them. Firstly, the disappearing punctuation mark. Will someone, in the name of heaven, tell me how an author can make his meaning clear between a man-eating shark and a man eating shark without the lowly hyphen? Secondly, the deplorable ignorance of capital letters. Without capitals and without punctuation marks will dph eventually mean Diploma in Public Health or Doctor of Philosophy?

This is what Loewe and Lerner, in "My Fair Lady," made Professor Higgins call "the cold-blooded murder of the English tongue."

A W BEATSON

Worthing, Sussex BN14 0DT

Police surgeons and child abuse

SIR,—In their article on legal aspects of child injury or neglect (13 October, p 910) Dr J A Black and Mr F Hughes do not mention the useful and valuable part to be played by the police surgeon. If all cases of suspected and actual child abuse were reported to him he could deal with the legal aspects, leaving the paediatricians free to solve the medical problems. Perhaps it is time that the police surgeon was appointed consultant forensic physician (part-time) to local hospitals and then these difficulties would not arise.

E O ROBERTS

Middlewich, Cheshire

Fetal hazards of altering hypotensive regimens in pregnancy

SIR,—Following our article (16 June, p 1591) we were disappointed to read a letter from Dr A M Nysenbaum and others (4 August, p 331) regarding the use of oxprenolol in pregnancy. This letter demonstrates clearly all of the problems of poorly documented anecdotal reports; despite the presence of at least four clear-cut high-risk factors for fetal death in the case described, a fifth cause is proposed.

The authors do not state the nature of the diabetic control nor the adequacy of blood pressure control on either of their regimens of treatment. They give no information regarding the presence of proteinuria or of renal function or impairment, and there are no data regarding fetal heart rate or its variability pre- or post-amniocentesis, a procedure which itself carries a considerable risk of fetal morbidity and mortality.

The fetus was clearly at risk of intrauterine death at least two weeks before its occurrence; all of the risk factors operative at that time continued and at least one, hypertension, became worse. Close fetal monitoring and measurement of the lecithin to sphingomyelin ratio at 30 weeks' gestation may have been advisable. If it were then decided that it was not in the best interests of the fetus to effect delivery, perhaps better control of hypertension by adjusting the dosage of the existing therapeutic regimen or by the addition of appropriate drugs to those already in use would have been the most appropriate course of action rather than merely switching to a new agent.

We feel strongly that the use of any pharmacological agent in human pregnancy must be subjected to close critical scrutiny. This must also include close critical scrutiny of the clinical situation in which the drug is used and

of all the other variables in management that produce an effect. Only by consideration of the whole picture can the importance of a particular observation be assessed correctly.

E GALLERY
D M SAUNDERS
STEPHEN N HUNYOR
A Z GYÖRY

Royal North Shore Hospital,
St Leonards, 2065 New South Wales

Work of a day-bed unit 1972-8

SIR,—The article by Dr J B Rainey and Mr C V Ruckley (22 September, p 714) on the work of a day-bed unit in Edinburgh was most interesting, and the authors must be congratulated on having one of the best day-bed units in the country. In commenting unfavourably, however, on the work done in the Coventry Surgical Day Unit reported by me in 1972, they are not comparing like with like. With his lavish accommodation—24 beds, twin theatres, two endoscopy rooms, etc—Mr Ruckley clearly had no option but to persuade all the specialties to use it, and the high numbers of gastroenterological and haematological investigations pay tribute to his success. But in Coventry the physicians already had an excellent endoscopy clinic, and the day unit was set up specifically for surgery, with 12 beds and one operating theatre.

