examination of the facts. The article on abortion is merely a statement of view from one man and his rather brusque dismissal of any alternative view will rightly offend many caring medical professionals and non-medical people.

It is an excellent article but would have been much better placed in the personal view column of the journal. Publishing this sort of essay as an editorial devalues the other editorials.

G M MACKENZIE

The Medical Centre,
Carlisle CA1 1DG

1 Paintin D. Abortion in the first trimester. *BMJ* 1992;**305**:967-8. (24 October.)

EDITOR,—You request responses to David Paintin's article on a woman's right to choose abortion in the first trimester.[1]

I number myself among those who maintain that "abortion is always wrong because it results in the destruction of a fetus" and who are "simplifying a complex subject." Abortion is undeniably a difficult problem, and those who advocate abortion on demand could also be said to be simplifying a complex subject. The late Francis A Schaeffer wrote, "Abortion does not end all the problems; often it just exchanges one set for another."[2] Whatever the result of a pregnancy, the fact that the woman had conceived and was carrying a child cannot be changed. I have personal experience of women, both married and single, who suffer acute distress after an induced abortion; this distress is exacerbated at the time the child would have been born and on the anniversary of the child's abortion. These women are aware that they have allowed the destruction of their child and will bear that burden all their lives.

Paintin rightly highlights the fact of the decline in marriage, but seems to think we should "maximise the advantages rather than deplore change." Can anyone explain the advantages of the decline in marriage?

The human race is created by God, who has issued a clear "rule book" for behaviour—the Scriptures of the Old and New Testaments of the Bible. The serious problems now faced over morals and ethics in general, and over abortion in particular, result from mankind ignoring God's absolutes in favour of arbitrary rules governed by expediency and self interest. God clearly lays down, among other things, His pattern for family life. This is based on sexual continence before marriage (I Corinthians vi, 18: Flee fornication. Every sin that a man commits are outside his body; but he who commits fornication sins against his own body); sexual faithfulness within marriage of man and woman (Exodus xx, 14: You shall not commit adultery); and the exclusiveness of the marriage relationship (Matthew xix, 5: For this cause shall a man leave father and mother, and be united to his wife: and the two will become one flesh). God also forbids the taking of human life (Exodus xx, 13: You shall not kill); and in many parts of Scripture (Jeremiah i, 5 and Isaiah xliv, 2, for example) it is clear that unborn human life is afforded the same status as "born" life. (These references are but examples of many such clear statements in the Bible.)

The fact that mankind has largely departed from the fear and worship of God does not set aside God's commands for our life. These commands are not to restrict us or make us miserable and frustrated but to give us the freedom that comes from the security of acting within the will of our Creator, who devised every rule for our benefit.

There are organisations, both Christian and otherwise, which exist to give advice and practical support to women with an unwanted pregnancy: CARE, Life, etc. They will also help to arrange for the adoption of the child if that appears the best course of action. I know from my experience as medical adviser to an adoption panel that there are many childless marriages where a loving home is offered to babies and older children who cannot be reared by their birth parents. Childlessness is made all the more painful by the knowledge that "unwanted" children are being deliberately destroyed. It is hard to give up a child for adoption, but I suggest that it is harder to live with giving up a child to death. I realise that I am using emotive language, but nothing is lost by facing the reality of an action in plain words.

E R M SAUNDERS

Machen,
Gwent NP1 8RF

1 Paintin D. Abortion in the first trimester. *BMJ* 1992;**305**:967-8. (24 October.)
2 Copp CE, Schaeffer FA. *Whatever happened to the human race?* New York: Crossway Books, 1983.

EDITOR,—I agree with David Paintin that "many decisions necessitate some compromise between conflicting moral principles" and also that "actions are ethical only if all relevant factors have been considered,"[1] but does his article not go on to ignore many relevant factors? Is it not therefore less than fully ethical?

As always when dealing with a pregnant woman, the doctor discussing abortion has two patients—the woman and the fetus. Paintin dismisses discussion of fetal rights in "People who maintain that abortion is always wrong because it results in the destruction of a fetus are simplifying a complex subject." There is no mention at all of the word father. The "partner" (not necessarily the same person) is mentioned only twice. Does the father have no say?

The gradual disappearance of the traditional family unit based on a stable marriage—agreed to be the cause of the increase in numbers of abortions—is not questioned. Many doctors would be concerned about wider health implications here. And could abortion have an effect on children already born or to be born? The editorial comment on this leading article notes correctly that "consumer choice has been accorded almost sacred status of late." I suggest that there are other principles which are genuinely "sacred" and that society and the profession must ask themselves of this particular proposed "consumer choice," is the customer always right?

