symptomatically cured by posterior excisional ano-rectal myotomy—a much less hazardous procedure than a definitive procedure.

Paediatric surgeons will agree with Shim and Swenson on the advantages of these patients going to a large children's hospital with specialized departments of radiology, pathology, and biochemistry. In the field of neonatal emergency surgery it is essential that a team of highly skilled surgeons and pathologists must be available round the clock, as newborn victims of conditions such as Hirschsprung's disease usually present as an emergency.

Tangled Bill

As the Abortion Bill becomes increasingly tangled up in the House of Commons standing committee opinion is growing outside that a fresh start ought somehow to be made. The legislative approach to this important social problem has often seemed—at least to medical men and women—to be at once impetuous and haphazard. The Times has suggested withdrawal of the Bill and a thorough inquiry into the facts here and abroad. Other critics believe a Royal Commission would make the issues plainer, though their opponents must command some sympathy in doubting whether a Royal Commission is the right instrument for the task.

Like the community at large the medical profession is not unanimous on how best to resolve the complex and emotionally charged problems, though it is worth reiterating that some leading gynaecologists doubt whether there is any need, either for the patient or for her doctor, to have the present case law embodied in statutory form. If it is to be, then one outstanding principle to follow is that doctors should be required to exercise judgement only on matters within their professional competence. What are often called social grounds for abortion—though perhaps sometimes more properly described as domestic—can come into the doctor's consideration of the case only in so far as they affect his patient's life or health. A doctor cannot take medical decisions, especially of such gravity as termination of pregnancy, for reasons which he is not professionally equipped to weigh up. The sponsors of the present Bill have shown themselves to be sensitive to this argument but disinclined to accept it in its entirety. The result now is to replace various proposed amendments defining the principal grounds for abortion by the following clauses:

(i) that the continuance of the pregnancy would involve risk to the life or injury to the physical or mental health of the pregnant woman or the future well-being of herself and/or the child or her other children;

(ii) in determining whether or not there is such risk of injury to health or well-being account may be taken of the patient's total environment actual or reasonably foreseeable.

If these words were to become law they would be the explicit guide to which doctors would have to turn in doubtful cases, of which there may be many. And lawyers too would be required to devote to them the same minute attention they have so often given, for example, to the McNaughton Rules. Yet the clauses need no more than a first reading for their ambiguities and obscurities to be obvious. How can a doctor estimate the future well-being of a mother as something separate from the risk to life or health of continuing the pregnancy? And, in the context of these clauses, what of the future well-being of "the child or her other children"? Again, what sort of difference is intended in the second clause between "health" and "well-being"? For all this to be the upshot of what our Parliamentary Correspondent called "three mornings of controversy and seven votes" must cause anxiety about the direction this legislation is taking. Is familiar case law to be replaced by a statute full of traps?

Management of Acute Poisoning

The incidence of acute poisoning in Great Britain has increased considerably in recent years. Thus probably about 36,000 patients will be admitted to hospital this year with acute poisoning, and over 6,000 people will die of it. In some hospitals these patients form as much as 10% of the acute medical cases, and large numbers of persons consult their family doctors about exposure to a potentially poisonous substance which proves to be relatively harmless. In general practice episodes of this kind are twice as frequent in children as in adults and amount to several thousands per year. Of the admissions to hospital for poisoning, on the other hand, not more than 27% are children. About two-thirds of the patients admitted to hospital are suffering from the effects of depressant drugs—which are classified as "analgescs and soporifics," and which include hypnotics, sedatives, tranquilizers, and, above all, barbiturates. This is not unduly surprising when it is realized that 30 million prescriptions for depressant drugs are dispensed annually in England and Wales alone.

To ensure that the facilities for treatment were put to best use the Central Health Services Council appointed a committee under the chairmanship of Professor Hedley Atkins to consider arrangements for the emergency treatment of cases of acute poisoning in hospitals. In 1962 this committee recommended that one general hospital in each area should be designated as the preferred receiving centre for patients with acute poisoning and that it should be called the district centre. Hospitals with special facilities such as intermittent haemodialysis—though this has only a strictly limited value in the treatment of poisoning—might serve as regional poisoning treatment centres. The report made no proposal to establish intensive-care units exclusively for cases of poisoning, but it recommended that "the district centre should be in the charge of a physician especially interested in cases of poisoning who should be designated to deal with such

1 The Times, 7 February 1967.
3 Ibid., 1966, 2, 1607.
4 Ibid., 1966, 2, 1649.
5 Ibid., 1967, 1, 512.