The abortion issue

To the editor: The worst evil often comes clothed in righteousness. Examples abound — the burning of heretics, the Holy wars, the anti-semitic massacres and the contemporary stonings of half-buried Iranian women accused of adultery.

Among the many priceless advantages Canadians enjoy is freedom of belief. It is, therefore, with some dismay and resentment that I view the current attempts of the members of the so-called Pro-Life movement to force their views on others by taking advantage of a badly conceived piece of federal legislation. That various religious groups are now supporting them is equally disquieting. Religious groups all over the world have always had great difficulty in reconciling their beliefs with the complex and varied imperatives of human sexuality: for example, some of the Pauline epistles, the Renaissance popes surrounded by their bastards, the ageing John Knox and his teenage bride, the divinely "justified" polygamy of the early Mormons, and the human bed warmers of Mahatma Gandhi.

There is, of course, no absolute right or absolute wrong in the abortion issue. Within the medical profession strongly held opinions vary widely. Physicians who refuse to perform abortions are perhaps more respected than those who perform this unpleasant procedure, but there is no consensus. After lengthy debate the Canadian Medical Association believes it should be a matter to be discussed and decided between the doctor and his or her patient. To say that this means "abortion on demand" demeans the efforts of the profession to give good advice after considering all the variables; perhaps the final decision should be made by the woman after all our advice has been given. A fetus is part of her body until it is born. Talk about fetal rights leads only to philosophic absurdity. When do the rights start? Should the unicellular zygote have the vote? If the fetus is old enough to be viable the profession takes every precaution to save it.

Unfortunately, logic no longer influences the abortion issue. Dogmatic emotionalism holds the field. A good friend of mine who has spent many years in an autopsy room wants to take the suburban ladies who lead the Pro-Life movement into the mortuary the next time he is faced with the body of a beautiful young girl hideously disfigured by the stinking sepsis of back-street abortion. It would be useless. Armoured by their righteousness, these ladies would merely hold their lace-trimmed handkerchiefs to their oh so virtuous noses and say "Serves the hussy right". Tolerance and compassion are unrecognized by fanatics. For this is what they are — people who can see only their own side of a complex problem and who then force their viewpoint on everybody else. I defend their right to hold to their beliefs, but we must all resist their attempts to dictate to others.

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Fluphenazine, trifluoperazine and perphenazine in Vacutainers

To the editor: It has been demonstrated that when blood samples are collected in Vacutainer tubes (Beckton, Dickenson Canada, Toronto), a plasticizer leaches from the rubber stopper and causes the displacement from plasma protein binding sites, redistribution into erythrocytes and consequent distortion of the apparent plasma concentration of drugs such as quinidine,[1] lidocaine,[2] propranolol,[3] alprenolol,[4] meperidine,[5] tricyclic antidepressants[6] and chlorpromazine.[7]

We have recently developed radioimmunoassay procedures that permit routine clinical monitoring of the antipsychotic drugs fluphenazine,[8] trifluoperazine (unpublished data) and perphenazine.[9] To establish whether the measurement of these weakly basic lipophilic drugs is affected by contact with Vacutainer stoppers, we collected duplicate samples of blood from nine patients, each of whom was given an intramuscular injection of one of the three drugs. The first sample was collected with the Vacutainer tube held vertically so the blood did not touch the rubber stopper at any time, and the second sample was collected with the tube held horizontally so the blood did touch the stopper. Plasma was prepared from the duplicate samples, which were subjected in parallel to the appropriate radioimmunoassay procedure.[8,9] In seven of the nine patients the concentration of fluphenazine appeared to be substantially lower when the blood had touched the stopper (Table I).

