Thyroid Medullary Carcinoma, Prostaglandins, and Nutmeg

SIR,—Many of those who read our article (5 July, p. 11) must have been both surprised by the low plasma levels of prostaglandin-like activity reported (pg/1) and jealous of the sensitivity of our assay. The values before and after surgery were 1 million times higher and should have read 5.4 and 0.5 ng prostaglandin E₂ equivalents/ml respectively. These correct values were in our original manuscript and the proofs and we are assured that they will appear in the reprints. —We are, etc.,

J. A. BARROWMAN
A. BENNETT
P. HILLENBRAND
K. ROLLES
D. J. POLLOCK
J. T. WRIGHT

King's College Hospital Medical School,
London S.E.5

Abortion (Amendment) Bill

SIR,—Dr. Myre Sim (28 June, p. 748) and others have a right to their own religious and philosophical views on abortion and must lead their private and professional lives accordingly. I, however, believe that it is right to terminate the life of a fetus when: (1) it is the mother's wish that an abortion be performed; (2) the pregnancy is at a stage when the fetus is unable to survive *ex utero*; (3) the risks to the health of the mother from an abortion are less than are the risks of a full-term pregnancy; and (4) the child which would result from the pregnancy going to term is unwanted, at physical risk, or threatens the health or well-being of the mother or her existing family.

I find no ethical distinction between the prevention of conception and the removal of the conceptus from the uterus. On medical grounds I much prefer the former, but when this fails or is omitted the life of the fetus may, in my view, be less important than the consequences of continuing the pregnancy. The fetus is part of its mother until it becomes capable of an independent existence, and I therefore believe that she should co-operate in any decision on termination.

Guided by these views I have on a number of occasions referred women to a gynaecologist for termination. I am pleased to record that these have been performed promptly in N.H.S. hospitals. Had this not been possible (as indeed in some cases it would not have been had I been working in Birmingham instead of London) I should without hesitation have referred the women to one of the private non-profit-making agencies which, I understand from friends who have used them, are excellent. I am only sorry that our profession has been so tardy in providing adequate outpatient facilities for early diagnosis, counselling, termination, and follow-up within the N.H.S.

I do not regard any of this as shameful, still less as "filthy," "sinful," or "murderous" (and neither, incidentally, did the women who were aborted or the gynaecologists who did the operations). I am simply very glad that the atmosphere of guilt, dirt, and secrecy which pervaded the subject of abortion when I was a medical student has disappeared, along with the knitting needles, syringes, and soapy water. I have no doubt

that our patients are better for it. As to the much-abused private sector, I and their patients are grateful to them for filling a gap in the N.H.S. as well as in the medical services of other countries. Only on the grounds of inadequate medical standards could I argue for a curtailment of their activities.

It is of no great concern to me that some people hold different views from my own; I have no wish to force them to act other than according to their conscience. I am, however, unimpressed by the claims to moral superiority typified by Dr. Myre Sim's talk of "stables" and by the grandiose title of the federation of which he is president. Neither do I take kindly to their attempt to enforce by legislation a point of view which to me has about as much relevance to the welfare of my patients as the taboos on blood transfusion or drug therapy advocated by some religious groups. The few women I meet who feel about abortion as Dr. Myre Sim does do not need legislation to protect them; their views are respected, and in any case an attempt to abort their fetus against their wishes would be a serious common law offence.

In conclusion, it seems to me difficult enough to square one's own conscience without trying to square other people's, and we must all take care of our own souls in the best way we can. Dr. Myre Sim and company may pray for mine if they wish; I shall not be offended. I do, however, claim an equal right of conscience in my private and professional life and I shall therefore make my views known to the House of Commons select committee on the Abortion (Amendment) Bill by sending them a copy of this letter.—I am, etc.,

ISABEL SMITH

Institute of Child Health,
London W.C.1

SIR,—It seems to be held that abortion is wrong because it takes the life of a potential child and that contraception is licit because it does not. I think this is a false distinction. The ovum itself is a potential child, and so abstinence from intercourse is a form of abortion and termination of pregnancy is a form of contraception. If this status of the ovum is denied it is necessary to explain why the moment of fertilization is chosen as the start of an independent life in favour of some other arbitrary point. I maintain that there is no point that can be logically defended as the start of a life and that there is no moral difference between allowing or causing an ovum to die and allowing or causing a child to die. It is part of being human that we have to compromise and live with the recognition that we are continually denying life to potential children.

It seems to me that discussion of abortion is confused because two questions are not sufficiently differentiated. Firstly, how early in the development of the ovum should intervention be classed as murder? And secondly, is it ever morally wrong to intervene before that stage and, if so, why? In my view, the answers are: firstly, it is the job of the legislators to specify an age after which abortion is deemed to be murder. This is not a moral decision but a political one based on what society will accept and what is enforceable. Secondly, I think it is sometimes morally wrong to procure an

abortion before the age at which it is legally murder and that the act can be wrong in itself (if it harms unduly an interested party) and the means can be wrong (if the most appropriate means are not chosen). To my mind the test of morality is what is believed to be the best compromise, taking into account the interests of all concerned, including the unborn child. For me "best" implies that which expresses most concern for the true interests of the parties.