In its first year (1971) 2475 operations were done, divided among general surgery (1020), ear, nose, and throat (575), urology (510), and orthopaedic surgery (225), with 89 cases of dental surgery. In addition, some 400 patients were treated for varicose veins by sclerotherapy, without operation. No gynaecology was done, mainly because the gynaecological unit was situated in another hospital five miles away. I am surprised that no ENT work is done in the Edinburgh unit; those in Coventry were mainly children, for whom, of course, day surgery is ideal. There may be advantages in carrying out both medical and surgical measures in one unit, but bigger is not always better, and there is much to be said for a specifically surgical day unit. I submit that with less than half the accommodation in Coventry, the figure of some 2900 cases (1971) compares most favourably with the Edinburgh figure of 3600 (1972).

On a personal note: after my article in the *BMJ* in 1972 I was reproved by Dr H G Calwill for having mis-spelt Nicoll. Mr Nicoll, surely the patron saint of day surgery, was, alas, long since dead and could not complain. I can, and do.

T H BERRILL

Gulson Hospital,
Coventry, Warwick

Too few necropsies . . . sarcoid heart disease

SIR,—I was very interested to see Professor J R Anderson's reply (13 October, p 932) to my letter (25 August, p 501). Of course I very much agreed with what he said and perhaps I might be permitted briefly to make a few points.

(1) Early in my training as a physician I worked for a year as a pathologist and 30 years later I still regard this as some of the most valuable time I have spent. I am disturbed to

find frequently the lack of interest shown in necropsies by otherwise good junior medical staff.

(2) Indeed, some of my complaints do arise from coroners' necropsies and my letter was finally precipitated by one such example. It is quite evident that the pathologist in question was under the sort of pressure mentioned by Professor Anderson, as he has been most courteous and helpful about the information he has provided—disappointing though it is. He had no clinical details even though the patient was a relatively young woman with a pace-maker.

(3) I would like to make it clear that my comments do not apply to East Anglian pathologists, from whom I have collected a disproportionate number of cases of sarcoid heart disease. This is helped by the habit of sending unusual hearts to the regional cardiac centre for further examination, and I would suggest that this practice might be more widespread.

(4) The continuing study on sarcoid heart disease is not just an academic one. Its importance is being increasingly recognised and the matter has arisen in connection with flying personnel.¹ I know that other important cases are under consideration in more than one country.

(5) Could I finally suggest that sarcoid heart disease should not be overlooked in any case of sudden death or unusual heart disease? I would urge the busy pathologist at least to take a few sections from the interventricular septum. If his duties do not permit these to be examined in his own laboratory, my pathological colleague, Dr P G I Stovin of the same address, would be happy to receive them.

HUGH A FLEMING

Regional Cardiac Centre,
Papworth Hospital, Cambridge CB3 8RE

¹ Pettyjohn, F S, *et al*, *Aviation, Space and Environmental Medicine*, 1977, 48, 955.

Reversible renal failure during treatment with captopril

SIR,—We were interested to read the report from Dr P Collste and others (8 September, p 612) of another case of renal failure in a patient with renal artery stenosis treated with captopril. We have already given our reasons for concluding that in our case the renal failure was more likely to be due to direct nephrotoxicity than to ischaemia (23 June, p 1680), but I would agree that in the patient they describe ischaemia was the likely cause. We have since treated another patient with captopril and to our surprise again noted an increase in serum creatinine beginning at the same time as a febrile episode and returning to pretreatment levels on withdrawal of the drug.

The patient, a white woman aged 30, was found to be hypertensive in 1974. Initial investigation showed normal intravenous urogram serum creatinine (110 $\mu\text{mol/l}$ (1.2 mg/100 ml)), and urinary 4-hydroxy-3-methoxymandelic acid; and microscopic examination showed no abnormality. Control was difficult over the next year and in 1975 she developed renal failure. Peritoneal dialysis was necessary for three months, during which time her blood pressure was better controlled and renal function improved (serum creatinine 450 $\mu\text{mol/l}$ (51.1 mg/100 ml)). Renal arteriography at that time showed no abnormality. Over the next three years her blood pressure was poorly controlled despite large doses of atenolol, frusemide, prazosin, methyl dopa, and spironolactone. At that time her serum creatinine was 291 $\mu\text{mol/l}$ (3.3 mg/100 ml),

creatinine clearance 18 1/24 hours, and results of liver function tests normal.

