discussion in each unit. This could promote both the quality of training and the continuity of care of patients.

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1 Beecham L. Junior doctors want legislation to cut hours of work. *BMJ* 1994;308:1657-8. (25 June.)

2 Hoffman J, Fischer A. Juniors' hours. *BMJ* 1990;301:1159.

Glaucoma induced by steroids

EDITOR,—Jeremy M Butcher and colleagues have warned about the long term use of steroid eye drops. The long term use of topical facial steroids also has risks.

In a series of five young patients (under the age of 30) reported recently, three had irreversible glaucomatous damage² after two to 12 years' use of topical facial steroids for severe eczema. Two also had posterior subcapsular cataract. The current *British National Formulary* does not carry any warnings on this, except in the "Over-the-counter sales" section where it states that topical steroids should be applied "sparingly over small area . . . for a maximum of 1 week."

It is well known that topical facial steroids are useful in patients with eczema, and long term use is inevitable in some cases. Glaucoma screening might be important in this relatively small group of patients. The test is simple and can be carried out as a part of an NHS eye test.

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1 Butcher JM, Austin M, McGalliard J, Bourke RD. Bilateral cataracts and glaucoma induced by long term use of steroid eye drops. *BMJ* 1994;308:43. (2 July.)

2 Aggarwal RK, Potamitis T, Chong NHV, Guarro M, Shah P, Khetarpal S. Extensive visual loss associated with topical facial steroids. *Eye* 1993;7:664-6.

3 Royal Pharmaceutical Society of Great Britain and British Medical Association. *British national formulary*. London: Pharmaceutical Press, 1994: 413 (No 27).

Global public health and the information superhighway

EDITOR,—Ronald E Laporte and others give a vision of how new technology—by making use of the information superhighway—can "vastly improve the accumulation and dissemination of information on public health." We agree that the possibilities are exciting but wish to contrast this potential taming of technology to benefit us all with the opportunity missed by the recently introduced "public health link," a cascade system for urgent communication between the Department of Health and NHS doctors.²

"Public health link" sets up a system whereby the public health doctor on call is alerted by pager to an urgent or immediate message from the Department of Health and is responsible for passing the message on to the next tier of the cascade. The problem is that the system is designed so that messages can be accessed only through EPI-NET terminals, which are usually situated in public health departments. This is easy enough during working hours, but gaining access to possibly distant workplaces can be difficult and time wasting out of hours.

In these technologically advanced times it seems unacceptable to expect the person to go to the message rather than the message to the person: opportunity costs are considerable, not least when a pager indicates a non-existent message. A less archaic solution would be for urgent messages to be accessible to authorised recipients through electronic mail networks as well as EPI-NET. This would allow public health doctors on call who have

access to a fax-modem to discharge their duties in this information cascade with the minimum of fuss and delay.

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1 Laporte RE, Akazawa S, Hellmonds P, Boostrom E, Gamboa C, Gooch T, et al. Global public health and the information superhighway. *BMJ* 1994;308:1651-2. (25 June.)

2 Department of Health. *Communications with the profession*. London: DoH, 1994. (PL/CMO (94)3.)

Waiting times and the patient's charter

EDITOR,—A M Ansons and colleagues say that they "have already had to accede to the divisive requirements of a two tier system engendered by fundholding and non-fundholding practices, which is inevitable (and undeniable)."¹ Guidance from the Department of Health and the Joint Consultants Committee issued in 1991 stated that "hospitals should not offer contracts to one GP or health authority which would disadvantage the patients of another."² The NHS Executive has not been honest enough to retract this publicly and connives and encourages preferential treatment for, in particular, patients of fundholding general practitioners.

It is up to doctors to stick to the principle of treating according to clinical need so that money available to the health service is used for maximum health gain. Once we give in to politicians and managers for short term gains the public will, rightly, lose faith in us.

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1 Ansons AM, Noble JL, Jones NP, O'Donoghue EP, Leatherbarrow B, Ridgway AEA, et al. Waiting times and the patient's charter. *BMJ* 1994;308:1717. (25 June.)

