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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

The Rothschild principle

SIR,—While I agree that State funds for medical research remain with the Medical Research Council, you are wrong (6 May, p 1167) in believing they ever left. And you are also quite wrong in the belief that the Rothschild principle was found wanting—it was never tried. As a member of the Chief Scientist's Panel of Advisers called (we supposed) to help dispose of the Rothschild gold I found myself instead with a front seat at a slightly dubious Whitehall farce. It was quite evident by our first meeting that there was no intention of finding ways to support applied research. Instead, we were asked almost immediately to approve the nomination of a preselected group of *already established* MRC research projects which the Department of Health and Social Security could then pretend were the applied research projects it had funded for the year. This was the mode of operation during my stint on the panel (and as far as I know it has not changed): papers on research already funded by the MRC were shunted back and forth between the offices at the MRC and DHSS and somewhere along the route a spurious price tag was put on by (or on behalf of) the DHSS. Thus money for "Rothschild" projects was taken from the MRC and given to the DHSS; the DHSS then nominated some of the existing MRC projects as "Rothschild" and paid the money back again. By shuffling the papers in this way the pretence

was maintained that the DHSS was operating the Rothschild proposals and funding applied research.

The proceedings were so fraudulent that several of us decided to quit the job after the first meeting but then decided to stay on to insist that we did the job for which we had been appointed. And we had one or two ideas about how to go about it, but all that was stopped by the brilliant and simple expedient of never calling a meeting of the advisers again. Appropriately to our work of ghosting non-existent research we were now a ghost committee.

I am not sure about the Rothschild principle and perversely, for that very reason, wanted to see it tried out. It was sad it didn't succeed but don't let anyone go away with the idea that it failed.

SAM SHUSTER

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SIR,—Though I find your leading article which outlined the failure of the Rothschild principle (6 May, p 1167) stimulating and informative, I must disagree with its conclusion—that control of the whole budget (for medical research) should be returned to the Medical Research Council. As a result of a long development of tradition and attitude the

MRC is thoroughly attuned to the formal biological approach which, if it were not an emotive word, could be called "reductionist." Put another way, the research which they have supported with such conspicuous success has been mostly concerned with mechanisms and processes.

There exists a great body of work, particularly in the clinical field, where the rigorous methods of the laboratory apply with less force and where by the nature of the clinical task the work is untidy, at least in its initial stages. Here, in spite of the much beloved controlled clinical trial (a concept that has become something of an *idée fixe* in British clinical science), I believe the present organisation of the MRC has been less successful. The analogy with the Science Research Council's equally unsatisfactory past support of engineering is tempting but fails in that the latter council is doing something about it. If, and only if, the MRC were to show signs of a reorganisation which redressed the imbalance of their present support would I for one be happy to see all the money in one budget.

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Beta-adrenoceptor blocking agents

SIR,—In December 1976 Sir Theo Crawford, then vice-chairman of the Committee on Safety of Medicines, wrote to all doctors giving an account of reports received by the CSM of suspected adverse reactions to drugs in this therapeutic group and asked doctors to continue to report. Since that date approxi-

mately 2500 reports relating to beta-blockers other than practolol (Eraldin) have been received. There have been reports of rashes or dry eyes associated with the use of all the drugs in this group, but in most cases the signs and symptoms have cleared when treatment was withdrawn.

The Committee has received no evidence that any of the currently available beta-blockers produce reactions of comparable severity to practolol, but in order to confirm this and also to exclude the possibility that serious adverse reactions of other types are occurring the Committee on Safety of Medicines would urge doctors to continue to report all untoward events occurring in patients on beta-blocking agents.

Betacardone (sotalol)	Duncan Flockhart and Co
Betaloc (metoprolol)	Astra Chemicals
Blocadren (timolol)	Merck Sharp and Dohme
Inderal (propranolol)	ICI
Lopresor (metoprolol)	Geigy Pharmaceuticals
Sectral (acebutolol)	May and Baker
Sotacor (sotalol)	Bristol Laboratories
Tenormin (atenolol)	Stuart Pharmaceuticals
Trandate (labetalol)	Allen and Hanburys
Trasicor (oxprenolol)	Ciba Laboratories
Slow Trasicor (oxprenolol)	Ciba Laboratories
Visken (pindolol)	Sandoz Products

ERIC SCOWEN
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What kind of cot death?

SIR,—The reports on the aetiology of cot deaths in your leading article (18 March, p 671) and in the subsequent correspondence (22 April, p 1054; 6 May, p 1216) have not yet suggested a relationship between the state of mind of the mother before the event and the loss of her baby.

In six cases in which a patient has been referred to me for emotional problems in pregnancy or the puerperium the child of that pregnancy has died with a finding of cot death. Four of these babies were already on an at-risk register because of the mothers' expressed ambivalence to the baby and the extremely disrupted marital situation. Two had older siblings who had been previously taken into care for part of their lives because the mother was not caring for them properly. In three cases the local authority had been actually warned that something was likely to happen to the baby who eventually died.

What these cases had in common was an ambivalence towards the child who died and a home situation which was so disrupted by emotional problems that it was easy to see that symptoms in a baby could be overlooked or misinterpreted, feeds made up incompetently, and normal conditions of hygiene not adhered to. The question must be raised as to whether in a proportion of cot deaths the mental disturbance of the mother plays any part in the situation.

ELIZABETH TYLDEN

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SIR,—With reference to your leading article (18 March, p 671) I would like to put forward my observations on this subject.

