Dr. Harris does not go on to draw the obvious inference that is entailed by his statement—viz., that it would be a serious waste of rations to give this patient any at all; and even less does he go the whole logical hog and assert that the saving of food would be very great if all those suffering from incurable maladies were denied their rations. If Dr. Harris's contention be accepted there is no logical stopping-place before we draw the inference that we should not "waste" our substance on the incurable, the objectionable, the hereditarily inferior, and, of course, the racially unsatisfactory.

Sir, our duty as doctors is to our patients, but it may be that advisers to Ministers have other primary duties; but, inasmuch as they have, they are the less doctors; and not only that, they have started down the slope, so easily descended, that ends in totalitarianism. The flower of our youth laid down its life for freedom and decency; the least we old buffers can do is to refrain from advocating the doctrines of their (and our) enemies.—I am, etc.,

London, W.1.

A. PINEY.

SIR,—It is distressing to read the views of two of your correspondents in the *Journal* of Jan. 11 (p. 69) in letters arising out of the action of the Ministry of Food officials in refusing extra food to a dying patient of Dr. Foxell's. One writer observes that as the patient was bound to die shortly most people would think that it would be a serious waste of six persons' weekly fat ration. The other writer appears to be much concerned with the preservation of the scheme and official forms. This outlook is contrary to established medical usage and Christian civilization. It is surely the ideal that the strong should sacrifice for the weak.

One hopes that this age will not become progressively utilitarian. There are many examples, both in the case of doctors and laymen, of lives being lost in an endeavour to save the dying.

Three small quotations from the last letters of Capt. Scott, of Antarctic fame, seem appropriate: "Subsidiary reasons for our failure to return are due to sickness of different members of our party." "If this diary is found it will show how we stuck by dying companions and fought the thing out well to the end." "We have done everything possible, even to sacrificing ourselves in order to save sick companions. I think this makes an example for Englishmen of the future." Scott and his comrades gave their lives for the weak, as have many others—an innumerable company. Officialdom appears to grudge a little butter for a dying patient. Is this the kind of attitude we are to expect under the national health scheme?—I am, etc.,

The University of Sheffield.

ELIZABETH COWPER EAVES.

SIR,—Dr. Wilfred Harris's suggestion (Jan. 11, p. 69) that a man who is not expected to have much more of life should not be allowed some of the food which he needs is surely contrary to medical tradition and practice. Such a cruel decision could only be justified in a population where deaths from starvation were imminent.

Surely also is implied a great misjudgment of the sane and generous people of these islands. Millions would willingly give up a minute fraction of their fat ration, and many would give the whole, to comfort the last weeks of an afflicted man. Those who doubt the extent of such generosity must have failed in observation or memory even of the years of war.—I am, etc.

Birmingham.

CRANSTON WALKER.

SIR,—It would be impossible for anyone to disagree more thoroughly than I do with your melodramatic leader (Jan. 11, p. 60) with the above heading. You infer that when the country is short of some food, which has therefore to be equitably rationed, it is interfering with the doctor-patient relationship if that ration cannot be altered to suit each individual case.

Surely, Sir, consideration of each individual case by Whitehall or a committee of experts would be chaotic and bureaucratic in the worst sense, and so to be avoided at all costs. Nor would it be feasible to allow doctors to order what they thought fit for the good of the individual when by so doing they might jeopardize the adequate supply of essential foods to the community. While food is in short supply the more

we give to the dying the less we give to the living. Is it then to be a principle that we feed the dying at the expense of the living?—I am, etc.,

Leeds.

R. A. MURRAY SCOTT.

**We regret that Dr. Murray Scott appears to have missed the point of the leading article he so severely, if not melodramatically, criticizes.—ED., *B.M.J.*

Curare

SIR,—I should like to endorse the remarks of Dr. Massey Dawkins (Jan. 18, p. 111) in respect of the use of curare. Although I am unable to cite the use of curare in a large series of cases, my experience of some of the after-effects of curarization has already led me to express the opinion that curare is not without its dangers. Upon two occasions I have met the post-operative condition which Dr. Massey Dawkins attributes to shock; in each case the operation, although abdominal, was neither extensive nor prolonged, and I do not think that shock could have ensued. My impression in each case was that the patient was in a condition of profound central depression resulting in prolonged unconsciousness and requiring active resuscitative measures. Neither patient received more than 15 mg. of curare; each received 0.5 g. of "pentothal," followed in one case by nitrous oxide, oxygen (30%), and minimal trilene, in the other by light cyclopropane; both were fit adults.

It seems that in some patients curare effects the cerebral synapses, that this action is prolonged and does not respond to physostigmine. I have not met paralytic ileus, but this seems analogous to the condition I have described and may well occur alone or in conjunction with the central depression I have met. This central depression appears to be unpredictable; it therefore behoves the anaesthetist to bear in mind the possibility of its occurrence and to make an early post-operative visit to those patients to whom he has administered curare.—I am, etc.,

Bournemouth.

S. F. DURRANS.

SIR,—Dr. Massey Dawkins's letter on this subject (Jan. 18, p. 111) cannot be allowed to pass without comment. Opinions, whether based on the impressions of the nursing staff or on statistical results, as to the post-operative effects of general anaesthesia alone, contrasted with general anaesthesia plus curare, are valueless unless the nature of the general anaesthetic is stated in each case. Assuming that Dr. Dawkins is considering cases in which the general anaesthetic employed, with and without curare, was the same, it is still only too plain that he is comparing a well-given (say) cyclopropane alone with a badly given cyclopropane-plus-curare administration.

To take his three points in turn. First, the question of shock and "insufficient anaesthesia": surely the use of curare has at last invalidated the old theory, meticulously copied from textbook to textbook since it was propounded by Crile in 1920, that the fall of blood pressure during visceral manipulations was due to "nociceptive" stimuli, the effect of which could be minimized by deep anaesthesia. The correct interpretation of the facts is possibly that deep anaesthesia (or better, the less toxic light anaesthesia, to ensure unconsciousness, plus curare) allows the surgeon to be as gentle as possible and thereby cause less trauma.

Secondly, "marked respiratory depression" may be caused post-operatively either by central depression as a result of relative overdosage with morphine and the more powerful anaesthetic drugs, or by muscular paralysis with curare. The first cause should not be effective if properly light anaesthesia is given with the curare, and to eliminate the second, correct dosage at the proper time is all that is required (the last dose being given not less than fifteen minutes before the peritoneum is closed). If for some reason the operation is finished more quickly, or the curare is eliminated more slowly than anticipated, then muscle tone is readily restored by the intravenous administration of a suitable dose of prostigmin.

Finally, the factors predisposing towards post-operative ileus are (1) local, that is, peritonitis, whether traumatic, chemical, or bacterial, and (2) central, that is, broadly speaking, drug-produced. The use of curare and the resultant relaxation do