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● ***All letters must be typed with double spacing and signed by all authors.***

Nursing grievances

SIR,—Dr Tony Delamothe's articles (6 February, p 406) contained comments which I hear often from all grades of nursing staff. Our morale is desperately low and working conditions are deteriorating with frightening rapidity.

I have worked continuously in the National Health Service since 1978 and have been employed in three London teaching hospitals. During this period I have seen a gradual deterioration in recruitment. At the age of 18 I would not have believed that I could feel such cynicism and demoralisation as I do now about a job I loved so much. How must the students of today feel?

The desperation we feel was shown in the recent strike. It was about pay and working conditions. Most nurses would rate working conditions as a greater cause of job dissatisfaction. We are professionals, not "angels," and we would like to have an acceptable standard of living. A small proportion of the workforce is prepared to take industrial action. On the day of action I felt that nurses were given little support by their medical colleagues. I thank Dr Delamothe for being our advocate.

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SIR,—Dr Tony Delamothe asks "Where do the nurses go from here?" (13 February, p 449). Sadly, an increasing number of them are going elsewhere. I was introduced to an enrolled nurse who had come to us for a few days through an agency. Her anticipation and obvious experience helped me to complete a complicated arterial case very quickly. She had resigned from the National Health Service and was doing agency work while waiting to start her new job as a counter clerk with the Post Office. This will give her a considerably better income than she can earn as an experienced scrub nurse.

Surgeons are under constant pressure from the Department of Health to reduce waiting lists. We are given occasional extra sums of money to help with this. It must be realised that waiting lists depend on the number of operations performed in a day and this depends on the speed with which each operation can be safely performed. It is becoming increasingly difficult to find people with the ability and skill to act as a competent scrub nurse. To pay those with these skills less than a counter clerk seems to be counter productive.

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HIV infection: the challenge to general practitioners

SIR,—At the end of his summary of how general practitioners see the present epidemic of infection with the human immunodeficiency virus (HIV) and their role in it (20 February, p 516) Dr Paul Hodgkin raises the question of false positive results in tests for antibody to HIV. He is right to focus on the one practical way to diagnose HIV infection unequivocally, but he misrepresents the present situation.

Firstly, his figure for HIV prevalence of 0·002% is far too low: it implies only 1000 infections in the United Kingdom, whereas by the end of 1987, 1227 cases of AIDS were known and over 6000 people had been reported to be HIV antibody positive. A more likely, though unproved, level of prevalence is 0·1%.

Secondly, Dr Hodgkin recommends that general practitioners should regard positive results as false until confirmed by specialised tests. Positive reports are sent to general practitioners only when the initial result has already been confirmed.

The system set up by the Public Health Laboratory Service in 1985, when testing on a national scale began, specifies that all initially positive samples will be retested and then referred to one of seven confirmatory laboratories, where other tests are done. The key point is that the extra tests differ in methodology, so that while all detect true positives they are not usually susceptible to the same false positive effect. The same principle has been applied successfully for years to serological testing for syphilis.

Most HIV antibody tests now commercially available are highly specific, reflecting the extraordinary efforts which have been put into their development. If each test is, as Dr Hodgkin suggests, 99·5% specific, a single test will lead to about 1 false positive in 200 samples. Two methodologically different tests each giving 1 in 200 falsely positive reactions would be expected to find the same sample falsely positive on 1 in 40 000 occasions and three tests on fewer than 1 in a million occasions. Applying this approach to testing a 50 000 sample of the UK population with an HIV prevalence of 0·1% would yield about 50 true positives and no false positives, figures different from those derived by Dr Hodgkin.

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Antigen detection in primary HIV infection

SIR,—Dr M van Sydow and coworkers reported that antigen p24 of the human immunodeficiency virus (HIV) is generally detectable during acute infection (23 January, p 238). We measured neopterin concentrations in subjects with established HIV infection and support the suggestion that HIV continues to be replicated in almost all infected individuals.

Neopterin is a sensitive marker for the induction of a cellular immune response.[1] It is produced from macrophages after stimulation with γ interferon. In common acute viral infections neopterin concentrations peak during antigenaemia and remain high as long as virus is produced. The presence of viral structures evokes a cell mediated immune response. Neopterin concentrations return to normal when antigen synthesis stops.