I offer support to families in which a cot death has occurred. While listening to these families give an account of the final hours of the child's life I became aware that many of them had not actually been looked at for some hours. I then began asking when they had actually last seen their baby. I heard of a mother who had a child sleeping in her room, yet got up, dressed, and went and made coffee without glancing at the baby. Another family had a young baby in the car with them; after driving for some time without a backward glance at the carry-cot they unloaded the car before looking at the baby. A final example is of an 8-week-old baby who had not been seen by its mother for 13 hours.

In these cases the social history has shown that there were other factors present that would lead one to believe that the baby was at some risk. It would appear that some mothers pay much less attention to their babies than others. I feel that the mother's ambivalence about the conception, difficulties experienced during birth, problems in bonding, and the mother's depression may all lead to her feeling the need to distance herself from the child. I suspect that near-miss cot-death babies have mothers who are vigilant about their babies and are therefore more likely to notice them when they stop breathing and stimulate them. There may be a group of babies with poor respiratory control who also have less vigilant mothers, like the ones I have described, who are less likely to notice a pale, blue or apnoeic baby and so lose the opportunity to stimulate the child.

The fact that parents had not looked at very young babies for a long period before they were found dead occurred in a sufficient number of cases to make me wish to put this idea forward for consideration. I would be interested to hear from anyone who has similar observations as I hope to make a more detailed study.

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Vitamin E and malignant hyperthermia

SIR,—I wish to report a case of malignant hyperthermia occurring under general anaesthesia in a patient taking vitamin E which he had obtained from a health food store. The exact dosage is not known but was probably in the region of 200 IU (equivalent to 200 mg of α -tocopheryl acetate) twice daily. A blood sample taken before the operation was later reported to have a serum vitamin E concentration of 19.4 mg/l (normal range 5.2–11.4 mg/l).

The patient, aged 69, was to have a cystoscopy and Millin's prostatectomy. He had had an appendicectomy and inguinal hernia repair in "the 1940s." Of the anaesthetics, it is known only that the induction agent was given rectally. He was given pethidine and promethazine premedication and anaesthetised with thiopentone, suxamethonium, nitrous oxide, and halothane. The trachea was sprayed with lignocaine and intubated; relaxation was maintained with D-tubocurarine. After 1½ h a transfusion reaction was suspected because of a rise in pulse rate. The operation was completed, but because of the patient's general condition he was kept on the operating table and ventilated with oxygen. The rectal temperature 2 h after induction was 39°C and remained static for the next 25 min, when it suddenly rose, reaching 42°C at the time of cardiac arrest, 2 h 50 min after induction. Arterial blood taken before the sudden rise in temperature showed pH 6.94, P_{CO_2} 12.6 kPa (94.7 mm Hg), and base excess -9.8 mmol/l. Treatment was attempted

with surface cooling, intravenous sodium bicarbonate, and dexamethasone but was unsuccessful.

Careful inquiry among the patient's seven siblings and their children has failed to reveal any death during anaesthesia, so a hereditary predisposition to malignant hyperthermia is unlikely. Dr F R Ellis of the Malignant Hyperthermia Investigation Unit has suggested that the vitamin E which this patient was taking predisposed him to the development of the malignant hyperthermia syndrome. The purpose of this brief report is to alert anaesthetists to this possibility; they may wish to monitor temperatures during operations in patients who are taking vitamin E or health products such as wheatgerm oil which are rich in vitamin E.

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Psychological evaluation in cases of self-poisoning

SIR,—The recent papers by Dr R Gardner and others (17 December, p 1567) and by Dr D R Blake and Professor J R A Mitchell (22 April, p 1032) highlight the increasing problem of self-poisoning and question the psychiatrist's role in assessment and follow-up.

Dr Blake and Professor Mitchell even doubt that self-poisoners are patients in the conventional sense in that they have not asked for treatment; but they are surely as much patients as accident victims, for example, the majority of them more so, as we find that approximately 30% are currently receiving psychiatric treatment and 60% have consulted their general practitioner in the four weeks before the overdose. Indeed, self-poisoning is often an expression of dissatisfaction with conventional methods of referral and treatment, so it is no surprise that in Dr Blake and Professor Mitchell's series the default rate in those referred to a psychiatric outpatient clinic was as high as 43%.

Bearing in mind the findings of Barraclough *et al*¹ that 41% of completed suicides had a previous episode of self-poisoning the two papers, far from invalidating the Hill Committee recommendations, would seem to underline their importance, in particular the need for designated treatment centres where all available help can be concentrated. Self-poisoners are for the most part impulsive people with a low tolerance to stress; over 60% in our experience are facing an acute marital crisis, and delay in referral for even a few days can mean that the critical time for intervention has passed. Whether the help is to be given by nurses, physicians, or psychiatrists seems immaterial, but I agree with Dr Blake and Professor Mitchell that the same team should be involved throughout, and intervention is clearly simpler in a compact unit where information can be readily co-ordinated.

In this general hospital an average of 400 self-poisoners a year are admitted to a specialised four-bedded unit run jointly by physicians and psychiatrists where the nurses do much of the work of assessment, taking an initial history, talking to visitors, and offering a 24-h Samaritan-type service with phone-in or walk-in help following discharge. One or more psychiatrists attend daily and interview patients and relevant family members or, when there are no relatives, the social worker, health visitor, or other key figures already in-