instances gave rise to suicidal attempts. It was always relieved by discontinuing the drug. A mild, ephemeral depression was also observed in several other patients. The disproportionately high incidence of side-effects as compared with psychotic relapses is very striking. While many of these were undoubtedly due to early inexperience in managing doses, and time intervals between injections, it was felt that they were a considerable obstacle to the widespread acceptance of the drug. We found that acute side-effects generally responded to intravenous procyclidine hydrochloride (Kemadrin), and this treatment is always available at the outpatient department in the hospital; benzhexol (Artane) is used for more chronic Parkinsonian side-effects, and promethazine hydrochloride (Phenergan) for akathisia. It is important to recognize side-effects before these give rise to serious disabilities and possibly hospital admission. We are presently trying out a newer preparation, fluphenazine decanoate (Modectate), reported to give fewer adverse effects.

Close collaboration between the nursing staff and local mental welfare services is essential. Several general practitioners have shown a keen interest and volunteered to give the injections to their patients, but otherwise they are given in the hospital outpatient department. Absentees are immediately notified to the appropriate mental welfare officer, who undertakes to bring the absconder to the outpatient department within the next 48 hours. Dissemination of information about the drug is also vitally important to keep everybody informed, avoid misidentification of the more bizarre side-effects—for example, akathisia, as a recurrence of psychosis; prevent patients on it being given oral phenothiazines in error; and dispel all-too-frequent prejudices and misunderstandings. Detailed bulletins about the treatment method are sent to the appropriate general practitioners in addition to the usual discharge letters. Joint case conferences are held weekly for nursing staff, other hospital workers, and mental welfare officers; there are frequent seminars for the nursing staff, and the patients and their relatives, whenever possible, attend an information/discussion group on the treatment day. The resettlement of schizophrenics in work should be awarded the highest priority, and we arrange for these patients to be given their injections on the wards in the evenings or at weekends.

We were able to achieve a 100% follow-up of these patients by means of a very close liaison between the hospital staff and the mental welfare service. When this is done there seems little doubt that the drug proves a most useful long-term prophylactic measure against relapse in the chronic paranoid schizophrenic, and to a lesser extent in the hebephrenic schizophrenic. With these patients it seems likely that the "revolving door" era of frequent hospital admissions will give place to one of outpatient management after initial inpatient stabilization.—I am, etc.,

M. W. P. CARNEY.

St. Annes-on-Sea,
Lancs.

Needle for Intravenous Infusion

SIR,—The simple device here illustrated is easily prepared from available equipment and works well in practice provided that it is properly cleaned directly after use to prevent rusting.

It consists simply of a pointed outer needle with a rather longer inner needle with a rounded tip which fits closely inside the outer needle. The skin and vein are penetrated with the outer needle projecting over the inner one. Then the inner needle is slid forward to cover the point of the needle. By using needles of suitable bore it is possible to give blood at adequate speed for most purposes.

The inner needle was prepared by rubbing down a pointed needle on an oilstone till a smooth edge was made.

With restless patients the vein wall is soon damaged by a pointed needle. If one introduces plastic tubing through a needle there is always some fear of breakage and displacement into the venous system, particularly if one is using old material. Also blood flows very slowly if fine plastic tubing of adequate length is used.—I am, etc.,

E. A. HARDY.

Victoria Hospital,
St. Lucia,
West Indies.

Headache following Lumbar Puncture

SIR,—For some time I have thought that the characteristic and self-limiting headache following lumbar puncture may be due to a lag in the restoration of the normal balance of fluid pressure between cerebrospinal fluid and brain cells and blood. Interference with the fluid content or pressure in any of these compartments might produce a temporary gradient in either direction between them, and account for the same type of headache arising in such conditions as dehydration, "hangover," premenstrual tension, etc.

A personal observation was that when subjected to lumbar puncture, and at another time myelography, I had no trace of headache. I attributed this to being in a relatively dehydrated state when these procedures were performed, having voluntarily restricted fluid intake for some hours beforehand. A simple trial on this basis might be easily conducted.—I am, etc.,

I. DUNCAN.

Student Health Service,
University of Sheffield.

Tetracycline and Nystatin

SIR,—The last time that one of my colleagues prescribed tetracycline for me I objected that it always gave me diarrhoea. My colleague changed the prescription to Mysteclin (tetracycline, nystatin) and I was impressed to observe that no diarrhoea supervened.