In people infected with HIV neopterin concentrations are high during acute infection and decline moderately thereafter.[2] Asymptomatic carriers of HIV antibody have increased neopterin concentrations in serum or urine when compared

with healthy heterosexuals and antibody negative members of high risk groups.[1] Asymptomatic people with detectable antigen p24 usually have the highest neopterin levels.[3] The neopterin data suggest that there is no real latency period for HIV infection. As long as activated T cells are detectable in infected subjects HIV will be reproduced. Failure to detect antigen p24 is due to the limited sensitivity of the tests rather than the absence of HIV expression.

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1 Fuchs D, Hausen A, Reibnegger G, Werner ER, Dierich MP, Wachter H. Neopterin—a marker for activated cell mediated immunity—application in HIV infection. *Immunol Today* (in press).
2 Eberhartinger C, Simader R. Akute AIDS-Retrovirus-Infektion. *Wiener Klin Wochenschr* 1987;**99**:18-20.
3 Fuchs D, Hausen A, Reibnegger G, *et al*. Immunological studies and HIV antibodies in patients with haemophilia—a longitudinal study. *Wiener Klin Wochenschr* (in press).

Late abortions and the law

SIR,—Dr Tony Smith rightly draws attention to the difficulties which would result if the Alton proposal to limit termination of pregnancy to 18 weeks was adopted (13 February, p 446). The proposal seriously restricts choice, for example, in some cases of fetal abnormality.

What do women (half the electorate) want? I have carried out a questionnaire study on a sample of 500 women aged 18 to 45 years, chosen by random selection from a practice list of 2000 women in this age band. I wanted to determine attitudes to prenatal diagnosis for Down's syndrome and other genetic defects and to termination of pregnancy. Of the 338 respondents, 88% said that all women aged 35 or more should be offered tests during pregnancy to check for possible abnormalities affecting the baby. A remarkable 99% of respondents said that women who already had a baby with an abnormality should be offered prenatal tests. When asked if they themselves would wish for prenatal diagnosis if at increased risk of a Down's syndrome pregnancy 95% of respondents said "yes." Of those favouring prenatal diagnosis, 75% said that they would want termination of an affected pregnancy; 21% would wish to consider the situation; and 4% said they would not want a termination. (Regarding termination of pregnancy in general, 95% of all those who answered the questionnaire said that when a woman's life and health were endangered she should be able to have a legal abortion. When the pregnancy was the result of rape 91% said that the victim should be able to have an abortion.)

People will accept preventive measures if they perceive the condition in question as being serious and intervention acceptable and effective.[1,2] Of those respondents who favoured prenatal diagnosis, 93% said that they would be prepared to spend three days to have the test, and 96% said that they would forgo their summer holiday. Clearly the respondents valued greatly the options presented by prenatal diagnosis. Despite the advent of chorionic villus sampling, many prenatal screening and diagnostic tests still have to be carried out at about 16-18 weeks' gestation. Results may not be available until about four weeks later. Using low maternal serum α fetoprotein concentrations as a screening tool for trisomy 21 will result in even more late prenatal diagnoses.

If the Alton proposals are accepted without amendment the choice of having a handicapped child or not, valued so highly by the sample of women questioned, will be seriously jeopardised.

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1 Rosenstock I. Why people use health services. *Milbank Mem Fund Q* 1966;**44**:94-123.
2 Calnan M. The health belief model and participation in programmes for the early detection of breast cancer. *Soc Sci Med* 1984;8:823-30.

SIR,—Dr Tony Smith's article (13 February, p 446) raises many aspects of the debate about late abortions. We have studied the attitudes of the general public to genetic counselling and therapeutic abortion.

As part of a study of the prevalence of genetic disorders a postal questionnaire was sent by JP to all families in her rural practice and to every household in the nearby market town of Barnard Castle. In addition to a request for details of familial diseases, opinions were sought on the value of genetic advisory services and on therapeutic termination for fetal abnormality. Altogether 1900 questionnaires were distributed in November 1986 and July 1987, before the current debate on David Alton's bill. Fewer than half of the families responded, but 979 opinions were expressed.

The question on termination was worded as follows, "Some major abnormalities may now be detected in early pregnancy. Would you be in favour of termination of pregnancy where it is known that the baby will be born with a serious handicap?" The responses were: strongly in favour, 579; in favour—some value, 226; undecided, 76; not in favour, 57; strongly opposed, 41.

