My comments on cost effectiveness have been misinterpreted. I did not wish to suggest that all anticoagulant treatment is not cost effective but wanted to draw attention to the expense of the treatment in those cases where adequate therapeutic control is not attained. The recommendation was that there should be better therapeutic control if the increased British Corrected Ratio ranges proposed and advocated by Loeliger¹ were adopted. The present suggested British Corrected Ratio range in Britain of 2.0-4.0² is too wide and encourages complacency, for though a British Corrected Ratio of 2.0 may be adequate for prophylactic venous thrombosis it is dangerously low for patients who have had heart valve replacements.

B MCD DUXBURY

Chase Farm Hospital,
Enfield,
Middlesex EN2 8JL

¹ Loeliger EA. *Thromb Haemostas* 1979;42:1141-52.

² Blackburn EK. *Prescribers Journal* 1977;17:73-4.

Women in general practice

SIR,—Many a time we have encountered criticism concerning the vital issue of the credibility of women in the medical profession. Often the negative comments probably reflect the element of prejudice in the mind of the critic. It was a real treat to read the interesting series of articles by Dr Patria Asher (30 January, p 317), Dr Gillian Jebb (20 February, p 566), Dr Jane E Everette (6 March, p 715), and Dr Sarah Boswood (27 March, p 951). These articles, along with many similar ones, convey the message that women, despite their obvious biological differences, can cope with the enormous stress and strain of personal and professional life with enthusiasm and grace.

Besides the appreciable contribution of women as general practitioners and specialists in various disciplines of medicine, there are two interesting observations pertaining to women doctors in India that illustrate one of the many facets of the suitability of women as doctors. Firstly, in a large number of medical colleges the departments of preclinical and paraclinical sciences are served largely by women medical graduates and postgraduates. Besides an individual's interest in selecting a particular subject, the relatively lighter work load and defined working hours could make both medical teaching and care of the family a practicable possibility. Beyond doubt, as medical teachers women are as capable as men. Secondly, in most of the medical colleges women form a major proportion of the medical faculty in the departments of obstetrics and gynaecology. To the surprise of many in the medical colleges, there is not a single male faculty member in these departments. Similarly, women candidates undertaking postgraduation in obstetrics and gynaecology very largely outnumber men. This type of preferential pattern is probably a response to delicate social and cultural attitudes, especially of the uneducated or undereducated rural community, which forms about 80% of India's population. The women are exposed very little to the world outside their home. Female patients wish to be examined and treated—especially for obstetric and gynaecological problems—by women doctors only. In fact, in such a social and cultural setting women doctors become indispensable. Possibly a similar situation also prevails in many neigh-

bouring countries which share their social and cultural background with India.

We wish to convey the message to those who feel and propagate the attitude of "misfit lady doctors" that, with the provision of suitable working conditions and the genuine co-operation of the administrative health authorities and fellow colleagues, women can always serve the medical profession to the best of their loyalty.

KAMAL DEV MOUDGIL

Department of Biochemistry

ASHA KHURANA

Genetics Unit,
Department of Paediatrics,
All India Institute of Medical
Sciences,
New Delhi, India

Special doctors for rape victims

SIR,—I was particularly interested to read the letter from Dr Raine Roberts (3 April, p 1048), who ended her letter by indicating that "the public and professionals are increasingly concerned about the problems of child victims of sexual abuse, the long-term consequences of which are often disastrous, as well as for the care of rape victims." She noted that there was an urgent need for the management of these matters to be greatly improved, and I very much welcome Dr Roberts's appeal for those working as police surgeons to gain as much in the way of expertise in forensic medicine as possible.

We would certainly endorse the comments about the lack of clear guidelines on the management, in particular, of children who have been sexually abused. In the pamphlet *Child Sexual Abuse* prepared by members of the British Association for the Study and Prevention of Child Abuse and Neglect's subcommittee on child sexual abuse (prepared with the advice received from representatives of the Department of Health and Social Security), we noted the very limited incidence studies in this country. (Pamphlet obtainable from John Pickett, 30 Bankfield Lane, Norden, Rochdale, Lancs OL11 5RS.) For instance, the survey which was carried out by myself in association with Beezley-Mrazek and Lynch¹ indicated reports by a variety of professionals of 1065 cases, giving an incidence of approximately 3 per 1000 children being reported for some form of sexual abuse during their childhood. The children reported covered the whole age span, both girls and boys, and in common with reports coming from the United States the proportion of children who were abused in their own families, compared to strangers, was of the order of three to one.

Although the Department of Health and Social Security in its guidelines on child abuse (1980) (Child Abuse—Central Register Systems. Circular LASSL (80)4) recommended that emotional abuse be registrable and that sexual abuse could be seen as one aspect of emotional abuse, there were no clear guidelines given for the registration of children who are sexually abused as being abused as such. It would clearly be in the interests of children who are sexually abused if specific procedures for handling the problem are laid down, and that a full interdisciplinary assessment of individual members of the family and the family as a group, followed by a case conference, should occur as in other forms of child abuse. The aim would be to identify the

needs for legal and therapeutic intervention and provide the basis for a co-ordinated plan to be worked out between the family and all relevant professionals.

