can we know whether the high pressure we record in the office or outpatient clinic is the patient's "real pressure"? You offer no solution other than admission to hospital. Surely there is a much simpler way—study the electrocardiogram. William Evans[1] taught that a high blood pressure in a patient with a normal electrocardiogram should be ignored, and subsequent studies have supported this view. Very recently, Sannerstedt *et al.*[2] have reported a close correlation between electrocardiographic evidence of left ventricular hypertrophy and the resting blood pressure and level of systemic vascular resistance. Patients with a raised blood pressure who had a normal electrocardiogram, had a normal vascular resistance.—I am, etc.,

DAVID SHORT

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1 Evans, W., *Lancet*, 1957, **2**, 53.
2 Sannerstedt, R., Bjure, J., and Varnauskas, E., *American Journal of Cardiology*, 1970, **26**, 117.

Miner's Nystagmus

SIR,—In the third edition of *Clinical Neuroophthalmology* by F. B. Walsh and W. F. Hoyt, reviewed in your columns (11 July, p. 92), there still persists one of the most curious statements that I have encountered in a modern textbook. It appeared in the first edition in 1947 and is to be found in the third edition 1969, Vol. 1 p. 278.

Under the heading of miner's nystagmus is the following: "In Great Britain it became such a serious problem that it gravely threatened the future of the coal mining industry, because of the huge sums which are paid out in compensation." The only alteration between the first and third editions is a change of tense; from present to past.

In the first edition Walsh wrote that: "it occurs so infrequently in this country (U.S.A.) I have recognized only one unquestionable case." In the United Kingdom it has also been rare for thirty years. I have not seen a case for twenty years. The extraordinary opinion that it jeopardized the future of the industry here is, so far as I know, a myth.

But then textbooks are full of them, aren't they?—I am, etc.,

J. D. SPILLANE

Cardiff

Karate Injuries

SIR,—The account of the medical student who suffered a fracture of the 5th metacarpal and a fracture-dislocation of the wrist with a karate blow in the delightful paper "Curiosa and Exotica" by Professor W. St. C. Symmers, sen. (26 December, p. 763) prompts us to report the following case. There have been a number of homilies in the daily press on the dangers of inflicting injuries by means of karate blows. This case, like that of Professor Symmers, records injury to the potential assailant rather than to the victim.

A young male Chinese student complained of progressive wasting and weakness of his left hand for two months, with flexion deformity of the ring and little fingers. There were no sensory symptoms. On examination, the wasting and weakness were limited to the abductor digiti minimi and the 3rd and 4th interossei. The power of abductor hallucis and the 1st dorsal interosseus was normal. There was no sensory loss. Electromyography showed signs of partial denervation in abductor digiti minimi; and a normal interference pattern in the 1st dorsal interosseus. A normal sensory nerve action potential (latency 2·5 msec and amplitude 30 μv) was obtained over the ulnar nerve at the wrist when the digital nerves of the little finger were stimulated with ring electrodes. With a needle electrode in the 1st dorsal interosseus the latency of the compound muscle action potential evoked by stimulating the ulnar nerve at the wrist was normal (3 msec). When the adbuctor digiti minimi was sampled the latency was 8 msec. These results confirm the clinical diagnosis of a lesion of the medial part of the deep terminal branch of the ulnar nerve, probably where it passes between the flexor and abductor digiti minimi muscles and before it turns laterally along the line of the deep palmar arch.

It appears that the patient began to study karate one month before the onset of symptoms. He had practised assiduously the chopping blow with the ulnar border of his left hand on tables and other hard surfaces. It is reasonable to assume that such repeated trauma might damage the deep branch of the ulnar nerve to produce this lesion. Clinical improvement followed appropriate advice to discontinue this form of self-injury.

—We are, etc.,

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P. G. SWANN

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and Neurosurgery,
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The Jet Set

SIR,—Your leading article "The Jet Set" (26 December, p. 759) is an unfortunate and misleading review of the work and rest patterns of civil aviation pilots.[1] It suggests that you are unfamiliar with the aviation environment but of more concern to us is the manner in which you have misled your readers.

You refer to two periods of sustained wakefulness in a pilot operating a schedule on the North Atlantic but fail to explain the circumstances in each case. In the schedule examined the period lasting 22·5 hours covered a flight from London to Toronto, during which the duty period commenced at 11.30 hr G.M.T. and was completed by 21.40 hr G.M.T. The pilot chose to "stay up" after the completion of his duty period until 03.15 hr G.M.T. the next day (23.15 hr Toronto time), and this ensured that his sleep pattern would be satisfactory preceding his next duty period.

