mortem dissection.[2] Interestingly enough, when we studied the incidence of neural tube defects in the siblings of 80 of our consecutive patients we found that out of four known siblings (out of 85 siblings) with neural tube defects, three were siblings of patients with a thick filum terminale (20 patients and 22 siblings), while only one among the 63 siblings of 60 patients without a thick filum had a neural tube defect. It is our belief that the lesion of thick filum (or "fibrolipoma") associated with meningomyelocele (ectopic spinal cord) is genetically different, with a higher recurrence risk in siblings. We feel that any study of recurrence in siblings and its prevention must take note of this observation. Conclusions like the one reported by Professor Laurence and others may be too hasty.

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1 Talwalkar VC, Dastur DK. *Dev Med Child Neurol* 1974;**16**, suppl 32:159-60.
2 Emery JL, Lendon RG. *Dev Med Child Neurol* 1969;**11**, suppl 20:62-70.

The right to live and the right to die

SIR,—It has been brought to my attention that my criticism of Professor R S Illingworth's letter (29 August, p 612) (12 September, p 726) has been misconstrued as implying that he is involved in giving hypnotic drugs to babies with severe spina bifida, or at any rate approving of this practice. Nothing could be further from the truth for, as I wrote specifically, he has always taught that drugs, even in normal doses, should not be started unless there are clear indications in the treatment either of the disease or of its symptoms. I wholeheartedly agree with this view.

He does, however, include the statement about the difficult decisions "whether to operate and prolong life or allow them to die." This is the perpetuation of the myth to which I referred. It certainly does not apply in the neonatal operation, as most paediatricians are now realising. In fact, in the surgical care of spina bifida one of the few occasions when life is threatened is in the acute blockage of a valve system—maybe at months or years of age—and even here the primary purpose of surgery is to relieve the intense headache by reducing pressure or to avert incipient loss of vision.

Relieving symptoms of severely handicapped children is, I know, a policy with which Professor Illingworth fully agrees—witness his magnificent work with spastics. We may differ on some points but not on this fundamental issue.

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***This correspondence is now closed.—ED, *BMJ*.

Microcomputers in antenatal care

SIR,—I too was most interested in the article by Mr R J Lilford and Professor T Chard (22 August, p 533) and in Dr I S Logan's comments (12 September, p 725). I think, however, that both he and they have missed what should be the true object of the use of microcomputers for this purpose. The use of such a versatile machine as a mere electronic notepad is a gross waste of its capabilities. It *is* "time consuming to try simultaneously to interview a patient and enter the results into a microcomputer via a keyboard." Far better transfer the responsibility for conducting the interview into the machine itself.

Several programmes have been written which question the patient and allow him to communicate his replies via the keyboard. Examples include general health screening (British United Provident Association) and more specific applications such as dyspepsia history taking (Dr Crean).[1] The removal of a human interviewer has not been found to depersonalise the process, and in fact is of value as patients are more "honest" in that they will admit to a greater consumption of cigarettes or alcohol to a computer than to a doctor. When the clinician has the results of this computer-conducted interview he is then in a better position and has more time to talk face to face to his patient undistracted by bureaucratic form filling and note taking.

All medical programmes and in fact all computer programmes should be written so that no special skill or intimate knowledge of the programme is necessary in the user. Not until microcomputers are thus allowed to assume the routine duties of the doctor will their full potential begin to be realised.

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1 Lucas RW, Card WI, Knill-Jones RP, *et al*. Computer Interrogation of Patients, *Br Med J* 1976;ii:623-5.

Diving is dangerous for diabetics

SIR,—May I through your columns bring to the attention of hospital consultants and staff and the greater number of general practitioners the problems of diabetes and diving. The Sub-Aqua Association was set up to complement the activities of the British Sub-Aqua Club. With the medical advisers to that club we share concern over the numbers of men and women currently diving for pleasure while on treatment for diabetes and regrettably being assured by their medical advisers that they have nothing to worry about. The problem does not arise with professional divers or with compressed-air tunnel workers since the statutory medical examinations which they undergo specifically exclude diabetics from hyperbaric exposure. The policy of the Sub-Aqua Association and the British Sub-Aqua Club is that diabetics should not dive.

The diabetic on insulin is always at risk of hypoglycaemia. The additional risk of this occurring underwater is great, and a combination of hypoglycaemia and decompression sickness is a diagnostic challenge which I am sure few would dare to essay. One death in recent years—by suicide—resulted from the inexperience of those attending the victim at all stages of his illness until he came to a naval recompression facility. Diabetes was a serious complicating factor. More recently I have had to treat a decompression sickness in a diabetic who believed he had some pre-existing neuropathy. I can assure you that it was a daunting experience.

The accelerated degeneration in insulin-dependent diabetics and the conditions which precipitate diabetes in those of riper years are usually themselves contraindications to diving, which is a sport demanding maximum fitness from its participants. Even so there are some conditions which do not preclude sport diving—as long as proper consideration is given to them before diving commences. Diabetes is not one of them.

Any doctor who has given approval to his diabetic patients to dive is urged to reconsider his position. In the light of the opinions held by those in the vanguard of hyperbaric medicine such approval should be immediately withdrawn and the unlucky patients should be at best referred to a hyperbaric physician for assessment of his illness so that some decision concerning future participation in the sport may be made.

As a more general observation it seems that many colleagues are keen to pass opinions concerning fitness to dive on the flimsiest of evidence and without the benefit of adequate training in diving matters. In this they are often swayed by the obvious enthusiasm of a prospective or practising diver who has himself little appreciation of the medical hazards of sport diving. It is an excellent sport and all who have the inclination and the health should be allowed to participate, but for some it is dangerous and for them to try to dive is socially irresponsible.

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Dealing with epileptics

SIR,—The letter from Dr R G Beran and Caroline Sutton (5 September, p 674) raises the question of the relationship between patients with epilepsy and their medical advisers. It stresses the need for an understanding of the psychosocial issues involved and highlights the problem of communication between the medical profession and the patient. May I point out that the role of "interpreter" and counsellor can be very well filled by professionally trained medical and psychiatric social workers? During my many years as principal psychiatric social worker at the National Hospitals for Nervous Diseases, I have worked closely with the consultants concerned in providing explanation and support for patients with epilepsy, and I have been able to remain a point of contact during times of social and emotional stress. I have also undertaken group therapy with epileptic patients and talked to epilepsy action groups in layman's language, which I have been told has been of value.

May I make a plea to the doctors involved in the care of patients with epilepsy that they make use of the skills of their social workers in this sort of task?

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Management of asthma in the child aged under 6 years

SIR,—The paper by Dr R S Jones on the management of asthma in the child under 6 (13 June, p 1914) prompts me to draw your readers' attention to some practical points that are proving helpful in clinical practice.

Many asthmatic children who are unable to co-ordinate inhalation when using conventional aerosol inhalers are now using the terbutaline "spacer" for symptomatic treatment. Some

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