Here, I think, everyone will agree; but it is for the B.M.A. to learn this lesson.—I am, etc.,

Institute of Psychiatry, University of London, London S.E.5. ELIOT SLATER.

SIR,—I have read with interest your leading article "Ethics and Abortion" (6 April, p. 3); the decision of the Council supporting the views of the Ethical Committee and those of the special B.M.A. Committee on Abortion (*Supplement*, 6 April, p. 3); the article on Medical Ethics by Sir Roger Ormrod (6 April, p. 7); and the Memorandum from the Medical Defence Union (23 March, p. 759).

I am fully in agreement with the decision of the Council in regard to Section 1 (i)(a) of the Abortion Act that one of the legally permitted criteria for terminating a pregnancy—namely, "that it would involve risk of injury to the physical or mental health of any existing children of the pregnant woman's family greater than if the pregnancy were terminated"—is unethical from the medical point of view. It appears, however, that there is some confusion in the minds of a good many people about the reasons why the Council of the B.M.A. and the special Committee on Abortion regard this as unethical. It is, I think, important that these should be fully understood. A most cogent reason is founded upon the basic principle that a doctor's first and overriding duty is to consider the interests of his patient regardless of the interests of any third party. This clause makes it permissible in law for a doctor to perform an operation upon a patient solely in the interests of a third party. It is certain that in the case of termination of a pregnancy on these grounds the woman's consent would in fact always be obtained, and therefore no actual abuse of the principle would be likely to occur. The danger, however, lies in the fact that once this principle has been weakened or abandoned it can easily, and almost certainly would, be extended to other aspects of medical practice involving other issues, such as, for example, euthanasia, experimentation on patients, incurable mental illness, and a number of others.

The ethical principle is entirely in the interests of the patient, and the public should do everything they can to help the medical profession to safeguard it in their own interests. The growing power of the State is a matter of anxiety in many countries, not excluding our own, and third-party interests of a political nature could easily conflict with the interests of the individual patient. In such a case the doctor's strict adherence to his medical ethics would be the patient's only protection. As the editorial states, "Medical ethics are the collective conscience of the profession, and a plea of 'superior orders' [or, I would add, any third party interests without regard to those of the individual patient] would be a sinister echo of something that ended 20 years ago at Nuremberg."—I am, etc.,

Poole, Dorset. DORIS ODLUM.

Child Welfare Services and the General Practitioner

SIR,—I have read the report of the discussion on the general practitioner in the local authority child health clinics (*Supplement*, 6 April, p. 26).

Being an ex-general-practitioner who did much of this work, I would like to suggest that experience and qualifications in child health should be recognized by the compiling of a supplementary register for this purpose among general practitioners analogous to that of the obstetric and ophthalmic lists. A differential rate of payment for sessions would promote the cause and enhance the standard of child health among general practitioners in the evolving health centres.—I am, etc.,

F. E. JAMES,
Principal School Medical Officer,
City of Nottingham Education Committee.
Nottingham.

Problems in Amphetamine Usage

SIR,—In a recent letter to all general practitioners and chairmen of general medical advisory committees (23 March, p. 754) the Chief Medical Officer of the Ministry of Health has drawn attention to the problem of illicit use of the amphetamine group of drugs. He did not define the substances which were to be regarded as members of this group, but the inference was that he was referring to all agents having a chemical structure related to amphetamine which are used therapeutically as appetite suppressants and antidepressives.

One of the principal reasons which led him to advocate the restricted use of amphetamines was that there is evidence of their use by intravenous injection. Presumably the addict prepares his own injection by extracting with water the soluble amphetamine salt from a conventional tablet, because amphetamine is not widely available in an injectable form. If this is so, we would point out that a resin-bonded preparation of amphetamine, which is the basis of our appetite-suppressant products Durophet and Durophet-M, is insoluble in water. Elution of the contents of a capsule would therefore result in only a weak solution of lactose and a precipitate of granules. A further distinction between plain tablets and long-acting preparations in the context of abuse was referred to in your article Today's Drugs (23 March, p. 753). "The drugs are best used in a delayed release form, when the stimulant effect is not so dramatic, the 'let-down' effect is less pronounced, and the danger of habituation and tolerance is decreased."

In support of his argument the Chief Medical Officer stated that a substantial body of authoritative opinion holds that the use of amphetamines is unnecessary in the treatment of obesity. This is a controversial topic, particularly when it has not been made clear which substances are to be included in the amphetamine group in this context, and when no distinction is made between various formulations. Furthermore, until the hazards of obesity are seen in perspective it is difficult to make an objective judgement. The dangers of cigarette-smoking have received widespread acknowledgement, yet the comparable increase in mortality which accompanies obesity seems to be a matter of lesser public concern. The treatment of obesity is notoriously difficult, and many clinical trials have shown the advantages of using anorectic therapy. The drugs most commonly used for this purpose are all amphetamine congeners.[1] There are, however, pharmaceutical and pharmacological differences between the various preparations in this group of substances which have a bearing on both their therapeutic value and capacity for misuse.