The other example covered a flight from Toronto to Manchester. The pilot awoke at 05.30 hr (Toronto time) but remained in bed until 09.30 hr. The duty period commenced at 16.55 hr (Toronto time), and was an overnight flight which arrived in Manchester at 07.00 hr G.M.T. This flight completed the schedule. The fact that the pilot chose to remain "up and about" until 21.10 hr G.M.T., except for a two-hour sleep during the morning, is irrelevant to the impression you are trying to give. A more detailed reading of the paper would have emphasized the importance of a *short* sleep period in the morning to obtain adequate sleep the same night.

In both these examples flying was completed long before the end of the wakeful period, and in the latter case the time which elapsed from the end of duty to the main sleep period (excluding the two-hour sleep) was over 15 hours.

Further, to believe that the pilot fell asleep half an hour before the landing—that is, during the complex manoeuvres of the let down—is, to say the least, ludicrous. It is unfortunate that this statement should be made in a leading article. With only a slight understanding of civil aviation it would have been appreciated by you that the duty of a pilot includes a period of half an hour after landing. This particular nap took place, as stated in the paper, during the coach journey from the airport to the hotel.

We would make clear that professional aircrew have a disciplined approach to the problem of achieving adequate sleep. From time to time doctors may be consulted by pilots regarding the question of suitable hypnotics. It is important in this context that the practitioner should be familiar with the problem of sleep disturbance and with the nature of the pilot's duties. We also spend much time and effort in educating the pilot against self-medication as undesirable side or after effects can be particularly serious in this occupation.—We are, etc.,

A. N. NICHOLSON

Royal Air Force Institute of Aviation Medicine,
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F. S. PRESTON

Air Corporations Joint Medical Service,
Hounslow, Middx

1 Nicholson, A. N., *Aerospace Medicine*, 1970 **41**, 626.

Consent Forms

SIR,—A member has written to us about recent instances when his patients have been invited to sign consent forms when already under the influence of "heavy preoperative sedation"; those concerned have been patients in private nursing homes or clinics.

There is no legal magic in a written form of consent and in some circumstances consent given verbally or implicit may be quite sufficient. Moreover, until recently private patients were rarely asked to sign such forms since they had invariably received from any surgeon concerned full explanations and had agreed the proposed surgical procedures. However, if a patient is required to complete such a form it should not be presented for signature unless he or she is in a fit state to comprehend its terms—for example, not under the influence of powerful sedative drugs—for consent given in such circumstances is worthless and likely to be considered by the courts as invalid.—I am, etc.,

HERBERT CONSTABLE

Secretary, Medical Protection Society
London W.1

Died Suddenly

SIR,—The phrase "died suddenly" occurs with conspicuous frequency in the obituary notices which you publish weekly in the *B.M.J.* and a similar phrase "after a short illness" is also seen very often.

To many of your readers, particularly the older ones, the obituary pages of the *B.M.J.* are of special interest and most of us have noticed the amount of suddenly fatal illnesses in our profession. I have just

finished surveying the obituary notices of the past year (1970) and my findings may be of some interest to others. For my purpose I divided the profession into three groups: (1) general practitioners; (2) consultants and specialists; (3) "other ranks"—administrators, public health, the services, etc. I divided the modes of death into three groups also: (1) sudden deaths; (2) short illnesses; (3) other causes.

The total number of obituary notices was 449 and in 126 of these the deceased had "died suddenly" (28%). There were 158 general practitioners, of whom 51 died suddenly (32%) and 14 died after a short illness. There were 193 consultants and specialists, of whom 57 died suddenly (29%) and 21 died after a short illness. There were 98 other ranks, of whom 18 died suddenly (18%) and 8 died after a short illness.

Although this small survey makes no pretence to be statistically exact, the differences between the three groups seem to be very much what one would expect. Is it possible that those members of our profession who achieve the distinction of an obituary notice in the *B.M.J.* are likely to have lived a more stressful life than their colleagues who have not been so distinguished, or do these high ratios of sudden death apply equally to the profession as a whole?

A more cheerful point which I also noted was that among the 449 cases there were 15 who lived to be 91 and over, including one of 100 and one of 101.—I am, etc.,

W. CAMERON DAVIDSON

Torquay, Devon

Foundation for the Study of Infants Deaths

SIR,—We have taken part in the original research into the problem of cot deaths and last April attended a seminar at Cambridge under the chairmanship of the Countess of Limerick, where the whole subject was reviewed in depth. Subsequent to this the Foundation for the Study of Infant Deaths was established with the following objectives:

(1) to undertake a broad investigation of all the possible old theories and new ideas of the aetiology of cot deaths,
(2) to identify the trigger mechanism that actually causes the infants to die,
(3) to obtain accurate statistical information by means of a nationwide survey,
(4) to organize support for bereaved parents.

On behalf of the Foundation we have been asked to request the co-operation of all the medical professions. The registered address of the Foundation is Rolls Chambers, Star Yard, Carey Street, London W.C.2.—We are, etc.,

J. M. CAMERON
H. R. M. JOHNSON

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Where's our Serpent?

