unveil the unconscious and dynamic nature of motivation and to demonstrate that what is repressed in our society is sexuality. Why this is so, despite the work of Freud, I believe still remains to be explained. Yet what is so remarkable is that after all this time the level of awareness of these things, as his work of course predicted, is quite extraordinarily restricted within the profession and among the public owing to the persistent inner needs of resistance to such insights in the individual.

Those of us with a little insight working, day to day, in the deceptively simple field of family planning see that forgetting to take the pill, for example, and the unwanted pregnancy that arrives are not accidental or simple and practical matters only, as they seem to be, but are meaningful in terms of the inner needs of the individual and her personal conflicts.

Until we are, most of us, prepared to face the problem of human sexuality as it were afresh, free from the preconceived notions which are unhappily the norm of our society, we will continue to experience failure in trying to contain it and its problems in what is, after all, an unnatural and artificial pattern to which we demand conformity. Aligning ourselves with the repressing forces of the unconscious may indeed produce this comforting conformity of behaviour. But it solves nothing and may greatly intensify the real personal problems it conceals. Certainly as far as authoritarianism and the regimentation of sexuality are concerned socially these, since Victorian times, have been tried and found wanting.

NORMAN CHISHOLM

London NW3

Cough suppressants for children

SIR,—Your leading article (28 August, p 493) which listed the commoner causes of cough in children omitted asthma, which so often causes nocturnal cough as the predominant symptom. This cough is by no means always accompanied by wheeze so that the diagnosis may well be missed, despite the usual presence of clues such as a history of infantile eczema.

If the cough is a manifestation of asthma it will be dramatically abolished within a day or two of giving a short therapeutic trial of a steroid (for example, prednisone 5 mg twice daily for five days).

DOUGLAS GAIRDNER

Cambridge

SIR,—Et tu Brute! How divorced from field medicine do you become in your ivory tower. Consultants, too, see only the odd complicated case, but on the strength of these rarities try to lay down what shall and shall not be done. Unfortunately, those who do the medicine do not have time to do the writing as well. But they know what it is all about. Moreover, hospital doctors can forget their failures and write-offs, but general practitioners still have to live with the families. Not only can they not afford mistakes, but they have to cover up the hospital deficiencies.

What craziness to suggest (leading article, 28 August, p 493) that antibiotics do not prevent bacterial complications of measles in most cases, and febrile asthma. If measles is now reasonably innocuous it is because of the antibiotics now routinely prescribed except in the mildest cases, and most cases of febrile

asthma settle under the GP's care with antibiotics and bronchodilators, with steroids if absolutely necessary, so that only the resistant virus cases, cases in very young children and babies in whom virus infections are more severe, and cases in which the cocci have already been eliminated by the GP's antibiotic reach hospital. Moreover, if a swab fails to produce cocci for whatever cause, even an error in technique, then the case is labelled as of viral origin. Thus hospital diagnoses are heavily biased towards the viral side.

Present-day doctors and consultants are almost all too young to remember preantibiotic days. May I remind you all of a few facts. My 1935 Taylor's *Practice of Medicine* quotes the incidence of complications in measles, amongst other things, as over 60% otitis media and 40% pneumonia. These conditions are mild now with antibiotics, but it used not to be so. It is now said that because 60% of tonsillitis cases are of viral origin antibiotics should not be given. But what about the remaining 40%, which are presumably bacterial? Should they be denied the benefit and protection too?

At my preparatory school at least 5% of the boys showed the horrible postauricular depressed scar of an acute mastoid operation. At my teaching hospital there were three ENT operation lists per week, and these each included at least three radical mastoid operations. Anybody involved in their postoperative nursing care could never forget the pain and screams evoked when the dressings were changed and the drainage plugs removed. In over 25 years in general practice with antibiotics I have not seen a case of acute mastoiditis. Nor have I seen any glue ears, thanks to the early exhibition of antibiotics. Sir, would you really have us return to those bad old days, when doctors stood by helpless and nurses were too busy nursing to parade the streets? For my part I have never regretted giving an antibiotic, but many times have I regretted withholding it. The occasional rash, quickly controlled by an antihistamine, is a small price to pay to prevent all the pain and deafness which would otherwise result.