We repeated this experiment with an additional 10 duplicate blood samples taken from volunteers receiving fluphenazine orally, and we also obtained duplicate samples of blood from eight volunteers receiving trifluoperazine orally and nine volunteers receiving perphenazine orally. Again, we found a substantial reduction (0.3% to 100%) of the apparent plasma concentration of fluphenazine, trifluoperazine and perphenazine when the blood had touched the stopper. Clinicians should be aware of this problem now that methods have been developed for

Table I—Concentrations of fluphenazine in plasma prepared from blood collected in Vacutainers held vertically and horizontally

Patient no.	Fluphenazine treatment		Plasma concentration (ng/ml)	
	Dose (mg)	Duration (wk)	Vacutainer held vertically	Vacutainer held horizontally
1	112.5	61	6.40	6.50
2	75.0	53	2.20	2.10
3	6.25	53	1.90	–
4	100.0	53	3.00	1.40
5	150.0	53	2.00	1.45
6	62.5	53	1.50	0.85
7	50.0	53	0.80	0.50
8	25.0	61	0.65	0.30
9	12.5	61	1.30	0.50

the routine measurement of plasma concentrations of these drugs.

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More anesthetists needed

To the editor: Although Charlotte Gray's article on physician manpower planning raises a number of valid and important issues, it also demonstrates the weakness of attempting to predict overall needs with very general data (*Can Med Assoc J* 123: 312, 1980).

Ms. Gray's comments on the report by Dr. W.A. Mennie of the Department of National Health and Welfare[1] present a case in point. By adding the total number of specialist anesthetists and the estimated number of nonspecialist physicians devoting 50% or more of their time to anesthesia Mr. Mennie got an overall figure suggesting that the desirable ratio of 1:13 742, as identified by the National Committee on Physician Manpower in 1975,[2] has been achieved.

In predicting the requirements for anesthetists the National Committee on Physician Manpower based its figures on a workload of 55.5 hours per week (excluding "on-call" time) and allowed a yearly caseload of 1260 cases per anesthetist in community hospitals and 1035 per anesthetist in teaching hospitals. The committee identified these figures as the maximum safe workload for the practising full-time anesthetist.

Many specialist departments of anesthesia have had much more excessive workloads for a long time. My department, for example, has averaged 1600 to 1800 cases yearly per anesthetist for many years. In view of the continued and valid pressure to provide ever higher standards of anesthetic care it should be clear that more anesthetists are required.

In Ontario alone 39 identified specialist anesthetic posts are vacant; this situation is the same across Canada in proportion to the numbers of anesthetists practising in the various provinces.

Unfortunately, the nonspecialist physicians identified by Mr. Mennie cannot take up the excess workload. By their geographic distribution and their level of training they are unable and, in many cases, unwilling to undertake such a task. All this points out yet another area of maldistribution of resources to which Ms. Gray refers in her article.

It is also unfortunate that Ms. Gray takes no account of the decrease in numbers of anesthetists due to emigration and retirement; in the latter instance the number will be large since the average age in this specialty group is over 48 years.

One of the constitutional aims of the Canadian Anaesthetists' Society is to improve the delivery of anesthetic services to Canadians. Our long-term goal is to provide specialists in anesthesia to most Canadians needing this service. It is clear that this goal cannot be met for many years; however, that time will never come if more anesthetists are not trained now.

While there is a good case for optimism about the future supply of anesthetists owing to the increasing number of Canadian residents entering anesthesia training programs,[3] this may be affected to some extent by the changing pattern of enrolment.[4]

In addition, there is continuing pressure to divert anesthetic residency positions to resident positions in other specialties in the face of limited and reduced medical school budgets.

It is essential that governments realize the need to expand residency programs in anesthesia and provide additional funds so that programs in other specialties are not reduced. This has been accomplished in Saskatchewan and other western provinces. It is required even more in the major population centres. It would be unfortunate indeed if the comments on anesthesia manpower in Ms. Gray's article were to deter medical students or recently qualified doctors from seeking a career in anesthesia. The resulting reduction in both the quality and quantity of anesthetic care would be unacceptable to Canadians.

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