

seems as if the medical profession has abdicated its responsibility to local authorities and voluntary organizations," a view you endorse in your leading article (p. 641).

Working in the preventive medical field as a health visitor, I and my colleagues take great responsibility for children known to be at risk, by closer supportive visiting. We are very aware of the need to liaise with other workers, medical and social, and indeed general practitioners and health visitors work increasingly from the same premises; this is part of everyday routine. At the same time it prevents either party abdicating any responsibility—merely sharing it.

None of us is perfect, but surely the reason for the authors' impression is the recent legislation (Local Authority Social Services Act, 1970), whereby responsibility for the care of young children was taken away from the health department of the local authority and placed with the social services department, the two departments being separately organized and situated.—I am, etc.,

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Poisoned Children

SIR,—The Medical Research Division of the Health Education Council has recently completed a study of accidental child poisoning in Bristol. The findings from this study¹ are particularly relevant to your recent leading article (17 August, p. 432).

The article states that nearly sixteen and a half thousand children aged under 5 years were admitted to hospital after suspected poisoning in 1972 alone. How many of these suspected poisonings were true poisonings? In the Bristol study of 183 episodes of suspected poisoning in which the child had been taken to hospital at least 65% were poisoning scares—that is, the child had taken either a substance which was innocuous (for example, penicillin syrup) or an innocuous dose of a potentially toxic substance. Of the 183 cases studied, 44% were admitted for one night or more, whereas only 28% of the children were defined as being cases of true poisoning, it being accepted that only in the presence of a symptom or sign should a case be so defined. This evidence suggests therefore that these hospital inpatient statistics do not accurately represent the true nature of the problem of accidental child poisoning.

The article emphasizes the dangers of medicines. Yet evidence from the above study shows that the severest injuries were caused by ingestion of domestic substances such as caustic soda and paraffin. The article also supports the recommendation for the introduction of unit packaging for certain medicines. However, there is no evidence available to suggest that unit packaging will have a significant effect on the poisoning rate. The only measure that has been shown through field studies to be effective is the child-resistant closure. Unit packaging is, in practice, restricted to medicines in tablet form and those which in small doses of one or two tablets are non-toxic; 25% of medicines and drugs in the Bristol study were in the form of liquids and creams.

Finally, your article mentions that there

are substantial amounts of drugs and medicines which are unwanted and unused in households and suggests that this vast array of medicines puts the younger child further at risk. However, evidence from the Bristol study showed that in 79% of the episodes involving medicines and drugs the substance was in use less than 24 hours before the accident. Therefore the campaign to reduce unwanted medicines and drugs may be relevant only to a small part of the problem.

In the light of our findings, especially of the proportion of non-poisoning cases mixed up in the statistics, we believe it is necessary to ask how far existing health education and the somewhat alarmist current debate may be shifting the threshold of anxiety in parents and clinical staff. If this were so it could increasingly impose unnecessary procedures on young children which in themselves may carry substantial risks. Thus health education may do harm. Prospective studies should carefully identify the rate of false positives among the allegedly growing number of cases of true poisoning—I am, etc.,

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¹ Calnan, M. W., *Community Health*, 1974, 6, 91.

Danger of Saline Emetics in First-aid for Poisoning

SIR,—It was with considerable interest that we read the recent article¹ and correspondence from Drs. C. J. C. Roberts and M. J. Noakes (14 September, p. 683) on the dangers of saline emetics in the treatment of overdoses. At that time we were investigating the case of a 21-year-old girl who had died shortly after admission, following transfer from a local psychiatric hospital where she had taken an overdose. The total dosage of drugs was known to be amitriptyline 750 mg, imipramine 250 mg, chlorpromazine 750 mg, diazepam 75 mg, and nitrazepam 50 mg. This did not seem to us likely to account for the particular features of the case, which included coma, hypotension, hyperpyrexia, paralytic ileus, multiple supraventricular and ventricular dysrhythmias, pulmonary oedema, and myoclonic jerks with repeated convulsions.

Quite the most remarkable biochemical findings were a serum sodium of 227 mEq/l. and a serum chloride of 195 mEq/l. Analysis of serum taken shortly after admission to this hospital showed levels of amitriptyline and imipramine within the therapeutic range and no drugs were detected in the peritoneal dialysate used in treatment. Post-mortem studies of hepatic tissue failed to reveal any evidence of chlorpromazine.

Retrospective inquiries to the psychiatric hospital concerned led to the discovery that the patient had been given large quantities of saline as an emetic. The actual amount of emetic consumed by the patient could not be assessed accurately, but was certainly in excess of 300 g and could have been as much as 600 g, the recommended dose being 50 g.

We believe that the antiemetic effect of chlorpromazine may have contributed to the high proportion of salt retained. We could agree with Drs. Roberts and Noakes that these possible dangers are as yet relatively

understressed and that those electing to use salt emetics should be aware of the effects of overdosage.—We are, etc.,

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¹ Roberts, C. J. C., and Noakes, M. J., *Postgraduate Medical Journal*, 1974, 50, 513.

Women in Medicine

SIR,—True equality between the sexes in medicine will not be achieved simply by concessions made within the profession itself. The change in attitudes towards women doctors, increased intake of female medical students, and retraining schemes which are mentioned in your leading article (7 September, p. 590) are welcome but not sufficient. What is actually required is a change in the pattern of child-rearing in society as a whole.

Nowhere in your article do you produce any evidence to support the assumption that of the two partners involved in the conception of children only the woman should be responsible for the upbringing of them. If both parents were equally accountable then your statements about "the dual responsibilities of a medical career and a family" and opting for "two careers" would cease to discriminate between the sexes. It is quite certain that you would not tolerate a situation in which it was possible for you to write: "The loss of these men to medicine is essentially due to marriage and family responsibilities," "it is a marvel that against all the odds so many men perform incredibly well in both careers," or "the return of men to medicine is possible after their family commitments have been reduced."

If you really wished to see an end to discrimination against women in medicine and the human and economic wastage this involves you would be calling strongly for change in child-rearing practices instead of being satisfied with the half-measures you describe. Where both parents are medically qualified they can quite easily continue to practise full-time in the sense in which you define this and look after their children provided that there are facilities to help them to do so. These facilities would include a greatly increased number of crèches provided for hospital staff, which would also benefit nurses and ancillary and other health workers. The crèches should be on the hospital premises and staffed by trained hospital personnel who wish to work part-time, such as male doctors with family responsibilities.

If medical parents were liberated in this way we should see fewer women doctors "choosing" public health, family planning, anaesthetics, pathology, and all the other unpopular branches of medicine in which they currently "specialize." They would have an incentive to obtain the higher degrees and diplomas which would open the way to more consultant posts and thus they could in reality "reach the highest points in medicine." Lost investment in training and the frustration of qualified women could be reduced at a stroke. Above all, this would benefit the patients, the majority of whom in most specialties are themselves women.—I am, etc.,

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