My greatest worry about your article is that it may have implanted in the minds of rapid readers an idea that all GP hospitals are costly. There has recently been a spate of closure threats from area health authorities seeking a simple solution to financial strictures. The busy members of these authorities rely on responsible sources for information on which to base their difficult judgment. They cannot be expected to read research documents in detail. It is the considered view of myself and many others that the closure of flourishing GP hospitals solves no financial problem.

Your suggested comparative trial and pilot scheme for different regions seems rational but is probably doomed before it starts because no two regions or areas are comparable and no GP hospital will allow itself to be closed for experimental reasons. To quote the Oxford document once more, "a full analysis has not been achieved mainly because of the enormity of the task of collecting data on so many outcome variables. . . . Doubts remain on qualitative aspects which are not capable of measurement. . . . Yet the qualitative aspects may ultimately be the critical factors in any decision."

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¹ Rickards, J A, *Cost-effectiveness Analysis of the Oxford Community Hospital*. Oxford, Department of the Regius Professor of Medicine, 1976

"Nurse consultants"

SIR,—I have just read an article (in another journal) by a lady whose official title was given as "clinical nurse consultant (anaesthetics)." When I had recovered my equanimity I felt I must write to ask you or your readers for clarification. To me "clinical" and "anaesthetics" do not marry well, nor do "nurse" and "consultant." I would be interested to discover just what grade on the Salmon scale such a person holds and what she actually does? I cannot conceive of any situation in which any nurse should call herself a consultant and if we allow these things to occur we shall very soon be in a position in which the nurses are at the same level as the senior medical staff. I may well be cantankerous and oldfashioned, but this I will fight to the end of my working life.

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Side effects of prazosin

SIR,—I am grateful to Professor C Rosendorff (6 November, p 1131) for clarifying the points which I raised about his paper on dose-related side effects of prazosin (28 August, p 508). I am sorry that he considered some of my assumptions to be sinister—they were not meant to be. However, in view of the lack of information in the original paper it was impossible to assess the full significance of his results. In this context one has to appreciate the limitations imposed by the "short report" format and clearly Professor Rosendorff has good evidence that these first-dose reactions are dose-dependent.

So far as the ethical context of this work is concerned, my comment is, of course, highly subjective. I accept that rechallenge is an acceptable technique in diagnosis and therapy and can be so in experimental work as well. My complaint is not a general one against the concept of rechallenge but a particular one in this case in view of the severity of some of the reactions to the drug. I am not sure that any further information has been gained from this study than could have been gained from a comparative trial of the drug using a smaller starter dose against placebo and against other established antihypertensive drugs.

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Diagnosis of Down's syndrome at birth

SIR,—Your leading article (9 October, p 835) rightly emphasises the importance of improving the clinical diagnosis of Down's syndrome soon after birth but comments on the shortcomings of existing clinical methods in achieving this.

One particularly characteristic clinical finding deserves wider recognition—namely, the size and *grouping* of the facial features. The newly born infant with Down's syndrome has eyes, nose, and mouth which are not only individually relatively small but which are grouped more closely together towards the centre of the oval represented by the face and forehead. The figure illustrates this in an affected infant (left) compared with an infant with similar but differently spaced facial features (right).

This finding appears so consistently that, taken in conjunction with the other discriminating features described by Jackson *et al*,¹ it should reliably increase the accuracy of diagnosis. Surprisingly it is omitted from nearly all standard textbook descriptions. It may not, however, apply to chromosome mosaic Down's syndrome.

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¹ Jackson, J F, North, E R, and Thomas, J G, *Clinical Genetics*, 1976, 9, 483.

Disappearing elderly

SIR,—Some 18 months ago a planning document circulated by one of our local authorities implied that the provision of residential accommodation and other services for the elderly were at higher levels per head of population than we believed them to be. Closer inspection revealed that this "improvement" had been achieved by a reduction of over

20% compared with 1971 Census data in the estimated number of people aged 65 and over resident in the local authority area. The new estimate had been obtained by counting the persons on the electoral register who had declared themselves as not liable for jury service by virtue of being aged 65 or over.

We have had an opportunity to investigate the accuracy of this method of estimating the size of an elderly population. The Whickham Survey, carried out from 1972 to 1974,¹ studied various aspects of health among the adults of a geographically defined area by taking a 1 in 6 sample from the appropriate electoral registers. Subsequently we attempted to identify in the electoral register published in 1975 the 557 persons who, from interview or medical records, were known to have been aged over 65 at the time of invitation to take part in the survey. Of the 514 so identified it was found that only 385 (75%) had declared themselves as not liable for jury service on account of age.

