NEWS AND NOTES

Views

While researching with the Nuffield Provincial Hospitals Trust team for the booklet *Talking with patients: a teaching approach* (published by NPHT price 50p) master communicator Professor Charles Fletcher was appalled to find his own technique at fault. On trying out the audiovisual equipment suggested for training medical students he found (he told Minerva recently) that he talked far too much during interviews with patients, and had a deplorable tendency to interrupt them at crucial moments. Other doctors who teach communication to students (and the many who still think it cranky) might try looking at themselves in the video mirror.

Two distinct types emerged from personality testing of a fairly large group of anaesthetists, say their journal "Anaesthesia" (1980;35:559-68). Most were detached, stable, and self-sufficient, but one-third were described as unstable, cautious, unsure of themselves, and with a sense of inadequacy. The big and unanswered question is how far personality characteristics affect performance.

Not many British schoolboys smoke five marijuana joints a day—but any who do should be warned that they may stay prepubescent indefinitely. A report from North Carolina (*Journal of Pediatrics* 1980;**96**:1079-80) describes a 16-year-old whose delay in puberty was attributed to pot; once he was persuaded to stop smoking he immediately shot up in height and matured sexually.

Ciba are now marketing their combination of rifampicin and isoniazid (Rimactazid) in 28-day calendar packs with days marked in English, Gujarati, Vietnamese, and Punjabi and with instructions in those four languages and Chinese and Urdu too. Certainly a good idea—but the problem remains that a high proportion of adult immigrants cannot read the language they speak.

Patients with the nephrotic syndrome may be so oedematous that dialysis is out of the question. The massive proteinuria and anasarca can be stopped by deliberate induction of renal artery thrombosis by passing steel guide wires with woollen ends into the renal arteries (*Journal of the American Medical Association* 1980;**243**:2425-6). One such patient with amyloidosis has been maintained with dialysis for 20 months since his kidneys were blocked off.

And another report in the "Journal of the American Medical Association" (1980;243:2371-2) describes how physicians at Brooklyn Hospital, New York, prompted by a 600% rise in the number of pacemakers inserted between 1972 and 1976 set up a committee of cardiologists to review the indications for pacing. In the subsequent two years the rate of insertion fell dramatically by half, without apparently affecting the outlook of those not treated.

No surprise at all in the finding by Australian psychologists that alcohol makes men angry and depressed (*British Journal of Social and Clinical Psychology* 1980;**19**:149-55) but the same research study also found that women reacted in the opposite direction after the same amount to drink. Perhaps, the report speculates, since it is not socially acceptable for women (in Australia anyway) to become intoxicated they deny the effects of alcohol and overcompensate to the point of reversing its effects.

A correspondent has sent further details of the Chinese technique for removing bladder stones by explosives (21 June, p 1541). According to the Xinhua News Agency, the surgeon made 100 open-air experiments and 13 practice blasts inside animals before working out the correct charge for his patient. No damage was caused to the bladder and the patient had "only a slight sense of vibration and numbness in his lower abdomen when the explosion occurred."

Whenever she comes across a completely new diagnosis Minerva believes that she cannot be the only one who is ignorant and wants to pass the information on. Malacoplakia of the testis, characterised by inclusions called Michaelis-Gutmann bodies with a concentric, laminated "owl's eye" appearance, is a late development in granulomatous orchitis (*Journal of Clinical Pathology* 1980;**33**:670-8), itself probably due to retrograde spread of a urinary infection with coliform organisms.

Aplastic anaemia may be another hazard of marathon running, says "Archives of Internal Medicine" (1980;140:703), for competitors who use a rubber cement containing benzene to keep adhesive tape in place over blisters on the feet.

Much delayed, the report of Professor R A Shooter's inquiry into the outbreak of smallpox at Birmingham University in 1978 has at last been published and contains no surprises (since Clive Jenkins leaked it two years ago). How Mrs Parker, the laboratory photographer who died, became infected will never be known for certain—though she should go down in history as the last smallpox victim.

