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Correspondence

Letters to the Editor should not exceed 500 words.

Powers of the G.M.C.

SIR,—Although I have the honour to represent my university on the General Medical Council, I am not serving on the Disciplinary Committee, which would seem to be the immediate object of the criticism expressed by Dr. H. Matthew (12 April, p. 114). I therefore feel free to comment, as a private individual, on an important matter of principle arising from his letter.

It is a condition of democratic freedom that the legislature, the executive, and the judiciary should each be independent of the others; the confounding of these three functions of the State was the basis of Burke's indictment of the French Revolution. To come to the specific case (the exorbitant prescription of drugs of addiction), although the G.M.C. has the obvious executive power of removing names from its own *Register*, its function is surely primarily judicial. There would be great dangers if the G.M.C. was made responsible for initiating what are essentially criminal investigations into conduct which it would later be called on to assess judicially. To be trite, justice must be seen to be done, and no man should be judge in a cause which he has initiated.

From the very highest motives, Dr. Matthew seems to me to be advocating, or at least supporting, a form of direct action against which the individual has no appeal. Even if a man has deserved to forfeit his rights, it remains our duty to observe them. The dangers of freedom are great, but they are less than the dangers of tyranny; and in spite of its obvious emotional appeal it is to tyranny, whether red or black, that direct action, perhaps by devious paths, ultimately leads.—I am, etc.,

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Perfusion and the "Artificial Heart"

SIR,—There seems no doubt that much misinformed and unjustified criticism has been directed at Drs. Denton Cooley and Salvatore Liotta after their insertion of an "artificial heart" into a patient at Houston. In particular, some have sought to criticize them on the grounds that this particular means of trying to save a patient's life was not backed up by adequate animal experimentation.

It is difficult to justify this point of view on logical grounds, since for many years human open heart perfusions have utilized heart–lung machines in which the damaging blood interface surface is of the order of 800–900 sq. in. (5,000–5,800 sq. cm.). Most cardiac surgeons outside Houston would accept a perfusion time for some routine open heart procedures of two and a half to three hours and many would be prepared to extend this period by another hour. From the published photographs of the implanted device it seems pretty certain that the blood interface surface area was about 50–60 sq. in. (320–380 sq. cm.). It was therefore perfectly justified to anticipate a perfusion time in excess of 48 hours, and not at all surprising that this was comfortably achieved. It is to be hoped that the significance of the Houston experience in this respect will not be lost among all the criticism of the surgeons involved.

Those of us concerned to develop and improve perfusion apparatus should probably be aiming as a simple first step to at least a ten- or twelvefold reduction in the blood interface area if perfusion times are to be prolonged in an important way.—I am, etc.,

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Supratentorial Intracranial Abscess

SIR,—Mr. J. Garfield's paper on supratentorial intracranial abscess (5 April, p. 7) is important in drawing attention to the continuing high mortality of this condition, but it is not quite as helpful in suggesting solutions to this problem as it might be. Mr. D. W. C. Northfield (19 April, p. 184) has already added some constructive comments, but the original paper could still be misleading unless certain aspects of this problem are clearly understood.

Stress is rightly laid on the importance of localization as the first step in successful management. But comparisons are made between different investigative methods without even mentioning focal neurological signs as a localizing feature; dysphasia and homonymous hemianopia are sensitive signs of temporal lobe abscess, while focal epilepsy frequently indicates the site of subdural pus. To delay drainage in such cases for 24 or 48 hours to await brain scanning, as is suggested, would seem quite unjustified.

Angiography is held to blame for some deaths, but from the cases described in detail this would hardly seem justified. That some abscesses which angiography failed to localize were *subsequently* accurately localized on the basis of E.N.T. sepsis suggests a curious priority of investigation. To fail to make immediate burr holes in a patient developing severe hemiparesis soon after mastoidectomy, and in whom angiography showed shift of both anterior cerebral artery and deep veins, seems strange (Case 3); the patient's subsequent death from undrained subdural abscess can hardly be blamed on the angiogram's failing to indicate this precise diagnosis. Indeed, after reading this account the reader is forced to wonder if the increase in the mortality from subdural abscess from 28% to 55% in the second 100 cases might be related to a reluctance to perform emergency exploratory burr holes now that other more sophisticated methods of investigation are available. Most surgeons recognize subdural