Our job as doctors is to help the patient to decide what are the true interests of all concerned and then to carry out her decision. We are apt to forget that what to do about an unwanted pregnancy is primarily the patient's problem, and it should therefore be the patient who makes the decision. I believe that the doctor should have the right to opt out, but he should not have the power of veto, so if he disagrees with a particular proposal of abortion he should be prepared to refer the patient to a practitioner whom he thinks would be more likely to agree with the patient. I think the basic fault in the present law, and in the proposed amendment, is that it takes the moral decision out of the hands of the patient. There must be a limit, but it should be incorporated into the laws prohibiting murder.

No doubt doctors are flouting the law, as Dr. Myre Sim asserts (28 June, p. 748), but that is not necessarily immoral, for many believe that the law is unjust. Moreover, if it is held to be immoral it is only the doctors themselves who can rectify the matter. It is not possible to make men moral by legislation.—I am, etc.,

J. B. METCALFE

Madeley,
Telford, Salop

Screening Methods for Covert Bacteriuria in Schoolgirls

SIR,—Dr. Bridget Edwards and her colleagues (31 May, p. 463) have shown very clearly that the dipstream technique offers a reliable method of investigating urinary tract infections in children. They have approached the problem of false positive results due to contamination in a practical manner and have shown that if non-faecal organisms or mixed cultures in counts of 10⁸/1 or more are excluded the false positive rate is only 1.8%.

However, their figures seem to show that if only the MacConkey side of the dipslide is inspected with the naked eye and any specimen in which growth fails to appear on that medium is considered uninfected the false positive rate becomes 4.6%, which is still very satisfactory. This procedure does not require skilled bacteriological assistance and I am sure it will be of great value to general practitioners, particularly in these times of high transport and postal charges.

This part of their investigation does, of course, cast doubt on the value of the CLED medium, the use of which appears to have actually raised the initial false positive rate from 4.6% to 13.5%. Though the practitioner can ignore any growth on the CLED side of the dipslide, misinterpretation would be minimized by the omission of this medium altogether. If this were done the investigation shows that only a very few cases of genuine bacteriuria in children would escape detection, and I venture to suggest that this will hold good in adult

general practice also. Of course, for the occasional complicated case of urinary tract infection CLED medium might be necessary, but dipslides are not intended for the full investigation of this relatively uncommon problem.

Incidentally, Dr. Rosalind Maskell's letter (28 June, p. 752) appears to misinterpret the findings of Dr. Edwards and her colleagues and also to contain a serious non sequitur. They showed that it was the CLED surface (not the MacConkey) that produced most of the false positive results and so if Dr. Maskell wishes to avoid false positives she should be using MacConkey-only rather than CLED-only dipslides.—I am, etc.,

ROGER HOLE

North Ormesby Hospital,
Middlesbrough, Cleveland

Antibiotic Policy

SIR,—Your leading article "Antibiotics at Risk" (14 June, p. 582) is a timely reminder to the profession of the dangers of the excessive and unnecessary use of these drugs. We believe not only that every hospital should have an antibiotic policy but that each major discipline should have one also. An account of our own antibiotic policy for surgical patients which it is hoped will help the surgeon choose the appropriate agent, is to be published shortly.¹

Not only is unnecessary systemic antibiotic prophylaxis to be deprecated, as stated in your article, but also topical prophylaxis, since penetration of the antibiotic is poor and the development of both skin sensitivity and bacterial resistance encouraged. The patient's bed clothing and the environment become polluted with antibiotic, exposing the hospital flora to the drug with the subsequent selection of resistant strains. The current vogue for using antibiotics topically in surgical wounds to prevent postoperative infection would therefore appear unwise. Two recent controlled trials have shown that the antiseptic povidone-iodine applied in aerosol form reduces wound infection both after appendicectomy² and after other abdominal operations, particularly in cases of intestinal resection and peritonitis, without inducing bacterial resistance.³—We are, etc.,

O. J. A. GILMORE

Surgical Professorial Unit,
St. Bartholomew's Hospital,
London E.C.1

P. J. SANDERSON

Department of Microbiology,
North Middlesex Hospital,
London N.18

¹ Gilmore, O. J. A., and Sanderson, P. J., *Annals of the Royal College of Surgeons of England*. In press.

² Gilmore, O. J. A., and Martin, T. D. M., *British Journal of Surgery*, 1974, **61**, 281.

³ Gilmore, O. J. A., and Sanderson, P. J., *British Journal of Surgery*. In press.

Surgery of Violence

SIR,—Most of the articles in your Surgery of Violence series have been excellent. A major disappointment was the article on gunshot wounds of the trunk by Mr. H. M. Stevenson and Mr. W. Wilson (29 March, p. 728). From their references it would appear that the Vietnam war ended (medically speaking) in 1966. In fact Heaton *et al.*¹ were among the earliest authors to write about the medical care of the injured soldier in

Vietnam. As the Vietnam war continued the low transit time from injury to hospital, normally by helicopter, often less than 30 minutes, resulted in the almost unsalvageable patient reaching hospital alive. In spite of this, 98% of those arriving alive in hospital survived.^{1,2} The figures quoted by Mr. Stevenson and Mr. Wilson for abdominal injuries give a 13% death rate. No mention is made of the death rate associated with thoracic injury.