This year's exhibition by the Medical Art Society is at the Mall Galleries SW1 until 4 August. As usual, the exhibits are dominated by pastoral landscapes, beaches, and holiday settings, and the standard is high. Many regular exhibitors get better year by year: almost without exception the prices asked seem far too low. Well worth a visit, chequebook in hand.

MINERVA

EPIDEMIOLOGY

Surveillance of subacute sclerosing panencephalitis

MARTIN H BELLMAN, GEORGE DICK

The UK register of cases of subacute sclerosing panencephalitis was set up in 1970,[1] and up to September 1977 96 cases had been included. The epidemiology of these patients has been reported.[2] By December 1979 a further 47 cases had been notified, and we describe these and complete the picture for the first 10 years of the register.

The diagnosis of subacute sclerosing panencephalitis is based on (1) the clinical history, (2) raised measles antibody titres in serum and cerebrospinal fluid, (3) electroencephalographic findings, and (4) brain histology. A confident diagnosis may be made on the first two criteria alone, as electroencephalograms may vary and brain anatomy is usually not examined antemortem. Of the 47 new patients, all had typical clinical histories and measles serology and 39 showed characteristic electroencephalograms on at least one occasion: in no case was brain histology performed.

Year of onset

Table I shows the year in which symptoms were first noted in the 143 cases. Because of the insidious early course of the disease there is often considerable delay between the onset and the time of diagnosis; furthermore, delays of up to six years have occurred before cases have been notified to the register. The number of notifications for later years is unlikely to be complete, and probably the few cases with onset recorded before 1970 do not represent the true totals for those years. When expected additional notifications are taken into account table I suggests an increasing incidence of the disease over the 10 years but numbers are small and, as noted, notifications are certainly not complete. In the United States the yearly incidence appears to be declining along with the reduced notification rate of measles resulting from the successful introduction of live measles vaccine.[3] In Britain measles vaccination is not so widely accepted and there is as yet no sign of a similar reduction of cases of subacute sclerosing panencephalitis.

Geographical origin of patients

Of the 143 patients notified since 1970, 24 lived abroad (mainly in the Middle East) and had come to Britain for investigation. The remaining 119 were residents in Britain, of whom eight were of Asian origin. The basic epidemiological pattern in the different ethnic groups was similar. (In future, patients who live abroad but are diagnosed in Britain will be excluded from the register.)

TABLE I—*Year of onset of first symptoms in notified cases of subacute sclerosing panencephalitis*

	Year of onset of symptoms													
	1962	67	68	69	70	71	72	73	74	75	76	77	78	79
Cases notified during 1977-9 (n=47)					1		3		2	5	10	15	9	2
Cases notified during 1970-9 (n=143)	1	2	1	2	8	12	16	11	17	20	24	18	9	2

Sex and age at onset

In the 10 years 96 male and 47 female patients were notified. Table II shows the age at which the first symptom referable to their disease occurred. The average age at onset for the 47 new cases was 9·6 years, and for all cases since 1970 9·7 years. In 87 cases (61%) the onset was between 6 and 11 years with a range of 3 to 27 years: only four patients were older than 15 years.

TABLE II—*Age at onset of subacute sclerosing panencephalitis*

	Age at onset (years)					Total
	3-5	6-8	9-11	≥12	Unknown	
Cases notified during 1977-9	6	17	11	13		47
Cases notified during 1970-9	18	38	49	35	3	143

TABLE III—*Age at time of measles infection*

	Age at time of measles (years)							Infection denied	Total
	<1	1-	2-	3-	4-	≥5	Unknown		
Cases notified during 1977-9	5	10	7	3	2	8	10	2	47
Cases notified during 1970-9	21	30	18	7	14	20	27	6	143

TABLE IV—*Interval between measles infection and onset of subacute sclerosing panencephalitis (incubation period)*

	Interval in years								Total
	<2	2-	4-	6-	8-	10-	≥12	Unknown	
Cases notified during 1977-9	2	5	10	4	9	2	3	12	47
Cases notified during 1970-9	4	10	28	23	25	9	7	34	143

Age at time of measles infection

The 110 patients with a known history had had measles at a characteristically early age (table III). The proportions in the 1977-9 and 1970-9 groups who had had measles before their second birthday were 41% and 46% respectively. In 27 of all 143 patients the age at the time of measles infection was not known and in six cases the infection was presumably subclinical, as a history of measles was denied. Only three children had received live measles vaccine: one of them was said to have had two doses and another had a subsequent infection with measles.

