Correspondence

Letters to the Editor should not exceed 500 words.

Abortion Law Reform

SIR,—After reading the memorandum on legalized abortion by the council of the Royal College of Obstetricians and Gynaecologists (2 April, p. 850) and also the points put by Lord Brain (19 March, p. 727) and the answer to these by Professor Philip Rhodes, I would like to endorse wholeheartedly the letter which was written by the latter (2 April, p. 859). Without wishing to appear pompous, as a senior obstetrician who has been in charge of an obstetrical service in a large provincial district for 20 years, I think that to bring in legalized abortion would be a terrible mistake.

It has been our policy to carry out an abortion where necessary on any case deserving it for therapeutic, social economic, or moral reasons, and to consider the question of sterilization with sympathy whenever requested. We have always consulted the general practitioner and had an opinion from the appropriate specialist in the case that is being considered. This ensures that there is no secrecy and that the person who carries out the abortion to a certain extent has some cover, and should there be a prosecution is unlikely, under these circumstances, to go to gaol.

There is no secrecy about the procedure. The patient is taken into the maternity hospital, is under specialist supervision, and in a public ward. The introduction of legalization would immediately produce delays, form-filling, and consequent publicity, and in my opinion would be a retrograde step. I feel that some trust must be put in the probity of the medical profession, and in this case the obstetricians and gynaecologists. There are black sheep in every walk of life, and it is rare that ultimately these do not get their deserts. I am also afraid that should abortion be brought under the control of the law the number of criminal abortions would increase. This was recently discussed in open forum in a meeting of the Edinburgh Medical Chirurgical and the Obstetrical Societies, and this point was put forward very strongly.

Personally, I would object strongly to notifying some Government department about every therapeutic abortion as I would object, in the same way, to notifying the lay administrators in the hospital regarding every case upon whom I operated. Professor Rhodes, so far as I am concerned, speaks for all classes of consultant—the professorial full-time teachers, the full-time consultants in clinical charge, and those who earn a living in private practice as well as hospital work. It must be remembered that the three groups all deal with a different grade of patient. It is very difficult to crystallize all points of view, but I must congratulate him on putting the case so clearly when breathing the rarefied air of a city/professorial unit in comparison to that breathed by us in the provinces.—I am, etc.,

RICHARD DE SOLDENHOFF.
Ayrshire Central Hospital,
Irvine.

SIR,—I am sorry that Dr. K. S. Jones (23 April, p. 1050) found some of my words potentially offensive. They were not intended to be so, and I agree with him that relations between gynaecologists and psychiatrists should be good, so that patients who need them both shall not suffer. The sentence to which Dr. Jones refers came at the end of a long letter and too clumsily compressed an idea which requires amplification.

I think that all would agree that it would be better if the operation of termination of pregnancy were made unnecessary. Theoretically this would be possible if psychiatric disorder were prevented, or conception prevented, or if the emotionally distressed woman became pregnant that she could obtain such swift social and psychiatric help that the pregnancy became tolerable. If gynaecologists refused to terminate pregnancies then it is probable that the outcry would be such that the social and psychiatric solutions to the problem would be pursued with even greater vigour than they are at present. I am not for one moment suggesting that gynaecologists should so refuse, nor am I accusing psychiatrists and social welfare workers of dragging their feet. In all the debate about abortion we may be in danger of losing sight of the fact that there are other solutions than termination of pregnancy in the psychiatrically ill pregnant woman. The facilities at the command of social welfare agencies and psychiatrists are usually not enough to pursue the alternatives to abortion, and I wish they were. To improve the facilities requires action by the whole of society, but the psychiatrists and social welfare workers must direct that action. This is what I meant by saying that these two groups should take up their full responsibilities. It was an unfortunate phrase, but these groups are mainly the ones in whose hands lie the alternatives to therapeutic abortion. As their expertise increases so the burden on the gynaecologist may be expected to lessen. I would wish them every success, but until they can achieve it I expect to retain my cordial relations with them.—I am, etc.,

PHILIP RHODES.
St. Thomas's Hospital Medical School,
London S.E.1.

SIR,—I would like to draw attention to two fallacious contentions made by and on behalf of gynaecologists in recent correspondence.

The first is that only gynaecologists can perform abortions, and the second that gynaecologists are the only people in a position to judge the issue in a particular case.

In the first place it is an exaggeration to suggest that to perform a dilatation and curettage for an early pregnancy requires nothing less than a consultant gynaecologist. Many general surgeons and indeed registrars or house-surgeons could cope with this sort of abortion if they wished and if the need arose—for instance, if gynaecologists wished to be relieved of performing operations which they found distasteful; and it would not be impossible to train others less skilled to do this work. Furthermore, the search for simpler methods of terminating early pregnancies may provide ways which will not need even this amount of skill. The vacuum aspirator, for example, is now being tried out in Britain.