It was unfortunate that their conclusions implied that the Royal Victoria Hospital, Belfast, was in a unique position with regard to the rapid arrival of seriously injured patients. I would like to remind your readers that the military surgeon in Vietnam had the same rapid evacuation of casualties, treated the same sorts of ghastly injuries, had a lower rate of sepsis, and was able to eliminate almost completely the acute renal failure that used to follow trauma before the work of Shires,³ Moyer and Butcher,⁴ and others showed the need for adequate electrolyte fluid along with blood in the resuscitation of the severely injured. Not all the papers were published in American journals.⁵⁻⁸—I am, etc.,

JOHN KNIGHT

East Melbourne,
Victoria, Australia

¹ Heaton, L. D., *et al.*, in *Current Problems in Surgery*. Chicago, Year Book Press, 1966.

² Chapman, R. D., *Minnesota Medicine*, 1970, **53**, 93.

³ Shires, T., *Surgical Clinics of North America*, 1965, **45**, 365.

⁴ Moyer, C. A., and Butcher, H. R., *Burns, Shock and Plasma Volume Regulation*. St. Louis, Mosby, 1967.

⁵ Dudley, H. A., *et al.*, *British Journal of Surgery*, 1968, **55**, 332.

⁶ Knight, R. J., *Anaesthesia*, 1969, **24**, 317.

⁷ Knight, R. J., *Lancet*, 1972, **11**, 29.

⁸ Knight, R. J., *Resuscitation*, 1973, **2**, 17.

Junior Hospital Staff Contract

SIR,—There has recently appeared in these columns not a little criticism concerning the introduction of the new junior staff contract. Indeed, one of the earliest letters voicing concern came from one of the writers of this letter (22 February, p. 458). We now feel that much of this genuine concern and apprehension is ill founded since it is based on a less than full understanding of the new contract. There are a number of points of concern that we would wish to remove.

The new contract is not based on the premise that all junior staff will be expected to work only 40 hours per week. There is no way in the interests of proper patient care that juniors can expect to do less hours than they do at present. The term "standard 40-hour week" relates only to the basis on which remuneration is made and not to the actual hours worked. It is unfortunate that the press and broadcasting media have always referred to the new contract as the "40-hour contract" since this has led to misunderstanding. From this it follows that a junior doctor will be expected to work whatever hours the consultant and he agree are necessary for maintenance of the highest standards of patient care. Thus training and service needs will not be changed in any way.

We know that some doctors do have posts which require little more than 40 hours' work per week and that they fear that their financial position will deteriorate. However, our negotiators represent all doctors and consider it of paramount importance that the

basic salary for 40 hours will never be less attractive than that they receive at present. Hopefully in years to come it will be considerably improved.

We would like to remind all junior staff that the new contract as a package whole has not been accepted until priced by the Review Body and that that is the time to assess its desirability. Until then no junior doctor should sign any new contract.

If the contract is priced realistically we believe that doctors' present concern will be allayed.—We are, etc.,

D. GUERET WARDLE

London N.2

N. D. L. OLSEN

London W.11

SIR,—I should like to make known the serious disquiet felt by junior doctors in all branches of pathology concerning the effect of the new junior doctors' contract on recruitment into the specialty. This stems from the fact that there is no formal on-call commitment for many junior pathologists. The new contract is thus likely to make financial rewards in this sector of the profession compare even more unfavourably with those in the clinical sector than is already the case with the existing 80-hour contract.

There is grave danger that the introduction of the new contract will result in an increased flow of junior doctors from pathology to other specialties and that it will also strike a severe blow at recruitment, which is at best inadequate for requirements. We thus feel that the contract may severely jeopardize the future existence of a medically staffed pathology service—a disaster which would set back the standard of health care in Britain.—I am, etc.,

J. T. WHICHER

Chairman,
Junior Members Group of the Association
of Clinical Pathologists

Bristol Royal Infirmary,
Bristol

Related Ancillary Staff

SIR,—May I through your columns draw the attention of Dr. B. J. Stafford (5 July, p. 44) to the Report of the General Medical Services Committee for 1974. There he will find on p. 9, para. 83, firm proposals which the working party, of which I had the honour to be chairman, drew up with what we considered the most rigid "safeguards." These were our reply to Sir Keith Joseph's objections—that is, the difficulties with public accountability and the risk of subsequent demands for the extension of any scheme—which he raised at our meeting with him. I have personally raised at most meetings of the G.M.S.C. the question of continuing to press the Department, and we now await their paper on the subject. I can assure Dr. Stafford that I will not cease to press and press again until we arrive at a satisfactory solution.—I am, etc.,

A. E. LODEN

Tunbridge Wells, Kent

SIR,—Dr. B. J. Stafford's letter (5 July, p. 44), is enough to make any medical politician weep. Dr. Stafford complains that the General Medical Services Committee has not