800 hospital liaison committees internationally, of which 36 are in Britain; these committees assist in linking both patient and doctor with specialists prepared to manage the patient in harmony with the patient's conscience. We hope that doctors will use these contacts as we have no wish either to pressure or to be pressured. Cooperation is always better than confrontation.

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1 Dyer C. Court says doctors were right to treat Jehovah's Witness. *BMJ* 1992;**305**:272. (1 August.)
2 Lord Donaldson of Lymington re T. Page 2 of judgment released to press by Court of Appeal.
3 Mallette *v* Shulman *et al*, Supreme Court of Ontario. (1991) 2 Med L R 162.
4 Lord Justice Butler-Sloss re T. Page 1 of judgment released to press by Court of Appeal.

Laboratory animals and recognition

EDITOR,—Writing about coincidences and vivisection, N H Naqvi quotes his young questioner as arguing that "all medical labs should erect dogs' statues and pay due respect to the animals who lose their lives during experiments." I agree wholeheartedly that laboratory animals deserve recognition, and in Japan they get it. Near the Kiso River, where a research laboratory of a large pharmaceutical company discharges water so clean that fish and other aquatic life are abundant, stands a stone memorial to laboratory animals. Each year many people attend the celebration of a Buddhist rite in this beautiful garden setting.

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1 Naqvi NH. Coincidences. *BMJ* 1992;**305**:94. (11 July.)

Advance directive bill

EDITOR,—Alison Tonks's report on the advance directive bill makes a strong case, albeit unwittingly, for legislation to give advance directives legal status.[1] On the one hand, both the BMA's representative, Anne Sommerville, and Simmy Viinikka of the Terrence Higgins Trust seem confident that doctors follow patients' wishes as expressed in advance directives. On the other hand, Tony Hope argues the case for ignoring them, and I am sure he is not alone in this view.

This is typical of the confusion that now exists over decisions regarding non-treatment. Nor can we seek help from the law. The reason that so many doctors feel compelled to practise so called passive euthanasia furtively is the uncertainty of the legal position.

In some small way the Medical Treatment (Advance Directive) Bill will help to clarify the situation for the benefit of both patients and doctors.

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1 Tonks A. Advance directive bill. *BMJ* 1992;**305**:139. (18 July.)

Plight of singlehanded consultants in A and E

EDITOR,—At long last it is recognised that consultants in accident and emergency medicine work longer hours, excluding time on call, than any other consultants.[1] This is especially so for the single handed. I know. For five years I worked single handed, and the cost was high: my now ex-wife went on to marry a farmer, having herself given up a promising medical career. I am now in the relatively fortunate position of having not only an excellent business manager but also a first class consultant partner.

But St Mary's Hospital is still the only hospital in North West Thames region to have two consultants in accident and emergency medicine. The problem is not just finance (though this is a problem, especially as most non-teaching hospital departments are understaffed at all levels); there are not sufficient suitable applicants available, especially in London (because of the cost of housing and spouses' dislike of the city). Harley Street is not an attraction as there is no private practice in accident and emergency medicine. In autumn last year 20 posts for consultants in the specialty were unfilled.[2]

At least two colleagues in my region would advertise tomorrow if they thought that senior registrars were available and would apply. It will take five years for the increased numbers of registrars to work through their training programmes to accreditation. Some might say it is easier to find a spouse than a consultant partner in accident and emergency medicine. What hope, then, for my 17 singlehanded colleagues (and their families) in the region, or the patients they serve, for in reality no immediate relief is in sight? Perhaps consultants in accident and emergency medicine should be able to retire at 55 as psychiatrists can, especially as many long term psychiatric patients are now cared for in the community (often attending accident and emergency departments).

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1 Smith R. Understaffing in accident and emergency departments. *BMJ* 1992;**305**:329-30. (8 August.)
2 National Audit Office. *NHS accident and emergency departments in England*. London: HMSO, 1992.

