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.,

BERNARD BENJAMIN.

Research and Intelligence Unit,
Greater London Council,
London S.E.1.

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.,

Leamington Spa,
Warwickshire.

A. J. KNELL.

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.,

Knightwood Hospital,
Anniesland, Glasgow.

M. GOVINDARAJ.

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. Mollison¹ 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.,

D. A. OSBORN.

Department of Pathology,
Institute of Laryngology and Otolaryngology,
London W.C.1.

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 "tele-

vision 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.,

PHILIP RHODES.

Department of Gynaecology,
St. Thomas's Hospital Medical School,
London S.E.1.

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

subheadings, so that all the drugs of similar action were to be found together. The anti-depressives are a case in point. Instead of all antidepressives being listed alphabetically, as in *MIMS*, *Medindex* classified them into monoamine oxidase inhibitors, thymoleptics, and others. Other useful sections were the paragraphs of indications and safety factors at the beginning of each section, and the index of official and other approved names.

I am sure there must be many general practitioners who regret the passing of *Medindex* as much as I do. I have written to the publishers asking them to reinstate it, and if we were all to do the same perhaps they would publish it again.—I am, etc.,

Maudeley,
Shropshire.

J. B. METCALFE.

Families in Flats

SIR,—I apologize for the delay, due to time and distance factors, in writing to comment on your leading article (18 November, p. 376) and Wing Commander Desmond M. Fanning's excellent paper on families in flats (18 November, p. 382).

I was an Army medical officer of health in Germany at that particular time with responsibilities for the health of all military families, other than R.A.F. dependants, in that same area.

You say that Wing Commander Fanning "provided an adequate control group and he was able to eliminate the major variables." On the evidence available this is not quite true, since he compares a total of 672 flat dwellers with a maximum figure of 162 house inhabitants—that is, a ratio of more than 4:1. The "first consultation rate" is affected by factors imposed by the patient, and if flat dwellers were less happy with their lot than house dwellers they would tend to visit the doctor's surgery more frequently for minor ailments.

There are other factors not mentioned which might vary between the two groups unless measures were taken to exclude these variables. Spread of respiratory infections in a house or flat may be affected by central heating. In Germany hot-water radiators are in general use, and this system dries the atmosphere and facilitates spread of respiratory infections. The degree of heating can also vary from one flat or house to another, as does the location of heating units. Variation in place of contact and closeness of contact of members of a family would occur from one living unit to another.

A vitally important factor not mentioned is the degree and quality of maternal care, with particular reference to children in the 0 to 5 age group. Service mothers living outside the United Kingdom are divorced from grandparents and close relations and friends. Also there are many social and other distractions which take parents out of the home frequently. Many mothers in this particular social class need the support of others in managing their families, and while our health visitors can and do excellent work in this respect they can only spend a relatively small amount of time with each family.

There is no proof that variation exists in respect of the above-mentioned factors between flat and house dwellers. However, these and other environmental and personal

health factors should be considered in future prospective cohort studies. We owe a debt to Wing Commander Fanning for starting the ball rolling. It is up to others to further research into this important field of public health.

Here in Hong Kong most of our military families live in multiple flats, six to fifteen storeys high. There is some evidence to support Wing Commander Fanning's views on morbidity, with particular reference to the neuroses. There are of course additional factors which do not occur in Germany—for example, extreme summer heat and humidity, relatively cold winters, lack of open space and recreational facilities in some instances, and noise factors. So few families live in houses that comparative studies are not possible, but sufficient evidence is available to suggest that as a way of life flat-dwelling is very different from house-dwelling, and that many families do not readily adapt to the change.—I am, etc.,

Hong Kong.