Captopril was introduced in gradually increasing dosage as recommended by the manufacturers, reaching a dose of 15 mg eight hourly; she had discontinued other medication apart from frusemide on the previous evening. Her blood pressure came under control in 24 hours, falling to 15/1000 mm Hg. At no stage did it fall below 140/90 mm Hg. Three days after treatment began she became pyrexial (38.3°C), and her serum creatinine rose to 325 µmol/l (3.7 mg/100 ml). By the fifth day it was 425 µmol/l (4.8 mg/100 ml) and the drug was stopped. The rise continued for a further three days, peaking at 507 µmol/l (5.7 mg/100 ml) and was back to pretreatment levels (226 µmol/l (2.6 mg/100 ml)) 10 days after the drug was stopped, although her blood pressure did not rise to pretreatment levels over this time.

It is possible that the reduced renal function following captopril was due to reduced renal perfusion pressure with the reduced blood pressure and does not represent renal damage; we did not perform renal biopsy. However, the rise in serum creatinine was accompanied by a pyrexia suggesting a drug reaction. We did not think it justified to expose the patient to the drug again.

K WOODHOUSE
P R FARROW
R WILKINSON

Department of Medicine and Nephrology,
Freeman Hospital,
Newcastle upon Tyne NE7 7DN

Perinatal mortality by birth order

SIR,—The paper by Professor Leiv Bakketeig and Mr H J Hoffman (22 September, p 693) shows a conclusion, that perinatal mortality falls with increasing parity, which is at variance with explanations given in their text. Their claim was that by taking a longitudinal approach in which sibship size was kept fixed they could show the declining perinatal mortality; this was supposed to contrast with an artefact of cross-sectional surveys by which risk increased with parity, at least for fourth and subsequent babies.

Yet Bakketeig and Hoffman state, "These results are consistent with the known tendency to become pregnant again after a pregnancy with an early adverse outcome and the higher probability of stopping childbearing after a successful outcome of pregnancy." They go on to relate the phenomenon of declining perinatal mortality with increasing parity to this tendency, but show no awareness that their own demonstration would then itself be an artefact.

A simple illustration can bring this out. Suppose the perinatal mortality rate to be constant at 20 per 1000, and that second pregnancies occur with certainty if the first pregnancy results in mortality, only half the time if the first pregnancy is successful. Accordingly, in 100 000 first pregnancies there would be, on average, 2000 failures and 98 000 successes. In the 51 000 second pregnancies (2000 + 98 000/2) there would be, on average, 1020 failures, 40 being repeat failures, 980 first-time failures. If we now compare perinatal mortality rates only for women who have had two pregnancies, we would see $\frac{2000}{51\,000} = 39.2$ per thousand for the first pregnancy, but only $\frac{1020}{51\,000} = 20$ per thousand for the second pregnancy.

By making comparisons fixed on sibship size, Bakketeig and Hoffman have only traded one

artefact for another. Increasing perinatal mortality with parity (but with no concern for sibship size) could as much reflect that higher parity pregnancies include relatively more high-risk mothers as that the risk actually increases with parity.

NATHAN MANTEL

Biostatistics Center, George Washington University
Bethesda, Maryland 20014

Professional standards for consultant appointments

SIR,—In recent times several consultants have been appointed who have not received a full course of training recommended by the appropriate royal college. In my own specialty appointments have been made of candidates who have not completed sufficient training to be eligible for accreditation by the Royal College of Obstetricians and Gynaecologists.

The appointment of such candidates in preference to others raises the whole question as to the value of such accreditation and at a time when there is a large backlog of well-trained and able senior registrars is exceedingly bad for morale in this grade.

PETER DIGGORY

Kingston Hospital,
Kingston upon Thames KT2 7QB

Aggressive patients—what is the answer?

