beta blockade . . . in no way prejudices the outcome of patients admitted to hospital with prolonged ischaemic pain. On the contrary, it may protect some patients from the development of a myocardial infarction and so enhance their long-term prognosis."—We are, etc.,

K. M. FOX
M. P. CHOPRA
R. W. PORTAL
CLIVE P. ABER

Kingston General Hospital,
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Battered Babies

SIR,—Throughout the country committees are being set up (and perhaps a central index) to investigate parents who may be harming their children. Recent reports by the National Society for the Prevention of Cruelty to Children and others show the alarming situation that may exist in this respect. These committees may well be not only helpful but essential, but they pose problems of principle that need to be ventilated and agreed.

They are self-appointed committees (composed basically of local doctors and health officials with power to co-opt the police and N.S.P.C.C.) with no authority from Parliament. No one doubts their good intentions; the members, however, have no special training in these delicate matters and it could be argued that these investigations are better left to the police, who have such training and know their responsibilities and their position in common law. These committees work in secret and the parents need not know they are under investigation (though eventually the parents and the neighbourhood are likely to find out—to the distress of both if the suspicions are unfounded—and can they claim redress?). Anybody can be reported to this committee by any person, be he an official, a doctor, or a neighbour. The potential for excessive keenness in investigation is alarming, and there is always a remote risk that such investigation could have a mischievous background.

If this principle is accepted, however, it could expand to other groups. Why not similar committees to investigate wife-battering, drivers with suspected drink or drug problems, officials in power with suspected psychotic disorders, etc.? Furthermore, what is the ethical position of the doctor to whom parents have come for help when he refers their case to this committee without their knowledge? I think we all accept that there will be cases in which the child clearly takes priority, but there are many borderline cases which are less easy to resolve. We could reach the stage where any mother seen pulling an unwilling child out shopping could find her name, unknown to her, on a computerized index of potential batterers.—I am, etc.,

R. F. N. DUKE

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Warwick

Impaired Colour Vision in Diagnosis of Digitalis Intoxication

SIR,—I am indebted to Mr. H. P. Williams and Miss Janet Silver for their kind letter (22 March, p. 682), but I should not like them to remain in the belief that the Pickford anomaloscope is a research instrument

only. Far from it; it has been employed for a routine colour clinic for schoolchildren in this unit since 1965 and has also been operated by two orthoptists in examining over 1500 schoolchildren in Kilmarnock and Ayr. Naturally it, like all instruments, requires a short period of training to familiarize oneself with the technique and it is necessary to establish a set of norms on a random population, but after this is done it is quite within the competence of a trained technician. I feel that every major eye unit should operate a colour clinic, not only for the diagnosis of congenital defects but in acquired diseases such as the subject of this correspondence.—I am, etc.,

W. O. G. TAYLOR

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Ayr

Better Medical Writing

SIR,—In the bibliography to your leading article (12 April, p. 56) you quote six books by medical or scientific authors on writing but none by non-medical authors. Is Fowler of no account? Or Partridge? Or Gowers? Do you really think that, outside the small range of literary matters peculiar to their disciplines, doctors and scientists know better than these giants how to teach people to write good English—in so far as it ever can be taught?

A much more important comment, however, concerns your discussion of how medical writing might be improved: your recipe boils down to "teaching postgraduates the elements of clear writing." You surely cannot believe such an attempt would achieve very much. Even undergraduate medical students, who in your dispensation would not—because of "the already overloaded curriculum"—be given any guidance at all on how to write, are made or broken English-wise long before they enter medical school. Why are they? And with what is the undergraduate curriculum overloaded? You give the answers yourself in your earlier leading article "Open Minds for Open Medicine" (12 April, p. 54): the overloading is to make them competent for "the inefficiency of much expensive health care" and is a sign of the "stagnation in medical educational methods." And they are already broken English-wise because of "the ever-increasing demands for higher A-level grades"—which prepare and condition them, of course, for the undergraduate overloading. Schoolchildren who have to concentrate exclusively on high science/maths A-level grades have no time to read, say, Miss Muriel Spark or Mr. Ted Hughes, or Tolkien, T. S. Eliot, or Ivy Compton-Burnett, let alone Swift or Sir Thomas Browne; and there now you have a septet that *might* teach the receptive young how, among much else, to write good modern English, of which the medical sort is but a tiny derivative, and to learn it by the best possible means, which is through the pores—in from much reading, and out as the sweat of much writing—and not from any pedagogic "core" course, to use the current jargon, inflicted in early middle-age.

There was once a tradition that doctors were men of culture (and that they were the better doctors for it); and in particular were somewhat acquainted with the classics and

with the correct, pleasing, and effective use of their own language. It is now, of course, in good part gone. We live in a world consisting mainly, not of two cultures, but of two second-rate barbarisms—one of ever-narrower technologists, commonly quite lacking culture, and the other of meretricious entertainers or "educators" who are very often ignorant of the technologies that enable them to spread their small messages and often not wholly at ease in culture proper. But I do not think one should connive at its extension by encouraging doctors to sink ever deeper into their particular acultural quagmire. Or do you not now have a sinking feeling?—I am, etc.,

JOHN S. BRADSHAW

How Caple, Hereford

SIR,—It is an unhappy coincidence that the very issue of the *B.M.J.* which contained your leading article on "Better Medical Writing" (12 April, p. 56) should also have had a leading article (p. 52) which began: "Recent neurophysiological and hormonal research is supporting the concept that primary anorexia nervosa reflects a psychological avoidance-response to the maturational demands of adolescence." As near as I can make out, this means that these patients wish to avoid the problem of growing up. Physician heal thyself!—I am, etc.,

ARNOLD KLOPPER

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Drug Combinations for Anaesthesia

SIR,—As Dr. J. P. Alexander (15 March, p. 626) has coupled my name with the use of intravenous methohexitone and intravenous diazepam for anaesthesia in patients requiring endotracheal intubation I wish to make it quite clear that the method which he describes and which he used in his experiments differs in important respects from the method I have used successfully in over 500 cases.

All my patients are given an oxygen-enriched mixture by a mask applied as soon as the patient becomes unconscious during the injection of methohexitone. The patient then saturates his blood with oxygen while he is still breathing and before the addition of diazepam. Intubation is usually carried out while the methohexitone effect is at its peak. Difficulties are liable to arise if this moment is lost and the methohexitone has to be replaced, some minutes later, by halothane anaesthesia.

My original comments (9 November 1974, p. 345) were made because my personal experience over the past few years suggests that the combination of these two drugs can be of great value and is no more lethal, though probably not less lethal, than any other combination of similar drugs. The efficiency of methohexitone, with the dose suitably adjusted to suit the patient and gain the end in view, plus not more than 10 mg of diazepam, can be gauged by the fact that only once in over 500 cases was it necessary to use suxamethonium as well to obtain conditions necessary for atraumatic intubation. If conditions similar to those produced by suxamethonium are deliberately sought it follows that the same stringent precautions in regard to adequate oxygenation also