C W F MCKEAN

Leominster,
Herefordshire

SIR,—In the masterly survey of your leading article on this subject (28 August, p 493) the whole area of the family and social consequences of acute or chronic cough is missed out. "As Gold remarked," you quote, in 1953 or "as Wade wrote" in 1961. I do not think that you have been a general practitioner, or if you were you have forgotten.

Mother comes in with Wayne or Rebecca because she has been awake half the night listening to the cough and has also had to deal with the murderous threats of father who has to get up at 6 am anyway to drive his lorry to Glasgow. Mother also has to get Willie ready for school and Mary for the day nursery. A simple cough suppressant is more than a placebo, it is a placebo, and the peace which ensues explains the 75 million doses of linctus. So on with the masterly reviews, every paragraph of which is important, but just one more, please, on easing the tensions of family life, preventing divorce, and decreasing the dangers of child battering.

A H BACON

Coventry

Nicotine, tobacco substitutes, and smoking habits

SIR,—Mr P M Gaylarde (14 August, p 419) puts forward the suggestion that "research should be undertaken to provide a safer cigarette for smokers" as if this were an area in which no work has been done at all. He also implies that without specific financial inducements the tobacco manufacturers will completely neglect such research.

Neither implication stands close examination. The members of the Tobacco Research Council are currently spending some £5m a year, either collectively or separately, on research prompted by the views of the medical authorities about the health hazards attributable to smoking. Much of this research is aimed at the modification of smoking products in ways which those authorities may be presumed to regard as less harmful. Already, since 1965, the sales-weighted average tar delivery of cigarettes on the British market has been reduced by some 40%.

Within the compass of a short letter it is impossible to spell out in full what has been learnt about the influence which changes in cigarette specifications are likely to have on the yields of the various substances which Mr Gaylarde mentions, but perhaps three examples will serve to show both that the stock of knowledge is already considerable and that the whole subject bristles with complexities.

The size of shreds of tobacco used (cuts per inch), the packing density, and the diameter of the cigarette have all been studied and their effect on smoke deliveries (for example, total particulate matter, nicotine, carbon monoxide, nitrogen oxides, benzo(a)pyrene) and condensate tumorigenicity determined. It is not unusual for the deliveries of some smoke constituents to be decreased while others are increased. For example, cigarettes manufactured from tobacco cut at 100 cuts per inch yield condensate which has only 79% of the tumorigenic activity of that from cigarettes with tobacco cut at 25 cuts per inch,¹ whereas the carbon monoxide deliveries move in the opposite direction.

Other work has shown that oxidants (particularly nitrates) reduce the polycyclic aromatic hydrocarbons in smoke condensate^{2 4} and the tumorigenic activity² but at the expense of an increased delivery of carbon monoxide and oxides of nitrogen in the smoke.⁵

A series of 94 additives has been studied by workers in the USA,⁶ including bleaching agents, catalysts, and inhibitors. However, the results were not always encouraging—for example, sodium perborate was shown to increase the delivery of benzo(a)pyrene by 80%.

Mr Gaylarde attaches importance to the use of oxidants as a possible explanation of differences between lung cancer rates in Britain and certain other countries, suggesting the "modification of [British] cigarettes by the omission of oxidants from their manufacture" (to quote his words). He has overlooked that oxidants, like other additives (these include bleaching agents), are *not* permitted in cigarettes sold in the UK. Nor could they be introduced in future without proper authorisation.

