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Correspondence

Letters to the Editor should not exceed 500 words.

G.M.C. and Abortion Act, 1967

SIR,—The shift in emphasis in the General Medical Council's recent review of the paragraph referring to abortion (20 April, p. 185) raises important questions. Before revision, a breach of the law of this land was not the sole consideration, for a doctor "who improperly procures . . . abortion or miscarriage overseas" could be charged with infamous conduct. Now it is "a serious matter . . . if done in circumstances which contravene the law." A charge will require a criminal conviction.

It is difficult for the ordinary doctor like myself to understand the role of the G.M.C. as regards medical ethics. Its change in attitude over abortion would suggest that the law of the land takes precedence over medical ethics, for the present law permits abortion for non-medical reasons. Does this mean that the G.M.C. will maintain only those medical ethics which do not conflict with the law, and that laws permitting euthanasia and sterilization of the unfit would receive similar sanction?

There is surely a conflict here not only between the G.M.C. and individual doctors but between the G.M.C. and those medical ethics which have international recognition.

If the G.M.C. abrogated its responsibility for the preservation of medical ethics the medical profession would be in a position to organize itself to ensure that proper standards were maintained. At present the body which has the statutory power has opted, in the face of declared opposition by the British Medical Association and the Royal College of Obstetricians and Gynaecologists, for Government control of these standards. With less grave issues the G.M.C.'s attitude would cause serious concern; under present circumstances it could spell disaster.—I am, etc.,

Edgbaston, Birmingham. MYRE SIM.

Abortion Regulations

SIR,—In the first draft (1966) of the Abortion Bill, Section 1(1) provided that termination would be lawful if "(*a*) the continuance of the pregnancy would involve *serious* risk to the life or *grave* injury to the health whether physical or mental of the pregnant woman whether before at or after the birth of the child."

This was amended in committee by removing the words "serious" and "grave," and adding "risk . . . to the future well-being of herself and/or the child or her other children" to the grounds for termination.

The newly issued *Abortion Regulations, 1968*,[1] make clear the full implications of these changes, since the two registered medical practitioners, before treatment for termination is commenced, are now required only to certify that they "are of the opinion, formed in good faith, that . . . the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated."

Since the almost nonexistent risk to the life of a healthy woman in an abortion properly performed early on in pregnancy is indeed likely to be less than the present very low, but not wholly negligible, risk in normal childbirth, it is hard to see how any doctor could justify a refusal to give such a certificate. Whatever Parliament may have intended, this is in effect abortion on demand, subject only to a doctor's right to refuse to participate if he can prove a genuine conscientious objection.—I am, etc.,

C. B. GOODHART.

Gonville and Caius College, Cambridge.

REFERENCE

[1] *Abortion Regulations* (Statutory Instrument 1968), No. 390. H.M.S.O.

Risks of Abortion

SIR,—The Abortion Law is here, and argument and discussion on the subject will certainly continue for many months to come.

The actual operation may lawfully be performed by doctors without specialized knowledge of the female pelvic organs, yet hardly a word has been writtten about the risks and dangers of the procedure to the mother. No one is suggesting that termination of pregnancy is a major operation, but neither should it be regarded as a "simple D. and C." For example, anaesthetists readily appreciate that there are distinct problems associated with a pregnant patient. The surgeon may produce damage to the cervix during dilatation, with subsequent long-term ill effects. Severe haemorrhage will occasionally occur regardless of the operator's skill. It is not difficult to perforate the wall of the pregnant uterus.

There are other considerations to be faced by the abortionist. Is the pregnancy too far advanced for vaginal termination via the cervical canal to be either safe or feasible? Has the uterus been completely emptied, or, conversely, has the uterine cavity been so enthusiastically curetted that permanent loss of the endometrium results? Is it logical in the majority of patients to terminate a pregnancy without performing sterilization?

This letter is not written by an alarmist. It just seems that much that has been published recently on the subject of lawful abortion has emanated from the philosophical armchair rather than from the practical operating-theatre stool.—I am, etc.,

Leamington Spa, Warwicks. JOHN FRAMPTON.

Familial Mediterranean Fever

SIR,—Several points in your leading article (23 March, p. 724) invite comment. Except for the frequency of heritable amyloidosis, familial Mediterranean fever in Sephardic Israeli patients is no different clinically or pathologically from periodic peritonitis[1] as occurs in persons of other religious or ethnic origin.[2] The limiting geographic adjective is