three points which we would like to put forward for further consideration.

(1) Our daughter found it of very great help that most of the people who knew she was expecting a baby were told about the death by someone else before she came home and had to meet them. In her case the most useful agents for passing on the information beyond the family circle proved to be the vicar and the local baby-sitting club (which naturally includes most of the local young mothers). Obviously circumstances vary enormously, but most parents will know someone who can help in this way, and our observation of the relief caused by knowing that the ground had been prepared for meeting people without embarrassment does make us feel that the point is worth mentioning in the pamphlet.

(2) It may also be worth mentioning that grandparents, too, can feel bereaved. My wife and I were, I think, surprised at the depth of our own sense of loss. The main point here, of course, is that if this is ignored or repressed it can lead to family resentments such as those mentioned in the draft, but if it is faced and shared it can provide strength to both parents and grandparents and can, as with husband and wife, deepen relationships within the family, in this case the wider family.

(3) The members of our family most closely involved did in fact derive much strength from their Christian faith. We quite realise that it may not seem appropriate to speak in such terms as this in a secular pamphlet, but we would like to suggest that some such phrase as "or other minister of religion" might be inserted after "chaplain" if only to remind people that in many cases an understanding priest or minister whom one knows may prove to be one of the most valuable sources of help.

I hope that these comments based on very recent experience may be of some service.

W J H EARL

Norwich

Antenatal education

SIR,—Professor R. Beard and others have suggested an information leaflet for patients who have stillbirths (21 January, p 172).

The Rotunda Hospital, Dublin, has just analysed the value of a similar education leaflet but given to antenatal patients. We endeavoured to provide basic information to women in the lower socioeconomic groups by a simple handout given just before the onset of labour in an effort to improve knowledge and attitudes to the event. Knowledge, pain, and anxiety scores in the group receiving the handout (82 patients) and in a matched control group (110 patients) were assessed by the completion of a postnatal questionnaire. The results are shown in the accompanying table.

It can be seen that the educated group (A) had significantly lower anxiety and higher knowledge scores than the control patients (group B). Dropout and non-attendance rates at formal education classes were similar in both groups, as was the length of labour and

operative delivery rate. Although previous studies have shown that informed patients progress more smoothly to delivery,^{1,2} our patients with the highest anxiety scores did not in fact have an increase in the length of labour, a point observed by Wood *et al*³ in a similar study.

While such a method of delivering knowledge is far from ideal it has been shown that the various methods of antenatal education complement each other.⁴ For patients who will not or who cannot attend formal classes it would appear that information leaflets given before labour and containing clear information about the forthcoming events are of definite value as a teaching and anxiety-alleviating aid.

We can endorse the approach of Professor Beard and his colleagues.

CYRIL THORNTON
ROBERT F HARRISON
QUINTIN HOGAN

Royal College of Surgeons
in Ireland,
Dublin

¹ Van Auker, W B, and Tomkinson, D. *American Journal of Obstetrics and Gynecology*, 1953, **66**, 100.

² Davis, C D. *American Journal of Obstetrics and Gynecology*, 1962, **84**, 1196.

³ Wood, C, *et al*, *Australian and New Zealand Journal of Obstetrics and Gynecology*, 1974, **14**, 210.

⁴ Chamberlain, G, and Chave, S. *Community Health*, 1977, **9**, 11.

"Baby and Child"

SIR,—While I am grateful for the space allocated to a review of my book, *Baby and Child* (28 January, p 228), and grateful for crumbs of comfort like "In general, her advice . . . is difficult to fault," Dr D P Addy has charged me with giving some "inaccurate or potentially dangerous information." Please allow me the right of reply to what is almost an accusation of negligence.

I do not state that "allergy . . . is due to an inability of the body to differentiate between harmless and harmful substances." I point out, as part of a lengthy discussion attempting to elucidate a difficult subject for lay people, that people who are subject to allergic disorders manufacture antibodies against substances which cause no reaction in non-susceptible subjects.

