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. The committees may well be not only helpful but essential, but they pose problems of principle that need to be ventilated and agreed.

Sub-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?). Anyone 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 not 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 an innocent mother is being unfairly suspected, and nothing short of shopping could find her name, unknown to her, on a computerized index of potential batterers. I am, etc.,

R. F. N. DUCK
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 children 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 colour 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 which none of the medical authors is. Is Fowler the one who is not of 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 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 “stagitation 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 product of much writing. Early from any such pedagogic “core” course, to use the current jargon, infected in early middle-age.

There was once a tradition that doctors were men of culture (and that they were the better for it); but that particular was 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 many. Anyone who has not already become acquainted with some of these must not only rise to the occasion but must do it with complete absence from any such pedagogic “core” course, to use the current jargon, infected in early middle-age.

—We are, etc.,

ARNOld KLOPPER
Department of Obstetrics and Gynaecology,
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 suxamethonium in 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 11 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 in my over 500 cases I was able to use suxamethonium as well to obtain conditions necessary foratraumatic intubation. If conditions similar to those produced by suxamethonium were deliberately sought for it seemed the same stringent precautions in regard to adequate oxygenation also