also had gonococcal urethritis. Four had identified contacts with gonorrhoea—two urethral and two rectal.

These figures do indeed suggest that infection of the pharynx is less common in London than has been reported in Denmark.—I am, etc.,

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Attitudes to Abortions

SIR,—The light is amber and may soon be red. It is sad to read in a leading article (13 April, p. 69) in a responsible journal with a world-wide distribution that conscience which "was manifestly essential" in 1967 to the clinical application of the Abortion Act is no longer just as important. Moreover, your article was inconsistent. "There will always be some women who are refused abortion by N.H.S. gynaecologists and later obtain a termination privately. The reason is simply that the private sector operates on a principle very near to abortion-on-request but the N.H.S. does not and should not—as the committee itself agreed." This acknowledges the reality of differing standards of case assessment and interpretation of the Act. "Conscience" helps when decisions are difficult.

In the reorganized Health Service it should be easier than hitherto for adequate teams to provide a comprehensive service in obstetrics and gynaecology if there is the necessary financial support. High ethical standards, conscience, and differing religious beliefs, when associated with freedom of thought and expression within the fellowship of a team, can prove enriching for the doctors and therefore beneficial to the patients. Delegation of work within the team by mutual agreement can avoid losing men and women of great potential from the practice of obstetrics and gynaecology, and probably from medicine. Having been privileged to work for over 30 years in a department which has helped train doctors of different cultures and religions from all over the world it has been possible to see something of what this fellowship of medicine can achieve. It includes respect for the ethics and principles of those with whom you may disagree over certain clinical decisions.

If doctors cannot, or will not, put their own house in order, they may find too late that control is passing into other hands. These may not be sympathetic ones.—I am, etc.,

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SIR,—Like Professors H. C. McLaren and J. S. Scott (11 May, p. 329), the Nazis thoroughly disapproved of abortion and were determined to stamp it out. Consequently, one of the first laws they passed when they came to power in Germany in 1933 was one increasing the penalties against abortion. Under this law the woman herself could be imprisoned for attempting self-abortion, and anyone permitting "the advertisement or display of instruments or other means for procuring abortion" could be sentenced to two years' imprisonment. I mention this for the historical record, since both your correspondents give the impression, no doubt unintentionally, that Nazi views about abortion were quite different from their own.

Professor Scott seems to labour under another misapprehension. He says, "The Lane inquiry has achieved what was probably the main political intention behind its institution—a decrease in the public expression of concern over the whole question of abortion." This is a puzzling remark in face of the fact that the inquiry was set up as a result of Roman Catholic pressure. As the Catholic M.P. Mr. Norman St. John-Stevas has made clear,[1] he organized the campaign in the House of Commons. And now that it has all ended so tiresomely, he may be wishing he had left well alone.

Another curiosity I observe in your columns is that doctors refusing to undertake abortions invariably seem to be credited with the highest motives, while those who support a more liberal law are considered to have not merely different moral attitudes, but inferior and disreputable ones. Hence, Dr. J. R. Nolan's observation (11 May, p. 330): "As they (that is, the morally superior) retire they will be replaced by other doctors who will be prepared to kill fetuses for the social convenience of their mothers." Such views and attitudes are analysed historically in a paper in the April issue of the *British Journal of Criminology*.[2]—I am, etc.,

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1 St. John-Stevas, N., *The Tablet*, 1974, **228**, 362.
2 Simms, M., *British Journal of Criminology*, 1974, **14**, 118.

Isolation System for General Hospitals

SIR,—The Control of Infection Group at Northwick Park Hospital have outlined the system used in the isolation unit of their hospital for the past few years (6 April, p. 41). However, some aspects of the system have become so over-elaborate as to detract from its undoubted value. There would not appear to be much justification for dividing "source infections" into three grades, particularly since the techniques described are almost identical and since it would not be possible to grade many of the patients admitted without several days of investigation in hospital.

In particular, of the list of diseases for which "strict isolation" is suggested, only infantile gastroenteritis really deserves inclusion and, though opinions may vary, the other diseases on the list do not really come into the category of serious infections with a high risk of spread. Examples include: suspected smallpox (which should never be admitted or retained in a general hospital); generalized vaccinia (which is probably no more infectious than a vaccinated person); severe staphylococcal infections (which are a risk only to debilitated "open ward" patients); pulmonary anthrax (virtually non-existent); and dermatitis with severe sepsis (surely no more infectious than any other wound or burn infection). Conversely, salmonella infections, which share with infantile gastroenteritis the worst reputation for causing hospital cross-infection, are relegated to a lesser degree of isolation.

While the overall technical measures described in the article are excellent and are broadly similar to those in use in most of the major infectious diseases units in Britain, I feel that the use of a single high-standard isolation routine would considerably simplify and improve the system and make it more suitable for adoption in other general hospitals.—I am, etc.,

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Drugs for Gastric Ulceration

SIR,—The title of your leading article (27 April, p. 186) is misleading and the advice in the concluding paragraph unjustified.

A desirable feature in management of patients is relief of symptoms, and yet "established clinical remedies" are dismissed in your opening sentence. Antacids are not specifically mentioned, and from this it might be inferred that these are not recommended. They give symptomatic relief[1] without acceleration of healing,[2 3] and are reasonably safe in moderate dosage or when not absorbed.[3] In contradistinction, carbenoxolone merely hastens the healing of gastric ulcers, but does not shorten the duration of pain,[4] and furthermore is dangerous.[5] It is surely unjustified to conclude that "carbenoxolone seems still to be the drug of choice" for all patients other than those specifically excluded. Antacids must remain the first choice; indeed, in only one[6] of the trials mentioned in your article were patients deprived of their benefits.

It is difficult to condone your uncritical assumption that simply because carbenoxolone hastens healing of gastric ulcers it has any place in the management of the disease at all. While rapid healing might perhaps reduce complications or the probability of recurrence, you quote neither possibility nor, for that matter, any other advantage, and no available evidence suggests any such benefit. In the companion article[7] to the one by Rudick[8] to which you referred, Sachar queried whether this drug will "produce any useful alteration in the long-term history of the gastric ulcers." You ignored this problem. Unless some demonstrable benefit other than simply accelerated healing is derived by patients, the present use of carbenoxolone should be restricted to controlled experiments.

Your nomination of deglycyrrhizinated liquorice as the "most logical choice" for patients in whom carbenoxolone is regarded as being too dangerous is suspect when the most said in support is that it is "probably reasonably effective" and appears to be free of side effects. It is fortunate that, since a proprietary preparation which contains deglycyrrhizinated liquorice also includes antacids, patients are coincidentally not deprived of their benefits.

Some years ago Gill[9] concluded that an essential factor both in relief of pain and in ulcer healing was the patient's belief that the treatment would be successful. A negative result of your leading article might be that doctors henceforth dispense this factor via the medium of dangerous carbenoxolone or possibly ineffectual deglycyrrhizinated liquorice, while beneficial antacids are ignored.

In your final sentence you refer to "the