Delay between measles infection and onset of panencephalitis

Table IV shows the incubation period from the known measles infection to the onset of subacute sclerosing panencephalitis. In the most recent group the average interval was 6·7 years, and in the 10-year group it was 6·8 years. The range in the whole group was 9 months to 18 years: 98 (69%) of them were between 4 and 9 years of age.

Conclusion

Subacute sclerosing panencephalitis is an interesting model of slow virus infection, and the Virus Diseases Unit of the World Health Organisation is attempting to co-ordinate investigations of its epidemiology throughout

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the world. The UK register was originally set up by GD for the Measles Subcommittee of the Joint Committee on Vaccination and Immunisation, and, although the absence of any new vaccine-related cases tends to confirm our earlier conclusion that there is no increased risk of the disease after measles vaccination,[2] the surveillance must be maintained.

The register has been transferred from the office of the British Postgraduate Medical Federation to the Epidemiological Research Laboratory, Central Public Health Laboratory, Colindale Avenue, London NW9, and cases should now be notified to Dr Christine Miller at that address.

[1] Dick G. Register of cases of subacute sclerosing panencephalitis. *Br Med J* 1973;iii:359-60.
[2] Bellman MH, Dick GWA. Surveillance of subacute sclerosing panencephalitis. *J R Coll Physicians Lond* 1978;**12**:256-61.
[3] Modlin JF, Jabbour JT, Witte JJ, Halsey NA. Epidemiologic studies of measles, measles vaccine and subacute sclerosing panencephalitis. *Pediatrics* 1977; **59**:505-12.

PARLIAMENT

NHS reorganisation

England

Mr Patrick Jenkin made the following statement to the House of Commons on 23 July on the Government's decisions as a result of the consultations on *Patients First*.

My Department has received over 3500 comments in response to last December's consultative document, *Patients First*.... There is considerable support for our proposal that the organisation of the National Health Service should be streamlined. I am therefore today issuing a circular to health authorities on the changes to be made to achieve this [HC(80)8 abbreviated at page 401].

On structure, we have decided to remove a tier of administration. Instead of 90 area health authorities administering 199 districts, we will create a single tier of district health authorities. Each will serve a population of, generally, between 150 000 and 500 000. I have asked the regional health authorities to make recommendations to me on the boundaries of the new authorities by the end of next February after full consultation with interested bodies. I have told them that in order to minimise upheaval, the new district health authorities should as far as possible follow the boundaries of existing health districts (including single district areas) because this should in most cases provide a satisfactory pattern.

I want the new authorities to enjoy considerable autonomy in managing their affairs. Greater freedom should encourage a greater sense of responsibility; and smaller authorities, closer to the communities they serve, should be more responsive to local needs.

With a view to enhancing local autonomy still further, I intend, later on, to review the role of regional health authorities. Regions' responsibilities for strategic planning, the allocation of finance to the districts, and the maintenance of financial disciplines will remain. Talks will be held between representatives of the doctors, my Department, and the National Health Service on the future management of medical staff contracts, with a view to seeking a way of reconciling my desire for more autonomy at the local level with the doctors' genuine concern that the benefits which have resulted from the existing arrangements should not be lost.

There is also strong support for our other main proposal—to strengthen management at the local level and remove the intermediate tier between the district and the local unit. Each district health authority, which will be served by a single management team, will therefore arrange the district's services into defined units, appoint senior people to manage them, and give those people their own budgets. As far as possible, support services will be organised at that level. My objective is to get decision-making down to the hospital and the community level. In order to give authorities greater flexibility on this, I am cancelling most of the existing instructions which require them to appoint specified officers to a substantial number of posts. District health authorities will decide for themselves what posts to create.

