bacteriologist) attending the meeting to appeal for our support that he might get financial help from the trust (Sir Farquhar Buzzard was our chairman) to carry out some investigations. He described his objective—to find something that could be used to check or even prevent the scourge of gas gangrene in war wounds. He had noticed in the literature a paper by Alex Fleming, etc, etc (as you so well explain). He wanted to follow this up first of all. He pointed out that work had been done by Carl Browning and others to show that drugs injected into the body could have selective action on bacteria in the body. Of course, we all agreed enthusiastically to support this appeal but were somewhat sceptical of the result of his research.

A few meetings later at Oxford I was sitting at dinner with Hugh Cairns, the brain surgeon, and he described to me his first experience of using the penicillin extract submitted to him by Florey in brain infections. He reckoned it "would do him out of his usual job" because his busiest occupation was dealing with infection within the skull.

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Choice of treatment in operable lung cancer

SIR,—I feel that I should comment on the letter from Mr J R Belcher and Dr Maxwell Caplin (5 May, p 1212) concerning the choice of treatment in operable lung cancer.

About 30 years ago I developed a malignant ulcer in my left main bronchus. I was advised that I had "just a chance" and should not undergo surgery or radiation of any kind. It was the best advice conceivable and, though the struggle for healing lasted for seven years, it was completely successful.

Perhaps it might be well for Mr Belcher and Dr Caplin not to be too dogmatic.

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SIR,—I cannot let Mr J R Belcher and Dr M Caplin's letter (5 May, p 1212) regarding your leading article on the choice of treatment in operable lung cancer (14 April, p 970) pass without protest.

It is very difficult to compare radiotherapy as a curative, as distinct from a palliative, treatment with resection in lung cancer. Many patients submitted to thoracotomy are found to have previously unrecognised advanced mediastinal disease and are closed without resection, which is therefore carried out on a highly selected group of the most favourable cases.

I have discussed the problems of radiotherapy as a curative treatment for lung cancer elsewhere.¹ I should like to point out here that tracheo-oesophageal fistula is not a complication of radical radiotherapy; it is occasionally met when palliative radiotherapy is given for dysphagia in patients whose tumour is invading the oesophagus, and who are therefore candidates for a fistula in any case. I should like Mr Belcher and Dr Caplin to enumerate the other causes of late mortality from radiotherapy which they feel exist. It is not my experience that radiotherapy for lung cancer is particularly unpleasant, but I commonly see patients who complain of persistent chest pain after thoracotomy.

I would agree, Sir, with your leading article that, although surgery still seems to be

the best treatment for suitable cancers in patients who are good operative risks, we need to understand much more about the natural history of the disease.

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¹ Mantell, B S, in *Radiotherapy in Modern Clinical Practice*, ed H F Hope-Stone, p 145. London, Crosby Lockwood Staples, 1976.

Accidental removal of endotracheal tubes

SIR,—Dr Sheena M Ross and others (14 April, p 987) report the disastrous consequences of a confused patient's removal of her intravenous catheter. In the past few months I have known of four young children in whom disaster occurred or was narrowly averted when they removed their endotracheal tubes. Three of these had croup or epiglottitis and the fourth severe asthma. All of these accidents happened in the intensive care units of large hospitals, and in each case management had been meticulous up to the accident.

No conscious child will tolerate an endotracheal tube if he can remove it. Reliance on sedation, nursing vigilance, or instructions to the child to leave his tube alone can be based only on blind faith, or perhaps some vague notion that restraints are cruel. Paediatricians, anaesthetists, and ENT surgeons involved with these acute respiratory crises in young children must make sure that the patients' hands are restrained securely by one of the standard nursing procedures (such as Tubegauze mittens tied to the side of the bed) before they leave the intensive care unit.

It may seem unnecessary to labour such a basic and obvious point, yet my experience suggests that self-extubation must be quite a frequent accident—especially in units that have little experience with children.

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Marriage matters

SIR,—As a divorcee, I feel very strongly about the conclusion of your leading article "Marriage matters" (5 May, p 1164). Clearly it would be marvellous if there were a marriage guidance counsellor available, particularly in general practices. It need not stop at general practice either; I have an endocrinological clinic and find that with between 10% and 20% of my patients at different times a marital problem is a most significant factor in the illness. As your editorial says, the problem may be presented in covert ways; but the solution of it may lie in the patient's personal life. Obviously none of this is new.

To suggest, however, that improvement of the "unprofessional" image of marriage guidance counsellors will increase their value is, I think, a great error, and symptomatic of a basic misconception widespread among people practising in these areas which surround the central core of traditional clinical medicine. This misconception runs like this: "If we take a person trying to deal with problems of a highly personal or emotional nature, and equip that person with a training (often referred to as skills) which is heavily orientated

towards, for example, psychoanalysis, psychology, sociology, or what have you, then that person will be better able to relate to the recipients of his or her care, will be better able to manipulate them, and hence will be more effective." This is particularly true of sexual counselling. The idea is that if you label people experts, then they must be able to give better advice and will become better listeners. The falsity of this can be shown by perusing newspapers and listening to the radio, which these days may deal with the topic several times a week. Without referring to individuals, I must say that I have come across many examples of arrogant or harmful views that seemed to arise from the "professionalisation" of the people involved. It is surely quite illogical when dealing with life matters to abstract from them some sort of unlikelike discipline which constrains and distorts the relationship and the advice and help offered but which is thought to be "authoritative."

The marriage guidance counsellor who was most help to me was a lady who did not take these views, but was patient and tolerant and had a degree of personal wisdom. Interestingly, she has now left the Marriage Guidance Council simply because of this false and pretentious professionalisation. What matters in counselling is the person, not the qualifications. Let us by all means have more people doing this, but let us let their wisdom grow unfenced by mental discipline imposed by enthusiasts.

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The health of the Maoris

SIR,—Dr Richard Smith has written an entertaining and generally perceptive view of New Zealand (14 April, p 996). There are, however, some inaccuracies in the section on Maori health.

The Maori population certainly declined seriously following the advent of Europeans but was never as low as 35 000. The lowest figure was 42 000 at the census of 1896. Dr Smith implies that whites shooting Maoris was a factor in the decline. Certainly whites and Maoris did shoot each other but in numbers too small to have any real effect on the population. Intertribal warfare, on the other hand, was an important feature of the Maori way of life. So long as this was limited to hand implements its total effect was small. The introduction of firearms by unscrupulous European traders completely changed the balance and the result did reduce the population.

The next major cause of the decline was disease. Cook's crew did bring tuberculosis and probably venereal disease. The viral epidemics, influenza and measles, came later and had a devastating effect on a non-immune population. Undoubtedly the worst European influence was dietary. Cook and Banks commented that there were no fat Maoris, a marked contrast with the situation they had just seen in Tahiti. The reason lay in the sparse diet of the Maoris. New Zealand did not have any large animals to form a protein source and the big flightless moa had been hunted to extinction. Cannibalism was not practised sufficiently regularly to make, as Dr Smith suggests, a significant contribution to the diet. It was, rather, an occasional (greatly enjoyed) victory ritual. The dog was a delicacy