barnes, R., *British Medical Journal*, 1969, **2**, 575.

³ Brown, J. T., and Abrami, G., *Journal of Bone and Joint Surgery*, 1964, **46B**, 648.

⁴ Garden, R. S., *Journal of Bone and Joint Surgery*, 1964, **46B**, 630.

⁵ Smyth, E. H. J., Ellis, J. S., Manifold, M. C., and Dewev, P. R., *Journal of Bone and Joint Surgery*, 1964, **46B**, 664.

⁶ Hunter, G. A., *British Journal of Surgery*, 1969, **56**, 229.

Induction Course for Hospital Medical Staff

SIR,—Induction programmes, formal or informal, have been developed to help newcomers learn about their hospital environment more easily, learn their tasks more quickly, and avoid disturbing errors. An effective induction programme is concerned with introducing the newcomer to physical environment, hospital personnel, duties to be performed, interrelationship with other departments, and background information concerning the hospital's place in the community, its goals and achievements. No newcomer can assimilate all this in one crowded and confusing day.

Though induction courses are run for some ancillary staff in some hospitals, this has not so far been done for professional and technical staff, and no formal induction course has yet been done for medical staff.

I carried out a survey of all the medical staff who had joined the Salford Group of Hospitals in the last 12 months. A questionnaire was sent to 37 doctors. 26 (17 English and 9 overseas) responded and the findings of the summary were:

Seventeen doctors were not told to whom they had to report on the first day of joining;

Seven were not told about the nature of their work;

Five only were taken to other hospitals nearby where they would work in close association;