Our research indicated that currently professionals are confused about how to manage this problem, and there is an over-reliance on legal response and insufficient attention being given to diagnosis, assessment, and treatment. Such co-ordination needs to be carried out at a local level so that some of the progress in this country which has helped physically abused children can also be extended to those children who have been sexually abused.

ARNON BENTOVIM

Hospital for Sick Children,
London WC1N 3JH

¹ Beezley-Mrazek P, Lynch M, Bentovim A. In: Beezley-Mrazek P, Kempe CH, eds. *Sexually abused children and their families*. London: Pergamon Press, 1981.

Elective surgery after myocardial infarction

SIR,—Dr R W Portal's excellent leading article (20 March, p 843) unfortunately reinforced the erroneously held opinion of many doctors that a physician should be consulted in order to determine a patient's fitness for surgery—that is, fitness for anaesthetic. In his letter, however, Mr P K Datta (24 April, p 1267) went to the opposite extreme in saying that a physician's opinion is rarely required.

The question surely that should be asked of the physician is not "Is this patient fit for surgery?" but "Is there any way in which this patient's medical condition may be improved?" When the physician has done all he can then the anaesthetist should be asked "Is this patient fit for anaesthetic?"

Only the anaesthetist is able to balance the risks of the anaesthetic against the risks to the patient were he not to have the surgery—for there is in fact no absolute state of "fit for anaesthetic." It is all a matter of balancing risks. A patient in poor condition may be considered fit for a life-saving operation but might be considered unfit for cosmetic surgery.

M S PEGG

Royal Free Hospital,
London NW3 2QG

Regular prescribing in a residential home for elderly women

SIR,—We were interested to read Dr S A Bruce's report (24 April, p 1255) of the drug treatment of residents in an old people's home. The drugs being taken most frequently were diuretics, which accords with experience in South Wales. In the course of a survey¹ among people over the age of 70 living at home in two adjacent villages we found that 79 out of 326 (24%) were taking diuretics. Plasma potassium concentrations were measured in 316 of these subjects, two of whom (both on diuretics) had values below 3.0 mmol(mEq)/l and were thus probably at risk of hypokalaemia. Two years later the subjects were seen again. Most of those who previously took diuretics still did so, and a further group had been prescribed these drugs, so that 81 of the 255 survivors for whom information was available (32%) were now taking diuretics. But the most striking finding arose when the patients were asked if

they suffered from dizziness. Fifty-one out of 81 taking diuretics (63%) complained of dizziness compared with 66 out of 174 not on diuretics (38%); the difference is highly significant ($p < 0.001$). The question about dizziness was asked before inquiry was made about medications in order to reduce bias. It is possible that in some cases the dizziness was due to the disease for which the diuretics were given, but it seems very unlikely that this could explain such a large difference.

The frequency with which diuretics are prescribed presumably varies between different practices, but our experience is probably not unusual. A survey of persons aged over 75 years and registered with an inner London practice showed that thiazides (quite apart from other diuretics) were the commonest drugs prescribed, being taken regularly by 18% of these persons.² A study of long-stay geriatric patients showed that many had been taking diuretics since their admission to hospital, with no record of the original indication for this treatment or any evidence of review. A controlled trial suggested that in most cases continuous treatment was unnecessary.³ If diuretics are a major cause of dizziness in the elderly (presumably due to postural hypotension⁴) they could be doing more harm than good in this age-group. It certainly seems desirable, as Dr Bruce says, to have a rigorous attitude to initial prescribing and to review continuous medication at intervals.

M L BURR
JANET MILBANK

MRC Epidemiology Unit
(South Wales),
Cardiff CF2 3AS

¹ Burr ML, St Leger AS, Westlake CA, Davies HEF. *Age and Ageing* 1975;4:148-51.

² Law R, Chalmers C. *Br Med J* 1976;i:565-8.

³ Burr ML, King S, Davies HEF, Pathy MS. *Age and Ageing* 1977;6:38-45.

⁴ Pathy MS. *Geront Clin* 1971;13:261-8.

Acute right heart failure complicated by hypovolaemia

SIR,—We read with interest the report by Drs R J D George and D Bihari (17 April, p 1159) of a patient with hypotension following acute inferior myocardial infarction, associated with a low pulmonary capillary wedge pressure. Since measurement of pulmonary capillary wedge pressure became available on this unit we have seen at least 10 similar cases, and we would like to make some comments concerning the volume and rate of infusion.

In the particular case reported the low pulmonary capillary wedge pressure was partially iatrogenically induced, but similar levels can be found without prior administration of diuretics, the electrocardiograph almost invariably showing inferior changes only. Even where such patients are closely monitored the rise in pulmonary capillary wedge pressure in response to transfusion can be precipitous. Furthermore, where there is no haemodynamic monitoring, because of the delay between the haemodynamic and radiographic changes of pulmonary oedema, fluid may unwittingly be given to a patient with a critically high pulmonary capillary wedge pressure. The electrocardiograph in these instances usually shows some anterior changes. Under these circumstances fluid challenge can have disastrous results, and one cannot always rely on diuretics and venesection to salvage the situation. We have seen fatal left ventricular failure precipitated by infusion of 100-150 ml

of fluid over approximately 25 minutes to an unmonitored patient. We would have serious reservations about the use of a "200 ml bolus of colloid," especially where the diagnosis of hypovolaemia is not proved but only "in doubt."