Ashworth Hospital

EDITOR,—In his editorial on the special hospitals Robert Bluglass merely jumps on the bandwagon when he states, "Proper value should be given to civil rights, to abandoning oppressive methods of control (including the excessive use of seclusion), and to recognising the patient's autonomy."[1] How can he assume that most of the staff do not do this? No one mentions the majority of staff in these hospitals who do a good job under difficult circumstances, who treat patients with dignity, and who go to work facing the threat of violence and criticism every day.

As an occupational physician at Ashworth Hospital I see the physical and mental scars of staff who have been violently assaulted by patients and whose careers have ended prematurely.

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1 Bluglass R. The special hospitals. *BMJ* 1992;**305**:323-4. (8 August.)

EDITOR,—As Dr Eileen Bell has been a colleague and friend of mine for over 20 years I know her to be both a conscientious and capable psychiatrist and a caring and sensitive woman. In the news article on the inquiry into Ashworth Hospital Luisa Dillner quotes Dr Bell as saying that the patients are "not just dangerous and often criminal but most are very nearly impossible to diagnose and therefore to treat," with the implication that this statement is unreasonable or incorrect.[1] Having visited Ashworth Hospital many times during the past 15 years to examine patients for mental health review tribunals, I am well aware of the complex psychiatric problems presented by the patients. Most of them are in Ashworth Hospital because other psychiatrists have failed in their efforts to diagnose and treat them.

In my opinion the problems at Ashworth Hospital are due to the criminal and indefensible behaviour of a small number of staff and to a poor and antiquated system of psychiatric care that has proved resistant to change. The authors of the report on the inquiry do no one a service in underestimating the management problems and dangers presented by many of the patients in Ashworth Hospital.[2] It is also sad that they undervalue the considerable efforts made by most of the medical and nursing staff to help and care for these unfortunate and challenging patients.

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1 Dillner L. Ashworth inquiry suspends staff. *BMJ* 1992;**305**: 385-6. (15 August.)
2 Department of Health. *Report of the committee of inquiry into complaints about Ashworth Hospital*. London: HMSO, 1992. (Chairman Sir Louis Blom-Cooper QC.)

The doctor's right to choose

EDITOR,—Trisha Greenhalgh is disarmingly frank, but she is wrong.[1] There is no point in fighting for a woman's right to choose abortion if you then unilaterally invent criteria for rationing that so called right. Because her patient failed to conform to her cultural stereotype of a woman seeking abortion Greenhalgh arbitrarily imposed her own inverse poor law concept of "the undeserving rich." I, too, was affronted by her patient's presumption—but, unlike Greenhalgh, I would have placed principle before prejudice.

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1 Greenhalgh T. The doctor's right to choose. *BMJ* 1992;**305**:371. (8 August.)

EDITOR,—Many readers will sympathise with Trisha Greenhalgh over her problem in being asked to endorse a patient's wish to have an abortion to allow her family holiday and subsequent pregnancy to be arranged at times convenient for her.[1] I suggest that doctors would not need to be confronted with difficult decisions of this type if the British abortion law was amended to match the law in most developed countries. Most applications for terminations for these rather difficult social reasons occur during early pregnancy, before 12 weeks' gestation. Most developed countries allow women free choice of abortion during the first 12 weeks of pregnancy, and a reason does not have to be stated; thus doctors are spared embarrassing situations of the type Greenhalgh describes. Of course, for terminations after 12 weeks the regulations that obtain in Britain at present would apply, but few, if any, women would ask for a late termination to allow a skiing holiday.

The Pro-Choice Alliance is an organisation that aims to give British women free choice during the first 12 weeks of pregnancy; it includes members of parliament in all parties, surgeons, gynaecologists, general practitioners, and members of the general public. Readers may like to join and support the Pro-Choice Alliance in its efforts to bring an amendment before parliament that would bring British abortion law into line with that of other countries in the European Community.

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1 Greenhalgh T. The doctor's right to choose. *BMJ* 1992;**305**:371. (8 August.)