is being used, so as to ensure that the recording is in fact of the fetal heart rate alone.—We are, etc.,

P. TIVY-JONES
A. KENNEY
R. D. DE VERE

Obstetric Department,
Westminster Hospital,
London S.W.1

Confidentiality

SIR,—We read about the confidentiality of the computer, but I feel we need to look at things much more human before we start on mechanization.

I have this morning received a letter from the appointments clerk to a hospital psychiatric outpatient department in which she states that a patient has an appointment to see a psychiatrist and that a note of any treatment she was having would be beneficial. The enclosed envelope is addressed to "The Psychiatric Department." I do not know what my protection society would have to say about this.

During the past month I was asked to send to the "organizing secretary" of the local mass radiography unit details of the diagnosis and subsequent treatment of a patient who had had an abnormal miniature radiograph. In this case my protection society was very doubtful that I should disclose this information to a layman.—I am, etc.,

C. LIPP

Sheffield

Methyldopa and Depression

SIR,—I read with interest the report by Mr. C. J. Bulpitt and Professor C. T. Dollery (27 October, p. 232) on side effects of hypotensive drugs and the subsequent correspondence which it aroused on the existence of methyldopa depression as a specific entity.

For the past three years I have been measuring mood changes in a group of new hypertensive referrals to the Sheffield Hypertension Clinic, using a standardized mood-rating questionnaire[1] which has been shown to be both valid and reliable. Patients completed this questionnaire at their first clinic attendance and at six-weekly intervals for a one-year follow-up period and the scores were recorded graphically.

For purposes of statistical evaluation, the patients were divided into two groups: (1) those taking adrenergic blocking agents, and (2) those taking reserpine or methyldopa. There was no significant difference in the prevalence of depression occurring in the two groups, but there was a statistically significant difference in the pattern of depression. The depressed patients on the adrenergic-blocking drugs reported themselves as mildly chronically depressed throughout the period of study. Patients who became depressed while taking reserpine or methyldopa showed a transient depressive swing within the first few months of starting the drugs. It is postulated that the two patterns of depression have differing aetiologies. Patients taking adrenergic-blocking drugs are likely to be more severely hypertensive and suffer more medical and social complications of their illness than the less severely hypertensive. This pattern of depression can be regarded as an "illness effect" rather than a direct effect of the drugs. On the other hand, the transient depression of the hypertensive on methyldopa or reserpine is in keeping with the known amine-depleting effect of these drugs. Other factors shown to be of significance in the aetiology of both patterns of depression were personality structure and evidence of previous psychiatric disorder.

I would like to suggest that the amine-depletion pattern of depression still exists, but to a lesser degree than a few years ago, owing to a greater awareness of the problem, but there is an increasingly large group of more severe hyptertensives suffering chronic depression, often unrecognized, resulting from the effects of a chronic illness on a particularly vulnerable personality. Further research on this subject is in progress.—I am, etc.,

WENDY BANT

Whiteley Wood Clinic,
Sheffield

1 Abraham, H. C., Kanter, V. B., Rosen, I., and Standen, J. L., *British Journal of Psychiatry*, 1963, **109**, 286.

Explaining to Patients

SIR,—Cancer, writes Professor W. A. Mackey (3 November, p. 297), is a "frightening, primitive word. . . . It is a pity that we do not have readily available a less horrifying name." When discussing the effect of words upon patients[1] I suggested the term growth. It is less frightening and allows discussion of different types of growth and their prognosis, starting with benign ones.

What to tell the patient is a big problem in many branches of medicine. So many diagnoses carry a halo of fear with them. Angina is associated with the thought of sudden death, a point that will be emphasized to the victim by many kind friends. Arthritis is linked with the worry of being crippled; mental or nervous symptoms with the fear of going mad. The word thrombosis, even if referring to a thrombosed pile, may strike terror, being misinterpreted as implying the same seriousness as coronary thrombosis. Perhaps someone should compile a glossary of diagnostic labels which may help to shield the patient from unnecessary and often unfounded anxiety. My contributions would be: heart attack instead of coronary thrombosis, Parkinsonianism and not paralysis agitans, rheumatism or "fibrositis" instead of arthritis (unless the doctor has time to explain the various and often harmless implications of the word), seizure rather than stroke, and growth or tumour instead of cancer.—I am, etc.,

CLIFFORD HAWKINS

Queen Elizabeth Hospital,
Birmingham

1 Hawkins, C. F., *Speaking and Writing in Medicine: The Art of Communication. Illinois*, Thomas, 1970.

Medical Education in Italy

SIR,—Professor Alberto Zanchetti's account of Italian undergraduate and postgraduate medical training (17 November, p. 409) may appear "excessively gloomy" but is, in the Italian context, very optimistic. From experience gained and the information available to me during three months spent in Italy as a student last winter it appears that certain facts and the translation of some Italian terms in the account are very misleading.

The official government estimate for the number of medical students for the year 1972-3 was 120,000, a third of whom were in the first year studying "A-level" subjects, and this represents a tripling of medical student numbers in four years. I agree with Professor Zanchetti's statement that ward round teaching is impossible, but would go further to say that for the vast majority of students it is non-existent. He refers to a six-month "internship." However, a more precise translation is "apprenticeship." The "apprentice," who may be a student yet to take university finals, is unpaid and is required only to be present at, but not involved in, routine hospital procedures. Even the postgraduate training does not put the "doctor" in the position of a houseman.

Worthwhile reform is unlikely since the last governmental reforms were too late and, from a British point of view, retrogressive. Therefore in arriving at future agreements and reviewing the peculiar existing arrangement the Italian medical training system should be much more thoroughly scrutinized. —I am, etc.,

MARIO BROWN

King's College Hospital Medical School,
Denmark Hill,
London S.E.5

Medically Oriented Language Courses

SIR,—Professor J. D. E. Knox asks for suggestions for medically oriented language courses (8 September, p. 546).

It is already the policy of the Junior Members Forum that such language courses should be provided, and a motion concerning this subject was carried by the meeting held at Coventry earlier this year.

From a personal aspect, as a medical officer in the armed Forces, I would find such courses, especially in German, extremely useful. Owing to the pressure on the majority of doctors' time, these courses should be available through postal means. There should be two courses for each language—one for the beginner and one for the doctor who already has a working knowledge of the particular language. These could be available on tape cassettes with a short explanatory booklet accompanying each cassette.—I am, etc.,

M. J. G. THOMAS
Chairman,
Junior Members Forum, B.M.A.

Colchester

Diabetic Pregnancy

SIR,—Thank you for the excellent survey of diabetic pregnancy by Dr. N. L. Essex and others (13 October, p. 89). It seems to me, however, that there was one important omission—namely, the extreme danger of continuing insulin in unchanged dose during and directly after delivery. I realize that this is well known to the initiated, but I take it the article was aimed largely at the uninitiated.

For reasons not known to me, for one, two, or even three days after delivery a normally insulin-requiring woman may need no insulin at all and may easily be precipitated into hypoglycaemia. Once one has