the Registration Committee to begin in December erasing those doctors who have not paid the retention fee. Such extremist action at this stage would only serve to exacerbate the situation, enlarging the rift between the General Medical Council and large sections of the profession, causing bitterness, and inevitably provoking retaliatory action by doctors in sympathy with those erased, action probably involving many younger doctors not yet deemed eligible to pay the fee but obviously concerned about their own future. Such developments could bring about serious disruption of the N.H.S. in certain areas and imperil the service given to the public. The attendant publicity and public concern would necessitate a government inquiry in any case.

It would seem wise to acquiesce to the wishes of the profession, and press the Government for the setting up without delay of a public inquiry into the structure, functions, and financing of the General Medical Council.—We are, etc.,

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** Since this letter was written the General Medical Council has met and endorsed the recommendation of its Registration Committee to start erasures. A report of the meeting is given in the *Supplement* at p. 51, together with the text of a statement subsequently issued by the G.M.C. (p. 54). See also leading article at p. 377.—ED., *B.M.J.*

Abortion Deaths

SIR,—Professors H. C. McLaren (30 September, p. 826) and J. S. Scott (4 November, p. 295) quote selectively and incompletely from my introduction to the 6th Report on Maternal Deaths.[1] Dr. Josephine A. C. Weatherall (21 October, p. 176) has given figures derived from her work on the analyses both of the inquiry and of notifications. Dr. C. B. Goodhart (4 November, p. 295) has introduced some other figures but not a continuous series.

It is beyond dispute that deaths attributed to abortion are now at a sustained low level compared with the years 1961-6. The figures may be incomplete but they are certainly more complete since 1968, when the help of the Coroners Society was invoked to ensure that cases known to coroners were so recorded as to be classified as abortion. In the years 1961-71 inclusive the annual numbers of deaths in England and Wales attributed to abortion were 54, 57, 49, 50, 52, 53, 34, 50, 35, 32, and 27. The death rate from abortion per thousand births was only once below 0·06, in the exceptional year 1967, before the Abortion Act came into effect on 28 April 1968 and before the action by the Coroners Society. Registrations of deaths investigated by a Coroner are often delayed until after April of the year following death. If this happens the delayed deaths are counted with those of the following year. For an unknown reason this happened with an unusually large number of deaths due to abortion (six) in 1967. These deaths have been counted with those of 1968. Since 1968 the rate has been in successive years 0·04, 0·04, and 0·03.

Deaths attributed to illegal abortion have fallen from a level around 30 per year through the early 1960s to 15 in 1969 and 11 and 6 in the two subsequent years. Since the number of legal abortions has greatly increased one would expect more deaths from this procedure, which has a definite though small mortality in any hands, but the number of those deaths has not brought the total back to the pre-1967 level.

The number of abortions of women living in England and Wales notified to the two Chief Medical Officers increased rapidly through 1968 to 1970 but it has increased little since early 1971, when action was taken to check on failure to notify. There is no way of being certain that it is, even now, complete but equally no reason to believe that it is less complete now than 18 months ago. The weekly notifications now are a little over 2,000, giving quarterly totals of around 26,000 and a probable figure for the whole year of between 105,000 and 110,000. There is also the foreign traffic, which produces still just under 1,000 notifications a week in addition.

The Registrar General's figures are more nearly complete than those of the confidential inquiry, but the accuracy of the information on individual cases in the confidential inquiry is of course more certain. Broadly, the information from the confidential inquiry bears out that from the Registrar General on the trend—including that not yet published. My introduction was written with the information available in the middle of this year—much of it published by the Registrar General—in mind. I do not wish to modify the opinion expressed in it.

The confidential inquiry into maternal deaths depends primarily upon the objective assessment of each case made by a group of regional assessors, in which Professors Scott and McLaren played a distinguished part. In each report I have attempted an overall appraisal of the national figures and that too has been objective to the best of my ability. This assessment is contained in the signed introduction and is not the responsibility of the named authors of the report, though they had seen it. There is no ground for complacency over the results so far achieved, and the introduction emphasized that a total of less than 100 maternal deaths a year should be obtainable —a reduction of one-third. Part of that should be achieved by a further reduction of deaths attributed to abortion, including the elimination of death following illegal abortion.

It is not my function to oppose or support the Abortion Act but only to report the facts as accurately as possible and to interpret them as far as I can. The interpretation which seems right to me is that the number of illegal abortions has fallen and with it the number of deaths from that cause. The number of legal abortions has increased greatly but seems now to be reaching a more stable level, and the real and highly regrettable mortality from legal abortions is less than the mortality which would have occurred had the previous level of illegal abortion continued. There has therefore been an improvement, still far from sufficient, in the mortality from abortion.

There is surely no doubt in any of our minds that it would have been far better to prevent these unwanted pregnancies than to terminate them, whether safely or not.—I am, etc.,

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1 *Report on Confidential Enquiries into Maternal Deaths in England and Wales 1967-69. Reports on Health and Social Subjects*, No. 6. London, H.M.S.O., 1972.

Geriatric Accommodation in Acute Illness

SIR,—Dr. P. F. Kallis (28 October, p. 238) has raised a very urgent issue and one which could in the advent of a major influenza epidemic explode into something near to a disaster. We are now witnessing the first signs of the weakness inherent in the theory that community care is the answer to chronic shortage of beds for the elderly. Almost any G.P. in active practice will know only too well that in the main the last thing the community cares about is individual responsibility to its senior citizens. The "in-built" daily wrangle with hospitals to find accommodation for some lonely old women temporarily incapacitated by an acute and often minor malady is one of the most time-wasteing and, to the State, costly feature of modern general practice.

All too often it is not really necessary to provide highly skilled nursing but to find reassuring and attentive support not in the day but at night. It is the thoughts of being left alone and unattended in an acute illness which precipitates the cry "something must be done." The practitioner is then faced with a tiresome round of pleas to social services, geriatricians, psychiatrists, and acute admissions, each party passing the ball in self-defence of rapidly diminishing bed space.

It is now useless to say that this situation should have been provided for. It must have stuck out like a sore thumb in the past 10 years at least. Diuretics and antibiotics coupled with digoxin have produced a great increase in the survival rate of the elderly, so easily predictable. The answer is seriously to reconsider the long-term effects of community care in the light of the modern view that one's elderly family are anybody's responsibility but the immediate relatives concerned. Short-stay reception stations similar to the Army C.R.S. could well be the answer, with 20-30 bedded, largish, old mansion-type accommodation. One trained nurse and several sensible voluntary and/or paid ancillaries could easily cope with most urgent situations, which could then be evaluated by the appropriate service involved.

A very simple test of ability to cope can be based on the simple chore of asking the patient to make a cup of tea. This will reveal much more than a stream of confusing memory tests such as the name of the Prime Minister, etc. It very soon becomes evident in many cases that the immediate necessities of life are beyond the patient's capacity, even if only on a temporary basis, and a reception station would be the answer.