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.

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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.

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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

mortality at our Penrith unit averages 4.7 per 1000 births and this includes those cases transferred in labour.

Maybe the association has evidence that some small units are unsafe. Each unit is different. To suggest closure of all such units is an act of high handed interference in others' affairs. We are told that "one third of mothers require the presence of an anaesthetist during childbirth." This seems highly unlikely. Only 1.7% of women starting labour at Penrith ever needed an anaesthetist. I am sure they are grateful for that service, but the other 98.3% would not see closure as a better "choice" (sic). It would be foolish to claim that anaesthetists are irrelevant to small units which select low risk deliveries. Much of the report has excellent suggestions but the association is being overbearing in suggesting to health authorities that small units should be closed. The association can know very little about such units as it has so little contact with them. No general practitioner is acknowledged as giving advice to the association.

If safety really was the prime concern of this report, then some of the conclusions are false and would not be in the patients' best interests. It would certainly not increase the patients' choice.

A more balanced decision is needed and I would welcome a meeting of interested parties.

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1 Association of Anaesthetists. *Anaesthetic services for obstetrics—a plan for the future*. London: Association of Anaesthetists, 1987.

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Delivery of hospital discharge letters to general practitioners

SIR,—Asking patients to deliver hospital discharge letters to their general practitioners (12 December, p 1523) has been practised in many centres. This is an efficient method of getting the information to general practitioners early, but there can be pitfalls particularly when patients wish to withhold information from their general practitioners.

In this hospital we have for the past four years used a discharge letter which consists of three sheets of carbonless copy paper. The top copy has the words "copy to GP" printed in the margin and is posted to the general practitioner at the time of discharge. The next sheet has the words "retain in patient's case record" and is inserted into the patient's case folder at discharge. The third copy is given to the patient in an envelope with instructions to hand it to the general practitioner when the next contact is made. The lower section of the letter is also used as a drug prescription sheet for take home medication, and the general practitioner can therefore see how much has actually been dispensed.

Although this form of letter requires slight duplication of effort, it does ensure the best possible chance of the general practitioner actually receiving information about the patient when it is required. Since the patients often carry their copy around with them we in the hospital have the additional advantage that it is sometimes the only information we have available when patients return to outpatient clinics and the medical records have vanished.

The local general practitioners find this helpful and it has certainly improved communication between us.

As one who firmly believes that patients can do far more than they are usually given credit for I would like to see this kind of system extended.

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Community care

SIR,—The work of a two year project funded by the DHSS looking at collaboration between district health authorities and family practitioner committees has reached conclusions that support Elaine Murphy's contention (12 December, p 1505) that general practitioners and family practitioner committees rarely participate in the planning, management, and delivery of community care services. To a certain extent this is historical. The mismatch of management resources between authorities and the independence of contractors are also limiting factors.

In City and East London, where the project is based, there are no primary care strategies agreed between the district health authorities and the family practitioner committees. There are no forums for discussing the primary health care agenda. Health authorities have joint care group planning committees to which contractors have little or no access beyond perhaps the token general practitioner, usually a local medical committee nominee. Lack of numbers prevents staff of family practitioner committees from attending these care groups. Not only are other contractors such as dentists not concerned in planning but little is done to bring in the generality of contractors in the early formulation of district health authority policies for care in the community, policies which will ultimately depend on contractors for real success.

Joint planning groups will be concerned in matters of finance, housing, and planning permission; much district health authority and local authority debate ensues. The provision of adequate services from contractors is too often simply assumed. While many general practitioners may be willing to participate more in community care and support its aims, there are those, particularly in the inner cities, whose circumstances, premises, etc, make active participation impossible. Planning groups must seek to talk to as many contractors as possible: a member of the local medical committee on a committee does not mean that the views of contractors have been properly sought or that sufficient information on the services that general practitioners provide has been vouchsafed.

The family practitioner committee's role must be one of increasing the participation of contractors in planning. The committee should seek to encourage planners to contact groups such as a general practitioner forum or a young practitioners' group. Many contractors will rely on the family practitioner committee to inform them of district health authority policies for care in the community: the committee must improve communications and develop information sharing so that planners have an accurate picture of what is available and what support it is appropriate to expect from contractors to complement their policies.

Health authorities cannot expect contractor support if their own decisions antagonise contractors. When decisions are taken by a district health authority the consequences must be understood. It is no good for a district health authority to expect contractor participation in community care if that

same authority takes decisions—for example, on FP10 prescribing or access to district health authority diagnostic and therapeutic services for general practitioners—without proper consultation.

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SIR,—Professor Elaine Murphy's articles (12 December, p 1505, and 2 January, p 6) review recent publications that reflect the government's concern to make a reality of community care. She is not yet so paranoid (or, alternatively, perceptive) as I am and so misses the point of all this concern: that cash limiting, which has been so successful in reducing hospital and community services, is to be extended to all forms of residential care, leaving the reality of community care as Hobson's choice.

There are major deficiencies in the Audit Commission's review,¹ most notably that it fails to acknowledge the greater disabilities of people in institutional care when proclaiming the "better value" of care at home. It confirms that residential provision has not increased but simply kept pace with the numbers of 75 year olds while losing beds in the most potent therapeutic sector—the hospitals. Yet there is outrage that so much has been spent on social security payments, whose recipients are caricatured as cynical money grabbers. There is now independent evidence that 93% of those receiving such payments for residential care could be managed in no other way—certainly in no other way that would be cheaper.²

Yet the radical reorganisation that the commission called for is on its way: the Comptroller and Auditor General recommends to the House of Commons "giving local authorities the responsibility for financing all residential care costs in both the public and independent sectors . . . agreement to be reached on the level of resources to be made available to local government. . . ."³

Thus, though there is little evidence that those payments have been misused, a new method of administration and cash limits are to be invoked to prevent misuse—to make a reality of community care. If such rationing is to be enforced it must be linked to the numbers aged 75 years and above, with an extra loading for those over 85 years in a locality. Limits linked only to the numbers aged 65 years would be unreasonable and punitive. Whatever arrangements are made seem likely to reduce the freedom of choice of old people to move to new localities by limiting the numbers of places funded within each locality. So much for freedom. This is the harsh reality of community care.

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2 Social Research Unit. *Supplementary benefit residential care assessment report*. University of York: Department of Social Policy and Administration, 1987.

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Hyperbaric oxygen for carbon monoxide poisoning in England

SIR,—Drs Tim Meredith and Allister Vale in their leading article (9 January, p 77) advocate the use of hyperbaric oxygen for this condition. The following National Health Service hyperbaric