Inquiries among a sample of 20 persons who had not declared their age at electoral registration suggested that in this small group at least the fault lay with the design of the registration form rather than with any unwillingness among elderly people to declare their age. Whatever the reasons, however, it is clear that in present circumstances use of the electoral register to count the number of persons aged 65 and over in an area may lead to a 25% underestimate. We wish to draw the attention of your readers to this finding in case this method of estimating elderly populations is being used in other areas for planning purposes. Our analysis is reported in detail elsewhere.²

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¹ Tunbridge, W M G, *et al*, Proceedings of the 7th International Thyroid Conference, Boston, Massachusetts, 1975.

² Evans, J G, Brewis, M, and Prudham, D, *Age and Ageing*. In press.

Educational placement of children with congenital rubella

SIR,—In 1964 Sheridan reported a follow-up at 8-11 years of 227 children whose mothers were considered to have had rubella during the first 16 weeks of pregnancy.¹ Of these, 206 (92%) were attending normal schools, seven of them with special provision such as hearing aids. It must be emphasised that the diagnosis of rubella was made during pregnancy on clinical grounds only, because serological tests were not then available.

In 1972 Gumpel reported on 83 children who had attended the Hospital for Sick Children, Great Ormond Street, and in whom congenital rubella had been retrospectively diagnosed.² She observed that only nine of the 72 school-age children (12.5%) were attending normal schools. Of the nine children, three were deaf, one of whom was being considered for a change to special education.

In March 1976 letters requesting follow-up information were sent to all doctors who had notified the Northern Registry of the National Congenital Rubella Surveillance Programme of children with confirmed or suspected congenital rubella.³ Information was requested about proposed or current schooling for 88 children of or approaching school age. Replies were received for 83 children, of whom four

had been lost to follow-up. Results for the remaining 79 children are given in the table.

	No
School for the deaf	35 (44%)
Partially hearing unit	17 (22%)
Partially sighted unit	1
Peripatetic teacher of the deaf	6 (8%)
Other special education	11 (14%)
Special school (unspecified)	2
School for the delicate	1
School for the non-communicating	1
School for the blind	2
School for the educationally subnormal (ESN) (severe)	2
School for the ESN (moderate)	1
Home for the mentally handicapped	1
ESN (severe) day unit	1
Normal school	9 (11%)
	(4 with hearing aids)
Total	79

The prospective study of Sheridan¹ is not comparable with that of Gumpel² or with the data presented above, but it may be erroneously interpreted as implying that the great majority of children with congenital rubella have no significant disability. We do not know how many children with prenatal rubella infections are not notified to the registry. What is abundantly clear, however, is that a substantial number of rubella-affected children are sufficiently disabled to require special educational facilities. It is important to set the high cost of special education against the cost of the national rubella immunisation programme.

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¹ Sheridan, M D, *British Medical Journal*, 1964, 2, 536.
² Gumpel, S M, *Archives of Disease in Childhood*, 1972, 47, 330.
³ Dudgeon, J A, et al, *Health Trends*, 1973, 5, 75.

Writing and speaking in medicine

SIR,—In his interesting article "Writing the MD thesis" (6 November, p 1121) Dr Clifford Hawkins displays certain misapprehensions concerning the degree of Doctor of Medicine. We are familiar only with the Cambridge MD, but since that degree has existed for more than 500 years it can claim a certain influence. Firstly, Dr Hawkins writes throughout of degrees being "awarded." Now a degree cannot be awarded, for there is nothing to award; it is not a diploma or a certificate or a medal but—as its name implies—a step in a ladder in a particular university. Hence the words "graduate" and "graduation." A degree certificate is like a birth certificate, merely a record of an event, and a degree can no more be awarded than a fellowship of a royal college; one is *admitted* to both. It is true that the new terminology has crept in at some universities, but we hope that the higher doctorates might be protected from this degradation.

Secondly, Dr Hawkins writes that the MD is "equal in status to doctorates in other university faculties." This is not true either in a formal sense or in terms of the standard of examination; formally, the Cambridge MD is senior to doctors of science, letters, and music but junior to doctors of divinity and

law, while so far as the standard of examination is concerned the procedure for submitting for an MD is so different from the procedure for submitting for other doctorates that no comparison is possible or even desirable. As befits a medical degree, the MD is more inclined towards the practical aspects of the subject. In Cambridge the difference between the MD and ScD is indicated by the fact that a Doctor of Medicine may be admitted to the degree of Doctor of Science in just the same way as in other science faculties. Naturally, it is expected that the standard of the ScD will be maintained across the faculties, but the MD has a life of its own and its de facto standing is in the hands of the Faculty of Clinical Medicine.