I attach high importance to effective collaboration between the National Health Service and local authorities. I propose therefore to retain the present statutory requirement for joint arrangements for collaboration. The creation of new district health authorities will however mean that in many parts of England, health authorities and local authorities will no longer have common boundaries on a one-to-one basis. It is my hope that in most cases two or more district health authorities will make up one complete non-metropolitan county. I am proposing, in line with many views put to us, that health authorities should average around 16 members—significantly fewer than existing area health authorities. Within this total, I propose that local authorities should appoint four nominees.

There has been considerable support for community health councils; they will be retained in the new structure, with one CHC for each district. Later this year I will issue a consultative paper seeking views on their membership, role, and powers. When, after a few years, we have had experience of the working of the more locally-based district health authorities, I will review the longer term case for retaining these separate consumer bodies.

As foreshadowed in *Patients First* I intend to retain the structure of family practitioner committees, but I shall wish to study all the suggestions that have been made to improve collaboration with health authorities, especially in the planning of primary care.

I attach importance to close working between the National Health Service and universities with medical schools. I will discuss with interested bodies the present arrangements for designating some health authorities as teaching authorities, taking account, for instance, of the extent to which medical students are now taught in hospitals run by non-teaching authorities.

The changes I have announced imply no criticism of health service managers. They have had to work in what turned out to be an unduly complicated structure. It is much to their credit that the Service has achieved what it has. However, staff at all levels will be affected by the changes, and there must be full consultation with staff interests on the ways in which change takes place. Staff must know that they are going to be treated fairly. We have put forward what I hope are seen as fair proposals for the filling of posts in the new authorities, for staff protection, and for early retirement and redundancy compensation. These proposals are being discussed with the staff sides and I hope that satisfactory agreements can be reached soon.

The 1974 reorganisation represented a major step forward in the integration of hospital and community health services including primary care. It is the Government's policy, like that of our predecessors, that people should receive care in the community wherever possible. Further, the National Health Service is often criticised for neglect of prevention and of the more positive aspects of health promotion. The changes I am announcing in structure and management will, by making the Health Service much more a local service serving local communities, reinforce this priority for community care, and should lead also to the closer involvement of the public with policies to promote good health. In this, the role of the relatively new medical specialty of community medicine will be of increasing importance.

The main purpose of the changes I am announcing is to provide a Health Service which is better and more efficiently managed, and where local decisions can be taken more quickly by local people. At the same time, I am confident that it will be possible to make significant reductions in management costs, and I have told the Health Service that I expect these to be reduced, after a transitional period, by some 10%, equivalent to about £30m a year at present costs. This will release resources which could be used for patient care.

Mr Speaker, management and structure, though important, will not solve all our problems. The Government has already embarked on a number of initiatives designed to get better value for money, improve links between the Health Service and local communities, and raise standards. In the autumn, I intend to issue a document outlining the Government's strategy and priorities for health. The proposals I am announcing today will, when carried into effect, help to achieve what we all seek, a better service for our people.

Wales

The Secretary of State for Wales made the following statement in the House of Commons proposals for reorganising the NHS in Wales.

I have today published a statement *The Structure and Management of the National Health Service in Wales* (HMSO, £4·50), which sets out my preliminary conclusions following the consultations on *Patients First*. I emphasise that these are preliminary conclusions and, in effect, this is a consultative document.

It reaffirms my intention that responsibility for managing the Service should be delegated as close as possible to the point at which patient services are provided by creating a new system of strong health management units at local level. I confirm also that community health councils are to be retained as are the existing arrangements for administering family practitioner services. There has not been general support for the view that it is not necessary for Wales, in its particular circumstances, to suffer the upheaval of breaking up the existing eight area health authorities in order to get the benefits of good management. It is evident, however, that many people have not understood the full implications of the proposal to delegate management authority to health units. I have,

therefore, concluded that before I make final decisions there should be further opportunity for comment in the light of the explanations in the statement and of local consultations about the pattern of health units. I am also inviting further comment on the arrangements at all-Wales level, where I propose to set up an advisory Welsh Health Council comprising representatives of the health authorities, the professions, and the Welsh National School of Medicine. My intention is that the council should meet in public thus facilitating public awareness of debates on major health issues. I also propose to promote further co-operative working between health authorities.