I do not say that asthma "can be treated by using a nasal spray." Sprays, aerosols, and inhalants are mentioned as among the possible routes by which *prescribed* drugs may be administered to children by parents when the doctor does not consider it necessary to attend recurrent attacks personally. Aerosol bronchodilators and disodium cromoglycate by inhalator are obvious examples. I do not specify them as I do not wish the book to encroach on the role of the doctor, who must decide what treatment is suitable for any particular patient.

I do not suggest "treatment of a severe attack of stridor . . . before calling for help." I describe the frightening symptoms of severe croup and, starting with the words "you need a doctor urgently but if you are alone in the house," suggest the optimum way to get a seriously distressed child a little extra oxygen while that doctor, an ambulance, etc, are on

their way. To say that this advice "could be fatal in acute epiglottitis" is absurd. In such a life-threatening emergency what else can a lone parent do but try to keep the child breathing while help comes?

I do say that febrile convulsions "seldom last more than a minute or two"—a manner of speaking, perhaps, but part of the overall message, which is, "Don't leave the convulsing child. As soon as the spasms cease, send for your doctor." How can it be dangerous to omit to mention the minute percentage of such convulsions which last for longer?

I do say, "If a child seems perfectly well and has a normal appetite you can disregard the diarrhoea." The paragraph refers to a single episode of loose stool. Careful discussion of the possible importance of continued diarrhoea has already taken place and the paragraph is immediately followed by a list of associated symptoms which should lead a parent to seek medical advice. There is a further reminder of the hazard of dehydration if vomiting occurs simultaneously.

Finally, Dr Addy refers to the final part of the book as a "medical encyclopaedia" and implies that he knows it was not "checked by a doctor." The book is about child development and care. The section of which he complains is an A-Z of all kinds of information, only part of which is medical. It has been read by several doctors. And I have never done the *Times* crossword puzzle in my life.

PENELOPE LEACH

London NW3

Physical deformity of Richard III

SIR,—May a non-medical man add a coda to your contributors' speculations on Richard III's anatomy?

After Professor Philip Rhodes's carefully balanced article (24-31 December, p 1650) it was odd to find Drs B Wolman and Gordon Dale (28 January, p 234) paying so little heed to the fact that Shakespeare was a writer of fiction and, in his *Richard III*, one busily engaged in constructing a melodramatic villain to rival Marlowe's. Not only is there no contemporary evidence that Richard III suffered from any deformity, but even the alleged unevenness of his shoulders is uncertain. When the Windsor Castle portrait was on loan to the National Portrait Gallery for a special exhibition in 1973 an x-ray revealed that the raised shoulder-line was an over-painting by a later hand.

Richard has been reported as "small in stature," and no doubt he didn't make much of a showing beside his brothers Edward and George. But which of us would have? They were both burly six-footers. The journal of Nicolas von Poppelau, a man of great strength but unknown height, tells us, however, that Richard was taller than Nicolas by three fingers, although slighter in build. This suggests not "certainly small" (Dr Dale's phrase) but possibly tall and thin.

Shakespeare's literary genius should surely not be allowed to lull us into forgetting that the deformity of Richard III was a Tudor myth rooted in political necessity. When Richard lay dead at Bosworth there were 29 people still alive with a better claim to the throne than Henry Tudor's. His usurping dynasty could maintain itself only by insisting on absolute submission to the crowned and anointed sovereign lord. How then could it excuse its

Knowledge, pain, and anxiety scores (mean $\pm$ SD)

Group	Knowledge	Pain	Anxiety
A (n=82)	6.7 $\pm$ 1.71	3.80 $\pm$ 1.22	2.38 $\pm$ 1.38
B (control) (n=110)	2.6 $\pm$ 1.47	4.93 $\pm$ 1.26	4.17 $\pm$ 1.45
	P < 0.001		P < 0.01