750 endoscopies are performed a year. Many of these are bronchoscopies performed under premedication and local analgesia. I have described the technique very fully elsewhere.¹ My work in this endoscopy clinic during the past 15 years has enabled me to form a clinical evaluation of many surface anaesthetics, and amongst those I have most experience of cocaine (5%), amethocaine (2%), and lignocaine (4%).

I have now had an experience extending to well over 200 endoscopies, using 4% prilocaine (Citanest), which has been supplied to me through the courtesy of Messrs. Astra-Hewlett, Ltd., as the drug in this strength has not yet passed the scrutiny of the Dunlop Committee. It is my opinion that this agent, when utilized in the pharynx and bronchial tree as a surface agent, has a perceptibly reduced latent period, a more effective action, and a considerably reduced toxicity, when compared with lignocaine. In these 200 cases, using an average dosage of between 6 and 8 ml. of 4% solution (240 to 320 mg.) I have not seen a single case of local anaesthetic intoxication in its mildest form.

In this situation, therefore, I look upon prilocaine with particular favour, and I hope your writer's very brief notes on its performance will not dissuade other clinicians from trying out its effectiveness.—I am, etc.,

T. N. P. WILTON.

Department of Anaesthetics,
Frenchay Hospital,
Bristol.

REFERENCE

- ¹ *Thoracic Anaesthesia*, ed. by W. W. Mushin, p. 410, 1963. Blackwell, Oxford.

Education in First Aid

SIR,—Your readers may recall the report of a working party set up by the Royal College of Surgeons¹ which advocated, among other things, that first aid and accident prevention should be taught in schools as part of the curriculum. Subsequently, a Joint Committee publicized a report on health education in which one of their recommendations was that health education should be taught in schools.² Not unnaturally, the first response from educationalists is that they are being asked to overload a syllabus which is already overfull. However, a most encouraging article has appeared in the *Times Educational Supplement* recently³ by the headmaster and the medical officer of Atlantic College—the recently opened international sixth-form college in Glamorgan. This article simply sets out their own approach to the teaching of first aid, health education, and accident prevention to male sixth-formers. The teaching of rescue service skills (rescue boats, cliff and beach rescue, and canoe life-guards) as a recreation is part of this school's policy of developing young men through the ideal of adventurous service to the community. The basic requirements of such training include the bronze medallion of the Royal Life Saving Society and the adult certificate in first aid of the Red Cross or St. John.

The first-aid course provides an excellent vehicle on which to hang some formal health education and accident-prevention propaganda. It is accompanied by a parallel course of scientific demonstrations in the biology laboratory.

There are a number of considerations of importance to the medical profession that

arise. To what extent is first aid or health education being taught in our schools? What should be its content? To what extent does the medical profession present a united front with a uniform standard of teaching in first aid and health education? In what way can teachers of first aid obtain help from the profession in the content of their lectures and the ancillary aids necessary for good presentation? Are we satisfied that the present first-aid methods reflect what we in medicine feel should be taught to the lay public? Do doctors, called upon to train people for first-aid certificates, set a sufficiently high and uniform standard of teaching and marking? Would it be of value to press for formal first-aid teaching in all the schools, and at what age should it start? What about the doctors; should they not, as undergraduates, receive the same basic and advanced training in first aid?

Could not television do more to provide reliable instruction? I would welcome some answers to these questions either privately or through your columns.—I am, etc.,

NORMAN CAPENER.

Medical Commission on Accident
Prevention,
Royal College of Surgeons,
London W.C.2.

REFERENCES

- ¹ Report of Working Party on Accident Prevention and Life Saving. Royal College of Surgeons of England, 1963. London.
- ² Report of a Joint Committee of the Central and Scottish Health Services Councils on Health Education, Chapter 10, 1964. H.M.S.O., London.
- ³ Hoare, D. J., and Llewellyn, D. J., *Times Educational Supplement*, 18 September 1964, p. 394.

Mongolism: When Should Parents be Told?

SIR,—I regret that I am not entirely convinced by the article of Dr. C. M. Drillion and Sister E. M. Wilkinson (21 November, p. 1306) that a mother should be told immediately after birth that her child is found to be a mongol. I note also that their conclusions have the approval of Professor R. S. Illingworth (5 December, p. 1459) and I venture, with respect, to make the following remarks.

What I am really not convinced about is whether a mother, who *already knows that her child is a mongol*, is likely to be entirely honest with the doctors, and with herself, when she says that she would like to be told as soon as possible. I feel that if mothers of normal children were to be asked this question—"Suppose your child were a mongol, when would you like to be told?"—then their replies might not be so definite.

One of the great joys of motherhood is the peace and contentment which comes with the arrival of a new baby. The delivery of the baby is surely the completion of a valuable and natural act, and in my view the mother's enjoyment of the discovery of things about her baby is sacred, and should not be disturbed unless absolutely necessary. In the event of a child being born with an abnormality which is immediately obvious, such as a hare-lip, then there is nothing that any doctor can do to protect her from the sudden crashing awareness of the defect. The sadness and depression which comes over a family on these occasions is a state with which most general practitioners must be familiar, and it can be most heart-rending to behold.