Thus 82% were in favour of termination for fetal abnormality. In addition 685 people were strongly in favour of a genetics advisory service, 229 were in favour, 37 were undecided, 10 were not in favour, and 3 were strongly opposed. It is of interest that an even greater proportion were in favour of the availability of regional genetics advisory services. Clearly, the public appreciate that genetic counselling has a broader relevance.

No attempt was made to ascertain moral or religious background, or gender, or if the opinions were from families with handicapped members. Phrases such as "early pregnancy" and "serious handicap" are, of course, open to debate in the climate of the current legislative debate. Nevertheless, we believe, based on our clinical experiences and on this survey, that a clear majority of British people feel that while there is a sound argument for lowering the gestational age limit for therapeutic termination this should not be at the expense of prenatal diagnostic services. Whatever the personal opinion of individual doctors, the medical profession as a whole should be vociferous in its defence of parental choice. The Alton bill must be amended to make allowances for the limits of our current diagnostic techniques.

Those who remain in favour of a universal 18 week limit might like to reflect on the fact that women over 35 will either have to have chorionic villus sampling with its much higher miscarriage risk or, if this is not available or they present too late to request it, will be forced to accept the risk of Down's syndrome. Many will refuse and will request termination before 17 weeks. More than 99% of those terminated fetuses would have been normal. In short, the Alton bill could end up killing more fetuses than it saves.

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SIR,—Dr Tony Smith says that "One of the lessons of history is that social evils are often best dealt with by attending to their causes rather than making their results into criminal offences" (13 February, p 446). History teaches no such thing. How does he explain the enormous increase in thieving since the welfare state ensured that no one need go hungry or the fact that the illegitimate conception rate has never been higher in spite of sex education and widely available contraception?

We are given figures for late abortions in residents of which it is stated 14% were on the grounds of fetal abnormality. Why are the 44% of late abortions done in Britain on non-residents omitted? Of total abortions performed after 18 weeks, under 8% were done for fetal abnormality.

Perhaps the greatest error in the article is in its interpretation of the law.

Many doctors (mainly in the private sector) are prepared to perform an abortion on any woman who requests it and has the money but this does not alter the fact that the law provides for abortion only when the mother's health is in danger or there is a grave risk of a handicapped child. Why does Dr Smith ask if it is ethically correct for a doctor to comply with the law? A patient of mine asked me to refer her for abortion because she had an important modelling engagement coming up in Rome. Was I acting unethically in telling her she had no legal grounds? (The doctor who performed the operation obviously disagreed with me.)

Dr Smith says that if the Alton bill becomes law "the well informed with enough money will go abroad for their termination." They will have some difficulty as there is nowhere in Europe where late abortions can be performed legally. Equally inaccurate is his suggestion that the poor will revert to illegal abortions. This allegation may be good enough for the media, but will he please tell his medically qualified readers where these late abortions are going to be done, how they are going to be done, and most important of all by whom? If illegal abortions disappeared 20 years ago who has trained these illegal operators and what have they been doing for the past 20 years?

Before the Steel Act became law, late illegal abortions were done by the same medically qualified people as did them legally afterwards. Sadly, I read his remark that the 1967 Abortion Act gave gynaecologists freedom to terminate any pregnancy when that seems to two doctors "the best solution for the mother *and the fetus*" (emphasis mine). It is rather horrifying that to be killed can be considered "the best solution" by two doctors.

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SIR,—The emotional cost of caring for a handicapped child is only one side of the question in genetic-eugenic abortion (Ms Madeleine Simms, 30 January, p 355). Geneticists expressed relief that the Abortion Act 1967 provided the opportunity to give "positive" help to couples at risk. But contrary to expectation, many couples, far from feeling relief, found they required considerable support after abortion.[1,2] A recent King's Fund conference highlighted this problem (12 December, p 1551).

On the BBC *File on Four* programme of 8 December it was said that the anxiety of women undergoing screening is now greater than that of women attending psychiatric clinics. The economic cost of caring for such children is repeatedly stated. Professor Barry Jay has suggested secondary prevention for genetic blindness, which "imposes a heavy social, health and education burden on the community."[3] Over the years