infection with a National Health Service certificate in case of the vague possibility that activity at work would worsen his condition. Surely the conclusions of Dr. Price and his colleagues justify the action taken by the doctor in the case in question, and are very strong arguments in his defence.—I am, etc.,

Brierfield,
Lancs.

H. C. PALIN.

Payment by Colour

SIR,—A matter of concern to the medical profession is the way in which discrimination against our non-White colleagues is practised in South Africa. As an example, the *South African Medical Journal* of 18 November 1967 advertised intern posts at the King Edward VIII Hospital in Durban at salaries of R.1,800 per annum for Whites, R.1,380 per annum for Coloureds and Indians, and R.1,260 for Bantu, while a medical superintendent's post at Stanger Hospital offered R.6,000 per annum for Whites and R.3,840 per annum for Indians; Bantu—Africans is the preferred term—were not even considered for the latter.

This distinction is bad enough, but within the past few months intern salaries for Whites have been increased to R.2,640 per annum, while non-Whites remain at their previous level. Threats of a walk-out and a go-slow strike by protesting non-White doctors were met by a blunt statement from the Minister of Health confirming that there would be no increases at all so far as they were concerned (*Cape Times*, 18 August 1968).

Since training for all races is proudly claimed to be equal, and is equally expensive, and the work done is equal in amount, quality, and degree of responsibility, what justification can there be for this inequality of salary? The usual argument put forward is that the cost of living is lower for non-White doctors. There is little that can be done to change South Africa's attitudes except through the exercise of moral pressure, and it is to be hoped that senior members of the profession will constantly point out to their South African colleagues that this sort of discrimination is not in the best traditions of the profession. Doctors who go to work in South Africa should be aware of the situation and perhaps should accept posts only on the assurance that equal pay is given for equal work regardless of colour.—I am, etc.,

London N.W.7.

R. HOFFENBERG.

Fitness to Drive

SIR,—In his review of the report *Medical Aspects of Fitness to Drive Vehicles* by the Medical Commission on Accident Prevention, Dr. Gavin Thurston (17 August, p. 422) very rightly states that this booklet gives much-needed guidance.

While agreeing with many of the recommendations in that report, I cannot accept unquestioningly that "The ability to read letters and numbers of a standard number plate at a standard distance corresponds to a visual acuity of 6/15 on the Snellen chart, and this is a satisfactory safety standard for private car drivers" (my italics), and that eye defects play only a small part.

The Road Research Laboratory report¹ quotes an investigation by Fletcher, who found that out of 103 fatal accidents at road junctions 71 involved a driver with defective vision in one eye; and 61 of these accidents occurred when the approaching other vehicle was on the side of the bad eye.

These two reports published almost simultaneously differ materially in the importance of defective vision in relation to the causation of accidents. I wonder if paucity of statistical evidence misled the Medical Commission? Accidents happen all the time, but how often, even if it were possible, are the visual standards of all concerned tested? The time-hallowed Snellen standard of 6/15 takes no account of the field of vision. A narrow field, such as is caused by chronic glaucoma, may not even be known to the subject and is frequently only discovered during routine screening. Yet a driver suffering from this condition of early tunnel vision loses that vital "corner-of-the-eye perception" which warns him of the child about to step off the kerb just ahead of his car.—I am, etc.,

Birmingham.

KEITH E. JOLLES.

REFERENCE

- ¹ Grattan, E., and Jeffcoate, G. O., *Medical Factors and Road Accidents*, Road Research Laboratory Report, 1967. Reading, Berkshire.

Starving Children

SIR,—May I comment on one sentence in your leading article "Starving Children" (28 September, p. 753)? "The greatest difficulty will inevitably be . . . the finding of locumtenents for the members of the team." How true!

For 10 weeks I have tried to assemble a three-man paediatric relief team for Oxfam. Thanks to the untiring help of my paediatric colleagues and the co-operation of the regional board, two team members, the most senior and the most junior, are ready to leave at once. But in spite of all the help and good will, in spite of the grapevine and innumerable telephone calls, in spite of advertisements in the national press, no replacement for my "number two" has been found. Apparently not one single paediatric registrar in the whole of the United Kingdom can do his locum job for three months.

Time is getting short and the corpses are mounting. Is it really beyond the capability of this country to detach and deploy such a tiny team? I continue to hope.—I am, etc.,

Lewisham Hospital,
London S.E.13.

BRUNO GANS.

Propranolol and Digoxin Intoxication

SIR,—Dr. K. Hazell (7 September, p. 619) has quoted my memorandum (17 August, p. 413) in support of his case against the use of propranolol in the treatment of digitalis overdosage. I would point out that my intention was to warn against a possible hazard of giving the usually tolerated dose of propranolol to patients suffering from digitalis poisoning without close observation of their subsequent course, and without being aware of the correct management of over-response to the drug. The first patient reported by me would almost certainly not have died at that time had atropine been

given; the second did not die at the time of propranolol administration, although the arrhythmia was of a kind which might well have proved fatal had it not been aborted by propranolol.

I do not believe that the benefits of propranolol should be withheld from patients suffering from dangerous digitalis-induced arrhythmias. I do, however, believe that it is a drug which should be given in this context only to the patient who can be closely supervised, with atropine readily available, and after a small test dose to assess the responsiveness of the individual.—I am, etc.,

Stobhill General Hospital, D. A. L. WATT.
Glasgow N.1.

The Fat Child

SIR,—On every side we hear of the problem of the fat child who grows into the obese adult with all the well-known attendant hazards.

As a general practitioner I am therefore more than a little dismayed to hear of the rather disastrous advice given to my young mothers by visiting and clinic public health personnel, this advice being to start supplementary fat-making carbohydrate feeding from the early age of only 3 or 4 weeks, whether the baby be breast- or bottle-fed, not only giving the new and often apprehensive mother unnecessary added work, anxiety, and expense, but also laying down an unhealthy feeding pattern for life. Can it be that commercial pressures are so strong that they can stuff the public health authorities, who in turn persuade the mothers to stuff their children in the erroneous belief that nature is absent-mindedly allowing birth to take place unaccompanied by the provision of a prefabricated, prepacked, precooked cereal.

Needless to say, the gastrointestinal upsets caused by this unsatisfactory diet are brought for treatment to the general practitioner. Sensible advice to feed more naturally is muddling to the mother and distasteful to oneself in that one is contradicting one's colleagues. Perhaps it is time for a complete revision of baby, infant, and child dietetics to ensure the development of a thinner, healthier adult.—I am, etc.,

Knayton,
Thirsk, Yorks.

M. J. OLDFIELD.

Medical Assistant Grade

SIR,—I would like to support Dr. C. S. Flowers (21 September, p. 747) in his approaching disillusionment with reference to this grade in casualty work. I have spent nearly three years in such a post, and can see no sign of any improvements being made, and have recently resigned because of this.

The salary and prospects are an insult, and there is no reward for all the time and money spent on acquiring an F.R.C.S. This is an obvious example of getting consultant work on the cheap, because although the medical assistant in charge of casualty is nominally under a consultant, this in no way relieves him of full responsibility for management of his patients either clinically or in law, and the consultant usually does no casualty sessions.