BRITISH MEDICAL JOURNAL

SATURDAY 12 OCTOBER 1974

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NO. 5936 BRITISH MEDICAL JOURNAL 1974 VOLUME 4 61-120 ASTM CODEN: BMJOAE 4 (5936) 61-120 (1974)
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR. SECOND CLASS POSTAGE PAID AT NEW YORK N.Y. WEEKLY 50p

CORRESPONDENCE

Correspondents are asked to be brief

Ethics and Halothane

SIR,—Dr. J. M. K. Spalding is wrong (21 September, p. 739). There is no evidence in your leading article (7 September, p. 589) to suggest that many well-informed and responsible doctors "believe in an association between repeated exposure to halothane and liver damage." What is made clear is that the Committee on Safety of Medicines was ill-informed and behaved precipitately by circulating a warning letter[1] on the dangers of halothane without waiting for the discussion of the scientific merits of the paper[2] on which the letter was based and that subsequently certain ethical committees behaved equally unwisely by interfering with the anaesthetists' right to decide what anaesthetic agent can or cannot be used in a specific clinical situation.

What is at issue is not whether halothane on rare occasions is associated with liver damage but whether the patient will come to less harm if halothane is not used and some other drug or technique is substituted. The evidence on this point is, to say the least, equivocal and Dr. Spalding's letter does anaesthetists a great disservice. In the present state of our knowledge the choice of an anaesthetic technique must be made by the anaesthetist concerned on the basis of his clinical experience, and the ill-judged letters from the Committee on Safety of Medicines and from Dr. Spalding have done nothing to make his task easier.

I cannot accept Dr. Spalding's assertion that members of ethical committees who followed the advice of your article would "find themselves joined with the anaesthetists in any action for negligence." Such an assertion could have serious repercussions for anaesthetists and other clinicians were it not for the fact that the Medical Research Council has expressed quite the contrary view:

"In the light of a review of existing data and of expert advice, the Council are agreed that these data are insufficient to enable a comparison to be made of the total risks from more than one exposure to halothane with those from the repeated use of other anaesthetics. The Council take the view that the question may best be resolved by undertaking a prospective survey of the incidence of liver disfunction and other effects following repeated exposures to halothane and to other anaesthetics."[3]

Thus anaesthetists and others who are concerned about the medicolegal implications of repeated exposure to halothane need not be too worried. They can be sure that in this connexion any decision based on their clinical judgement will have not only the backing of the great majority of their colleagues but also the moral support of the Medical Research Council.

From a broader aspect, the current controversy arose as a result of the distribution of the circular letter on the subject by the Committee on Safety of Medicines and Professor J. Parkhouse (28 September, p. 807) is surely right when he asks if it is a proper part of the Committee's function "to enter the arena of clinical judgement in the use of drugs." Many of us would like to see that question answered.—I am, etc.,

J. P. PAYNE

Research Department of Anaesthetics, Royal College of Surgeons of England, London W.C.2

1 Mansell-Jones, D., CSM/AR/S/121, 3 January, 1974.
2 Inman, W. H. W., and Mushin, W. W., *British Medical Journal*, 1974, **1**, 5.
3 *British Medical Journal*, 1974, **3**, 268.

Dangers of Oxytocin-induced Labour to Fetuses

SIR,—Like Mr. W. A. Liston and Mr. A. J. Campbell (7 September, p. 606) and Mr. G. V. P. Chamberlain (14 September, p. 684) we have been concerned with the possible undesirable side effects of drugs used to induce or stimulate labour. In two studies comparing oxytocin and prostaglandin E_2 (PGE_2) for the induction and augmentation of labour we fulfilled the criteria suggested by Mr. Chamberlain.

A group of consecutive patients in whom labour was to be induced or augmented were given one of the drugs (PGE_2) and these patients were then carefully matched according to age, parity, maturity, and Bishop's score or cervical dilatation with a group of patients given oxytocin. The obstetric management, apart from the stimulant drugs, was identical in the two groups. For intravenous therapy a constant-rate infusion pump was used, and all labours were continuously monitored by means of a presenting-part electrode and an intrauterine pressure catheter. A double-blind trial was not considered ethical.

In the induction series[1] there was no significant difference between the two groups in induction-to-delivery interval, Apgar scores at one and five minutes, or incidence of post-partum haemorrhage. However, resting uterine tone, frequency of uterine contractions, and incidence of incoordinate