objective criteria, however crude, to bear on a clinical situation which, at the moment, is not apparently governed by any clear guidelines. We anticipate that these criteria will be refined or perhaps replaced as evidence from other centres (supported by results) becomes available. We are, etc.,

A. B. LOACH
A. C. YOUNG
J. M. K. SPALDING
A. CRAMPTON SMITH
Radcliffe Infirmary,
Oxford

Working of the Abortion Act

Sir,—In carrying out a survey for quite different purposes, over 600 doctors have replied to a questionnaire which included a request for their views on the present Abortion Act. These doctors are all general practitioners holding the postgraduate diploma of the Royal College of Obstetricians and Gynaecologists and have a median age of about 36 years. They are likely therefore to be doctors of first contact to a considerable proportion of the unwanted pregnancies in this group.

Sixty per cent of these doctors thought that the present Abortion Act was a reasonable compromise, 22% that it was a major social advance, and only 14% that it was a tragic mistake. The other 4% gave less easily classified answers. A survey of over 200 rural practitioners gave almost identical results.

Policy-making by referendum may not be wholly without its difficulties; but these figures were thought to be of sufficient general interest to warrant separate publication.—I am, etc.,

ERIC WILKES
Department of Community Medicine,
University of Sheffield Medical School,
Sheffield

Sir,—There has recently been much defence by doctors of their freedom to undertake private practice, and receive a fair fee for work done. In contrast, these columns have seen little reaction to the Abortion (Amendment) Bill which, however, disguises a much greater threat to the freedom of doctors and of women. This Bill has not been considered by a select committee whose members were chosen two-to-one in favour of its acceptance.

Ostensibly designed to ward off the rare but reportable exploitation of women under the present Act, the Bill is also attracting the support of some who are committed to the abolition of private practice or who are influenced by its distasteful implications regarding the use of fetal tissue. However, little public interest has been given to its removal from the present law of the invaluable yardstick for comparison—namely, that of the damage that would result were the pregnancy to continue to term. This, along with the insertion of two adjectives, “grave” and “severe,” will make interpretation of the proposed law impossible.

Further, the onus is to be on the doctor to prove its innocence, in complete contravention of the principles of British law. It is conceded that this is a throw-away clause; the effect of the Bill will none the less remain essentially unchanged when, as is inevitable, this clause is removed to pacify opposition. These words would be grossly to reduce the (still inadequate) possibility of having an unwanted pregnancy terminated and thus of causing the unwelcome resurgence of back-street abortions.

In this International Women’s Rights Year the attempted denial by this Bill of the right of women to equality through the control of their own fertility, and its restriction of the freedom wishing to submit whatever treatment is in their best interests, is a threat that must be met by a much more determined protest than has yet appeared. We are, etc.,

P. A. CARTER
J. H. SIMMONS
F. H. BOWSHIER
S. E. DUNN
Students’ Union,
The London Hospital,
London E.I

Iron Treatment of Dialysis Patients

Sir,—The drawbacks of regular intravenous iron therapy to patients undergoing regular haemodialysis treatment are clearly presented by Dr. S. Hussein and his colleagues (8 March, p. 546). Their emphasis on monitoring the exact amount of iron therapy needed is justified by the increased marrow iron stores of most of their patients. What is not so clear is how their data allow this dose to be calculated and overloaded avoided.

Since there is no good evidence to suggest that oral iron is less effective than intravenous iron in patients on regular haemodialysis, nor that it can overload marrow iron stores, a safe alternative is to give oral iron to all these patients. In contrast to Dr. Hussein and his colleagues we have found a significant correlation between transferrin saturation and marrow iron. Rises in haemoglobin level with oral iron are significantly greater when transferrin saturation is below 30%.1 Transferrin saturation thus provides a simple indication of the likely response of patients treated with oral iron; it may not reflect iron overload, but this has not proved a problem if the parenteral route is avoided. We are, etc.,

D. M. CHAPUT DE SAINTONGE
F. E. BOUTON
The London Hospital Medical College,
I. D. STRICKLAND
The London Hospital,
London E.I

