On the other hand, syncope, angina, or dyspnoea at the end of exercise should raise the question of dynamic subaortic stenosis of hypertrophic obstructive cardiomyopathy.

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¹ Braunwald IE, Lambrew CT, Rockoff SD, Ross J Jr, Marrow AG. *Circulation* 1964;30(suppl IV): LV3-119.

Medical charities and prevention

SIR,—I am surprised at the outburst from the medical charities (19 January, p 178, and 26 January, p 249) on your recent leading article on medical charities and prevention (22-29 December, p 1610). They make so many points (excuses?) that I am reminded of the saying "The best way of hiding a leaf is in a forest."

Both cancer and heart disease have a common connective factor, that of smoking. But one charity says that "the means of changing people's social habits have yet to be devised . . . and further research is needed into preventive education before large sums are committed to propaganda." Yet we know 25% of cancers could be prevented if we could stop the smoking epidemic.

If the charities are worried about the public and their need to be accountable to it, then I as a member of the public—a concerned general practitioner and one who donates to these charities—will be looking for more effect in the preventive field before I next contribute.

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Introduction of U-100 insulin

SIR,—Dr C Hardwick and other specialists in diabetes make out a strong case for the planned introduction of U/100 insulin (24 November, p 1363). Insulin preparations containing 100 units/ml used with syringes graduated to contain one unit per division have been under trial by the British Diabetic Association and successful results have been reported in 18 insulin-dependent diabetic children receiving not less than 16 units of insulin daily.¹

Paediatricians will welcome the additional safety and simplicity which would follow the change to U-100 insulin. We do have reservations, however, about the implicit suggestion that 100 units/ml insulin will be the only strength of insulin preparation available. The problem arises when very small insulin doses are required and this is likely to increase as monocomponent insulins are more widely used. Dr Hardwick describes such cases as "very rare"; but reviewing 40 new cases referred to our paediatric clinic over four years we found that 24 (60%) required maintenance doses of 4 units of insulin or less at some time during their clinical course.

Children's needs are different from those of adults. It is to be hoped that the small advisory committee supporting the officer co-ordinating the introduction of U/100 insulin will include a paediatrician so that the need for a small syringe (0.5 ml) and methods of administering

small doses of insulin can be given consideration.

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¹ McKinlay I, Farquhar JW. *Arch Dis Child* 1976; 51:796-8.

Control of proliferative diabetic retinopathy

SIR,—Dr P J Watkins's review article (9 February, p 350) on insulin infusion systems reminds that mildly affected diabetics who do not require insulin can often be excluded from the likelihood of developing proliferative diabetic retinopathy by the chlorpropamide-alcohol-flush test.¹

This could be quite important practical news because Kohner and Leaver explain² the importance of having an expert retinoscopist rather than a GP to identify the early proliferative lesion to provide easier, quicker, and much more effective photocoagulation. This would omit from the expert "mild" diabetics who do not or cannot be persuaded to attend diabetic clinics. The omission might in practice be clearly limited if these mild diabetics were to have the "flush" test.

Annual retinoscopy to catch the early lesion³ is necessary despite photocoagulation's ability in 60% of eyes to halt or reverse retinopathy where vision has not progressed beyond 6/36.⁴ Visual acuity is too late a casualty in the proliferative lesion, but it remains interesting that use of the insulin mini-pump can cause regression of lesions.⁵ Retinoscopy for the whole diabetic population could be tedious and expensive.

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¹ Leslie RDG, Barnett AH, Pyke DA. *Lancet* 1979;ii: 997-9.

² Kohner E, Leaver P. *Br Med J* 1979;iii:48.

³ Cheng H. *Br Med J* 1979;ii:365-6.

⁴ Irsigler K, et al. *Lancet* 1979;iii:1068.

⁵ Hercules BL, Gayad II. *Br Med J* 1979;ii:1710.

Unwillingly to school?

SIR,—Dr G F Goddard's Personal Paper (5 January, p 21) on the reasons for children developing emotional and behaviour problems made interesting reading, and I share his concern at the level of bullying in some of our secondary schools. However, some of his sweeping generalisations should surely not be allowed to go unchallenged any longer.

"Children go to school only because they have to and not because they want to"—really, when Mitchell and Shepherd¹ found only 5% of Buckinghamshire children disliked school according to parental report, 30% of boys and 40% of girls liked school very much, and the remainder fell into an intermediate category. Dr Goddard's experience as a child psychiatrist is likely to have been with a selected sample, as there was a high risk of children disliking school, showing poor academic attainment, anxiety at home, and problem behaviour in school. "Peer persecution is responsible for . . . school phobia, truancy. . . ." But a mass of evidence² suggests that these problems are multifactorially determined, and the clinical experience of others supports the notion that fear of separa-

tion from home is often of paramount significance.

"Good schools are almost non-existent." Perhaps Dr Goddard should give us his definition of a good school so that we can evaluate this statement. Professor J A Davis, in his letter (2 February, p 333) supporting Dr Goddard, suggests that we should consider the need for two types of school—therapeutic schools for the deprived and schools primarily concerned with education, in its academic sense, for ordinary children. He may be right, though it is only fair to point out that current educational thinking³ is opposed to this view, and lays emphasis on the value of firm educational objectives in teaching maladjusted children, and on the sense of pride and achievement which disturbed, chronically failing children enjoy when at last they experience educational success. What is needed is more evaluative research into special schooling, so that different approaches can be more rationally compared.

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¹ Mitchell S, Shepherd M. *Br J Educ Psychol* 1967; 37:32-40.

² Rutter M, Hersov L. *Child psychiatry: modern approaches*, ch 19 and 21. Oxford: Blackwells, 1976.

³ Committee of Enquiry into the Education of Handicapped Children and Young People. *Special Educational Needs*. London: HMSO, 1978.

Medicine and the humane society

SIR,—I am sorry Dr Martin F Shapiro (9 February, p 398) has misunderstood my review of his book (17 November, p 1285). Of course I believe in our "ability to transform society and . . . sustain all that is good in science and medical practice while so doing," but the whole question is *how* this may be done. It is my view that the logic of medical science will increasingly lead those doctors who are loyal to it into collision with the social forms that at present constrain and distort it, and into entirely new social alliances. I therefore see all the caring professions, particularly the doctors, as a reserve of progress rather than reaction, despite all outward appearances to the contrary. I am in this respect a committed optimist, and he a pessimist.

We have to start from where we are, with the people we have.

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Meningococcal infection

SIR,—In their communication Drs J R Oakley and A N Stanton (25 August 1979, p 468) reminded practitioners of the importance of maintaining a high index of suspicion of possible serious meningococcal disease in infants who show altered behaviour and haemorrhagic skin rashes. As the authors emphasised, such patients must be promptly hospitalised and, if the diagnosis is confirmed, treated without delay. A subsequent leading article (20 October 1979, p 953) agreed with the concluding remarks of this paper—namely, that practitioners ought to administer an injection of benzylpenicillin en route to the hospital. In fact, the practice of administering "a shot of penicillin" or other antibiotics prior to hospitalisation has been noted in about 50% of the patients admitted to hospital with