2 NHS Management Executive. *Joint guidance (NHSME/JCC) to hospital consultants on GP fundholding*. London: NHSME, 1991. (EL(91)84.)

Travellers' malaria risks

EDITOR,—Following the television programme on travellers' malaria risks¹ there has been concern among patients over appropriate chemoprophylaxis for the Gambia. The British published guidelines² give proguanil plus chloroquine and mefloquine as equal alternatives for west Africa. Revised guidelines being finalised following a meeting of the United Kingdom specialists' committee earlier this year moved towards a slight preference for mefloquine but consider proguanil plus chloroquine to be an acceptable alternative.

The programme gave one extreme of a spectrum of sound opinions, it ignored issues of side effects, the protective effect of proguanil plus chloroquine in the presence of some chloroquine resistance, and the need to continue prophylaxis for four weeks after return to the United Kingdom. It did, however, make the crucial point that no drug gives 100% protection.

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1 Bradley DJ. Three sides of "the box." *BMJ* 1994;309:347.

2 Bradley DJ. Prophylaxis against malaria for travellers from the United Kingdom. *BMJ* 1993;306:1247-52.

Touched by greatness

EDITOR,—My heart sank when I saw the review of *Thirty-two short films about Glenn Gould*.¹ It is a tragedy when musical genius is subjected to ignorant psychobabble and demoted to the status of a mere instance of mental pathology. I would like to set the record straight.

Glenn Gould was a renaissance man of the McLuhan age. In addition to his transcendent pianistic technique and intense interpretative musicianship, Gould was one of the few instrumentalists blessed with a powerful abstract intellect. This inspired the biography, *Glenn Gould: music and mind*, by the philosopher Geoffrey Payzant, which concentrates on Gould's contribution to aesthetics.² Furthermore, Gould was an essayist of elegance and distinction—a generous selection of his work was published by Faber in 1984.

Gould was a master of communication—albeit of communication at a distance through recorded music, the written word, radio, television, and the telephone. He always inspired a cult following, which continues to grow, and includes the present writer—the character of Gould featured in my "experimental" music-drama, *Solitude, exile, and ecstasy*, which was broadcast by BBC Radio 3 in 1991. The man himself was not the "sad figure" described by your reviewer, but one of the great musical intelligences of the century, who led a life characterised by solitude and a contemplative ecstasy of a rare kind. It was apparently the life he wanted, and there is an astonishing arrogance involved in assuming that the ability to form promiscuous and genial personal relations is the single criterion by which a life should be judged. Purveyors of such standards reject Thoreau and Wittgenstein in favour of the Oprah Winfrey Show.

Far from being a "cruel irony," it is extraordinarily apt that the Voyager space probe contains a recording by Gould. No one did more than Gould to infuse the cool abstractions of modern communication and recording media with that intense yet controlled emotion characteristic of the highest levels of human achievement.

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1 Spence S. Touched by greatness. *BMJ* 1994;309:65. (2 July.)

2 Payzant G. *Glenn Gould: music and mind*. Toronto: Key Porter Books, 1994.

Corrections

Safer use of traditional remedies

An editorial error occurred in this letter by Bérengère I Vander Stricht *et al* (30 April, p 1162). The final author, not mentioned in the published version, is Dominique Quertinier, general practitioner, Tamines, Belgium.

Cancer of the upper gastrointestinal tract

An editorial error occurred in this letter by R J Donnelly *et al* (25 June, pp 1716-7). The last sentence of the fourth paragraph should read: "The previous randomised trials addressing this question were small and were collectively inconclusive; O'Reilly and Forastiere did not mention a trial that showed an advantage—albeit not statistically significant—to the group given radiotherapy alone."

Proposed alternatives are incorrect

An editorial error occurred in this letter by Gary Reah and Ian Sanders (9 July, p 124). The beginning of the second paragraph should read, "Oxygen must be given at 3.04×10⁵ Pa [not kPa, as published] to supply the body's total demand in the form of dissolved oxygen (60 ml/l)."