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Correspondence

Correspondents are asked to be brief.

Reviewing the Abortion Act

SIR,—The recent announcement[1] by the Secretary of State for Social Services that he is considering whether to set up a review of the Abortion Act emphasizes the importance of the report by the council of the Royal College of Obstetricians and Gynaecologists (30 May, p. 529). It is to be hoped that a wide range of doctors will participate in the discussion of the report during these next few weeks. The contributions of survey experts would also be helpful—though I suspect they might draw different conclusions from the council of the College about the finding that no less than 30% of the consultant gynaecologists who returned questionnaires thought that the present Act should not be restricted and a further 9% did not answer the relevant question (this was in addition to the one in five who did not return their questionnaires). If a review is subsequently set up, thorough discussion by the profession at the present time will maximize the chances of a balanced review.

It is possible that the council has information about the morbidity and mortality associated with abortions for different groups of patients and for the different procedures for carrying out terminations, and if so it would be helpful if this could be published. As the report points out, information about the outcome of women refused abortions would also be valuable. At first sight it is puzzling that the council suggests that terminations cause only extra work until one remembers that the decrease in work, in terms of prenatal care and deliveries, occurs in obstetrics rather than gynaecology. It would be helpful if the council could comment on the best ways of re-organizing work loads. It is possible that the reduction in the work of obstetric departments has not been as widely felt as it might have been because a quite separate change is taking place concurrently—namely, the increasing hospitalization of childbirth.

Two aspects of the report give cause for disquiet. The first is that the council continues to assert categorically that abortion on social grounds alone is unethical. This widely circulated and authoritative statement appears to be saying that at least 30% of gynaecologists and many general practitioners, paediatricians, and other doctors are socially irresponsible. Is it wise for the council of a royal college to condemn those who have special experience of, and concern about, the problems of the unwanted child and who judge the situation differently? Does this not devalue professional ethics and raise some thorny problems for the Central Ethical Committee and the medical defence organizations?

The second cause for disquiet is that those who supported abortion law reform, unhappily described in the report as "ardent pro-abortionists," are said to be "beginning to express the view that prevention of an unwanted pregnancy is better than its removal." As a former member of the executive committee of the Abortion Law Reform Association I strongly resent the word "beginning" and can produce a wealth of evidence to show that it is untrue. Many supporters of the present law have worked for years to improve family planning services and to encourage responsible parenthood.

I would appeal to the profession to acknowledge the existence of differences of moral judgement on this complex issue, and I would further urge that the wider aspects of abortion, including the present uncertainties about oral contraception, are given full weight in our discussions.—I am, etc.,

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REFERENCE

1 *Hansard*, 13 July 1970.

Epidemiology and Pathogenesis of Influenza

SIR,—We must all welcome the latest of the excellent investigations of respiratory infection in general practice by the enterprising Dr. R. E. Hope-Simpson (11 July, p. 74). These studies are particularly appropriate not only because of the massive contribution of respiratory infections to the work of general practitioners, but also because the epidemiology of these infections cannot be fully elucidated by studies limited to the selected minority of severer illnesses reaching hospital. Indeed, some remaining paradoxes may not be resolved until we can explore more effectively the numerous minor illnesses and silent infections which do not come to the attention even of general practitioners, but which may nevertheless be epidemiologically significant.

Dr. Hope-Simpson comments pertinently on the anomalous age-distribution of the epidemic "febrile respiratory disease" which was equated with Hong Kong influenza. I am particularly interested in the lack of serious impact of influenza on infants and young children to which attention has been drawn elsewhere,[1 2] and which is illustrated by the absence of increased morbidity under the age of 10 in Dr. Hope-Simpson's study. I have recently speculated that the low clinical attack rate of influenza in very young children may reflect the minimal response of unsensitized individuals.[2]

By analogy with respiratory syncytial virus, it is conceivable that in most cases an individual's first encounter with influenza virus may cause trivial illness. This single infective episode, normally in early childhood, may not result in solid immunity to a second encounter with the same virus a few years later. This second infection, however, occurs in a host sensitized by the initial experience so that the illness-response is likely to be modified and increased, and the immunological "boost" of this second antigenic stimulus is likely to produce good immunity