We share the concern of those whose difficult task it is to deal with, and advise on, the problem of illicit drug-taking. However, we believe that the rather sweeping suggestion that the agents involved should not be prescribed would contribute little to the solution of the fundamental problem. We would ask that in any appraisal of the amphetamines the members of the group should be clearly defined, and the attributes of particular formulations taken into account.—I am, etc.,

H. E. LEWIS,
Medical Adviser,
Loughborough. Riker Laboratories.

REFERENCE
[1] Duncan, L. J. P., and Munro, J. F., *Practitioner*, 1968, **200**, 167.

Coroners' Necropsies

SIR,—Mr. R. M. Kirk (6 April, p. 53) raises the question of post-mortem reports and attendance of clinicians at necropsies. He says that "terse reports" may be "purchased after a delay."

These reports are doubtless copies of the pathologists' reports to the coroners, and, so far as the question of "purchase" is concerned, perhaps I should point out that the coroner has to pay somebody to make the copy, so not unnaturally he looks for recompense up to the amount allowed by the Coroners' Records (Fees for Copies) Rules, 1954.

Attendance at necropsies should present no difficulty if the clinician asks the coroner's officer who is to do the work in each case, and then makes an appointment with him direct. At any rate that seems to work here, and also I have to a large extent solved the copy problem by asking the pathologist in each case to make an extra copy of the report and post it direct to the consultant or general practitioner concerned. This is of course the cheapest way of doing it, for little extra cost is involved in making a carbon copy, and the pathologists who carry out examinations at my request have co-operated in my suggestion.

The result is that the clinician's copy reaches him, in most cases, on the same day as the original reaches me.—I am, etc.,

F. G. HAILS,
H.M. Coroner,
Stoke-on-Trent. City of Stoke-on-Trent.

Royal Malady

SIR,—I am surprised that Dr. Ida Macalpine and others (16 March, p. 705) in their reply to my letter (17 February, p. 443) quote Dr. J. Waldenström,[1] who has observed the occasional occurrence of diarrhoea in a different disease, acute intermittent porphyria, as evidence that diarrhoea also occurs in acute porphyria variegata. Porphyria variegata is the inherited porphyria that is so common among white South Africans, especially where I practise in the Eastern Cape, where the prevalence of the disease is 1 in 250 of the white population. Over the past 22 years I have seen well over 100 patients in attacks of acute porphyria variegata. In none of these patients with acute porphyria variegata have I seen diarrhoea, but constipation is the general rule. If diarrhoea occurs it must therefore be very uncommon.

The authors take issue with me that those who inherit porphyria variegata and avoid the drugs that can precipitate an acute attack of porphyria remain in good health except for increased sensitivity of the light-exposed skin. The evidence for this is that the forebears of porphyric families in South Africa in the seventeenth, eighteenth, and nineteenth centuries had just as large families as average—and the average family was large, usually 8 to 15 children—which is why the porphyrics increased in number *pari passu* with the descendants of the rest of the small nucleus of early South African Free Burghers. If they were having attacks of acute porphyria and died from the attacks before the advent of modern drugs their descendants would not have increased as rapidly as they did. Furthermore, here in the Eastern Cape there is not a doctor with a general practice of any size who has not among his patients men and women who have inherited porphyria variegata, and they can confirm that their porphyric patients do not have attacks of acute porphyria except after taking drugs, usually a barbiturate.

In my last letter I ended on the kindly note that their claim was "not proven." This time I shall end more firmly by promising to "eat my hat" (a paper one) if the authors can produce convincing evidence that they are right.—I am, etc.,

Port Elizabeth, South Africa. GEOFFREY DEAN.

REFERENCE

1 Waldenström, J., *Acta med. scand.*, Suppl. No. 82, 1937, pp. 70, 72, 73.

SIR,—It was suggested in your leading article (6 January, p. 2) that evidence of porphyria in James Edward Stuart and his descendants would be worth seeking, as, if found, it might dispose once and for all of the allegation that substitution was practised at his birth. Such an investigation, whatever its other difficulties, would involve only a small number of individuals, while, as Charles Edward secured the legitimation of his daughter Charlotte Stuart in 1783, all the descendants of James Edward are legitimate and easily traced. (Incidentally, Sir Compton Mackenzie[1] records Charlotte's death in 1789 as being due to a malady brought about by a fall from a horse.)

