Letter from . . . Denmark

Problems of Prevention

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In 1970 Denmark revised its Abortion Act to allow women who already had four children or who were more than 38 years old to have a pregnancy terminated if they wished. As expected, the number of legal abortions increased considerably. A new Act in October 1973 went further and made it entirely free for women aged over 18 to decide to have a pregnancy ended. In 1974 twice as many abortions were performed as in 1972. Soon an impression grew that abortion was often considered an alternative to contraception. Now everybody is gravely concerned for both ethical and more practical reasons.

Costs of Contraception

Contraceptive advice is easily obtainable from family doctors. Traditionally, however, contraception is a private affair and accordingly not paid for by the public health service. Patients—or rather clients—must pay the doctor's fee as well as buy their pills or appliance from a chemist. In October 1974 the Department of Health withdrew pills with an oestrogen content of more than 50 µg. Evidence had gradually accumulated to nourish a suspicion that high oestrogen pills had a slightly higher complication rate than others. In the course of five years 20 women in Denmark had died of thromboembolism believed to have been caused by oral contraception.

The withdrawal of certain brands of oral contraceptives was meant to be a cautious, undramatic step. Whatever the intention the effect turned out to be rather overwhelming. The popular press launched an all-out effort to squeeze every dramatic drop out of the event. A great many women taking an oral contraceptive without a thought were scared out of their wits. Many discontinued their pills and many of them became pregnant. As they were entitled to a free abortion it is small wonder that quite a few chose this solution. Doctors have written in the newspapers to correct the most blatant errors and misunderstandings and have tried generally to put things right. After all, pregnancies and childbirth, to say nothing of abortions, are also occasionally accompanied by serious complications.

While we wait for the ideal contraceptive there is no sense in repressing the fact that a choice is necessary. Contraceptives totally without risk to health are not very effective, whereas complete effectiveness is not entirely free from risk. Though substantiating figures are not available there is a growing impression that Danish women are gradually recovering from the nasty shock last autumn. They seem to realize that the risk to health is very slight and by no means any greater than during all the years before the sensational press campaign.

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If any moral can be extracted from this deplorable experience it is that we must realize that doctors have an even more demanding task than we thought to offer more and, above all, better information to women who want contraceptive advice. Otherwise they are more or less defenceless victims of persuasive misinformation. The Danish Parliament also has had second thoughts about the evident lack of sense between the two official attitudes: (1) that contraception is no disease and so must be paid by the individual, but (2) if, on the other hand, the same individual becomes pregnant and demands abortion then instantly she is a gynaecological patient and her stay in hospital is free. Negotiations are now taking place on how to provide a free contraceptive service. Only thus may the deplorably high abortion figures be lowered.

Undoubtedly this is going to cost a lot of public money. But hospital beds are not cheap either, and they should be used for other patients and to reduce long waiting lists.

Safety Belts

Sadly, road accidents are responsible for an appalling number of deaths and severe injuries. In Denmark, with roughly five million inhabitants, the annual numbers of killed and injured have for some years been about 1200 and 25 000 respectively. Ever since the Arabs helped us to more or less voluntarily slow driving we have continued, though somewhat grudgingly, to drive more slowly than was our custom. Now we have to accept speed limits of 110 km/h on motorways, 90 km/h on other roads, and 60 km/h in towns. The police take these limits seriously. We note with great satisfaction that a few hundred expected deaths have been avoided in 1974. Of course many more lives might be spared if generally we were more careful drivers, and if we always used safety belts. This alone might save an estimated 170 road deaths a year.

The use of safety belts will be compulsory in Denmark from 1 January 1976. The police will not have much chance to exert efficient control. Many drivers are emotionally against safety belting. As foreseen, much controversy has been evoked, and there have been heated debates in the newspapers. The antis maintain their democratic right to drive without belts if they want to, illustrating their views with tales about somebody who was *not* killed for the very reason that he did not use a safety belt. The pros find that Parliament has acted as it must in order to do something about the road fatalities. The most ardent and eloquent advocate is Professor J. Dalgaard, professor of forensic medicine in the University of Aarhus. He has appeared on T.V., and in newspapers he has given a series of short, well-written and well-illustrated lectures to inform the public about car accident mechanisms and the consequences with and without safety belts.

He has made us all—or most of us anyway—see that the belt is an effective and cheap health insurance. In a convincing and matter-of-fact way he has shown that safety belt antagonism is founded on poor and mostly misinterpreted evidence.

To sum up in Professor Dalgaard's own way: "If you are injured or killed in a car accident with your safety belt properly fastened it is not because of it but in spite of it."

