tunately, this preference confounds the sex of the child with his birth order.

Firstborn children of either sex are different from laterborn children: They are more achievement oriented, ambitious, conscientious, creative, intelligent, self-controlled, serious, and adult oriented. They are more likely to attend college and to achieve eminence but also more likely to be conforming, susceptible to social pressure, anxious and dependent.

Secondborn children of either sex have been described as cheerful, easygoing, popular, practical, likely to seek help, talkative, and nervous. Notice that firstborn children resemble our masculine sex role stereotype while secondborn children resemble the feminine one. In fact, if firstborn children actually are boys and secondborn children are girls (with an older brother), the resemblance increases.

In short, uncritical use of sex choice technology is likely to create more masculine men and feminine women than are currently seen. Recent research indicates that this would probably be unfortunate. The double disadvantages of being secondborn and female, coupled with the biological disadvantages of having been born to older parents, are likely to hinder severely the progress of women into the full privileges and responsibilities of adulthood. At the same time, the pressures on men to achieve would become even greater. Furthermore, masculine men and feminine women seem to lack the flexibility in behavior and response that is critical for adapting to our complicated social structure. People with mixtures of traits, people who can be aggressive or sensitive, as the situation demands, have been found to be healthier and happier.

We strongly recommend that sex choice technology be used to select the sex of the second child—but not the first. This would avoid confounding sex with birth order, and all that it implies, while allowing people to guarantee variety in the sex of their children.

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Re-certification

To the Editors:

As most physicians in practice, I am concerned with maintaining and improving the quality of care received by the patients in my community. Obstetric and gynecologic care is provided by family practioners, general surgeons, internists, and noncertified obstetrician-gynecologists.

I feel that it is most unfortunate to subject those physicians who have been conscientious and competent enough to become certified to the rigors and trauma of re-certification, while all other physicians providing similar care to women are not so liable. The possible outcome is that competent certified physicians may refuse to undergo re-certification or, for various reasons, fail re-certification. We then would have a situation wherein the more competent practioners in a community would be stigmatized, while the noncertified obstetrician-gynecologists as well as other physicians providing obstetric-gynecologic care would remain status quo.

Re-certification is untried and untested. There is no reason to believe that it can measure a physician's competence, and we do not know if it will improve care in a community. It certainly cannot effectly do so, since it is only directed at those physicians of proved competence.

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Role of malnutrition in pre-eclampsia and eclampsia

To the Editors:

In the November 1, 1975, issue or the JOURNAL (page 543), Dr. Jack Pritchard reported 154 cases of eclampsia treated at Parkland Hospital in Dallas, Texas, over a period of 20 years, ending March, 1975. He reported no maternal deaths among these 154 women who were "typically" teen-age, nulliparous, and "black." I think his work is a testimonial to the wisdom of therapeutic nihilism, especially in regard to the use of such drugs as sodium diuretics and heparin. It became clear to me many years ago that diuretics which attack the plasma volumes of both mother and fetus are harmful and can cause maternal and fetal deaths (AM. J. OBSTET. GYNECOL. 83: 1352, 1962). Readers should be aware of a historic hearing on the use of thiazides in pregnancy held at the United States Food and Drug Administration's offices in Rockville, Maryland, on July 17, 1975, Professor Leon Chesley presented a devastating attack on the use of these drugs in human pregnancy. He gave eight scientific reasons why sodium diuretics are contraindicated in pregnancy and "especially in pre-eclampsia eclampsia."

As you know, for many years, I have tried to raise the question of the role of malnutrition in the etiology of eclampsia, or convulsive metabolic toxemia of late pregnancy (MTLP). I have claimed no originality for this "discovery" which was made by M. B. Strauss (Am. J. Med. Sci. 190: 811, 1935) at Harvard and by Robert A. Ross (South. Med. J. 28: 120, 1935) in North Carolina at the same time. There has been a rigid prejudice against this nutritional thesis among United States obstetricians, and it is reflected in Pritchard's

report and the discussion which follows it in the JOURNAL. There seems to be a vague sort of consensus among our eclampsia experts that this disease ought to be "preventable," yet, as Dr. de Alvarez observed, it remains with us. It is very clear that we cannot consciously prevent any disease as long as its basic etiology remains entirely unknown, as long as we remain so totally in the dark regarding the essentials of its pathophysiology. For this reason, I must continue to try to emphasize the validity of the Strauss/Ross thesis.

In the Contra Costa County Medical Services' prenatal clinics, since July, 1963, I have been carrying on a nutrition education program with one basic aim: to prevent MTLP in as many patients as possible. At the Richmond, California, prenatal clinics, we have 50 per cent so-called "black" patients. I have personally cared for several hundreds of so-called "high-risk" pregnant patients who are poor, teen-age, nulliparous, and black; yet, in more than 12 years, we have not had a single case of eclampsia or convulsive MTLP. This clinical observation is not original with me; Reginald Hamlin showed us how to eradicate eclampsia among public clinic patients in Sydney, Australia, over 20 years ago (Lancet 1: 64, 1952).

At the present time, my chief interest lies in the *prevention* of human reproductive pathology caused by malnutrition, but the evidence is very clear that infusion of human serum albumin is of value in combating the hypovolemia and hemoconcentration of severe MTLP. I have a detailed bibliography on this point if readers are interested.

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Advanced course in colposcopy with video tape tutorial, July 22-24, 1976

An advanced course in colposcopy will be held during Montreal's Summer Olympics on July 22-24, 1976, at the Jewish General Hospital, Montreal, Quebec, Canada. Invited speakers include Drs. Duane Townsend, Arthur Herbst, Adolph Stafl, and Ralph Richart.

The registration fee is $250 and includes advanced colposcopy, a session with a live patient, video tape tutorial, and lunches. Registration should be accompanied by a check payable to: Alex Ferenczy, M.D., Registrar, Jewish General Hospital, Department of Pathology, 3755 Cote St. Catherine Rd., Montreal, H3T 1E2, Quebec, Canada.