science, but we make ourselves so when our writing concentrates attention on singular cases rather than plural obligations. When doctors are being invited to maintain excellence by selling it to a few while ignoring the needs of the population as a whole this would be a timely and useful development. We can look forward to an even better journal when this rule has become generally accepted.

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SIR,—I wholeheartedly endorse Sue Burkhart's statement that medical writing needs exact and unambiguous language (19-26 December, p 1585); I suggest that "direct" and "jargon free" could usefully be added to the list of requirements.

The problems inherent in presenting ideas, observations, and information from one person to a wider readership are numerous and need to be understood by all concerned: authors, publishers, and readers. Publishers form the group with the greatest responsibility for establishing acceptable workable solutions and for taking a creative and flexible approach as the use of language changes among the reading population. Publishers are well placed to work with writers in finding the most appropriate solutions and they should also make it clear to readers which solution has been adopted.

Ms Burkhart referred to one of the books we have recently published and to the solution to the problem of using male and female pronouns which I established and agreed with the author,¹ and *BMJ* readers may be interested in the reasons for this decision. The author had originally used the more cumbersome "his or hers" and "he or she." We both felt that we could not assume that readers would automatically read "he" to include both men and women and that random use of different pronouns would simply confuse. We agreed that the use of both was cumbersome and would distract the reader from the ideas and discussion. The option which Sue Burkhart suggests, of using the plural, was not open to us either because the subject, caring for dying people, involved a sensitive and often intimate level of communication between carer and cared for, and the use of the plural would have distanced the author from the subject and implied an unwelcome distance between carer and patient, one of the particular problems which the author was trying to support the reader to overcome. We decided that the least cumbersome and most workable solution was to use female pronouns for nurses of both sexes and male pronouns for patients of both sexes, except where a specific example demanded otherwise and to inform our readers of this convention at the start of the book. Given that about 90% of nurses in Britain are women,² this seemed a reasonable, pragmatic solution. This is the solution we have adopted for the time being as our house style for books and for the journal *The Professional Nurse*.

Authors, publishers, and readers need to accept that there are no perfect solutions to the problem of sexism within our language and remain open to the need for different solutions at different times and for different purposes. What matters most is that the author's ideas are made available to readers as clearly, directly, and accurately as possible.

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1 Neuberger J. *Caring for dying people of different faiths*. London: Austen Cornish Publishers Ltd in association with the Lisa Sainsbury Foundation, 1987:vi.

2 United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *Annual Report 1985-1986*. London:UKCC, 1987.

Major abdominal operations on elderly patients

SIR,—As a physician involved in medical pre-operative assessment of surgical patients, I find the results reported by Mr A V Pollock and Miss Mary Evans (12 December, p 1522) disturbing.

It seems misleading to draw comparative conclusions about mortality rates and complication rates of abdominal surgery in the over 80 age group when 77% of the operations were done on an emergency or urgent basis and 43% were for cancer. Furthermore, the authors compare this group with a younger age group but give no indication whether or not surgery was carried out on an emergency basis or for cancer in this group. In most reports the causes of abdominal emergencies in patients over 70 are entirely different from those in a younger age group.¹

There is evidence to suggest that surgery among those aged over 80 is safe and that age related risk seems to increase only in those aged over 95.^{2,3} Indeed, centenarians ("as close to immortality as a human can be") generally tolerate even urgent operations well.⁴ Other groups report a declining mortality for emergency abdominal procedures in geriatric patients (12% in one series of 472 emergency operations) but not in patients with advanced malignancy.¹

Increased awareness of the relative safety of elective surgery in elderly patients may make physicians more willing to operate on an elective basis and thus reduce the number of elderly patients for whom emergency surgery (and its considerable mortality) is necessary. The rationale for postponing elective surgery in the elderly seems questionable if this seemingly unnecessary mortality is to be avoided.³ Surgery should not be denied in the elderly on the basis of age alone.^{5,6}

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1 Reiss R, Deutsch AA. Emergency abdominal procedures in patients above 70. *J Gerontol* 1985;40:154-8.

2 Djokovic JL, Hedley-Whyte J. Prediction of outcome of surgery and anaesthesia in patients over 80. *JAMA* 1979;242:2301-6.