In the case of the mongolism, however, the doubts about the normality of her baby dawn upon the mother slowly—indeed, she may almost shut her eyes to the defects for a time, seeing in her child only the good points, and disregarding all others—and, provided she has available at all times the counsel of her family doctor, I do not think she can come to much harm. After all, why should she be told immediately? If it is just to save her worrying, then it seems to me to be of doubtful value to replace worry by sadness and defeat. In the relatively few mongols that I have had to deal with as a general practitioner over the last 15 years I have usually made a point of seeing the babies more frequently than usual, for checks of weight and so on, and it is possible to spot the moment when the mother's doubts begin to arise. On this occasion leading questions may be asked, and thus facilitate the opening of the discussion about the child's possible defects. I believe that in this way the information about mongolism in her baby is passed to the mother much more gently than would be the case if she were told earlier on. Since she has already learnt for herself that the child is not abnormal in every respect, and is not completely unresponsive to her, then she readily understands that her efforts in producing this baby have not been entirely without recompense.

The diagnosis of mongolism is not always easy, and I think it may be downright unkind to tell a mother immediately after birth, particularly if there is a risk that the doctor may be wrong. Professor Illingworth indicates a similar point in his letter. What I am suggesting is not an avoidance of the doctor's responsibility, for he must be prepared to speak with authority, and to take some definite action, immediately the occasion arises. I think, however, that there should be a deliberate delay in order to allow the mother time to get to know her baby. In my experience, between two and three months seems to be appropriate.—I am, etc.,

Barnard Castle,
Co. Durham.

K. H. PICKWORTH.

Specialty of Chest Medicine

SIR,—Dr. Neville C. Oswald's account of the specialty of chest medicine (10 October, p. 935) has interested all who work in this field and who are concerned with the way this specialty will develop in the future.

When "integration" is discussed there is a widespread tendency to overlook the sheer volume of work handled by chest physicians throughout the country. Some statistics for 1961 in regard to the area served by the Wessex Regional Hospital Board serve to illustrate this. For a population of 1,665,000 there were 13,328 new out-patients referred to the chest clinics, compared with 17,225 new out-patients referred to the general medical departments in the Region. The out-patient attendances of "old cases" amounted to 54,635 at the chest clinics, and 76,533 at the general medical departments. In other words it would appear that general physicians see 4.5 "old cases" per new referral, whereas chest physicians see 4.1. These data are especially interesting, since Dr. Oswald's analysis of 25 representative chest clinics indicates that half the out-patient attendances of "old cases" at chest clinics nowadays are non-tuberculous patients.

In respect of in-patients during 1961 in the Wessex Region there were 17,307 patients discharged from 892 beds in general medical wards, and 2,874 discharges from 607 beds in chest hospitals. These figures are not comparable because some of the chest hospital beds are necessarily and properly used for long-stay patients (e.g., tuberculosis, respiratory invalids, or lung-cancer cases), whereas long-stay patients are avoided so far as possible in general medical wards.

It is difficult to agree with Dr. Oswald that in the district hospitals of the future "to expect that one of three or four consulting physicians . . . should limit himself to chest diseases is to exaggerate the importance of the specialty." So great is the volume of chest work that the best service to the public will occur when one physician does spend most of his time engaged in chest medicine, although this should not divorce him entirely from the ordinary stream of general work—as used to be the case far too often in the past when chest physicians were predominantly concerned with the management of tuberculosis.

Specialization in medicine has come to stay and the chest specialty will not disappear. It is the most important branch of general medicine, not only by reason of mere numbers, but also because of the increasing importance of bronchitis and lung cancer in the health of this country. The comment by Dr. P. D. B. Davies (5 December, p. 1464), that "the chest service has in many respects set a standard of medical practice which the various branches of general medicine would do well to emulate," will not surprise anyone familiar with the traditions of the chest service which we to-day inherit from our predecessors' concern to help tuberculous patients in every aspect of their lives. During the past 16 years considerably wider credentials than a knowledge of tuberculosis have been required in the appointment of chest physicians, and of course many chest physicians with greater seniority than this are exceedingly competent in chest medicine in its widest possible sense. At the present time, with the control and management of tuberculosis proceeding straightforwardly in many places, the interest and enthusiasm of some chest physicians is rightly attracted toward other, newer, problems in chest medicine.

"Integration" is essentially an architectural problem; about one-half of all chest clinics are outside general hospitals, and there can be few centres where the in-patient accommodation in existing general hospitals is sufficient for the non-tuberculous chest patients who should be admitted. Provided that proper facilities for chest medicine are made available in the new district hospitals as these are built, the difficulties that beset the chest service at present will disappear.—I am, etc.,

Bournemouth.