J D EDWARDS
P O'NEILL

Withington Hospital,
Manchester M20 8LR

Mastectomy and its consequences

SIR,—We read your occasional survey "Mastectomy and its consequences" by Mr Feeley and his colleagues with interest (24 April, p 1246). The authors are rightly concerned about the suffering caused by mastectomy for breast cancer. Unfortunately, when considering the available remedies they fail to mention the possibility of avoiding mastectomy in some cases. Several series of patients have now been treated with "lumpectomy" and radiotherapy and followed up for many years.¹⁻⁴ All have shown that these patients have a long-term survival comparable with similar patients treated in other centres by mastectomy. Excellent locoregional control is also obtained without disfigurement. More recently Veronesi and his colleagues,⁵ reported the results of a controlled trial comparing radical mastectomy with "lumpectomy" and irradiation in T1 breast cancer. Follow-up figures at five years again confirm that both local control and long-term survival are identical in both groups. We would also like to draw the authors' attention to the recent excellent article on this subject by Dr Balawajder and her colleagues.⁶

As more information becomes available it is becoming clearer that in early breast cancer radical surgery offers no advantage over conservative surgery with radiotherapy. Although we appreciate that this is still not the universal view, we feel that in 1982 articles discussing the consequences of mastectomy should mention breast conservation.

R ASHFORD
A DRURY

Westminster Hospital,
London SW1P 2AP

¹ Peters MV. *Int J Radiat Oncol Biol Phys* 1977;2:1151-6.

² Peters MV. In: Rubin P, ed. *Current concept in cancer*. Chicago: American Medical Association, 1974:272-4.

³ Mustakallio S. *Clin Radiol* 1972;23:110-6.

⁴ Prosnitz LR, Goldenberg IS, Packard RA, et al. *Cancer* 1977;39:917-23.

⁵ Veronesi V, Saccozzi R, Del Vecchio M, et al. *N Engl J Med* 1981;305:6-11.

⁶ Balawajder L, Antich P, Boland J. *Cancer* 1982;49:1587-96.

Support ancillary workers

SIR,—As William Russell says (15 May, p 1486), the "going rate" for pay awards is about 6%, and if this were applied throughout the Health Service it would be regarded as fair in that it would preserve the differentials between different grades of responsibility. The decision to offer only 4% to ancillary workers is manifestly unfair and divisive within the service (which may have been the intention).

Pursuit of the lost 3% would, I suggest, be better replaced by the profession redirecting its energies to urging the Government to correct this anomaly, which would avoid

much of the hardship that our patients are likely to suffer from the inevitable reaction.

B CASHMAN

Bedford General Hospital,
Bedford MK42 9DJ

Further threats to medical schools

SIR,—Over the last year there has been much discussion in your columns and elsewhere about the devastating effects of the cuts in university finance imposed by the University Grants Committee last July. The arbitrary removal of any protection for clinical medicine has exposed medical faculties, with their high turnover of clinical academic staff and fixed student intakes, to disproportionately serious damage, and this has provoked vigorous protests from the profession, which greatly values the high standards of medical education traditional in this country. Furthermore, because university clinical medical teachers also have clinical responsibility for patients in NHS hospitals, the freezing of clinical academic posts has directly harmed patient care. The extent of this damage has been the subject of an urgent investigation by the House of Commons Select Committee on Social Services, which is due to report its findings shortly.

Having thus weakened and disrupted the system the Department of Education and Science now chooses to deliver to medical education a further blow. For while the Department of Health and Social Security has agreed salary increases for NHS hospital doctors and dentists averaging 6%, the Department of Education and Science, through the University Grants Committee and the Committee of Vice-Chancellors and Principals, has stated that salary increases for doctors working as clinical teachers in universities must be limited to the 4% available under university cash limits.

Since 1968 clinical academic staff have been paid on the same salary scales as NHS hospital doctors and dentists. This principle of parity of salaries was established by the National Board for Prices and Incomes, which recognised in its 98th report that university and NHS jobs were interchangeable, and was accepted by the Government. The principle has been regarded both by the universities and the NHS as fundamental to the close reciprocal arrangements which they have developed for the staffing and funding of medical schools and teaching hospitals. If these arrangements are to continue and the quality of medical education is to be maintained, it is essential that clinical academic and NHS hospital staff should be able to work side by side in the same hospitals carrying out the same clinical, teaching, and research duties for the same salary.

If the principle of comparability is allowed to be sacrificed, the recruitment of good quality academic staff will become an impossibility, and standards will decline dramatically.

The Government must be persuaded that the training of our future doctors is well worth the small amount of additional funding which the University Grants Committee would require in order to maintain the principle of parity, and to grant clinical academic staff the same salary increase as that awarded to NHS hospital doctors and dentists.

JAMES PAYNE
Chairman,
Medical Academic Staff
Committee

London WC1H 9JP