I wish to minimise continuing uncertainties, particularly for NHS staff, so I am asking that further comments be submitted to me by 31 December and I would then hope to publish final decisions early in 1981.

MEDICAL NEWS

Health Education Council annual report

Encouraging people to improve their diet, avoid smoking, take regular exercise, and think of their mind and body as an entity is a long-term goal of the Health Education Council (*Annual Report 1979/80*, 78 New Oxford Street, London WC1A 1HA, 01-637 1881). Its emphasis on self-care over the past two years has been rewarded by a lower consumption of sugar, junk foods, cakes, and biscuits, and an increase in the proportion of non-smokers. It also reports that attitudes towards diet, exercise, smoking, and self-care in general have improved. Seventeen million pieces of information on health have been distributed.

Still, about 16 million people continue to smoke, and more than 50 000 die from the effects every year. There have also been proportionate increases in mental illness related to alcohol, cirrhosis of the liver, teenage convictions for drunkeness, volume of advertising of alcohol, and quantities consumed. The programme to combat alcoholism has hardly begun, comments the report, and complete prohibition of tobacco advertising and sponsorship and new health warnings are urgently needed.

Memorial symposium

A memorial symposium for Sir Derrick Dunlop, who died on 19 June, will be given by the University of Edinburgh on 17 October 1980. Professor R H Girdwood, Sir Eric Scowen, Professor G Teeling-Smith, and Professor R Hoffenberg will speak. The symposium will be opened by the Principal of the University in the George Square Lecture Theatre and will be held from 2.30 to 5.00. It is open to anyone who wishes to attend.

New drug standards

British Pharmacopoeia 1980 has just been published by HMSO in two volumes at £60. It contains the official standards that will come into effect in the United Kingdom on 1 December 1980 for a wide range of substances used in medicine and pharmacy.

COMING EVENTS

Association Européene et Méditerranéene de Coloproctologie—Annual meeting, 9-13 May 1981, Czechoslovakia. Details from Professor Z Maratka, Hospital Bulovka, 18081 Praha 8, Czechoslovakia.

International Symposium on Human Milk—18-21 May, Czechoslovakia. Details from Ing Lubomír Vávra, Fakultnínemocnice KÚNZ, Tkáňová ústředna, 500 36 Hradec Králové, Czechoslovakia.

Castle Priory College—Course on "Programme analysis of service systems," 12-17 September, Wallingford. Details from the college, Thames Street, Wallingford, Oxfordshire OX10 0HE.

Association for the Study of Medical Education—Annual conference, 15-16 September, Dundee. Details from the association, 150b Perth Road, Dundee DD1 4EA. (Tel 0382 26801.)

Two radiological meetings—Details of the joint radiological meeting of the Royal College of Radiologists, British Institute of Radiology, and Royal Society of Medicine Radiology Section, 19-20 September, Bath, and symposium on clinical oncology, "Colorectal Cancer," 27-28 February 1981, London, are available from the meetings secretary of the college, 38 Portland Place, London W1N 3DG.

St George's Hospital Medical School—Trainee day for junior psychiatrists in South-west Thames and South-east Thames Regions, 24 September, London. Details from Dr Sireling or Dr Hall, 01-672 1024, or Dr Waters, 703-5411.

Institute of Obstetrics and Gynaecology—Details of a teach-in for senior registrars, "Recent advances in obstetrics and gynaecology as practised at the Institute of Obstetrics and Gynaecology," 6-10 October; and symposia, "Genetic aspects of obstetrics and perinatology, 14 November, and "Neonatal haematology," 12 December, London, are available from the symposium secretary of the institute, Queen Charlotte's Maternity Hospital, Goldhawk Road, London W6 0XG. (Tel 01-748 6802 ext 354.)

