Management of self-poisoned patients in hospital

SIR,—Although we are in broad agreement with the conclusions of Dr R Gardner and his colleagues (18 November, p 1392) we would dispute the methods they adopted to assess success or failure in management. It has been clearly shown that psychiatrists show no uniformity in the management of this group of patients.[1] Therefore it is not surprising that physicians proved to be as competent. We would also dispute that success in management can be assessed solely by a junior physician agreeing with the psychiatrist who has trained him over future management.

Quite correctly Dr Gardner and his colleagues state that many self-poisoning patients "have taken tablets or medicines prescribed by medical practitioners." However, in a recent study of 236 patients suffering from overdoses in Newcastle upon Tyne we found that 20% were receiving psychiatric treatment at the time of their overdose while a further 25% had at some time been under the care of a psychiatrist. This would not support the conclusion that better training in psychiatric assessment necessarily offers any advantage. We would suggest that from their data one has the right to conclude only that physicians are equally as incompetent as psychiatrists in assessing these patients and that perhaps we should look further to see if another professional discipline can help us.

D BLAKE
M G BRAMBLE

Department of Medicine,
Royal Victoria Infirmary,
Newcastle upon Tyne

[1] Blake, D R, and Mitchell, J R A, *British Medical Journal*, 1978, **1**, 1032.

Caring for babies of very low birth weight

SIR,—Your leading article (21 October, p 1105) correctly stresses the intensive care required by these infants. However, there are two areas in which your article was, in my view, mistaken.

Firstly, you imply that neonatal intensive care units and special care baby units (SCBUs) are two separate things, the former offering all the facilities you describe and the latter a far more basic level of care, sometimes not even extending as far as checking the babies' temperatures. I cannot say whether this is true for parts of London, as you suggest, but in the rest of the UK I think it is true to say that almost every SCBU provides the skilled care, including ventilation, which you regard as the hallmark of a neonatal intensive care unit. The latter name has not been used up to now to avoid provoking parental anxiety and I hope we shall not have to change merely to convince one or two purists that "so many years in SCBU" on a curriculum vitae does not mean just looking for a thermometer.

My second point concerns the transportation of sick neonates. There is more danger of something going wrong in transit than in a proper SCBU and it is courting increased morbidity and mortality to encourage a policy of abandoning the present provision of adequate intensive care in most hospital SCBUs in favour of transporting a larger number of sick babies longer distances to fewer regional centres. Where unexpectedly a sick baby is born at home or in a hospital without proper SCBU facilities then of course safe transportation to the SCBU (my kind, not yours) is important. However, the uterus is the best transport incubator and when problems can be predicted it is safer to transfer the mother before delivery to a hospital with full obstetric and neonatal services.

F N PORTER

Department of Paediatrics,
Raigmore Hospital,
Inverness

Social mobility in African patients with duodenal ulcers

SIR,—We have studied the occupations of 206 patients (150 Indians and 56 Africans) with duodenal ulcers and compared them with their parents and with patients with other gastrointestinal diseases. These included 31 with chronic pancreatitis, 25 with irritable colon, 51 with oesophageal reflux, 14 with ulcerative colitis, 71 with miscellaneous gastrointestinal diseases. There were also 124 controls. All patients were subjected to endoscopy, and appropriate diagnostic studies were undertaken before assigning them to the various diagnostic groups. A study of number of years in the urban environment revealed no differences between the patients of any diagnosis, race, or sex. This contrasts with Susser and Stern's hypothesis that duodenal ulcers are associated with early urbanisation.[1] Segal *et al*[2] have shown that significantly more patients with duodenal ulcer in Johannesburg were born in towns than their controls. They claim that this fits with Susser and Stern's theory of early urbanisation; but this requires explanation, as the greater numbers of patients born in Johannesburg appear to show the opposite. Duodenal ulceration is a common condition in Durban, in both Indians and Africans. It is possible that there are different characteristics in the population compared to Johannesburg.