Mr Gaylarde also suggests that there is a link between cigarette diameter and tar: nicotine ratio. How he has drawn this conclusion is not clear as it appears to be based on a table incorporating no direct information on diameter at all. In any case it

seems unlikely to be true, as the nicotine content of the smoke depends upon the nicotine content of the tobacco, and the tar: nicotine ratio in the smoke is controlled mainly by a suitable choice of tobaccos.

C G JARRETT
Chairman,
Tobacco Research Council

London SW1

¹ Tobacco Research Council, *Review of Activities*, 1970-1974. London, TRC, 1975.

² Hoffmann, D, and Wynder, E L, *Cancer Research*, 1967, 27, 172.

³ Bentley, H R, and Burgan, J G, *Analyst*, 1960, 85, 727.

⁴ Wynder, E L, and Hoffmann, D, *Deutsche Medizinische Wochenschrift*, 1963, 88, 623.

⁵ Terrell, J, and Schmeltz, I, *Tobacco Science*, 1970, 14, 78.

⁶ Burton, H R, and Benner, J F, Tobacco and Health Research Institute Workshop Conference, University of Kentucky, 11-13 January, 1972.

The elderly in a coronary unit

SIR,—The paper by Dr B O Williams and others (21 August, p 451) is an excellent study of the place of the elderly in a coronary unit. In this area the great majority of subjects over 70 presenting with acute chest pain are immediately admitted to this department. These patients and any other seriously ill patient requiring intensive care facilities are initially admitted to our own 12-bed intensive care area equipped with facilities for continuous ECG monitoring on a central display with associated arrhythmia monitors, automatic ECG write-outs, and visual and auditory alarms, together with synchronised DC defibrillation service.

Our experience is in accord with that of Dr Williams and his colleagues that elderly patients with severe confirmed myocardial infarction who require synchronised DC shock and defibrillation respond well to this procedure. But it is sad to note that, having shown the benefit of intensive care facilities for the older patient with an acute myocardial infarction, the authors conclude by suggesting cutting him off from these facilities. May I suggest that the majority of these patients do not require the full services of a coronary care unit but intensive care facilities in an area that is well staffed by nurses and doctors fully conversant with the basic equipment for the adequate monitoring and resuscitation of all acute seriously ill older people.

We in no way set out to be a coronary care unit, having neither the expertise nor the full range of services to do so. Fortunately our cardiology colleagues will immediately take over any of our patients who require pacing or other aspects of their special expertise. Once the period of full coronary care service is completed, the patient is transferred back to our care. This arrangement ensures that the small number of older persons who require very expensive technological services and expertise are not denied it if appropriate to the adequate management of their condition.

M S PATHY

Geriatric Unit,
University Hospital of Wales,
Cardiff

Admission of old people to hospital

SIR,—It is usual for those involved in discussions of the merits of institutional and community care to use emotive language and see no virtue in the other side's arguments. In particular, those in favour of reducing

institutional facilities dwell on infringements of personal freedom, horrors of institutionalisation, and cruel incarceration. Almost every committee of inquiry makes play of the inadequacies or frank malice of those responsible for the care of persistently disabled people.

In the name of preserving personal freedoms, obviating institutionalism, etc, and improving the quality of institutional care available to those acutely ill the number of beds now planned for the adult mentally ill has been reduced to such a low level that in itself this variable determines the sort of patient that can be admitted and the length of time he can stay in hospital. Few chronically disabled patients remain so persistently disordered that they can count on hospital as home.

Dr A A Baker, having contributed to the present state of services for the younger mentally ill,¹ is now heavily involved with old people (4 September, p 571). While I vigorously support the view that home is the best place to live out one's life, in full understanding that dementia carries with it a reduced life expectancy and that hospital admission carries a morbidity, it is clear to me that the "long-stay" ward has an important positive role to play in a comprehensive community service for the elderly mentally ill. For those who care to look farther than "Hello" or "Good morning" a fuller complex of human interactions is there to be seen on a well-run "death-do-us-part" ward. The nursing skills required to elicit maximal communication are comparable with those more tangibly demonstrated in other forms of "intensive care." The management of death is truly as important as anywhere else. When the issues involved are faced up to, unpleasant modes of death can be avoided more surely than among those left in fear and ignorance to their own devices.