SIR,—Most doctors these days are so grossly overworked that in all probability they will be reading the January 2 issue of the *B.M.J.* around Easter. Hence the absence, to date, of a storm of protest at the absence, from the front cover, of our traditional symbol—the serpent and staff.

Our old friend, surmounted by its Metro-Goldwyn-Mayeresque scroll, was always—and rightly—accorded a central place on the cover, and its prominence there not only acted as a constant reminder of our great heritage as a truly international profession but also facilitated ease of recognition in the darker recesses of the world's medical libraries. Its sudden disappearance came as a shock to me, in much the same way, I would imagine, as the sudden abolition of the cross as the symbol of the Christian faith would come as a shock to a bishop. Other medical journals in this country and throughout the world are not ashamed to give continued prominence to this traditional link with our past. Your venerable contemporary *The Practitioner* has two serpents entwined in a somewhat compromising manner (perhaps it's just a loving embrace?) on the same staff. Our great banking houses are proud to display their traditional signs—a walk down Lombard Street would soon convince you of that—our pawnbrokers are attached to their balls and no barber worthy of a tip is without his pole. That our ancient symbol should have been sacrificed for a ha'porth of printers' ink is scarcely credible. I am not, I hope, an unreasonable man. I am not asking for an anaconda coiled around a telegraph pole—clearly in our straitened circumstances funds would not run to that—but a small serpent, say a viper or an asp, should be within our means and would keep alive our link with the past, and act as a constant reminder that we are the guardians of a great tradition and accountable, as such, to future generations for our guardianship.

Never before in this country has our traditional freedom as a profession been so threatened as it is now, and we shall require all, and more, of the serpent's wisdom if we are to continue to preserve this freedom and enjoy our independence.—I am, etc.,

ARNOLD PEARCE

Basingstoke,
Hants

Technicians' Crisis

SIR,—I write in support of your leading article (26 December, p. 761). How tragic that this loyal and hard-working group of people should be driven to consider strike action to secure for themselves a fair and decent salary. For many years the technicians in cardiac units have been wretchedly paid. This has interfered with recruitment and with the running of cardiac units so that some of our leading hospitals have chosen to bypass the Ministry's regulations by employing their technicians through the university and paying them on university scales. Thus, some of the cardiologists who might have been best placed to bring pressure to bear on the Ministry have not been too directly concerned with technicians' pay scales within the Health Service.

Many cardiac units like my own are faced with an acute shortage of technicians. The pay scales are so poor that very few men enter the profession. Many girls serve us well but leave sooner or later to marry and have children. There is also substantial wastage of trained technicians through emigration and because well paid jobs are available to them in industry. Inevitably standards are falling, partly because there is no one to give "in-service training," and partly because of the relentless pressure of work on the technicians. It is morally wrong that poorly paid and partly trained technicians should have to carry such heavy responsibility. It tends to be forgotten that these people are key members of large and very expensive teams of people doing cardiac catheterization and cardiac surgery. Over the 15 years which I have spent exclusively in cardiology I have many times seen investigations and operations postponed because of shortage of cardiac technicians. Substantial sums of public money have been wasted and are being wasted in this way.

It is easy to see that the Government may not now wish to award a pay rise of greater than 15%. However, a very small group of people is involved, it is widely agreed that this group is being grossly underpaid, and the poor pay scales have resulted in substantial wastage of hospital money. It is hoped that the Department of Health will have the courage to meet this crisis now because if it waits for the implementation of the recommendations of the Zuckerman Committee there may be very few trained technicians left.—I am, etc.,

MALCOLM K. TOWERS

Thoracic and Cardiac Surgical Unit,
Harefield Hospital, Middlesex

House Calls

SIR,—I would like to support Dr. H. M. Moolla (9 January, p. 115) in his remarks about house calls made by general practitioners. These requests increase out of all proportion the time it takes to treat an individual patient, and, as we all know, the reason the visit is requested is not always due to medical necessity.

I personally find that late requests for house calls prove most disrupting to any attempts to run an efficient appointment system. If the N.H.S. think it reasonable to pay a fee of 10s. for the administration of one immunization injection followed by three drops of polio vaccine—taking less than one minute of our time, assuming we actually carry out the procedures ourselves—then a fee for a house visit, preferably paid by the patient, is not unreasonable.

At present our final net income is inversely related to the numbers of visits we do, and in these days of rapidly increasing motoring costs this amount is not insignificant. Finally, a high percentage of complaints against general practitioners stem from disputes over home visits not being done. These disputes serve only to erode the doctor-patient relationship. Home visiting from a doctor's point of view can sometimes be time wasting—frequently disrupting to any attempt at practice organization, often a source of patient dissatisfaction, and always a source of loss of income by way of motor expenses.