J. G. P. POWER.

Human Tissue Act

SIR,—The Automobile Association is to be congratulated on the initiative shown in an issue of *Drive*¹ in encouraging the donation of human tissue for organ transplantation. But unfortunately the law has been misinterpreted in two important respects. Under the Human Tissue Act 1961, which lays down the methods by which parts of a body may be made available for therapeutic purposes or for purposes of medical education or research, the person lawfully in possession of the body may authorize the removal of a part of the body if the deceased, either in writing at any time or orally in the presence of two or more witnesses during his last illness, made (and did not withdraw) a request that his body or a specified part of it should be used for one of the stated purposes. The Medical Defence Union has been advised by leading counsel that, save in the exceptional case, the hospital where a patient died is not lawfully in possession of the body for the purposes of the Act. On the contrary it is the executors or the close family—for example the spouse, if any, or children of the deceased—who must authorize the removal, and they may veto the wishes of the deceased if they choose. The hospital has no power to authorize it. Furthermore, every road-traffic death must be the subject of an inquest, and the Act specifically lays down that in such a case there shall be no removal of any part of the body without the prior consent of the coroner. When the deceased has not expressed the wish that his body should be used the procedure under the Act can be even more difficult to operate.

The Medical Defence Union, although fully aware of the reservations mentioned in Lord Brock's profound review in *The Times*,² believes that the advance in medical knowledge and techniques during the past seven years makes it urgently necessary for the Human Tissue Act to be looked at again.—I am, etc.,

PHILIP H. ADDISON.

Secretary, Medical Defence Union.

London W.C.1.

REFERENCES

- ¹ *Drive*, No. 4, New Year, 1968.
- ² *The Times*, February, 1968.

Ambulance Services

SIR,—I was interested in the excellent study of the ambulance services in the Portsmouth district by Mr. W. N. F. Boughey (10 February, p. 369). May I add a few remarks on two aspects of the subject?

The ambulance itself is often unsatisfactory, as Mr. Boughey himself suggests. If any of your readers have had acute peritonitis and have then been tightly strapped on to a 2 ft. (60 cm.) wide wooden shelf in an ambulance body inadequately bolted on to an old Bedford chassis (as I have), they will need little convincing that the ensuing journey may contribute to the death of the patient. It is true that many modern ambulances have good points, but most are unnecessarily large and costly. Mr. Boughey makes the point that the ambulance crew cannot deal efficiently with more than one seriously ill or injured patient at a time. There is therefore little object in having space for two or more stretchers. Standard models such as the Citroën "Safari" estate car require little modification to accommodate one stretcher and attendant and one relative, while their suspension system is superb.

The other point is the training of the ambulance driver. The idea of "rushing the patient to hospital" still survives and is much more likely to be lethal than life-saving except in the rare cases of uncontrollable bleeding. While fluid flywheels and torque converters help in avoiding jerky starts, much can be done with skilled use of an ordinary clutch, and gentle braking should be inculcated. I believe that smoothness is far more important than speed. There is a legend that Sir Henry Royce kept a store of empty hunter watch cases at his works at Derby. A tester had to snap an open watch case shut by driving a front wheel on to it without bending the metal before the chassis could be delivered to the coachbuilders. What wonderful ambulance drivers those testers would have made!—I am, etc.,

London N.6

C. LANGTON HEWER.

Stature and Personality

SIR,—It is traditional to refer to Napoleon as a little man seeking to prove to the world that he was a big one, as Professor Martin Roth does (3 February, p. 309). But the belief rests on a misconception, or rather on a mistranslation. Capable observers of men, the sailors Captain Meynell and Captain Maitland, of the *Bellerophon*, and a soldier, Major-General Sir Henry Bunbury, estimated his height when he was alive at from 5 ft. 5 in. (1.65 m.) to 5 ft. 7 in. (1.70 m.); and after his death Antommarchi by actual measurement made it 5 pieds, 2 pouces, 4 lignes, which is 5 ft. 6 in. (1.68 m.). The unit measurement in France at the time, the *pied de roi*, was divided into 12 pouces, each of 12 lignes, and it added up to 0.324 of a metre, compared with the 0.305 of the *pied anglais*, the English foot. This difference accounts for the low estimates of his height in English translations of the writings of his valet, Constant, his secretary, Baron Fain, and others. Mulhall's *Dictionary of Statistics* (1891) gives the average height of a French adult male in the nineteenth century as 5 ft. 5 in. (1.65 m.), and that of an Englishman as 5 ft. 7½ in. (1.71 m.).