3 Greenbury AF, Saik RP, Coyle JJ, Peskin GW. Mortality and gastrointestinal surgery in the aged. Elective vs emergency procedures. *Arch Surg* 1981;116:788-91.

4 Katlie MR. Surgery in centenarians. *JAMA* 1985;253:3139-41.

5 Johnson JC. The medical evaluation and management of the elderly surgical patient. *J Am Geriatr Soc* 1983;31:621-5.

6 Keating HJ. Preoperative considerations in the geriatric patient. *Med Clin North Am* 1987;71:569-83.

Pain in the jungle

SIR,—One lesson which emerges clearly from Dr Jane Wilson's vivid account of the effects of a scorpion sting (19-26 December, p 1642) is that morphine in tablet form is quite the wrong choice of strong analgesic for dealing with severe acute pain, whether it be in the jungle or anywhere else.

Single doses of morphine by mouth have poor analgesic activity: Dr Wilson would have gained more relief from two aspirins.¹ This surprising fact has tended to be forgotten as oral morphine has become the preferred strong opioid analgesic for the treatment of chronic cancer pain. Morphine in repeated oral doses is more potent, and the explanation for the difference may reside in the contribution of one or more active metabolites.² Dr Wilson's somnolence the day after several doses of morphine may have been because morphine-6-glucuronide was still active in her central nervous system.

For her next expedition to the jungle I would suggest Dr Wilson take some buprenorphine

tablets. Buprenorphine is a potent opioid analgesic and for the treatment of acute pain is almost as effective taken sublingually as by intramuscular injection.³

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1 Beecher HK, Keats AS, Mosteller F, Lasagna L. The effectiveness of oral analgesics (morphine, codeine, acetylsalicylic acid) and the problem of placebo "reactors" and "non-reactors." *J Pharmacol Exp Ther* 1953;109:393-400.

2 Hanks GW, Hoskin PJ, Aherne GW, Turner P, Poulain P. Explanation for potency of repeated oral doses of morphine? *Lancet* 1987;ii:723-5.

3 Bullingham RES, McQuay HJ, Dwyer D, et al. Sublingual buprenorphine used postoperatively: clinical observations and preliminary pharmacokinetic analysis. *Br J Clin Pharmacol* 1981;12:117-22.

Charging patients for eye tests

SIR,—The present controversy about free eye testing should be used as a golden opportunity for reform. It should not be used as a stick with which to beat the government, as an opportunity for putting opticians into their (non-medical) place, or as a defence of the rather undignified position of the ophthalmic medical practitioner.

The ophthalmic medical practitioner is a trained clinical ophthalmologist expert in the detection of eye disease. Yet, working as he sometimes does in the ill equipped back room of an optician's shop, he does not have the opportunity of using his talents to the full. The optician is also a highly trained professional but with minimal education in eye disease is not a suitable person to carry out screening without supervision and instruction. The financial rewards of the ophthalmic medical practitioner depend on throughput and of the optician on sales.

The skill and manpower for an efficient ophthalmic screening programme are therefore available within a malleable financial framework. It should thus not be beyond the wit of man to devise a programme for screening large sections of the population, not by extra funding but by making good use of existing skills. Such a programme would enhance the status of the ophthalmic medical practitioner, increase the importance of the optician, and be for the public good.

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Anaesthetic services in obstetrics

SIR,—The Association of Anaesthetists has recently published *Anaesthetic Services for Obstetrics—a Plan for the Future*.¹ This mainly consists of defamations of small obstetric units. The association recommends that "small units which offer a substandard level of anaesthetic service should be closed" on the grounds of safety, yet nowhere in the report is there any evidence that closure of such units would improve safety.

The report states that some 8-10 women die in England and Wales each year as a result of anaesthetic complications and that the perinatal mortality rate in 1985 was 9.8 per 1000 births. It also states that only 1% of deliveries take place in very small units (those having under 500 deliveries per year). It is hard to see how their closure would have any impact on mortality unless the units result in an undue proportion of deaths. Several authors have shown quite the contrary.^{2,4} Such units can show very low perinatal mortality (as one would expect with good selection). The perinatal