Treatment of Paracetamol Poisoning

Sir,—Your otherwise informative leading article on paracetamol poisoning (8 March, p. 536) states that “biochemical treatment will therefore need to be restricted to the first 48 hours after ingestion of the paracetamol.” However, there is no evidence that the only proven effective antidote in man, cysteamine, is effective after 12 hours.1 In people with induced liver microsomal enzyme systems are particularly prone to damage2 and in one such patient, who was an alcoholic, treatment nine hours after gross overdosage was only partially successful.3

Hepatic damage seems to be irreversible by these means 12 hours after overdosage and treatment at this stage with any compound that is largely taken up and metabolized by the liver is potentially dangerous. In our experience of one patient who treated there was a transient fall in level of consciousness.

If a controlled trial is thought to be justifiable, then only those patients treated within 12 hours of overdosage should be compared with untreated subjects. We are, etc.,

N. WRIGHT
Regional Poisoning Centre,
York Hospital,
Birmingham

L. F. PRESCOTT
Regional Poisoning Treatment Centre and
University Department of Therapeutics,
Royal Infirmary,
Edinburgh


Practolol and Sclerosing Peritonitis

Sir,—In their article on “Fibrinous Peritonitis: A Complication of Practolol Therapy” Mr. W. O. Windsor and his colleagues (12 April, p. 68) observe that immediate withdrawal of practolol may result in regression of the condition. We have recently observed a similar case of fibrosing peritonitis which presented with intestinal obstruction one year after cessation of practolol therapy. At laparotomy this man, a man of 66, showed the characteristic fibrous membrane enclosing the small bowel, with thickening of both visceral and parietal peritoneum, and the histological diagnosis was “sclerosing peritonitis” by Brown et al.1 Special stains and all routine investigations were non-contributory. However, it emerged that the patient had had a psoriasis rash while on practolol therapy, this being the reason for its withdrawal. The patient subsequently died from rupture of a tractions diverticulum of the caecum, produced by the peritoneal adhesions, four weeks after laparotomy.

Of the cases of practolol-associated sclerosing peritonitis recently reported, two occurred eight months after stopping practolol2 and another one, like our case, presented 12 months after practolol had been discontinued.3 All the patients appear to have received the drug for over one year. We would like to emphasize that withdrawal of practolol does not necessarily protect the patient from sclerosing peritonitis and that it is therefore worth checking the
drug history of all patients presenting with intestinal obstruction.—We are, etc.,

W. HALLEY
J. D. S. GOODMAN
Wycombe General Hospital, High Wycombe, Bucks


Cigarette Advertising

Sir,—Thirteen years after publication of the first Royal College of Physicians' report on "Smoking and Health" the Government has, as you report (19 April, p. 149) been unable to get the tobacco industry to accept six proposals aimed at curtailing cigarette promotion. It is clear that the tobacco industry hopes that it will continue to secure voluntary "restrictions" which are known by them to be unlikely to affect sales and will never agree to any more effective measure such as Dr. David Owen has proposed. Such measures will therefore require legislation to bring them into effect.

We are starting a parliamentary campaign in relation to a private member's Bill designed to give legislative force to Dr. Owen's proposals and wish to ensure that it has sufficient support by M.P.s to gain Government backing. It would be helpful if doctors who would like to see tobacco sales promotion curtailed were to write to their M.P.s asking them to support any Bill with this aim. We would be glad to provide any background information for them and to hear of any replies received.—We are, etc.,

C. M. FLETCHER
Chairman.
K. P. BALL
Hon Secretary.
Action on Smoking and Health
London S.E.1

Geriatric Admissions

Sir,—With reference to the letter from Dr. May Downie (19 April, p. 142) has it ever been considered what the geriatric patients themselves would wish? Too often geriatricians are influenced by relatives and the pressure of colleagues on acute wards to admit on a long-term basis.