Institute of Obstetrics and Gynaecology—Refresher course for general practitioners on modern management of obstetric and gynaecological problems in hospital and general practice, 29-31 October, London. Details from the symposium secretary of the institute, Queen Charlotte's Hospital, Goldhawk Road, London W6 0XG. (Tel 01-748 6802 ext 354.)

Ophthalmological Society of the United Kingdom—Annual congress, 8-10 April 1981, Southampton. Details from the society at Royal College of Surgeons of England, 35/43 Lincoln's Inn Fields, London WC2A 3PN. Closing date for submission of papers or films 19 September.

Czechoslovak Medical Society—Details and copies of the 1981 programme of medical congresses and symposia are now available from the Czech Medical Society, Vítezného února 31, CS-120 26 Praha 2, Czechoslovakia and Slovak Medical Society, Mickiewiczova 18/1, CS-883 22 Bratislava, Czechoslovakia.

BMA NOTICES

Medical Assistants' Subcommittee (CCHMS)

Nominations are invited from medical assistants holding permanent posts in the National Health Service for representatives to serve on the Medical Assistants' Subcommittee for the session 1980-1.

The representatives will be appointed on a regional basis as follows:

Northern	1	Wessex	1
Yorkshire	1	Oxford	1
Trent	1	South-western	1
East Anglia	1	West Midlands	1
North-west Thames	1	Mersey	1
North-east Thames	1	North-western	1
South-east Thames	1	Wales	2
South-west Thames	1	Northern Ireland	1

It will also be necessary to appoint a deputy for each representative. Nomination forms are obtainable from the undersigned and must be returned not later than *Friday 22 August*. In the event of a contest arising for any seat, voting papers will be issued at a later date.

J D J HAVARD
Secretary

Instructions to authors

The following are the minimum requirements for manuscripts submitted for publication.

A stamped addressed envelope or an international reply coupon *must* accompany the manuscript if acknowledgment of its receipt is desired.

(1) Typing should be on one side of the paper, with double or triple spacing between the lines and 5-cm margins at the top and left-hand side of the sheet.

(2) Three copies should be submitted.

(3) Spelling should conform to that of *Chambers Twentieth Century Dictionary*.

(4) References must be in the Vancouver style (*BMJ*, 24 February 1979, p 532) and their accuracy checked before submission.

(5) SI units are used for scientific measurements. In the text they should be followed by traditional units in parentheses. In tables and illustrations values are given only in SI units, but a conversion factor must be supplied. For general guidance on the International System of Units, and some useful conversion factors, see *The SI for the Health Professions* (WHO, 1977).

(6) Authors should give their names and initials, their current appointments, and not more than two degrees or diplomas. Each author must sign the covering letter as evidence of consent to publication.

(7) Letters to the Editor submitted for publication must be signed personally by all the authors.

(8) The editor reserves the customary right to style and if necessary shorten material accepted for publication.

(9) Acknowledgments will *not* be sent unless a stamped addressed envelope or an international reply coupon is enclosed.

(10) Detailed instructions are given in the *BMJ* dated 5 January 1980 (p 6).

UNIVERSITIES AND COLLEGES

MANCHESTER

Appointments—Dr J H Scarffe (senior lecturer in medical oncology); Mr S D Chowdhury, Mr C D Costello (senior lecturers in urological surgery).

LONDON

MD—O D Cuthbert, D D Mathews, A D Stephens, Elaine C Wright.

CONSULTANT APPOINTMENTS

BIRMINGHAM AHA(T)—Dr P M Rauchenberg (psychiatrist).

MANCHESTER AHA(T)—Mr D C S Gough (paediatric surgery).

SALFORD AHA(T)—Dr S Waldek (nephrologist).

WESSEX RHA—Mr J M Symes (general surgery); Dr L J Cook (dermatology).