Regarding the study of the effect of occupational position, we feel that Segal *et al* erred in arbitrarily grouping together professional, technical, clerical, and transport workers for comparison with service and production workers and ignoring other groups. They used only a classification of occupational prestige (status). We have examined occupational position on three scales—namely, prestige, based on the work of Castle[3] and Schmidt[4] in Southern Africa; a scale based on authority or control over others; and a scale based on responsibility. The last two scales were developed in the Centre for Applied Social Sciences of the University of Natal. We found that Indian males with duodenal ulcers had significantly improved on their parents' prestige (χ^2 6·3; $P < 0·01$), unlike other patients and controls, but were more likely to be in the lower category of authority compared with those with other gastrointestinal diseases (χ^2 25·8; $P < 0·0005$). Indian females with duodenal ulcers showed no distinctive occupational prestige but tended to be in lower classes of responsibility compared with other patients (χ^2 5·3; $P < 0·025$). African males showed no distinctive position on any scale whatsoever compared with their parents, other patients, or controls.

It is apparent that our findings are not consistent across race groups and sexes, suggesting that stresses within occupational categories may manifest differently in different communities. The diminished authority and responsibility in some groups of ulcer patients, with or without increase in prestige, suggests that "powerlessness" in the work situation may be important in the causation of stress. We are at present carrying out a more detailed research project designed to identify the nature and occurrence of the stresses themselves.

M G MOSHAL
L SCHLEMMER
N K NAIDOO

Faculty of Medicine,
University of Natal,
Congella, Natal

[1] Susser, M, and Stern, Z, *Lancet*, 1962, **1**, 1115.
[2] Segal, I, *et al*, *British Medical Journal*, 1978, **1**, 469.
[3] Castle, W N, *Tropical Doctor*, 1978, **8**, 44.
[4] Schmidt, J J, *Beroepsprestige onder die Bantoe in 'n Stedelike Gemeenskap*. Pretoria, Human Sciences Research Council, 1973.

Dealing with residual bile duct stones

SIR,—One method of dealing with residual bile duct stones after choledocholithotomy is the technique of wire basket extraction through the T-tube track, popularised by Burhenne.[1] In some patients, however, the small calibre and the tortuosity of the track make the procedure difficult and time consuming, leading to an unnecessary increase in the radiation exposure to the patient. Furthermore, when the T-tube is brought out in or near the midline there is the added hazard of increased exposure to the radiologist's hands. When the T-tube is brought out laterally the hands may be kept out of the primary beam.

While it is appreciated that in the practice of most surgeons residual stones are unusual, nevertheless they do occur. The purpose of this letter is to point out that in view of the problems mentioned above removal of stones by the Burhenne technique is greatly facilitated if (*a*) the T-tube is brought out directly lateral to the common duct and (*b*) the largest possible T-tube, preferably at least 12 French gauge, is used.

RICHARD MASON

Department of Radiology,
Middlesex Hospital,
London W1

[1] Burhenne, H J, *Radiology*, 1974, **113**, 567.

Extending the role of the clinical nurse

SIR,—I write in response to your leading article (11 November, p 1320) on "Extending the role of the clinical nurse."

The point about specific, appropriate, and adequate training for nurses to whom traditionally medical functions are delegated is well made. In the Soweto service stress is laid on a health care team approach with primary health care nurses and doctors working together. The former manage alone 80% of the problems of the daily sick (a substantial contribution), but the doctor is available in the Soweto Clinic for referral of more complex disorders or on request. This arrangement is not simply one of necessity or expediency but a positive measure to provide better health care services by suitably trained people able to communicate and relate realistically to the people they serve and having the time and interest to do this. It enhances vital community participation in health matters and allows optimal use of available manpower. Is it realistic, considering the cost and content of specialised knowledge involved in present medical training, to expect doctors to meet the entire needs of primary health care in any community? One may employ a cordon bleu