ratios above 1:1 at about 32 weeks "would probably have been induced at 32 weeks' gestation; but combining such serious prematurity with severe haemolytic disease had resulted in almost a 40% neonatal mortality." It seems that you misread this very easily understood statement. It is a pity that your readers should be thus misinformed.

C R WHITFIELD

Department of Midwifery,
Queen Mother's Hospital,
Glasgow G3 8SH

¹ Whitfield, C R, *et al*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1972, **79**, 931.

² Palmer, A, and Gordon, R R, *British Journal of Obstetrics and Gynaecology*, 1976, **83**, 688.

³ Fairweather, D V I, *et al*, *British Medical Journal*, 1967, **4**, 189.

*We regret an error in the reference numbers. The statement in our leading article that "most series treated by intrauterine transfusion alone record a 40% survival" should have referred to the paper by Professor Whitfield and his colleagues,¹ and the reference to the neonatal mortality at 32 weeks is, of course, derived from Palmer and Gordon's paper.² The report by Palmer and Gordon does raise serious doubts about the value of intrauterine transfusion, and we consider that a re-examination of its value in relation to the new development of plasmapheresis is indicated. This conclusion is independent of any discussion of the exact mortality figures of the untreated disease, which we agree are difficult to obtain.—ED, *BMJ*.

Overheated wards

SIR,—Why are hospital wards invariably overheated? It seems paradoxical that patients, cured of their life-threatening illnesses, are becoming endangered by that fiendish species—the NHS radiator. All too often I have witnessed prostrate patients perspiring away their water and electrolytes, which are enthusiastically replaced intravenously by harassed house officers who fail to understand why their patients are so dehydrated. Please, before this summer's heatwave, will someone in the heating department have a brainwave, and economise?

ANDREA HEMLOCK
Medical student

Birmingham

What to tell the employer

SIR,—Dr John M Goldman in his letter (7 May, p 1221) raises some very interesting points, and I feel the following personal case is probably worth reporting.

Some years ago an old student of my own, who now was an assistant medical officer of health in a certain county in England, came to see me when on leave. I was horrified to find that he had an advanced cancer with secondaries in his liver, and all that one could do to relieve his obstruction was to bypass it, but this of course did not in any way prevent the fatal onset, which was only going to be 2, 3, 6 months ahead. While the young man was in hospital I had a letter, in confidence, from the chief medical officer of the county asking *in confidence* for the medical details of the case. I replied very fully, again in strict *confidence*, pointing out that the man had less than some six months to live. I got no acknowledgment

of my letter, but one can guess the reaction when my patient some weeks later read in the *Journal* that his appointment was now being advertised. I don't think I have ever had such a case of bad faith, and it naturally has made me very careful of what to tell the employer.

IAN FRASER

Belfast

What to tell the occupational physician

SIR,—I was distressed to read Dr J M Goldman's letter (7 May, p 1221), in which he discussed communication with occupational physicians, such as me, and even more distressed to read the headline "What to tell the employer." Please let me emphasise that a consultant or a family doctor corresponding with an occupational physician is *not* corresponding with an employer any more than I am corresponding with the area health authority when I write to a consultant. Dr Goldman's first paragraph contains the offensive suggestion that occupational physicians are not primarily concerned with the welfare of their patients and do not preserve medical confidence. And what would Dr Goldman say if I were to write, "An inquiry from an oncologist can sometimes best be answered by a telephone call—one has then the opportunity to satisfy oneself about the doctor's essential good faith"?

I suggest that Dr Goldman refers to the BMA publication *Medical Ethics*, 1974, p 31: "The doctor in occupational medicine and the general practitioner have a common concern—the health and welfare of the individual workers coming under their care. Less often, this concern may be shared with the hospital doctor, the community physician or some other professional colleague. As in all cases where two or more doctors are so concerned together the greatest possible degree of consultation and co-operation between them is essential at all times—subject only to the consent of the individual concerned."

No person, neither employer nor doctor, is entitled to any medical information whatever from a doctor about an employee or a candidate for employment without the consent, explicit or implied, of the patient. No occupational doctor will tell an employer anything without such consent, and even with consent he will tell the employer only what he properly needs to know. So when an occupational doctor asks, with the consent of the patient, for detailed medical information it is entirely proper for him to be given it. It is his job, in which he is a specialist, to interpret that information honestly and in the interest of his patient.

Dr Goldman's second paragraph discussed what should be told an employer who asks for a patient's medical history. He says that a prospective employer is not entitled to full medical information but "he is (presumably) entitled to be forewarned against the risk of taking on an employee who will very soon be incapacitated. . . ." He goes on to say that the patient's own doctor may properly give a favourable report without the consent of the patient. Few doctors I hope would be prepared to give any information, favourable or unfavourable, without the consent of the patient. A moment's reflection would make it plain that, if it were permissible for a doctor to report favourably without consent, his refusal to report could immediately and rightly be

assumed to be equivalent to an unfavourable report. Dr Goldman also suggests that the patient's family doctor and not the occupational physician should decide in all cases whether a man will be accepted into employment as fit to do any particular job. I find this a very strange suggestion, and one unlikely to appeal to many prospective employers. Dr Goldman's suggestions are—shall we say?—ingenuous, but then if I were to address you on the chemotherapy of leukaemia I would hardly do better.

R E W FISHER

London N5

Hot flushes and cold turkey

SIR,—The recently increased interest in the menopause encourages me to draw attention to the similarity between features associated with this state and those related to withdrawal of drugs of addiction or dependence. The characteristic features of the menopause are classified into three groups: autonomic instability, emotional and psychological instability, and biochemical changes. Of these the first two are also prominent characteristics of the addicted subject who is exposed to acute, or even phased, denial of his narcotic, nicotine, or alcohol. That the autonomic instability is in the one instance typified by "hot flushes" and in the other by "cold turkey syndrome" could be reflective merely of the different sites of activity of the agent of dependence. If relief of the emotional and autonomic symptomatology associated with the menopause is not completely provided by substitution therapy, this could indicate simply that the critical compound was an apparently minor metabolite of one of the female sex hormones.

A similar picture is surely to be seen in the puerperal subject. Indeed, I have for some years referred to the puerperium as the "mini-menopause," and would respectfully suggest that those intensively engaged in investigation of the menopause might benefit from a consideration of the postpartum patient as a "model" for study.

J SELWYN CRAWFORD

Birmingham Maternity Hospital,
Birmingham

Oral contraceptives and the uterine vessels

SIR,—Your leading article on pregnancy and oral contraceptives and the uterine vessels (30 April, p 119) asks if oral contraceptives cause disease of the uterine arteries.^{1 2} We have previously found that changes in small uterine vessels, those in the endometrium, are one of the earliest effects of taking oral contraceptives. Proliferation of endometrial arterioles is related to headache and migraine incidence,³ distended sinusoids to tiredness and dilated leg veins, and stromal condensation round sinusoids to leg cramps.⁴ Sinusoid changes and headaches usually precede development of thrombosis. One patient had particularly large sinusoids after 43 years of treatment. She had developed migraine for the first time in her life during cycle 40 and bilateral phlebitis in cycle 43.

There has seemed little doubt to me that oral contraceptives cause generalised vascular over-reactivity, probably by alteration of immune mechanisms. These changes are