The suggestion that gynaecologists should, or are best placed to, judge the merits of the case would be barely tenable even if they alone were competent to terminate pregnancies. It is seldom that in fact the issue is one of gynaecological consideration, and it is more usually a socio-medical issue or a predominantly psychological one. The key figure who is most likely to know about the woman and able to see the significance of a pregnancy as it affects her and her family is the general practitioner. He will also have to cope with the outcome. Whatever this may be he will have to deal with the consequences for better or worse for many years to come. If the issue is that of the woman's mental health this may well need the expert advice and possibly prolonged help of a psychiatrist.

Gynaecologists should no longer feel that it is their responsibility to give an expert opinion on matters which fall outside their own field.

It would be a pity if changes in the law insisted that abortions should be performed only by gynaecologists, for this might at times saddle gynaecologists with judging issues in realms beyond the normal scope of gynaecology or with the obligation to perform operations at the behest of other experts but against their own conviction.—I am, etc.,

Woodford Green, Essex.
S. F. HEWETSON.

SIR,—The admirable report by the Council of the Royal College (2 April, p. 850) presumes knowledge of the present law, but since Lord Silkin's Bill itself misstates the present law some clarification is needed.

Lord Silkin's Bill contains a passage:

> "3. In a prosecution under Section 58 of the Offences against the Person Act, 1861 (which makes it a felony to administer drugs or use instruments to procure an abortion . . ."

Canon Rumsey's committee in its revised draft of the Bill[1] retains this passage intact. It is merely rephrased from Dr. Glanville

Williams's draft for the Abortion Law Reform Association.[2]

Sections 58 and 59 of the Act are conveniently quoted by Mrs. Jenkins.[2] The word "unlawfully" occurs six times, and became the main issue in *R. v. Bourne*, 1938, which established that abortion can be lawful and unlawful, only the latter being felonious.[3]

That the Act is capable of being misinterpreted by jurists of the eminence of Rupert Cross (in a broadcast talk) is sufficient reason for restating the law, but only increases the need to restate the law accurately.

A myth has been created that every time a surgeon performs an abortion the police turn a blind eye, much as they are expected to if he has left his car in the wrong place during the operation. It ought to be understood, once and for all, that abortion is an operation like any other operation: the law can neither compel a surgeon to perform it nor, provided his position is ethical, punish him for performing it. What needs changing is not the law but the myth.—I am, etc.,

ROBERT J. HETHERINGTON.
Birmingham 18.

REFERENCES

[1] *Abortion: An Ethical Discussion*, 1965. Church Information Office, London.
[2] Jenkins, A., *Law for the Rich*, 1960. London.
[3] Rex *v.* Bourne [1938] 3 All E.R. 615.

SIR,—With regard to the subject of legalized abortion, there are two aspects for decision: (*a*) what are the indications? and (*b*) under what circumstances and with what method is the operation reasonably safe?

The indications may well be considered as social as well as medical. The operation is obviously medical, and here I would cross swords with the Council of the Royal College of Obstetricians and Gynaecologists (2 April, p. 850).

They claim it is difficult to reconcile the low mortality rates in eastern Europe with the experience in northern Europe and in Britain. Three paragraphs lower ". . . it has been said that newer techniques . . . (including) the employment of suction apparatus are less hazardous (than orthodox methods in this country) . . . this is not true."

I have used the suction curette for over a year now and on over fifty cases, with no untoward effects whatsoever and a minimum of both blood loss and operating time. I hope to publish these results in another journal in more detail shortly.

It is quite ridiculous that constant emphasis should be placed on the dangerous and outdated methods of surgery and that newer methods be criticized with, I am sure, ignorance.—I am, etc.,

Newcastle-upon-Tyne. D. M. KERSLAKE.

Biological Units and Anti-Rh Sera

SIR,—We are grateful to Dr. Bruce Chown for drawing attention (2 April, p. 862) to a point in our letter (26 February, p. 540), since this reply enables us to emphasize the essential similarity of the use of the unit notation for blood-group antibodies to other instances where biological units are used.

We stressed the need to estimate potency of incomplete anti-D (Rh_0) sera in terms of international units by comparative laboratory assay in terms of the recently established international standard for Rh antibody anti-D (anti-Rh_0). We submit that this is at present the only practicable way to make specification of potency (and thus dosage) of these Rh antibodies reliably quantitative. To Dr. Chown, however, it seems "a serious fallacy" to use this means of specification for an anti-serum employed to prevent Rh sensitization, on the grounds that "potency" can only be measured in the patient.

