cause of cardiovascular disease, which accounts for about half the excess mortality from smoking.

You state that there is little substantial decline in either cigarette sales or the number of people who smoke, yet you do not point out the dramatic fall of cigarette smoking in doctors, in other members of social class 1, and in class 2, especially among men. You refer to the impossible goal of stopping smoking by health education programmes, yet after the first of the two recent Thames Television programmes, "Dying for a Fag," it was estimated that about 160 000 people stopped smoking at least temporarily, and this represents about 2% of the smoking population. The fact that the tobacco industry is putting some of their workers on short time illustrates that the fall in tobacco sales which followed the recent tax increase is expected to last. It would have been more appropriate if, instead of decrying health education you had followed the B.M.A. Council's recommendation[1] in relation to smoking that "more attention should be paid to the way in which information is disseminated and attitudes are formed and an evaluation made of the methods used."

It is conceivable that in 20 years there may be evidence to show that cigarettes which include synthetic materials are indeed safer. Until this time arrives we strongly deplore the use of the term "safer cigarettes," though we agree that efforts to investigate forms of smoking which may be less lethal should be encouraged.

Doctors should give patients the same advice to stop smoking which they themselves have accepted and which has been such an important cause of the reduction in mortality from both lung cancer and coronary heart disease in the medical profession.—We are, etc.,

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Chairman,
KEITH BALL
Hon Secretary,
Action on Smoking and Health
London S.E.1

1 *British Medical Journal Supplement*, 1971, 2, 91.

Better Medical Writing

SIR,—Dr. J. S. Bradshaw (26 April, p. 194) is confusing three different things: the techniques of medical writing, the correct use of the English language, and literature.

Medical writing—at least in its most important branch, that which deals with reports of original research as distinct from didactic or review articles—has no connexion with the kind of literary writing to which Dr. Bradshaw refers. It is a technique whose principles and practices are applicable whatever the language used. If the language used happens to be English of course it is best for it to be good English, but above all it should be plain and simple English, because the world's research workers do not read English with ease. Work reported in the style of T. S. Eliot, Swift, or Sir Thomas Browne, as Dr. Bradshaw recommends, would be liable to be ignored in the research laboratories of Moscow and Peking, or even in those of Baltimore or San Francisco.

Giving scientific papers a standard formal structure has solid advantages, and these have been ably analysed elsewhere.[1 2] It is comparable to writing hospital case-notes according to a uniform pattern. Both these practices make for orderly thinking by the writer and easy assimilation by the reader. But neither research reports nor case-notes are literature. Case-notes, incidentally, and written examinations are the first branches of medical writing that we meet in our medical career, and this is one of many reasons why notions of medical writing should be taught at an early stage. To say that undergraduates should not be taught the elements of medical writing because they already know (or should know) how to write would be analogous to saying that they need not be taught the elements of medical statistics because they already know (or should know) how to count.

The book[3] which Dr. Bradshaw inaccurately calls a "pedagogic 'core' course" is, as its name indicates, intended specifically as a guide for those who want to write papers in English. Therefore, naturally, it deals with both (1) the principles of scientific writing and (2) the correct use of English in scientific writing. But the principles of scientific writing that it outlines are applicable to writing in any language.

Some authorities believe that eventually all "important" research will be reported in English, other languages being used only for papers of purely national interest. This may be true for countries whose languages practically no one else understands. But for France, the cultural leader of a huge francophone community, it is neither desirable nor necessary. Unfortunately, some French medical writers scorn, like Dr. Bradshaw, modern medical writing techniques and regard the use of the French language as necessarily linked with literary writing, thereby lowering the credibility of their country's medical literature and preventing their country's research from receiving the international recognition it deserves. According to an eminent French surgeon,[4] ambitious young surgeons in France do not take French medical publications seriously and some French official scientific bodies do not recognize papers published in French journals. Happily, we have watchful medical editors to protect our British journals from ideas like Dr. Bradshaw's.—I am, etc.,

J. A. FARFOR
Paris

1 Lock, S. P., *British Journal of Anaesthesia*, 1970, **42**, 764
2 Soffer, A., and Weinberg, S. L., *Chest*, 1975, **67**, 5.
3 O'Connor, M., and Woodford, F. P., *Writing Scientific Papers in English*. Associated Scientific Publishers, Amsterdam, 1975.
4 Détrie, P., *Nouvelle Presse Médicale*, 1975, **4**, 675.

SIR,—I enjoyed your leading article "Better Medical Writing" (12 April, p. 56) and look forward to the publication of the seminar on "Speaking and Writing in Medicine" that is scheduled for this autumn. It is a pity that more American medical writers cannot avail themselves of this learning experience. As one who has spent an entire professional career in medical communication, I am frequently chagrined by the general low calibre of English language usage by medical writers on this side of the Atlantic. All too frequently the results of excellent clinical investigations are rejected for publication simply because the authors are incapable of expressing themselves in clear and coherent English prose. On the other hand, all of us have noted the consistently higher quality of medical writing by our British colleagues. This is why the *B.M.J.* is such a joy to read.—I am, etc.,

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Injudicious First-aid

SIR,—I have followed with considerable interest the recent correspondence on injudicious first-aid. There seems little doubt that it is essential for personnel trained in first-aid to attempt resuscitation when it is indicated. The problem lies in the poor standard of the training given. As a corps surgeon in the St. John Ambulance Brigade, I examine in first-aid very often and am highly critical of the average standard of performance in resuscitation. It is often too painfully obvious that the candidate is trying to carry out from memory a mechanical operation read in the manual, without any idea whatsoever of the physiological principles which lie behind what he is doing. This leads to some quite remarkable performances. In my view no first-aid certificate should be granted until the candidate shows clearly that he understands not only the practice but the principles of resuscitation. This is not met by a few puffs into a resuscitation model.

I fear the blame for this unsatisfactory state of affairs must lie to a considerable degree with the medical profession. In my own area, and I suspect in many others, voluntary groups such as the St. John Ambulance Brigade have the greatest difficulty in recruiting doctors to do the training required. Some brigade divisions have not had a divisional surgeon for years and their attempts to interest local practitioners meet with no success. If resuscitation is worth doing, as it obviously is, then medical practitioners must be willing to co-operate with the first-aid organizations so that it is properly taught.—I am, etc.,

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Dextran 70 and Thromboembolism

SIR,—I was very interested in the paper by Mr. A. L. Kline and others on this subject (19 April, p. 109) with its encouraging clinical message. I would like, however, to ask two questions: (1) Have they any reason to believe that two bottles of dextran are any more effective than one? and (2) is it possible that the increased bleeding commented on is from an overfull vascular compartment?

Dextran 70 is hypertonic, and in the absence of bleeding a 500-ml infusion could be expected to increase the blood volume by 10-20%. My own practice is to use 500 ml of dextran 70 prophylactically but in the absence of significant blood loss to give only 250 ml during surgery and the remainder postoperatively.

I have not seen increased bleeding with this regimen that could not be explained by a combination of excess fluid and vaso-