undergo a particular line of treatment which is also dangerous. We wish the treatment to be as safe as it can be made, but it is still up to the patient or his relatives to decide whether to accept it or not. If things go wrong, and especially if one had more or less forced a decision, it is the surgeon who gets the blame, not the patient.

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Children's rights—parents' responsibilities

SIR,—It is unfortunate that your leading article on this subject (2 October, p 775) perpetuates the myth that doctors cannot apply for a place of safety order when they believe children to be abused or at risk. In fact, section 28 of the Children and Young Persons Act 1969 places no restriction whatsoever on the categories of person who may apply to a magistrate for such an order. Doctors should also be aware that the grounds on which a care order (and a fortiori a place of safety order) may be sought are less restrictive than your article suggests. The 1969 Act has always admitted as a ground the *probability* that a child will be abused, neglected, etc, if another child in the household has previously been so treated, and the Children Act 1975 enables this probability to be established by the child's being (or being likely to become) a member of the same household as someone convicted of a relevant offence laid down in the Children and Young Persons Act 1933. This strengthens the protection of children, by either care or place of safety orders, from known abusers, even if a child in their household has not yet been ill-treated.

Finally, it is worth mentioning that (although one hopes that any decision about applying for a care order would be taken only after a case conference discussion in which paediatrician and general practitioner were fully involved) doctors are not wholly dependent on social workers to apply for care orders under the 1969 Act, since both the police and the NSPCC also possess statutory powers to make applications.

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New kinds of doctors

SIR,—The interview with Dr Julian Tudor Hart on new kinds of doctors rambled around the subject without advancing concepts in any way. In fact, the advocacy of a return to the Gladstone bag, and the provincial view that London patients are endowed with greater understanding of pathology and the position of their organs, and are rendered able to give a history in medically significant terms from contact with the teaching hospitals, is plainly provincial bunk and regressive thinking.

If I thought I knew what Dr Hart meant by "very few GPs who have been in practice for 15 years or more can hold their own at the level at which consultants and registrars operate their gamesmanship" I would disagree with it. But then I don't know what it means except perhaps that Dr Hart considers himself to be one of these few.

When he says that "in North America

health consciousness has become egotistical," "a market commodity that is bought and sold," while here "we have an opportunity to set a real value on health," I suspect he knows little about the matter and expresses a view tinged by resentful socialism from the Welsh valleys. We could do with more of the North American view of health, and my own observations confirm at a London swimming club that American students do their lengths while the British lads stand in the water and talk. What does it indicate?

Dr Hart must not mind my being so critical, since he believes "we need to move closer to the hospital pattern, where it becomes possible to have mutual criticism in a way that is not damaging." Fine! Here he shows himself not to be a very new kind of doctor, for small group meetings are being held here—why not in Port Talbot?

What is health, then? I would say you are healthy when you wake up each morning, stretching and feeling By God! It's good to be alive! Doctors, and their drugs, whether charged for on prescription or not, are not in the market for this type of health. Just as Dr Hart rightly states, "Education should not be a prerogative of teachers alone," so should concepts of health be promoted not only by doctors. Doctors are taught to understand by analysis into components. The degradation products thus considered are always less than the sum of the parts in action. It is the comprehension, or should I say apprehension, of fully aspirant living that the new doctor needs. It seems to be coming strangely enough through attempts to become more adequate when dealing with the dying patient and his family.

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Management of acute myocardial infarction

SIR,—Dr P J Baxter and his colleagues (14 August, p 423) comment on the article by Professor J F Pantridge and Dr J S Geddes (17 July, p 168). They consider that information on the extent of myocardial infarction occurring in industry would be helpful in deciding whether lay or medical personnel working in factories should be trained in cardiac resuscitation techniques. This question concerned me for some while, when I was medical officer in a steelworks. The works employed 12 500 people and during the two years 1973-4 13 men suffered acute myocardial infarction while at work. Of these, four were dead when I saw them on site or immediately on admission to the works surgery and one died in surgery. The other eight survived the journey to hospital. The one man who died in the works surgery failed to respond to resuscitation; ECG monitoring showed irregular and feeble ventricular beats and he eventually died in asystole. At post-mortem he was found to have a massive occlusion and no resuscitative measures would have succeeded.

After collecting these cases for the two-year period I asked two questions: (1) Is the delay in reporting symptoms and in obtaining medical aid less in industry than at home? (2) What facilities should the industrial medical service provide?

The answer to the first question was very interesting. McNeilly and Pemberton¹ reported a median delay in seeking medical aid

of 1 h 17 min and a delay in reaching hospital of 8 h. In the steelworks both these times were very much less, being 30 min in each case. It was clear that in industry with a medical service the patient knows that he can seek help very much more quickly, he reports his symptoms very early, and there is a very reasonable chance of getting him to expert help in hospital within an hour of the commencement of symptoms.

I discussed the second question with the consultant physician who would eventually see these cases. We came to the conclusion that a rapid but calm evacuation to hospital was the best measure. We kept adrenaline, atropine, and lignocaine always ready, but on only one occasion during the two years did we use the adrenaline.

Admittedly this was a very limited experience, but during the same time a colleague was collecting data from a number of steelworks with a total population of 56 000. During the same two-year period there were 100 cases of myocardial infarction occurring at work. Eleven patients were dead on arrival at the works surgery, six died within 1 h and nine between one and 24 h of reporting, and ten died later within the same year, giving a one-year mortality of 36%. Of the six who died within 1 h of reporting, five died in the works surgery (this included the one case in my own study). Two of these victims died before a doctor arrived, in one case after 80 min. In the other three cases resuscitation was attempted, including the use of external cardiac massage. Only my own patient was monitored; I do not know whether the other two had ventricular fibrillation.

I came to the conclusion that it is best to get the patient to hospital, even if the diagnosis is uncertain, as quickly and calmly as possible. It is very unwise to keep a patient in the works surgery while waiting for a doctor to arrive. The chance of a doctor or a specially trained nurse reaching a patient in time to use a defibrillator successfully seems very remote.

My former colleague, Dr John Watkins, who was collecting these data, tells me that he has continued this survey. It is still incomplete and it will be some time before the results can be published.

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¹ McNeilly, R H, and Pemberton, T, *British Medical Journal*, 1968, 2, 139.

Diets for diabetics

SIR,—Your leading article (2 October, p 780) summarises the recent tendency to increase the carbohydrate content of diabetic diets. It stated that insulin requirements would be "relatively little affected by an increase in carbohydrate intake provided that the calorie total remains unchanged." A recent study,¹ not included in the review, suggests an important exception: unrefined starchy carbohydrates decrease the requirement of hypoglycaemic drugs and insulin in many but not all mild maturity-onset diabetics, who may recover eventually normal carbohydrate tolerance even if either the hypoglycaemic agent or insulin has been discontinued.

Previous US studies had reported that a high carbohydrate diet improved glucose tolerance in normal individuals^{2,3} and in mild diabetes.^{2,4} The recent study¹ compared