Our case rests on the premise that the laboratory assay measures the same active substance (in this case antibody) which causes the intended effect in man. This premise is common to all instances where biological activity is determined by laboratory assay and where "potency" is traditionally expressed in biological units. Although some laboratory methods estimate the activity in man more specifically than others, until it is tested no laboratory substrate can ever be assumed fully to represent man. There is indeed always a need to relate potency estimated in the laboratory to activity in man.

It is easier to study this relation for some substances than for others. Where it is particularly difficult, as might be with anti-Rh sera, it is reasonable and usual to make an interim working hypothesis that a selected *in vitro* test (in this case classical haemagglutination) does reflect activity in man (one example of which is the ability of the antiserum to prevent sensitization of the mother).

Clearly sera must be assayed in terms of a standard of the appropriate antigenic specificity, and work has been in progress for several years collecting and selecting sera for standards for at least the commoner important Rh specific groups. It is not yet clear which particular type(s) of antibody (IgM, IgG, IgA, IgD) for each group specificity is/are responsible for protective ability in the patient; nor what is the influence of the different binding power of different antibodies on to red cells. Answers to these questions may shed some light on the relationship of *in vitro* tests with *in vivo* function, and may lead to improvements in assay methods.

Quantitation of dosage of sera for the prevention of haemolytic disease is but one application of the estimation of anti-Rh antibodies. The international unit provides the yardstick for laboratory assays, including those which are at present universally used and on whose results important clinical decisions are made. It is the prerogative of the clinician to determine and decide how many units of an antiserum constitute a suitable dose for a particular purpose, disease, or patient.—We are, etc.,

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D. R. BANGHAM.
International Laboratory for Biological Standards, London N.W.7.

Late Post-traumatic Headache

SIR,—I was sorry to see in your otherwise well-informed leading article on post-traumatic headache (23 April, p. 995) that "manipulation should be avoided." This is true, of course, if the cause is neurosis or when injury has uncovered a latent tendency to migraine, but does not apply to the upper cervical-occipito-frontal headache that may follow concussion, especially in middle-aged people. Though it is true that forcing the cervical joints under anaesthesia often makes the pain worse—and to that extent manipulation *is* contraindicated—the reverse applies to manipulation using the techniques of orthopaedic medicine which is often immediately and lastingly successful. Manipulation, like any other measure, must not be condemned by study of the results of manipulating the wrong way.—I am, etc.,

London W.1. JAMES CYRIAX.

SIR,—It seems remarkable that sportsmen and athletes very rarely suffer from late post-traumatic headache. Boxers who are knocked out by the "chin knock-out"—a single blow to the jaw—generally rouse by the count of seven and are able to get up themselves at the count of ten and can walk to their corners unaided. They do not complain of headache, nausea, or vertigo. There are no late symptoms, and they are anxious to get back to boxing, although they are obliged to stay off boxing for at least four weeks. Those who go down as a result of several blows to the head may complain of headache, nausea, and vertigo, and the headache may persist for several days. After that time they are quite symptom-free.

On the rugger and soccer fields players are frequently concussed and after the application of a cold sponge are able to continue playing. (They are not given a compulsory period off playing as in boxing!) The footballers also very rarely have any post-concussional or post-traumatic headache, nausea, or vertigo.

Probably the absence of the profit motive in sport results in a rapid recovery to the *status quo*.—I am, etc.,

London W.1. J. L. BLONSTEIN.

Treatment of Claudication

SIR,—The writer of your leading article on treatment of claudication (16 April, p. 931) states ". . . the lower popliteal artery, which for some reason is frequently less affected by arteriosclerosis." Recent work[1] sheds some light on the reasons for this finding.

About 70% of femoro-popliteal occlusions originate at the adductor region, and distal extension of the occlusion is usually limited by one of the larger popliteal branches, sural or genicular. The popliteal artery beyond the occlusion is protected by the lower distal arterial pressure, and atherosclerotic changes do not progress at the same rate as formerly. This situation is analogous to the relatively healthy state of the femoro-popliteal segment in patients with aortic occlusion.

Atherosclerosis of the distal popliteal artery, however, is sometimes severe. Occlusion may originate in the popliteal artery above the level of the knee-joint or at the popliteal bifurcation, leading to occlusion of the popliteal artery from the bifurcation to the level of the descending genicular artery. These cases of total popliteal occlusion have no distal patent segment to which a vein graft can be attached, and amputation is the usual sequel in older patients.

Mavor[2] stated that the popliteal artery below the level of the knee-joint was usually healthy and free of branches, but did