Doctors and Public Attitude

As is seen from the case of the contraceptive pills, people generally fear disease and may act in panic to avoid a slight risk, but why do they not fear accidents? After all, disability or death is much the same to the sufferer regardless of causes and mechanisms. It is an odd and grim fact that 20 deaths in five

years due to oral contraceptives evoke storming emotions while some 6 000 traffic fatalities over the same period are considered a rather normal price of modern life.

Would it be possible to change public attitude if doctors and medical journalists made a serious informative effort along new lines? Traditionally we talk and write much about the prophylaxis of certain diseases and types of accidents, but why should we not instead concentrate on how to prevent disability and handicaps irrespective of their origin? Should we perhaps forget the term accident and confine ourselves to talking about the consequences of disease, traumatic as well as non-traumatic?

Any Questions?

We publish below a selection of questions and answers of general interest

Which Pill for Women with Premenstrual Tension?

What is the most suitable oral contraceptive for women who suffer from premenstrual tension and irritability?

Premenstrual symptoms in the normal cycle are due to progesterone from the corpus luteum. Often suppression of ovulation by any combined contraceptive pill will relieve the patient of tension and irritability. Individual variability of response to the contraceptive pills is very great and may be unpredictable. But for patients with premenstrual discomforts, it would first be sensible to choose a contraceptive with the least amount of progestational activity. This cannot be fully inferred from the dose of the gestagen in the formulation. The oestrogens in contraceptive pills are usually either ethinyl oestradiol or mestranol (ethinyl oestradiol 3-methyl ether). The progestogens are in two groups: (1) 19-nortestosterone derivatives, norethynodrel, norethisterone, lynestrol, ethynodiol diacetate, and norgestrel; and (2) 17-alpha-hydroxy progesterone derivatives, chlormadinone and megestrol acetate.^{1 2} A table published in the *British Medical Journal*³ in an article on choosing an oral contraceptive gives a useful categorization of overall clinical effects of commonly used pills. There, the weakly progestogenic are given as Volidan, Conovid, Conovid E, and Previson, and some sequential preparations. This article should be consulted by the questioner.

¹ *British Medical Journal*, 1969, 3, 344.

² *British Medical Journal*, 1969, 4, 789.

³ *British Medical Journal*, 1968, 1, 690.

Insanitary Conditions

When requested as Proper Officer to take action under Section 47 of the National Assistance Act difficulty often arises over the interpretation of the term "insanitary conditions." Is there a definition which is simple and comprehensive which could be used for relatives and friends of the patient?

History lends a clue. While "sanitas" means simply "health," the adjectival form came into use in the mid-nineteenth century, the Sanitary Era, in relation to investigations and legislation directed against the gross environmental hazards associated with major epidemics of communicable disease and malnutrition. The converse adjective, insanitary, became current after the Royal

Sanitary Commission (1869-71), which led to the great Public Health Act of 1875 with which "Section 47" is in direct lineage. "Section 47" is concerned to secure necessary care and attention for persons who suffer from gross chronic disease or being aged, infirm, or physically handicapped, are living in insanitary conditions and are unable to care properly for themselves, or to be satisfactorily cared for.

The law requires the medical officer to certify in writing that removal of the person concerned is necessary in the interest of that person, or others, or both. It is therefore desirable that the terms of the statute should not be so closely defined as to circumscribe the exercise of his professional judgement. It is preferable also for any explanation to relatives and friends to be related to the circumstances of the individual case rather than given in stereotyped form.

Pregnancy after Ovarian Cystectomy

What are the chances, statistically, of pregnancy in a woman who has been operated on for an ovarian cyst and had the ovary plus Fallopian tube removed on one side as compared to a woman who has both adnexa present?

If the remaining tube and ovary are completely normal her chances as compared with a woman with internal genitalia intact are scarcely reduced at all. Much more depends in prognosis for fertility on the nature of the cyst removed, whether there was any inflammation in the pelvis at the time of operation, and whether the postoperative course was smooth or stormy. And, of course, statistically fertility declines with age. Even when there has been no operative interference with the genitalia, about 10% of all marriages are infertile.

Moniliasis and Vaginal Diaphragms

Is there any evidence that a vaginal diaphragm can carry monilia and reinfect a patient?

Since monilia forms spores the answer to both parts of the question is yes. If a patient is successfully treated for vaginal moniliasis it would seem sensible for her to obtain a new diaphragm. Old diaphragms could be sterilized by x rays, ultra-violet light, or ethylene dioxide. It hardly seems worth the bother.