After many years in geriatric social work I have found that most elderly people would prefer, as Dr. Downie terms it, square conditions etc., to hospitalization as they view this as waiting for death, rejection by family and society. It is appreciated that better living conditions are desirable, but if one has no desire for change then it will be a sorry day if after the age of 65 the citizen cannot at least make some sort of choice unaided.—I am, etc.,

MARY INGLIS
Princess Louise Hospital, London W.10

Consultant Negotiations

Sir,—After allowing the dust to settle, I still feel as incensed now at the Central Committee for Hospital Medical Services decision to recommend the lifting of "sanctions" as I did at the time the recom-

My principal reason for this attitude is that it has been made to appear that the profession has lifted its sanctions in order to gain the Review Body's agreement to the proposals. The B.M.A. may deny this, but it is a fact that this is the impression they have given to the public.

Secondly, the basis for this recommendation was an apparently satisfactory interpre-
tation of the maximum part-time contract by Mrs. Barbara Castle. This is, of course, a question of opinion, but I cannot see anything satisfactory in the Secretary of State's letter about this when all it needed to say was that a maximum part-time contract was a 9/11ths contractual obligation with a total ethical obligation.

Thirdly, the sanctions were originally recommended jointly by the B.M.A. and the Hospital Consultants and Specialists Association. The recommendation to lift sanctions should also have been made jointly by the two associations. The B.M.A. broke its gentleman's agreement with the H.C.S.A. at the most critical stage.

Fourthly, given that the sanctions had nothing to do with any possible pay award from the Review Body, why was it necessary to act within hours—unless, of course, the two were related? Before the application of sanctions the B.M.A. sought the opinion of its members through its links; why did it fail to do so before recommending the lifting of the sanctions? Why indeed?

At the C.C.H.M.S. meeting on 18 April Mr. Grabham was put through the hoop with many of the criticisms made by Mr. F. E. Weale and Mr. M. Spro (3 May, p. 280). His bearing, his level-headed sanity and absolute cool in the face of many needlessly provocative statements and misinterpre-
tative answers with no glib, easy side-
stepping earned him the unstinted admiration of, I think, the entire committee—no mean feat. Several members of the Negotiating Subcommittee paid tribute to his superb conduct of those 14 hours of that long night, a night which none of them recall as "amiable."

I have written this, Sir, realizing well that I may be accused of fulsome flattery and fawning adulation, but I do so because it is not really possible for those not present to appreciate the impact and effect which Mr. Grabham's positive reasons for lifting them had on the C.C.H.M.S. in its consideration of the Negotiating Subcommittee's recommendations.

To summarize the reasons accepted by the C.C.H.M.S. the government has been called for since all forms of negotiation approaches about a new contract on the "principles of the profession" had failed. These principles embraced the 10-session contract and the inclusion of day release. However, after the past year's discussions and talks among senior staff about contracts it has become clear that the 10-session contract has steadily lost favour, nor does there seem to be much support for item-of-service, and more and more it is being felt that perhaps the existing contract is not so bad after all if certain elements of it could be given adequate recognition.

In this changing climate of opinion the reasons for sanctions at the time of their application held less validity for their continuance. Still, there had to be some good, sound, reasonable reasons for lifting them. The negotiating team was sufficiently satisfied by Thursday, 17 April that worthwhile formal negotiations on the existing contract could be resumed. As our appointed negotiators, they did not believe that the hazardous thing—they took a decision and recommended to the C.C.H.M.S. the lifting of sanctions.

So now they and the C.C.H.M.S. are accused of acting arbitrarily without proper consultation and with indecent haste so that the Review Body report might not be held up by Government—that is, they had sanctions lifted so that our mouths could be stilled with gold. It will be interesting to see how many consultants are choked with the gold of this award. Had the Government, however, refused to implement the report because it did not want to sanction them then there also would have been screams of rage that the recommended and long-overdue award was being denied because of the insincerity of "the B.M.A." coterie. We may be back to square one, but at least with the B.M.A. undoubtedly much wiser. The issue is now quite clear. We are now going for improvements on the present contract, some of which have already been mentioned both in principle and which have no technical or administrative problems. Let such an item—for example, emergency recall—be a test item, and here I would ask the forbearance and support of specialties such as pathology who may see nothing in this item for them.

If this easily identified and recognized