W. H. TATTERSALL.

Domestic Burning Accidents

SIR,—A not uncommon minor accident which I have seen on several occasions is a scald on the dorsum of the fingers. The usual story is that a kettle, which has boiled dry but remained over heat, has been filled with water. The resulting cloud of hot steam which issues from the kettle burns the

fingers holding the handle and the unwary subject is away from work for several days with painful and blistered digits. No doubt some readers will have suffered momentary agony, but probably escaped injury, when filling a kettle which still holds some hot water.

The thoughtful design of potentially dangerous household appliances is of great importance, as Dr. J. P. Bull, Mr. D. M. Jackson, and Miss Cynthia Walton reiterate (5 December, p. 1421). In this instance the conventional kettle, which is filled immediately below the handle, after removing the lid, could surely be replaced by a modified kettle of the "whistling" type, where the filling is done through the spout well away from the handle. This hazard would then be removed.—I am, etc.,

King's College Hospital,
London S.E.5.

A. P. WYATT.

Dangerous Spectacle Frames

SIR,—A young woman who is learning to drive a car was sent to me to-day by her driving instructor because her lateral vision was defective. She had moderate myopia. With glasses her vision is normal, except her fields of vision are considerably constricted by the heavy modern frames with very wide sides which are now fashionable.

This type of frame with wide, heavy sides is not often in use, but should not car-drivers be warned not to wear them?—I am, etc.,

Ilminster, Somerset.

G. F. TAYLOR.

Lost Potential in Medical Manpower

SIR,—At a time when hospitals are understaffed, and there is a growing shortage of medical manpower, there have been a number of published comments on the "lost potential" among medically qualified women. We would like to draw attention to one aspect of this problem.

For many years it was possible to obtain consultant work for a varying number of weekly sessions—anything from four to seven being common. This was particularly so in ancillary specialties such as anaesthetics, physical medicine, and radiology, but it was hoped that similar opportunities might be available in medicine, obstetrics, pathology, and other specialties. In recent months, however, there appears to have been a complete change in policy, and the available consultant sessions are advertised, almost without exception, as full-time or maximum part-time appointments. Frequently this has been achieved by an amalgamation of posts from three or four hospitals, each requiring two or three sessions only. However, in a number of recent cases such posts have not been filled because of the lack of suitably qualified candidates.

There are many women who, realizing the problem inherent in having both a family and a career, chose specialties in which they were led to believe that part-time consultant work would be available. Some of these, highly qualified after years of specialist training, now find the prospect of full-time work more than they may reasonably wish to undertake. However, they are offered no alternative, while at the same time posts remain unfilled

or, what is surely undesirable, staffed permanently by locums.

We feel that the present state of affairs, if it continues, will discourage many of those women who qualify from attempting to continue with a medical career. We wish to suggest that consultant work in all branches of medicine should be available to those seeking part-time employment as well as to those who wish to work full-time.—We are, etc.,

MORAG J. R. BASTABLE, ANN BEARDWELL, ELEANOR BESTERMAN, MARGARET CASH, EVELYN COATES, MARY CORBETT, JEAN COLSTON, PRETIFAR CRACROFT, ULUNED DAVIES, CELIA DAVIES, PATRICIA EDWARDS, RUTH EDELSTON, PAULINE EMERSON, CHARLOTTE FELDMAN, BERYL GOETZEE, HELENE GOODMAN, SYLVIA HEPTON, SHIRLEY JONES, LEILA LESSOF, URSULA HAMILTON PATERSON, PATRICIA LAST, JEAN PRITCHARD, KATRINA RHODES, MURIEL SIDAWAY.

London W.1.

Foot Health

SIR,—It was immensely gratifying to see the good coverage which the daily press gave to last week's Conference on Foot Health. In 1933, as a result of a pilot experiment in toddlers' examinations initiated by the late John Macmillan, M.O.H. for Woolwich, I appealed in my Presidential Address to the Maternity and Child Welfare Group of the Society of Medical Officers of Health for regular scrutiny of toddlers' feet, posture, and gait to preclude the development of deformities, which I had already detected in children from their second year up in routine examinations. These ran the whole gamut of adult deformities. The group reacted by including foot-health sessions in several of their clinical meetings and the National Association of Maternity and Child Welfare Centres for several years until the outbreak of World War II set specific questions on foot health and children's shoeing in their annual Empire-wide mothercraft competitions.

In 1937 the Borough of Woolwich published a pamphlet entitled the *Choice of Children's Shoes*, which was handed free of charge to every mother attending a toddlers' clinic (to which children were specifically invited, by card, in their birthday month for at least one full annual examination). The shoe manufacturers responded rapidly by improving their children's lasts to physiological requirements, and in World War II the shoe trade was persuaded further, through the War Office, to design a "model" last to supply the three Women's Services—a design which spilled over even more rapidly into the "utility" shoes made by the same firms, under Government sponsorship, for ordinary "lay" consumption. These were low-heeled shoes which retained their popularity for both day and evening wear for some years after the war till the American and Italian fashion designers got busy. At that time there was no specific teenage provision, nor was there essentially a market—since everybody, woman and child, walked with a low heel with pleasure. Times have changed: there is something to be said, both aesthetically and functionally, for a higher-heeled shoe for certain wear.