reports on bronchodilator infusions which were given as initial therapy for acute asthma and for short periods only, where it would be a simple matter to change treatment for those who failed to respond. We cannot really contest his views on the ethical committee, which may apply criteria more stringent than elsewhere. The information presented in our paper suggested that a salbutamol infusion of 10 µg/min is no more effective than the aminophylline infusion, and Professor Grant may well be correct to state, as we inferred, that with adequate administration of nebulised bronchodilator drugs an intravenous infusion may not make a significant contribution to airway function.

The analysis for significant differences in lung function between the two infusion groups included all the patients up to the time of withdrawal from the study if before 36 h. Dr Anderson assumes incorrectly that the data on those patients withdrawn before 36 h were not included in these analyses. The fact that of the six patients withdrawn from the salbutamol group before 36 h, two were responding faster than the group as a whole makes the response between the two groups less marked than Dr Anderson suggests.

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Electron microscopy of cell membranes

SIR,—Having read Minerva's comment (6 May, p 1220) on Dr Harold Hillman's controversial views, may I refer her to Ghadially's book on cell ultrastructure¹ in which there are numerous examples (for example, pp 109, 123, 175, and 231) of the widening and blurring of unit membranes due to oblique cutting and the effect of section thickness. Indeed, I could supply many more from my own work. These examples completely contradict Dr Hillman's assertion that unit membranes always appear to be of identical width in electron micrographs—a statement so patently untrue that many electron microscopists are at a loss to understand how such a fundamental misconception could occur. It is hardly surprising, therefore, that so little interest has been taken in Dr Hillman's comments.

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¹ Ghadially, F N, *Ultrastructural Pathology of the Cell*. London, Butterworths, 1975.

Ginseng and mastalgia

SIR,—Mr B V Palmer and his colleagues (13 May, p 1284), in reporting the occurrence of mastalgia in a woman taking ginseng, suggest that the preparation may have mild hormonal activity.

Such an observation is not unexpected, since small quantities of oestrone, oestradiol, and oestriol are present in ginseng root.¹ This is not the only possible type of complication with ginseng; some of the products concerned appear to affect blood levels of glucose as well as glycogen levels in liver and muscle, and it has been suggested that they may interfere with the regulation of diabetes.² At least one of the components is closely related

to digitoxin and could in theory cause problems in patients already taking cardiac glycosides.³ Unfortunately, most of the clinical literature on ginseng is very uncritical and provides no help in allaying or confirming such suspicions.

Since ginseng products, while generally evading medicines legislation, are apparently widely promoted and sold throughout western Europe there is every reason for the physician to determine whether his patients are taking them; they may well be a cause of interactions and adverse effects which have not yet been recognised as such.

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¹ Court, W E, *Pharmaceutical Journal*, 1975, **214**, 180.

² Dukes, M N G, *Side Effects of Drugs Annual*, 1977, **1**, 374.

³ Oura, H, *et al*, *Journal of Biochemistry (Tokyo)*, 1975, **77**, 1057.

If I had . . .

SIR,—Since the cataract surgeon of my choice has retired, my colleagues and I have often discussed to which surgeon we would go and what we would wish done in the event of developing cataracts in each eye. It was therefore with interest that I read the article by Mr Brian Harcourt (29 April, p 1121).

Each cataract surgeon, I am sure, believes that he or she knows the best way to deal with this common event. I agree with Mr Harcourt on most points in his detailed analysis of what he would do. I would, however, spend much time picking the surgeon of my choice, whose ability and judgment I would consider to be impeccable. I would hope that this mythical person might be persuaded to operate on me before my vision fell to 6/24 as I would find it impossible to continue my work at this visual level. I would pick a surgeon with experience of conventional intra- and extra-capsular lens extraction and one who is familiar and experienced with the technique of phacoemulsification. I would hope that he would evaluate the relative advantages of phacoemulsification versus conventional surgery in my case.

If my lens nucleus was not hard, and if I were a myope (which I am), I would value the freedom and safety of a small wound and that an intact posterior capsule would give me postoperatively. From personal experience I would not be too anxious at the thought of prolonged irrigation or corneal damage resulting from a straightforward phacoemulsification with eight seconds' irrigation, in competent hands, and I know that I would be happy with the quiet, painless eye 24 h later. I would expect to take a chance of the necessity of a posterior capsulotomy after five years if my capsule thickens, but I would hope it would not. I would like to get up and get home early—not to play golf but because, much as I think I would be treated well in hospital, home is nicer, and in common with other doctors I believe I would be an impatient patient and anxious to get on with the process of seeing again. If I had had a phacoemulsification I believe that I would be able to get my contact lens fitted sooner than if I had had conventional surgery.

If, however, my mythical surgeon chose conventional surgery I would hope that he would reduce his instrumentation to a

minimum in order to reduce the possible dangers to my corneal endothelium as much as he could. Like Mr Harcourt I would not, as yet, opt for intraocular lens insertion, though I hope that my cataract will stay away long enough for the problems of this mode of surgical replacement to be solved so that I might be able to experience it in safety. Failing that, I would of course opt for contact lenses.

If I had cataract, however, I believe I would be too much involved to make unemotional decisions and therefore, having done my bit by picking my surgeon and behaving as I hope all my own patients will do, I would lie back and let him do the worrying, trusting to be one of the majority of cataract patients who do have an uneventful postoperative convalescence and who do achieve good post-operative sight.

I trust that neither Mr Harcourt nor I will for a long time (I hope never) be in a position to write you an article on "When I had cataract"—but it would be interesting to hear the opinions of some ophthalmic surgeons who must have had this operation done. In the meantime the search for impeccable judge and able and uninvolved surgeon continues.

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Assaults on doctors

SIR,—We read your leading article on this subject (13 May, p 1229) with some concern. At the recent annual meeting of the Casualty Surgeons' Association in conjunction with the Royal College of Nursing Accident and Emergency Forum one of the themes of the conference concerned our legal rights concerning patients. At the same meeting we heard a discussion document from a joint working party investigating the occurrence of violence in accident and emergency departments. Despite the inability of this working party to show any objective evidence to suggest an increase in violence, the general body of opinion was that measures must be taken to protect the staff from patients.

Hence against a background demonstrating a singular lack of evidence to support the contention that violence to medical staff, paramedical workers, and nurses is increasing we are confronted with a demand for more comprehensive protective measures. Certainly in Derby we have no real problem of violence in the hospital although we cannot speak for other areas, which may experience local difficulties. It seems to us that by sensationalising a problem which seems to be generally no worse than it ever has been we are at risk of attracting a violent element of the public to our hospitals and so creating a real problem.

Although we concede that medical workers must not be expected to take assault as a matter of course, it must be accepted that potentially violent situations will occur because of the very nature of our work. We have coped with them in the past using guile, tact, and sympathy, often for ill or highly stressed individuals. We must not replace this subtle approach with a display of alarms and indiscreet security men or be too ready to use our statutory powers under the Mental Health Act to deprive patients of their liberty. Let