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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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Cardiac transplantation in severely ill patients

SIR,—Heart transplantation is one of the success stories of modern surgery. I have commented that the five year survival rate reported in the early 1980s was considerably better than that obtained by surgery for many kinds of cancer.[1] The investigation by health economists of the two British centres at that time reported that, taking account of both duration and quality of survival, heart transplantation was more cost effective than many procedures commonly carried out without hesitation.[2]

It is most unfortunate that this study, funded by the Department of Health and Social Security, was never published in a general journal—because it testified to the value both of heart transplantation and of economic appraisal. The reward for the surgeons who had the courage and confidence to allow their practices to be scrutinised by outsiders was that additional resources were made available for heart transplantation soon after the report was received by the department.

It appears from the recent paper from Harefield (19 March, p 817) that the selection criteria for transplantation have now been broadened to include patients with overwhelming cardiac failure, with or without multisystem dysfunction. Of 33 such patients, six died waiting for transplantation after an average of 34 days' intensive treatment; another five died within 24 hours of surgery and another one 10 days later (length of preoperative intensive care for these patients not stated). No fewer than eight different figures are given for success, mortality, and survival, leaving the average reader uncertain about how good the results really were. None the less, the authors claim that "the excellent results justify the expenditure and staffing requirements necessary to treat these terminally ill patients." No costs are given and no mention even made of the previous economic appraisal of heart transplantation in this unit.

Some technologies become more cost effective as experience is gained. When, however, the selection criteria that led to early successes are later relaxed the opposite can happen. The original claim to cost effectiveness may not apply to the additional, differently selected, patients, who both incur greater costs and are less likely to benefit. The data in this paper are inadequate to judge whether that is the case for the new constituency of patients now being considered for heart transplantation.

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1 Jennett B. *High Technology medicine; benefits and burdens.* Oxford: Oxford University Press, 1986.
2 Buxton M, Acheson R, Caine N, *et al. Costs and benefits of the heart transplant programmes and Harefield and Papworth Hospitals.* London: HMSO, 1985. (DHSS Research Report No 12.)

Late abortions

SIR,—We write on the anniversary of the implementation of David Steel's Abortion Act, which legalised abortion under certain conditions. Since then over three million women in Britain and Europe have had operations which have become progressively safer over the years. In 1985 the *BMJ* published an article about the need for late terminations of pregnancy for reasons other than fetal abnormality, which was based on experience in Tower Hamlets.[1]

We looked at the women who had been seen in 1987 to assess the effect of a change in the law to prevent abortions after the beginning of the 18th week of pregnancy. In practice this would prevent abortions after 16 weeks as doctors operate to a limit at least two weeks below the legal one.

We examined the records of 32 of the 37 women who underwent abortions after 16 weeks in 1987. They included seven women with fetal abnormalities, who had operations that would still be permitted under clause 2 of the proposed new law (which makes exceptions for the life of the mother, the likelihood of severe fetal handicap, and rape or incest under the age of 18). The 30 other women had operations for social reasons. These are often referred to in terms of "holidays in Spain," "beauty competitions," and "tennis matches," but in our experience the reality of these social problems is very different.

Our patients included a 26 year old single Somali woman with two children, living on social security, who spoke little English. Her two children were on the at risk register, the eldest was in hospital, which had delayed her from seeking advice, and she suffered from agrophobia. She had just discovered that her boyfriend was married. She was unsure of her dates but was clinically 16 weeks when first seen and 17 weeks when her abortion was performed. Another was a 13 year old girl who had been referred promptly by her general practitioner when she realised that she was pregnant at 21 weeks' gestation. Clinically she was a little smaller than this, and ultrasound suggested a 19 week fetus. She refused to name the father, but the