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,
Hull

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

Warwick Hospital,
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

Ophthalmic Unit,
Heathfield Hospital,
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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University of Aberdeen

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

apply. Would Dr. Alexander keep a patient for "2-3 min" without oxygen enrichment after an adequate dose of suxamethonium? Even the "vigorous" method of ventilation, on his figures, seems inefficient.—I am, etc.,

M. W. P. HUDSON

London W.1

Cerebral Vasodilators

SIR,—Like the *British National Formulary* 1974-76, the excellent article on the treatment of organic brain syndromes by Dr. R. A. Wood (29 March, p. 723) makes no mention of the so-called cerebral vasodilators. These are widely advertised and prescribed but they are expensive and, once their exhibition is begun, there is seldom any reason why this should not be continued indefinitely (however bad things may be, one can always think they might otherwise be worse). The drugs must cost the country a fortune. May we assume that Dr. Wood thinks they are no good?—I am, etc.,

H. G. EASTON

Glasgow

** We showed Dr. Easton's letter to Dr. Wood, whose answer is printed below.—ED., B.M.J.

SIR,—The two most widely used cerebral vasodilators, cyclospasmol and hydergine, have been available for many years and have been generally regarded as ineffective, though occasionally benefit appears to have been shown in the controlled trial setting. There is little current support for cyclospasmol, a vasodilator pharmacologically similar to papaverine. Hydergine is more fashionable and is an ergot derivative which antagonizes alpha-adrenergic cerebral vasoconstriction but lacks the direct vasoconstrictor effect which makes many ergot alkaloids unsuitable for long-term use.

It could be argued that hypoxia already represented a maximal vasodilator stimulus on diseased vessels themselves incapable of dilatation. However, a redistributive effect cannot be ruled out, as with nitrites in the ischaemic myocardium. Because of the probability that primary neuronal dementia is not a vascular disease and because vasodilatation seems so unlikely in cerebrovascular disease the drugs are also talked of as "cerebral activators."

I am one of a majority, including Dr. H. M. Hodgkinson (5 April, p. 23), who do not accept the evidence for the use of these drugs. Despite the telling fact that they have not caught on in an age when many placebo remedies have, it is still not possible to say conclusively that they are useless so long as some properly conducted trials point to benefit.—I am, etc.,

ROBERT A. WOOD

Perth

Poisoned Children

SIR,—We would like to reply to the comments by Mr. M. W. Calnan and Dr. J. W. Dale and by Mr. C. P. de Fonseka (1 March, pp. 511-512) on our letters (26 October 1974, p. 231 and 11 January, p. 95) regarding the

problems of accidental poisoning in children.

We agree that a separation into true poisoning and poisoning scares is important from an epidemiological and prevention campaign point of view, but for the practical management of children suspected of being poisoned it is of less value. Questions should be asked of the parents in terms of the possible substance ingested. If this proves to be a substance which is known to be non-toxic—for example, one of the penicillins or oral contraceptives—then no further treatment is required except that of advice to the parent to keep all medicines out of reach of children. However, if the substance is potentially toxic then full evaluation of the patient, with adequate treatment and observation, is necessary. Aspirin is the commonest substance with which children are poisoned, and some reduction of the numbers of children admitted following such episodes could be achieved by following the nomogram published by Done,¹ in which a fairly accurate assessment of the likely severity of the poisoning episode can be obtained by measuring the blood salicylate level six hours after ingestion. There are very few other commonly ingested substances which can be easily measured, but iron and digoxin estimations may prove useful and may be available in the larger centres.

The suggestion that an 18-month-old child left alone with a bottle of aspirin for only one minute could have ingested only one tablet at the most indicates a lack of understanding of the abilities of some children of this age and indeed indicates why mothers may on occasion underestimate the severity of the problem.

We maintain that any campaign of health education should be directed to prevention of the poisoning episode and not to the dangerous suggestion of asking parents not to bother the primary care services with what the parents consider to be a serious situation. We agree that education of the primary care physician or accident room house officer to differentiate between toxic and non-toxic substances should be encouraged, but to suggest differentiation between true, possible, and unlikely poisoning with a potentially lethal substance is to court disaster.

In our view an important aspect of health education is that part of it must be directed not to the public at large but to "the powers that be." We entirely agree with Dr. Dale and Mr. Calnan when they say that parents should be provided with preventive measures which have been shown to be effective through experimental and field studies. Lack of initiative and drive at Government and Departmental level is the main reason why such measures (whether child-resistant containers or strip packaging) have not so far been introduced, and health education directed at those responsible for this would pay handsome dividends if it was successful in effecting the introduction of child-resistant containers etc.—We are, etc.,

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University Hospital of Wales,
Cardiff

J. R. SIBERT

¹ Done, A. K., *Pediatrics*, 1960, **26**, 800.

Adverse Effects of Publicity

SIR,—I should like to offer some thoughts in response to the letter from Miss Margaret J. Witt (1 March, p. 514).

While the Horizon programme on the induction of labour was biased, I believe it was rightly so. For it demonstrated clearly that inductions have been performed when they were not necessary and to the detriment of mother and child. Such a position is indefensible and the "consumer" has every right to challenge it. That other doctors are finding it difficult to persuade mothers at term that an induction would be to her benefit results not from the publicity but from the (collective) misuse of the technique.

In contrast, the "consumer" may also demand treatments—for example, "the happiness pill"—which may or may not be to her benefit. A responsible profession must respond to demands from within and without by utilizing rationally based therapies which give benefit to those who receive them. It must not attempt to constrain the popular voice in an attempt to conceal its own shortcomings.—I am, etc.,

MICHAEL HART

Westwood Hospital,
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Treatment of Eye Injuries

SIR,—In their description of the treatment of casualties arising out of the recent bomb explosions in Birmingham (5 April, p. 25) Mr. T. A. Waterworth and Dr. M. J. T. Carr mention that one of their patients (no. 17) who sustained bilateral corneal abrasions was treated with amethocaine and sulphacetamide drops.

Sulphonamides exert their action by competitive inhibition of the enzyme tetrahydropterotic acid synthetase, which is required for the production of tetrahydropterotic acid, a folic acid precursor, from *para*-aminobenzoic acid and 2-amino-4-hydroxy-tetrahydropteridine. This action is the result of the similarity of the structure of *para*-aminobenzoic acid and sulphonamide. Amethocaine is a derivative of *para*-aminobenzoic acid and it will therefore interfere with the action of the sulphonamides. Thus amethocaine plus sulphacetamide is a therapeutically inactive combination.

I note that the other two cases of conjunctivitis (cases 10 and 14) were treated with chloramphenicol drops without the use of amethocaine, with no comment on the reasons for preferring chloramphenicol in some cases and sulphacetamide in others.

I have found that amethocaine is unsatisfactory for routine use in casualty work, since every patient complains of severe irritation following its application, which ceases after some few minutes when its local anaesthetic action becomes manifest. For this reason I no longer use amethocaine but instead use oxybuprocaine, which is free of this irritant effect. Of course, oxybuprocaine and sulphacetamide cannot be used together.—I am, etc.,

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¹ Garrod, L. P., Lambert, H. P., and O'Grady, F., *Antibiotic and Chemotherapy*, p. 243. London, Churchill Livingstone, 1973.