The position, however, in the House of Hanover would seem to be very different. Not only are the numbers much greater, but the illegitimate members of a generation greatly outnumbered the legitimate at times—for example, in 1817, as Dr. D. L. Gullick (20 January, p. 178) points out. Nevertheless, as regards the "royal malady" of haemophilia, J. B. S. Haldane[2] was able to conclude that the most probable place and time for the mutation which led to its appearance in European royal families was in the nucleus of one cell of Edward, Duke of Kent, in the year 1818, and he gives reasons for that probability as regards place, but not (in that edition) as regards time, except that Edward's only child of that marriage, the future Queen Victoria, was born in the following year, 1819. Presumably Edward's other children, born earlier, were investigated by Professor Haldane and found to be free from haemophilia, and he states (loc. cit.) that Victoria's half-brother, son of the Prince of Leiningen, was not haemophilic. He showed that two of Queen Victoria's daughters were heterozygous for haemophilia, and transmitted haemophilia to (among others) the royal families of Spain and Russia, as did her haemophilic son Leopold to some of his descendants. If Queen Victoria's father was not only the unwitting *fons et origo* of those calamities but a victim of porphyria as well, as suggested in the very interesting study by Dr. Ida Macalpine and her colleagues (6 January, p. 7), he would seem to be unfortunate indeed. That he and no fewer than three of his brothers should all suffer from porphyria and yet be followed in the next generation by only one case—Princess Charlotte—might seem surprising, but investigation of their other children, whether legitimate or otherwise, this time for porphyria (as Dr. Gullick suggests in the case of the Fitzclarences) might reveal a very different state of affairs.

A second hiatus on the Hanoverian side is the long gap of five generations in the direct line from James VI and I to George III without known clinical evidence or discoloration of the urine. Here Dr. M. Duddle's letter (20 January, p. 178) about George I's death might help, and Sir Compton Mackenzie's account (loc. cit.) that George died in Osnabrück at midnight following a surfeit of melons on top of a heavy supper confirms at least that abdominal symptoms were prominent at the end.

Further investigation of the House of Hanover for porphyria would seem very much more difficult than a study of the later Stuarts—but potentially more rewarding.—I am, etc.,

Stepps, Glasgow. A. F. MACLEAN.

REFERENCES

1 Mackenzie, C., *Prince Charlie*, 1932, London.
2 Haldane, J. B. S., *Keeping Cool*, 1940, London.

Was it a Drug?

SIR,—Is it not time that Regulation 16 of the National Health Service (Service Committees and Tribunal) Regulations, 1956, was abandoned?

Every week one hears of a substance being decreed not a drug or medicine which the executive council feels bound to provide, and the general practitioner is fined the cost of the preparation. Frequently the product has been prescribed on the advice of a consultant. The general medical practitioner is in the position of having to give all proper treatment on the one hand, and to anticipate the decision of some distant referee on the other. It is made clear that the adjudication in one particular case is not binding on any other.

This cause of resentment can easily be removed. Abandon Regulation 16.—I am, etc.,

Sutton Coldfield, Warwicks. R. C. BROWN.

Blood for Sale

SIR,—Your leading article (20 April, p. 129) rightly points out the medical disadvantages of adopting a commercial attitude to blood transfusion. There is another aspect equally important. The urge to altruism is an integral part of normal human personality. The satisfaction of doing something for another out of pure disinterestedness and without hope of personal gain is difficult to achieve in a sophisticated society where everything has its price. That blood donation has proved so widely accepted a means of fulfilling this yearning underlines its value. If the money likely to be spent on buying blood were devoted to publicity there would be a ready response from a public starved of the avenues for social dedication previously offered by war, voluntary hospitals, and the poor, all of which appear to be fading away from the contemporary scene.—I am, etc.,

Huddersfield, Yorks. S. L. HENDERSON SMITH.

Hiatus Hernia

SIR,—One of the methods necessary for the alleviation of symptoms of hiatus hernia is to raise the head end of the bed some four to six inches (10 to 15 cm.). This has usually been done by using bed blocks.

A very simple and efficient way of achieving the same object is to remove the castor-bearing feet from the lower end of the bed and to fix the castors directly to the base.—I am, etc.,

London W.1. WILLIAM W. FOX.

Dealing with Bedsores

SIR,—Having read the review in the *B.M.J.* (6 April, p. 40) by Professor H. Ellis on Mr. B. N. Bailey's textbook *Bedsores*,[1] I feel constrained to make one comment.

While a large part of the text is both valuable and unexceptionable, certain aspects are contrary to the practice and teaching of this unit. In view of Professor Ellis's last sentence I feel I must dissociate myself and this unit from some of the recommendations in Mr. Bailey's book.—I am, etc.,

J. J. WALSH,
Director,
National Spinal Injuries Centre.
Stoke Mandeville Hospital,
Bucks.

REFERENCE

1 Bailey, B. N., *Bedsores*, 1967. London.

Colour Coding

SIR,—The increasing practice of colour coding of National Health Service general-practitioner records makes it essential that, when new needs for such coding arise, such a code is allocated nationally.

The new situation with regard to measles vaccine highlights the need for each patient in the age group liable for vaccination who has had measles to be clearly colour-coded. It is suggested that 1 in. (2.5 cm.) by ½ in. (1.25 cm.) black and white chequered Sellotape be fixed to the top left-hand corner of the N.H.S. record—that is, when the open end is upright facing the observer—of those patients who do not require measles vaccination. It is realized that this will be a temporary need for the next five years, but full computerization of medical records which would obviate this need is not likely to be achieved during this time.

It should be possible to build up such a coded population by questioning parents or searching through the patients' N.H.S. record envelope for the recorded entry of "measles" at an appropriate parent and/or patient contact.—I am, etc.,

Royal College of General Practitioners, London S.W.7. E. V. KUENSSBERG.