developed rapidly in recent years. Most, if not all, regional hospital boards have computers, and other larger computers are available on a service basis. Not £100m., not even £100,000, but a mere £20,000 would enable experimental and productive work to begin in one centre (as it *is* beginning in others). The educational process has already begun (as is evidenced by this dialogue) and will, I am convinced, take less than 20 years. To achieve it we need to demonstrate much more *useful* results than the self-evident difference between "spells" and "persons," about which I am sure that no clinician loses much sleep.—I am, etc.,

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Research and Intelligence Unit,
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Deaths from Asthma

SIR,—Is it really true that sedatives "are absolutely contraindicated in acute asthma," as stated in your leading article (10 February, p. 329)? Many patients benefit from judicious treatment with chlorpromazine or promethazine, which suppresses the alarm generated by the sensation of dyspnoea. Is morphine as dangerous in asthma as the textbooks would have us believe, or is this a medical dogma which has little real evidence to support it? Its value in the treatment of pulmonary oedema is not disputed, yet the arguments advanced against its use in asthma apply with equal force here. The essential point is that asthma is a disease with a pronounced psychological overlay, which requires treatment just as much as the bronchospasm.—I am, etc.,

A. J. KNELL.
Leamington Spa,
Warwickshire.

SIR,—The increasing death rate from asthma cannot be attributed to increase in the case incidence or change in diagnostic habits (Dr. F. E. Speizer *et al.*, 10 February, pp. 335 and 339). As there is no definite evidence incriminating the corticosteroids or the pressurized aerosols, a possible explanation for the rise in death rate is that the *episode* incidence rate may have risen. In other words, asthmatics may be getting acute attacks more frequently than before. As asthmatic deaths occur during acute episodes, an increased "attack rate" could account for the rise in death rate. This is not inconceivable, though we will have to find a reason for this, perhaps turning again to the drugs. To take an extreme example, a patient who once experiences dramatic relief from corticosteroids is likely to want it again the next time he has a wheeze. And, if denied, the anxiety thus generated could precipitate a severe attack. It is common enough for patients to get acute attacks soon after a course of corticosteroids has been tailed off. Would such patients have had attacks less frequently had they not been given drugs? It may be impossible to find an answer, but the possibility is worth consideration.

A further point I wish to make is regarding the figures of 66% and 86% given for the proportion of the fatal cases who had been on corticosteroids and aerosols respectively. This is slightly misleading, since we do not know the percentages among the total number of cases within which the fatalities occurred. If, as seems likely, the corresponding figures among living asthmatics are considerably less for corticosteroids and more or less the same for aerosols the figures of 68% and 86% among the fatal cases would put a different complexion on the relative dangers of the drugs.—I am, etc.,

M. GOVINDARAJ.
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Errors in Blood Transfusion

SIR,—Dr. J. W. Mostert's proposal (3 February, p. 317) for the routine monitoring of blood transfusion under anaesthesia calls for further comment. Inspection of the supernatant plasma for the presence of haemolysis is a routine procedure in the investigation of transfusion reactions and, in so far as it was reliable and practicable, it could be useful during the course of transfusion. However, it is unjustifiably optimistic to imagine that such an examination could be as efficient as your correspondent claims.

Errors can result from either confusion with haemolysis due to causes other than incompatibility or failure to detect significant levels of haemoglobinaemia. In the first category must be included the collection of the specimen, and the method of sampling capillary blood as advocated by Dr. Mostert is not devoid of risk as regards haemolysis. As stated by Dr. P. L. Mollison[1] in his book to which Dr. Mostert refers, a haemoglobin concentration of 20 mg./100 ml. in serum or plasma produces a very faint pink colour *when viewed in a thickness of approximately 1 cm.* If such a solution is drawn up into a capillary tube of the type commonly used for micro-haematocrit determinations it becomes quite indistinguishable from normal plasma. In the same capillary tube a solution of 100 mg./100 ml. haemoglobin in plasma produces a suspicious tinge when viewed in a good light and preferably compared with pre-transfusion plasma.

It follows, therefore, that Dr. Mostert's claim to be able to exclude concentrations of more than 10 mg./100 ml. haemoglobin in the supernatant plasma by macroscopic examination will be at variance with what is likely to be common experience. I would not wish to detract totally the value of such a procedure, especially in connexion with transfusion under anaesthesia. Nevertheless, I am concerned, in the context of my previous letter (2 December, p. 550), that anyone would wish to shift the emphasis from an attempt to eliminate initial error to one of detection after the mistake has been made.—I am, etc.,

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REFERENCE
[1] Mollison, P. L., *Blood Transfusion in Clinical Medicine*, 1967, 4th ed. Oxford.

Doctors on the Box

SIR,—The appearance of doctors on television to discuss controversial medical matters is a subject which I will leave to others, but it is well to remember that this is only one aspect. Mr. J. M. Potter (10 February, p. 378) rightly says that "television is *primarily* entertainment." But the important secondary purpose is education, and I believe that Lord Reith and probably later directors-general of the B.B.C. did not lose sight of this. Anybody who has seen programmes for schools teaching languages, or for doctors, for managers, and for the general public can scarcely deny this educational value of television. Doctors should not ignore their opportunities in this sphere, though such opportunities should be used to project medicine and not personalities.

Together with several colleagues, I have recently prerecorded a series of programmes for the Further Education Department of the B.B.C. designed to be of help to expectant mothers. Each week the programme reaches about two million viewers, who it is hoped will get an idea of what modern obstetrics is about, and the co-operation and understanding of patients in matters of childbirth is deemed by most people to be of value. Perhaps the same may be true of other branches of medicine. The producer and interviewer were as keen as the doctors that a proper image of obstetrics was given, and the series was a co-operative effort with the doctors and patients supplying the basic content, while the television staff contributed their own special expertise to communicate with an audience whose characteristics they knew better than we did. We were always treated with courtesy and no attempt was made to make entertainment capital out of us.

Mr. Potter believes that the education of the general public on medical matters might be better achieved by straight talks on the radio. But this ignores the fact that education depends on a combination of auditory and visual stimuli, which television uniquely can employ. The illustrations for our programmes were first-class, and where we supplied the basic ideas the professionalism of the artists and production team translated them into pictures with real educational impact. Many of the ideas we wished to convey simply could not have been projected by radio alone, nor even by illustrations made to go with radio.

The ethical problem of names is still a very real one, and even the guidance of the *B.M.A. Handbook*[1] on ethics is not very helpful in a specific instance. The viewing public have some right to know the status of those who are presuming to instruct them, yet on the other hand no special advantage over his colleagues should accrue to the doctor who appears on television. Again politeness in discussion in the studio seems to require that names should be used at least occasionally. In the face of these conflicting demands we compromised by allowing our names to be spoken, but only our status appeared on the credit titles at the end of the programme.—I am, etc.,

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REFERENCE
[1] *Members Handbook*, B.M.A., London, 1965.

Medindex

SIR,—I was very sorry to see that the publishers of *Medindex* had altered its format. *MIMS*, which covers the same ground as *Medindex*, is not nearly so conveniently arranged for the general practitioner.

The main value of the old *Medindex* was that the drugs were classified under many