SIR,—The time was 3.15 am when the telephone roused me from my slumbers. An irate voice demanded my presence instantly at his house to attend his sister and grandmother. Being acquainted with the medical history of the two patients concerned, I had no hesitation in accepting the summons, although I was not too keen on the rude language with which it was delivered. I was not given a chance to elicit any more details over the telephone, since all the man could repeat was, "Send the bloody doctor here right now."

I was met at the door by a somewhat hostile young man in his twenties—the owner of the voice—who, even before I had examined the two patients, demanded their immediate removal to hospital. The usual bunch of neighbours and relatives joined the chorus, trying to render moral support to the young man, who was doing all right by himself, and creating more confusion. This concerted attempt to bully me into conceding to their wishes was not successful, since we are fairly used to this kind of behaviour from patients in this area. After examining the two patients, I decided urgent admission would serve no purpose—the elder of the two patients suffered from an advanced inoperable ovarian cancer, and her main complaint was constipation. The second, younger patient suffered from chronic pyelonephritis and hypertension, and she had decided to stop all medication for several days. Although her blood pressure was not unusually high with her medical history, she denied any symptoms of discomfort, apart from slight headache. Both needed reassurance, with the emphasis placed on the continuity of the medication. I spent half an hour with them, and before I left the house I gave the young man a little friendly advice on how to request a home visit, especially at such an unearthly hour.

I must have taken no more than 15 minutes to arrive at the patients' home after receiving the call. While I was en route, however, it transpired that the angry young man had rung my home twice, wondering "where the hell" I was, and promising to "do that bloody doctor in when he comes." Because I was out on the call rather longer than usual, and also because of these threats, my wife eventually decided to ring the local police station and ask someone to go and see if I was still in one piece. I learned of this later bit of nonsense only when I rang my wife from the surgery before returning home. I telephoned the police to let them know I was alive and well, and, although they were relieved to hear it, nevertheless they said they would go along and give the young chap a word of warning, which, in fact, they did. I must say I was impressed by their speed of action in those days when we hear so much criticism of our police service.

My first reaction on returning home was to remove the family from our list; then I began to wonder if this is the only solution to the problem—in fact, it is not a solution at all but merely a case of passing the buck. Abuse of doctors and their families appears to be on the increase all over the country, both in quality and quantity. One hears of doctors being attacked in the Liverpool area, surgeries constantly being vandalised in Glasgow and other major cities, but our patients seem to be second to none in their verbal abuse. If I hear a polite voice on the other end of the telephone, it is an occasion to remember, which, unfortunately, does not happen very often. I have worked in general practice in Hertfordshire, Midlothian, and Derbyshire, and for the past five years in this beautiful part of North Ayrshire, and I never cease to wonder why it is that the patients are so much more aggressive, abusive, and impudent. In fact, the same old offenders are passed from practice to practice with unfailing regularity, whether we like it or not. Is there an answer to this problem? And what is the cause? Is it sheer ignorance of basic common courtesy, lack of education, or social deprivation? Or could it be a compensatory measure for their own inferiority and inadequacy? Or maybe even projection of their guilt in neglecting their loved ones? One can go on rationalising the behaviour of these patients for ever.

Why should it be that patients can report doctors, fairly or unfairly, to the local family practitioner committee (FPC), when doctors are forced to accept abusive and offensive patients on their lists. It seems an unfair and one-sided situation. As far as I am concerned, I see it as gross injustice to our profession that we should be deprived of our right to report these patients to the local FPC or some Government body, who should have the power at least to discipline them or reprimand them for their behaviour, as we are dealt with when reported by patients.

I have often heard it said that patients get the treatment they deserve, and I think it is very true. I am sure that most doctors would agree a little politeness and civility—which cost nothing—would make a world of difference in the doctor/patient relationship. Until someone comes up with a realistic answer to this problem, then I truly fear for the future of the National Health Service, already afflicted with an ailing economy.

K RAGHU

Ardrossan,
Ayrshire