This personal experience gave me a particular interest in the report by the Clinical Trials Subcommittee of the British Tuberculosis Association (16 November, p. 411). In my view the conclusions drawn from this trial are invalid because of a fault in the design of the study. The fault is the inclusion in the trial of patients already suffering from gastrointestinal symptoms before receiving the test drugs. Table III shows that many of the subjects had signs of an alimentary disorder, probably due to infection by micro-organisms such as the currently ubiquitous adeno-, Coxsackie, or E.C.H.O. viruses. The variable course of this infection, likely to be unresponsive to either tetracycline or nystatin, introduces a complication which entirely vitiates any conclusion as to the effectiveness of nystatin in preventing tetracycline diarrhoea. An initially symptomless alimentary tract would appear to be a prerequisite for subjects in any future trials.—I am, etc.,

D. D. ADAMS.

Endocrinology Research Unit,
Medical Research Council of
New Zealand,
Dunedin, New Zealand.

Intermittent Claudication

SIR,—I should like to support the views expressed by Dr. M. D. Churcher (21 December p. 775). I have used chemical sympathectomy in 40 cases of intermittent claudication over the past 15 years. The technique I use is that advocated by H. A. Haxton¹: 4 ml. of 6% phenol is injected after a positive response to a test dose of a similar quantity of 2% lignocaine. The results have been encouraging, and several patients have had repeat injections after one or two years, and have been kept active for many years.

This procedure is done in the outpatient department and is completely safe. The only complication experienced has been some sensory irritation of the first lumbar nerve root in about 10% of patients, and this may last for about three to four weeks.—I am, etc.,

J. W. WARRICK.

Weymouth and District
Hospital,
Weymouth, Dorset.

REFERENCE

- ¹ Haxton, H. A., *Brit. med. J.*, 1949, 1, 1026.

Methaqualone

SIR,—In recent months I have been asked to see a number of cases of anxiety and depression who in the initial stages of their illness have been prescribed methaqualone for insomnia. I often found it difficult to switch them over to less powerful hypnotics even after the main psychiatric illness had been treated.

I have also noticed that those heroin addicts under my care who had previously been prescribed methaqualone in the course of their wanderings through various doctors' surgeries and outpatient clinics ask for methaqualone in preference to any other hypnotic to deal with their chronic insomnia. When questioned about it they all say it is much better than any other similar drug, and some-

have admitted that it actually gives them a "buzz" (addict jargon; positive pleasure response to some drugs, particularly morphine derivatives). This preference for methaqualone over barbiturates and other hypnotics shown by the young heroin addict could be ominous.

It may be wise, therefore, for practitioners to prescribe this powerful hypnotic less routinely and to keep a closer watch on those patients in whom they considered its use is indicated.—I am, etc.,

R. DE ALARCON.

Medical Research Council,
Clinical Psychiatry Research Unit,
Chichester, Sussex.

Death Certificates

SIR,—The time is over-ripe for altering the medical certificate of the cause of death in England and Wales to bring it into line with other countries. The minimal requirements, it is thought, are as follows: surname (maiden name), forename(s), date of birth, place of birth, main occupation, and other details, as mentioned by Acheson.¹ It is indeed strange that this country is behind Holland, the U.S.A., Canada, Scotland, New Zealand, and Australia in providing sufficient details for the purposes of critical investigations and in obtaining more accurate mortality statistics.

Making the death certificate a secret document, as in Holland, would enable practitioners to give information which would not upset relatives. For example, recently a

patient objected to the words "due to cigarette smoking" being put on the death certificate when the husband died of lung cancer, this particular patient having been a heavy smoker most of his life. To obviate this, a counterfoil could be modified to indicate the main cause of death, and the medical certificate itself, which should be posted to the registrar, would contain all the relevant details as to the mode of death.

The present certificate seems to be medically orientated, and does not help research workers. For example, I feel that there is about 20% under-reporting of lung cancer patients in this country—that is to say, patients may be stated to have died of pneumonia or bronchopneumonia when they may have died of lung cancer, perhaps to avoid upsetting relatives. In this practice deaths due to lung cancer greatly outnumber those dying from pneumonia or bronchopneumonia. It must of course be emphasized that these figures are applicable only to this practice.

It is also felt that by making the certificate of cause of death up to date the disparity between clinical and pathological cause of death would diminish. As is well known, there is agreement only to the extent of something like 45–51% shown in previous investigations on post-mortem examinations of in-patients in several hospitals.²—I am, etc.,

M. MACLEOD.

Wallasey,
Cheshire.

REFERENCES

- ¹ Acheson, E. D., *Medical Record Linkage*, 1967, pp. 84 and 85, London.
- ² *Brit. med. J.*, 1966, 2, 1465.

