I have worked in the East End of London as a casualty officer and experienced abuse of the emergency ambulance service at first hand. The problem in my view stems from the inadequacy of primary health care and health education, which is, unfortunately, a feature of the more deprived areas of the community. Our efforts at improvement should perhaps be directed at the latter rather than discouraging patients from using what, at the present, is an excellent and indispensible service.

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Bioavailability of dihydroergotamine

SIR,—I was interested to read the article by Dr Ian N Olver and others (26 July, p 275), in which it was shown that in two patients with autonomic insufficiency only about 0·5-1% of an oral dose of dihydroergotamine was absorbed.

In two healthy volunteers we were not able by radioimmunoassay to determine any drug in the plasma after a single 7·5 mg oral dose (unpublished results). Furthermore, in the beagle the amount of a 7·5 mg oral dose of the drug reaching the systemic circulation, obtained from the ratio of the area under the plasma curve after oral administration to that after intravenous administration, was only 1·2-1·4% of the dose. In this respect there was no significant difference between the two brands tested (Orstanorm and Vasogin).[1] However, both in human[2-4] and in animal[1-5] studies we have determined a clear systemic availability and drug response after a parenteral drug administration. On the other hand, a single 0·5-1·0 mg intravenous injection caused no measurable amounts of dihydroergotamine in the human saliva or cerebrospinal fluid.[4]

This slow penetration of the biological membranes and the quite high extrarenal clearance (693 ml/min) in comparison with the renal clearance (0·18 ml/min)[4] may be the main reasons for the low bioavailability after oral administration of dihydroergotamine. The 24-hour urinary excretion of dihydroergotamine in the beagle was only 2·7-3·1% of a single 0·5-1·0 mg intravenous dose[1] and in healthy volunteers 0·02-0·04% of a single 1·0 mg intravenous dose,[4] further indicating an intensive hepatic metabolism of dihydroergotamine ("first-pass" effect after oral administration). At present, however, we have no exact knowledge of the metabolism and possible clinically effective metabolites of dihydroergotamine. The apparent high first-pass effect in the gastrointestinal mucosa or liver could produce active metabolites not measurable by radioimmunoassay.

In conclusion, apparently the gastrointestinal absorption of dihydroergotamine is slow and erratic and more clinical pharmacological work is needed to resolve this problem.

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Generic prescribing

SIR,—Clearly the very worthy and public spirited Dr Ronald Law (16 August, p 520) and Dr Michael Jolles (30 August, p 623) are not aware that if the family doctor were to adopt the policy of overwriting their prescriptions for brand-named drugs with the words "The generic equivalent may be supplied" then within a very short time he could expect a most unwelcome visit from the area manager for that drug company threatening him with a variety of legal proceedings should he persist in using its brand name to obtain drugs not so named. See the letter by Dr T Russell in your own columns.[1]

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1 Russell T. *Br Med J* 1977;ii:1158.

Clinical and managerial aspects of hospital admission

SIR,—I read that the BMA Scottish Secretary, Dr Dale Falconer, has "condemned an agreement that gives nursing staff the right to veto admissions at a psychiatric hospital." It appears that at the Royal Dundee Liff Hospital, following a recommendation for an admission by a consultant psychiatrist, the nursing officer and charge nurse then decide whether the admission should be granted. Apparently admission is refused if the patient has been or is likely to be physically violent to himself or others. May I make a few observations from my own experience which may illuminate the situation?

Clearly only a medically qualified person is ultimately able to decide whether or not a patient is suffering from any illness and further whether the nature or extent of the illness is of sufficient gravity to warrant hospital admission. This is a clinical decision. However, before admission actually takes place one further decision has to be made—namely, whether the hospital at that particular point in time has available the facilities needed for the proper care and treatment of the patient. This, as it involves the deployment of resources, is a managerial decision, not a clinical one. In psychiatric practice, and I imagine to a large extent in medical and surgical practice, the usual limiting factor is the availability of adequate numbers of experienced nursing staff. The group best placed to assess the adequacy of nursing coverage is, or should be, those responsible for the deployment of the nurses—namely, the nursing managers. It would, therefore, seem to me entirely appropriate for the consultant to discuss any proposed admission with the nursing managers to ensure that adequate nursing staff coverage is available. In the absence of suitable coverage it would appear quite inappropriate, certainly inadvisable, to proceed with the admission.

In my own practice, I personally assess all referrals and select those patients in need of admission. These I discuss with the senior nursing officer responsible for the sector, and then usually proceed to admit. In the occasional case where nursing resources are not adequate at the time I either defer the admission or treat the patient at his place of residence. The hospital administration is informed of any difficulties regarding admissions by both myself and the senior nursing officer involved. In practice this system has worked very well indeed. It enables me to concentrate on that for which I am trained (that is, clinical work) and the nursing managers to focus on running the hospital.

I understand that some consultants are concerned that the nursing managers may attempt to obstruct or veto admissions on inadequate grounds. This appears to reveal a lack of confidence in their integrity. In the absence of evidence to the contrary, surely one might assume that nursing managers would use their authority responsibly and act in the best interests of the patients and the hospital service as a whole. A failure to behave in such a manner would suggest a weakness within overall Health Service management.

Much more importantly, a two-stage admission procedure enables any deficiency in the staff numbers or services to be brought to the attention of the hospital administration immediately. After all, it is the responsibility of the health authorities, not the consultants, to provide the services and they need to be made aware of any inadequacies. If this is not done the service is likely to become less and less adapted to the actual needs of the patients and their illnesses.

I am, however, disappointed to learn that the agreement in Dundee was reached between the Tayside Health Board and one of the nursing unions (COHSE). It would seem to me preferable for the initial agreement to be reached between the consultants concerned and the nursing managers of the hospital. It appears that in Dundee no such agreement was forthcoming, which forced the union to act instead. Furthermore, in Dundee only security-risk patients are considered under the terms of the agreement, whereas in my own practice all patients are considered in some detail by the nursing managers prior to admission.

I hope that the BMA might be prepared to reconsider its position here. In particular, I would emphasise that an admission to hospital entails both clinical and managerial considerations, and that at times in a less than ideal world managerial views may have to override clinical ones. When these are not made explicit, and therefore not considered objectively, a great deal of underlying tension and resentment may be generated, to the detriment of the hospital service as a whole.

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1 *On Call* 1980;**14**(28):1.

***The Scottish Secretary writes: "The point of concern is how to assess whether the patient is likely to be violent and to what extent; surely the responsibility for this must remain with the consultant psychiatrist, in close collaboration, of course, with his nursing staff. It is surprising that the Tayside Health Board would make an agreement with COHSE without reference either to the British Medical Association or, apparently, to the Royal College of Nursing. There are also other dangers in looking after patients; might COHSE, for example, refuse to admit patients with jaundice?"—ED, *BMJ*.

Thanks from a retired GP

SIR,—May one who has now been retired for five years use your columns to say "thank you" to Tony Keable-Elliott, who has recently retired as chairman of the General Medical Services Committee.

My financial security is almost entirely due to his efforts to improve the pensions of general practitioners. Black was the prospect before his voice was heard, and I know my thanks will be echoed by many who have retired—and I hope by all the profession.

I was privileged to be a contemporary of Tony on the old Buckinghamshire Medical Committee, and it shows no mean ability on his part that the voice which could sway us in committee should also be heard and heeded by successive governments. Well done, Tony—and thank you again.

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