Cruelty to the elderly can take many forms.² Let us be no party to reducing those facilities that are capable of giving care. Rather let us make plans for strengthening institutional as well as domiciliary supports.³

D J JOLLEY

Department of Psychiatry,
Withington Hospital,
Manchester

¹ Baker, A A, *Lancet*, 1969, 1, 1090.

² Baker, A A, *Modern Geriatrics*, 1975, 5, 20.

³ Blessed, G, *British Medical Journal*, 1976, 2, 478.

SIR,—As everything that comes from his pen, Dr A A Baker's paper (4 September, p 571) is both humane and provocative. The following response comes to mind.

Much of the problem which Dr Baker describes so vividly arises from our muddled attitudes. It is suggested that we must get used to certain guide lines in our decisions about old people who become increasingly deteriorated in their homes. We must come to realise that, especially towards the end of life, death is not the greatest evil but that pain, dyspnoea, and distressed feelings and thoughts are. This holds for the old women and an occasional old man about whom Dr Baker writes, and as far as distress is concerned also for their neighbours and "responsible" relatives. In general, one would say that an old man or woman who shows no undue decline in orientation, memory, and other mental functions and who clearly wishes to remain in his own home should be left there even if his or her presence causes a lot of distress and annoyance to others. However, where there is more severe mental

disorder (either with or without disturbed thought content) and also perhaps serious physical disease, as well as considerable distress to the human environment, admission ought to be arranged. Continued stay at home would sooner or later cause the patient grave symptoms (burns, fractures, or increasing states of fear due to abnormal thought content and experiences).

The fact that some 25% of elderly confused patients die within three weeks of admission should not worry us unduly. Although in many cases the sequence of events is no doubt that described by Dr Baker and related to removal from home, those of us who have studied elderly patients in the old mental observation wards know that in many cases admission had, in fact, been precipitated by the physical illness which led to early death. Much more serious is the situation which is described by Dr Baker in his case report enumerating a long sequence of treatments. No doubt he gave it to demonstrate that there are unfortunately still some doctors who are not sufficiently sensitive to the significance of pain and distress and who "strive officiously to keep alive."

FELIX POST

Maudsley Hospital,
London SE5

SIR,—Dr A A Baker's perceptive article on the treatment of old people living alone (4 September, p 571) rings true in every detail. The thinly disguised bullying which goes on to force these defenceless patients into hospital is conducted out of deference to three distinct errors.

(1) The assumption that the ordered life of the hospital ward must necessarily be preferable to the untidy state of affairs to which the patient has become adjusted at home. A much greater tolerance of less than perfect conditions with freedom and independence is needed as long as such obvious dangers as fire risks can be avoided.

(2) The obsessional belief that because admission to hospital can often add to length of life it is thereby automatically preferable to a shorter existence in imperfect surroundings. Absolute honesty would also inculpate many of us in that by pressurising the old into hospital we are rid of an unwelcome work load. When principle coincides with expedience the former is that much more attractive.

(3) The heresy born of contemporary materialism that living is always preferable to dying. We need to accept dying as something positively desirable in advanced age, not as an enemy but as a friend. Mere extension of life has no inherent merit except that of an unreasoning sentiment. "Enough is better than more" is a sounder philosophical attitude than "as much as possible," and any old person who takes the former view should receive the utmost respect.

S L H SMITH

Huddersfield

Fetal activity and fetal wellbeing

SIR,—I wish to congratulate Mr J F Pearson and Miss Judith B Weaver for their interesting article on this subject (29 May, p 1305). Most of their data agree with my own observations. I would like to make the following comments:

(1) We have observed that women who record fetal movements for 12 hours a day, as