and would like to comment on the views of Dr J Horder and others (19 May, p 1507). I take great exception to being accused of going through "five university years in the indiscriminate collecting of factual knowledge . . . largely excluding other mental processes." I agree that the A level curriculums were more intellectually stimulating than any of the undergraduate basic medical sciences but this "hard core" of knowledge remains essential to medical education if only to stimulate later an "independent critical thinker."

I find it hypocritical to criticise junior doctors for being motivated by examinations, when throughout stages I and II of medical education these are the sine qua non for progression and employment. In "reasons for failure" of the present system it is argued that educational merit is gained in a period of "study in depth" but then later contradicted by "it is most unlikely that a lack of wider experience can be made good by deeper experience." What is really meant?

One objective of the proposed general professional training is: "To provide time and incentive for the individual doctor." The incentive is automatically self engendered, but the time and finances allowed for postgraduate medical education are singularly incommensurate. It is suggested that the postregistration year should be spent in clinical appointments in subjects other than the chosen specialty. How does the hierarchy imagine that the junior doctor decides on his career of choice? If he then decides that one of these appointments suits him that would count as failure in this second stage medical education schedule.

Surely critical thinking is developed continuously as medical students discriminately collect factual knowledge and are even occasionally encouraged (not trained) to think critically. Ultimately, however, junior doctors are forced by the dictate of "accepted medical practice" and more directly the immediate superior's practice to preserve the status quo and are not allowed to think critically or be innovative.

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Major disaster planning

SIR,—Mr A R Bliss's appraisal of the management of the M5 coach accident (12 May, p 1433) has prompted us to compare our experience in dealing with the bombing attack on the Band of the Royal Green Jackets in Regent's Park in 1982 by the Irish Republican Army.

Twenty one soldiers arrived at this hospital at 1 30 pm (within half an hour of the bombing). Ten of them were treated in casualty but were later discharged. Eleven were admitted and nine subsequently required surgery. Two seriously injured soldiers were transferred urgently to the operating theatre, one for neurosurgery. He later died of overwhelming injuries. The remaining patients sustained extensive soft tissue injuries but none was life threatening. Resuscitation was started in casualty and dressings applied. These were not disturbed until the patient was anaesthetised. Radiographs were taken en route to a central holding ward. The casualty department was cleared by 3 00 pm as there were warnings of possible further attacks. Surgical manpower was not a problem with a central pool of junior staff from all firms coupled with a reservoir of research registrars. All anaesthetists and theatre staff were made available after cancellation of routine lists. All surgeons attended a ward round at 3 15 pm when an order of priority for theatre was drawn up irrespective of the period of preoperative fasting. Once the police had confirmed that further bombings were unlikely, surgery started at 4 00 pm. Six operating theatres, with two in reserve, were used simultaneously with two or three junior surgeons for each patient. Apart from the patient who underwent neurosurgery, which lasted six hours, the other patients were in theatre for between one and a half to two hours. Extensive debridement and packing were performed. One consultant and one senior registrar supervised all theatres and three other consultants stood by to give specialist advice on vascular and orthopaedic problems while three consultants supervised the anaesthetics. All surgery was finished by 10 00 pm. Every case was reviewed under general anaesthetic at 48 hours. Of the 30 or more serious wounds treated, the only one to become infected was a compound knee injury that had been closed. After seven days most wounds had been grafted or closed as delayed primary procedures.

Every disaster has certain unique features but the thrust of Mr Bliss's argument is that delay in the treatment of wounds leads to an increase in infection, that it is easy to underestimate the time needed in the operating theatre (and thus the need for surgical and anaesthetic manpower), and that delayed primary closure of wounds is only partially safe.

We agree with some of these points. Operative delay should obviously be avoided but lifethreatening injuries will take priority. Consultants should generally supervise rather than operate but the number of staff available and the nature of the injuries may alter this policy. Delayed primary suture is demonstrably safer than primary closure and we can see no place for the initial closing of extensive soft tissue injuries; we thus agree with the comments of Mr Lowdon (2 June, p 1694).

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How large is the problem of medical negligence?

SIR,—I was interested to read Mr Simanowitz's letter (12 May, p 1460), but I do think that equating "adverse factors in medical care" with medical negligence is hardly fair. "Adverse factors" (unless precisely defined) may cover several possibilities including errors of clinical judgment, situations developing unexpectedly beyond the competence of the doctor concerned, or even unforeseen difficulties with equipment. These occurrences, although unfortunate, do not necessarily constitute negligence.

Mr Simanowitz may be right in his suggestion that negligent practice is more widespread than is acknowledged but I do not think that this view is adequately supported by the data he quotes.

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SIR,—I have been taken to task by Mr D Bolt (26 May, p 1616) and Dr I R Fletcher for equating the term "adverse factors" with medical negligence.

It is worth noting that it is not Dr B Wood and others (the authors of the original article) who have challenged me and I suspect that this is because their description of "adverse factors" must only amount to the legal definition of medical negligence. In their paper (21 April, p 1206) they refer to a total of 154 babies. "In 116 deaths no evidence of departures from accepted practice was found." If medical negligence is the failure to reach accepted standards then in the remaining 38 deaths there was clearly medical negligence. This contention is further supported when the adverse factors are detailed, all of them with the possible exception of "intubation difficulties" would amount to medical negligence in law. Finally, the authors refer to "avoidable" deaths. Surely if the deaths were avoidable then they were the result of somebody's negligence?

It seems that both correspondents are guilty of trespassing on the lawyer's domain. I advise doctors against doing this when discussing the requisites of a medical report for legal purposes involving medical negligence. The medical facts are for doctors, but negligence is a legal concept and can be defined only by lawyers.

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Visual hallucinations in children receiving decongestants

SIR,—We were very interested in the correspondence from Dr M A Stokes (19 May, p 1540), Dr M G Miller, Dr P C Drennan, and Professor J Bain (2 June, p 1688) in which further cases of visual hallucinations with the combination of pseudoephedrine and triprolidine (Actifed) are reported. We support Professor Bain's final conclusion that the "widespread prescribing of these drugs has to be more seriously questioned."

In Professor Bain's summary of the findings of his trial he points out that 6% of the children had to be withdrawn because of side effects. A closer look at Professor Bain's paper shows that nine out of 74 children who were prescribed pseudoephedrine were withdrawn because of the side effects, which included bad temper, irritability, poor sleeping, dizziness, and general malaise. The incidence noted in this trial suggests that it is pseudoephedrine rather than triprolidine that is responsible for the side effects that we have reported. Furthermore, the incidence of side effects in children given these preparations may be very much higher than has been generally recognised.

The public response to the publicity given to our paper (5 May, p 1369) has been remarkable. We have received over 100 communications and out of these we have identified more than 50 other possible cases of central nervous system side effects caused by Actifed, consisting of either visual hallucinations, or behaviour disturbances, or both. In addition similar effects have been reported in adults, and a further five reports of side effects in children given Actifed and subsequently pseudoephedrine hydrochloride (Sudafed) or vice versa. A further report outlines similar effects and visual hallucinations in a child prescribed Sudafed and we have had a further case of similar reactions with Sudafed only, which would further implicate pseudoephedrine.

We consider the following points concerning the use of pseudoephedrine, either alone, or in combination, are worthy of