ANDREW FERGUSSON

Christian Medical Fellowship,
London SE1 8XN

1 Paintin D. Abortion in the first trimester. *BMJ* 1992;**305**:967-8. (24 October.)

EDITOR,—David Paintin rightly places the increasing number of abortions in the context of the changing sexual behaviour and the poor provision of sex education.[1] He grants rights to the mother but does not address the issue of the fetus. Is the fetus a person? Does a person have rights only if he or she is able to demand them? If we cannot prove that the fetus is or is not a person are we at liberty to destroy it? These complex metaphysical questions are central to the issue of whether a woman has a right to an abortion in any circumstances.[2] They require answers even if some of those who raise them can be suspected of being sexually repressive.

I hope the profession will abandon polemics and face the painful complexity of the ethics of allowing abortion on demand.

P H JONES

London SW8 1DJ

1 Paintin D. Abortion in the first trimester. *BMJ* 1992;**305**:967-8. (24 October.)
2 O'Donovan O. *Begotten or made?* Oxford: Oxford University Press, 1984.

Propofol infusion in children

EDITOR,—We wish to reply to S Cook's letter[1] referring to our paper on propofol infusions in children.[2] Cook says that the baby in case 4 received a propofol infusion for 64 hours and not the 74 hours stated in our paper. Cook also says that she died almost three days after the infusion was stopped. Later he states that these inaccuracies lead him to wonder if there are similar inaccuracies in the other case reports. We have reviewed the notes on case 4, including the propofol infusion chart. This baby received a propofol infusion over 74·5 hours, although this included a gap of almost an hour when no propofol was infused. The interval between the infusion being stopped and the baby being certified dead was 38 hours.

We agree that the raised core temperature and peripheral vasoconstriction would have contributed to the metabolic acidosis in case 5. These high core temperatures, however, occurred for only 10 hours before death. A base deficit of 9·5 mmol/l had been seen about three days before, some 20 hours after the propofol was started, when the highest recorded core temperature had been 38·5°C and the blood urea concentration 3·6 mmol/l and the creatinine concentration 76 μmol/l.

Acute deterioration, with an abrupt fall in heart rate, did take place at about the time of the first intravenous dose of ceftazidime, and the two may have been related. All the other case reports, however, described similar events and none of those children received ceftazidime.

The question of whether to report possible adverse drug reactions in the medical press before they are fully investigated and understood is difficult. Evidence suggests that use of propofol to sedate children in intensive care units is becoming widespread: it was used in 14 of 15 paediatric intensive care units polled in the United Kingdom.[3] If the events that we describe are related to propofol more deaths would probably occur during the time needed to carry out a definitive investigation. In our view the correct course was to publish these cases and to suggest that widespread use of high dose propofol to sedate children should be stopped pending further investigation—a view with which the manufacturers seem to agree.

R J BRAY
P J SMITH

Royal Victoria Infirmary,
Newcastle upon Tyne NE1 4LP

1 Cook S. Propofol infusions in children. *BMJ* 1992;**305**:952. (17 October.)
2 Parke TJ, Stevens JE, Rice ASC, Greenaway CL, Bray RJ, Smith PJ, *et al.* Metabolic acidosis and fatal myocardial failure after propofol infusions in children: five case reports. *BMJ* 1992;**305**:613-6. (12 September.)
3 Matthews AJ. Sedation, muscle relaxation, and analgesia in PICU. *Care of the Critically Ill* 1991;**8**:34.

EDITOR,—S Cook fears the time when "we must practise medicine in a transatlantic manner, with use of agents being controlled by fear of litigation and not by scientific investigation."[1] Scientific investigation into the use of propofol infusions has so far shown that even induction doses of propofol are associated with appreciable adrenocortical depression.[2-4] In 1983 another drug, etomidate, was used to sedate patients in intensive therapy units, also without a product licence, and was found to be associated with increased mortality, due possibly to adrenocortical suppression.[5,6] This association remains controversial and inconclusive, but etomidate is no longer given by infusion in these patients.[7]

Cook reports having looked at "several" children and finding no evidence of a direct effect of propofol or its vehicle on any aspect of metabolism in these patients. This seems to be at odds with the work of O'Flaherty *et al.*[2,3]

Why all the fuss? There are other drugs available