Consultant Contracts

SIR,—At the request of the Ministry of Health the Negotiating Committee of the Central Committee for Hospital Medical Staff considered proposals for revising the contracts of consultants. At the last meeting of the C.C.H.M.S. (*Supplement*, 21 December, p. 73), we were asked to approve the proposed draft contracts, which included the requirement for consultants to live within a certain distance of their main hospital appointment. During the discussion it was pointed out that under the present regulation whole-time consultants who wished to change to maximum part-time were permitted to do so only provided that they did the same amount of work and held the same responsibility for patients as when they were whole-time.

This arrangement is obviously unfair. During the 16 years that I have had a maximum part-time contract I have had to do a work-load in excess of 11 sessions. As a result the regional board has had work done without having to pay for it, and the total amount involved is over £10,000. In addition, my pension will be £300 less than that for which the work-load should have entitled me. Any alteration in these regulations cannot affect me now, and by drawing attention to this anomaly I am only trying to help the large number of my colleagues who are or may be in a similar situation. Many of the newly appointed consultants have had their nine sessions defined so that they do no more work than that for which

they are paid, but this situation could be altered by the Ministry. In one case in Wales a nine-session consultant was told by his regional board that he must take on two additional sessions without additional payment. When many years ago the Ministry were asked by the Joint Consultants committee to permit whole-time consultants to change to maximum part-time their request was refused until an offer to do the same amount of work was put forward. The Ministry were not slow in getting something for nothing and accepted this solution and also agreed that unless there was some special local reason all contracts should be advertised as whole or maximum part-time. The C.C.H.M.S. at their last meeting by the narrowest possible majority refused to refer this matter back to the Ministry, largely on the ground that to do so would give the Ministry an opportunity of withdrawing the part-time option.

It would be interesting to know the opinions of other consultants on this matter. Do they agree that the present requirement is a travesty of justice, and which, if our profession were to be represented by a union, would not be permitted to continue?—I am, etc.,

London W.1.

H. A. KIDD.

*The motion was as follows: "That the discussion of draft model contracts with the Ministry be deferred and the principles underlying them be debated in the committee."—Ed., *B.M.J.*

Specialist Adviser or Controller?

SIR,—Your leader on the administrative structure of the National Health Service (28 December, p. 783) claims that "there is complete agreement within the profession that the Health Service should be run by doctors and not by laymen." If this is true, I don't think it ought to be. Situations in which it is necessary or desirable for the doctor to have control are much more limited than you apparently recognize, and the running of a comprehensive Health Service is not one of them. His professional expertise in this regard fits him to be an adviser rather than a controller. It is important to distinguish the two functions.

On the one hand, a doctor is trained to employ special techniques (many of which would be harmful in unskilled hands) for the diagnosis and treatment of disease. For the proper exercise of this function it is essential that his clients accept a passive role (i.e., become patients) and allow themselves to be under his control. When he is acting in this way nurses or relatives or other "ancillary" workers have to accept a role as his technical assistants, and are also therefore controlled by him.

On the other hand, the doctor's specialized knowledge enables him to advise clients (individually or corporately) as to how they may avoid illness, or recover or increase their health. The recipients of advice are not adequately defined as patients, since they are required to be active rather than passive in following the advice given. For example, the doctor may advise his individual client to take a special diet, or he may advise the relatives or nurses to give a patient a special diet; or he may advise a community agency to make special diets available for particular groups of people at risk. In each case, control remains with the person advised, not with the doctor.

It would appear from the current discussion of administrative reorganization in the fields of health and social service that many of us confuse these two functions and claim rights of control in situations where our function should properly be advisory only. One hopes that those who control the health services will listen to medical advice, but perhaps not always take it; for, if they do, there is little doubt that an excessive proportion of resources will be devoted to curative medicine, and far too little on preventive measures and on the care of those for whom medical science has no cure to offer. It is doubtful how much curative medicine, as contrasted with general social betterment, contributes to the health of the community at large.^{1 2}

I must confess to feelings of considerable discomfort in reading the "cogwheel" report on the organization of medical work in hospitals³—where the absence of any consideration of the role of the nursing staff in determining how medical work will be carried out makes the document seem hopelessly irrelevant to my experience: for it is the ward nurses who control a great deal of medical work, not the doctors, who only advise (even if they call their advice instruction). I feel embarrassment when I hear my colleagues so vehemently opposed to the suggestion in the Seebohm Report⁴ that social workers should be under the control of someone other than a doctor: I am happy to be a