Finally, Dr Hawkins is implicitly critical of universities which "perhaps parochially, only accept theses from their own graduates," of which Cambridge is one of the many. A higher doctorate (Dr Hawkins's phrase) has to be higher than something, and since it is itself a degree it is natural for it to be higher than some other degree of the same university. In Cambridge all the higher doctorates are *secondary degrees* and are open only to those who have been admitted to one of the primary degrees of the university (in the case of medicine, the bachelors' degrees of medicine and surgery). No corporation that has retained the concept of membership can be happy with the idea of omitting a step on the ladder, except in the case of honorary degrees—which is one of the reasons why honorary degrees are such marks of esteem.

The proliferation of degrees in recent years has naturally opened the way for a discussion of whether the old principles are still relevant, but there should be no illusions: the standing of any doctorate depends upon the standing of those who hold it, and only in the very short term does the reverse apply.

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SIR,—I read "Writing and speaking in medicine" (6 November, p 1113) with mixed feelings. We are lectured on brevity and asked, "Why is it that intelligent people . . . become imbued with verbosity the moment they put pen to paper?" To this unanswered question I would reply that, if they do, it is because they use journalese as the author does in the phrase "put pen to paper." In the same paragraph we are told that the *OED* says that "revealed" really means "made known by divine or supernatural agency." The *Concise Oxford Dictionary* (6th edn, 1976) gives the alternative meanings of "disclose, divulge, betray, show, let appear." The average reader would know precisely what the author meant by "His results revealed," etc. The moral is to use the *Concise Oxford Dictionary* and not the 15 volumes of the *Oxford English Dictionary*.

Twice I found you, Mr Editor, using "shut up" when "stop" is much more appropriate than the billingsgate. I am surprised that you allow abbreviations, some like *OED* and others like "it's" and "don't," and, I presume, "I'll." I will continue to write, "Do not tell me it is the modern style." Why if an article should not have adjectives and adverbs do you in the next paragraph ask, "Is it scientifically reliable?"

Rule 17 of the Association of Physicians states that "scientific communications shall be spoken, not read. No such communication shall last longer than 15 minutes." That rule was in existence before the second world war. The Medical Research Society and the Surgical Research Society some 10 years later were treading in well-printed footsteps. You, Sir, appositely say, "Editors constantly see articles that have been written for speaking, but are quite unsuitable for publishing." Would you agree that when an author knows that a paper he is delivering is going to be published he should write for publication? He can then speak from notes thereon or, as is happening more often, read from his slides.

One cry more! Please help the young and old contributor with advice. They do not expect you to translate their efforts into "decent prose." Needless to say, embryonic writers need coaching by friendly consultants. Ghost writers, pace Roger Williams, are no substitute. I think a friendly referee, who should not be a peer but a superior person, could be helpful. If the prime function of the Editor of the *BMJ* is to monitor and control his referees, may the subeditors give more help to the promising young men.

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Quis whatsit?

SIR,—Dr Michael O'Donnell (20 November, p 1253) in his preoccupation with Dr Whimster's dangling pronoun seems to have missed in the first sentence of his Whimster extract two errors as egregious as the one he castigates in the second (which, incidentally, contains a dangling "sort of thing" as well as a dangling pronoun). That first sentence reads: "The passage which follows shows many common examples of all of these failings, while the succeeding list shows how these infelicities may be improved." Firstly, is not "improving an infelicity" itself an infelicity? For what does "improving" mean? Making the thing even more infelicitous or less? Secondly, common usage aside, even the tyro with Fowler¹ knows a "that" clause to be defining and a "which" clause not; and in his sentence Dr Whimster clearly meant to define "the passage," which should therefore have been succeeded by "that follows," not by "which follows." Four errors in two error-correcting sentences: riches indeed. I recommend Fowler, by the way, as a stiffener for Dr O'Donnell's engagingly *recherché* recommended-reading list.

Your own "Instructions to Authors"² is not included in that list so I wonder if any of Dr O'Donnell's cheering, cap-in-air crew (doubtless up from Slagthorpe for the day) noticed an error in their own editor's letter as printed. The reference he quotes from his own journal appears in yours as "Sabbagh, K, *World Medicine*, 1976, 25, 112," suggesting—if you are observing your own explicitly stated conventions²—that the volume number in question is "25." In fact, since we are only now at volume 12 of *World Medicine* the reference he quotes (I suspect—I cannot be sure, my copy of the relevant issue having gone the way of all good journals) must have appeared in "*World Medicine*, 1976, volume 11, number 25, page 112." I hesitate to render this *BMJ*-fashion. The alternative to Dr O'Donnell