and duration of admissions during a corresponding period of equal length before starting therapy with long-acting phenothiazines. All patients received their first injection during a period of psychiatric relapse, but only 50 were admitted to hospital.

The follow up period ranged from 12 to 40 months, with an average of 24.8 months. All other necessary therapy remained constant throughout both retrospective and follow up periods. The Table summarizes our findings

	Admissions	Duration in Days
Prior to Receiving Long-acting Fluphenazine ..	241	10,048
After Long-acting Fluphenazine	50	1,335

A more detailed analysis of the causes of the admissions during the follow up period is shown below.

Psychiatric relapse	34	Duration	1022 days
Side effects	5	"	70 days
Default in attendance for injections with psychiatric relapse	11	"	243 days

In our series hospital admissions have been reduced from 241 to 50, and in patient time by 8,713 days. We feel that our findings substantiate the claims made in your leading article.

You mention the lack of double blind controlled studies of long-acting fluphenazine. This may be caused by the risk that substitution of a placebo in this vulnerable group of patients is very real and therefore poses ethical problems. We would like to bring to your attention two double blind controlled studies of fluphenazine enanthate. One is by Del Giudice *et al.*¹ who divided 63 hospitalized male schizophrenics into three groups on discharge. Group I (24 patients) received oral fluphenazine tablets. Group II (20 patients) received oral fluphenazine and were visited by a nurse every 15 days when a placebo injection of sesame oil was administered. Group III (19 patients) received oral placebo tablets and a visit from a nurse every 15 days when a fluphenazine enanthate injection was given. The efficacy of treatment was judged by the number of days out of hospital to the end of the follow up period or until readmission if any. The mean for Group I was 133 days, Group II 164 days, and Group III 287 days. Statistical comparisons between Group I and Group II was not significant; between Group II and Group III was significant to the level of $p < 0.001$; and between Group II and Group III was significant to the level of $p < 0.01$. Ravaris *et al.*² found 30 out of 34 hospitalized chronic schizophrenics developed regression with placebo.—We are, etc.,

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¹ Del Giudice, *et al.*, 7th Congress of the Collegium of International Neuro Psychopharmacologists, 1970, Prague.

² Ravaris, C. L., Weaver, L. A., and Brooks, G. H., *American Journal of Psychiatry*, 1967, 124, 248.

Representation of Regional Consultants

SIR,—The control of British medicine is moving rapidly from the hands of the individuals to central committees. The power of the Department of Health in monitoring and affecting our affairs is growing as is seen in the new proposals (see *Supplement*, 20 February, p. 47) for the Central Advisory Committee on Hospital Medical and Dental Staffing, which has an "overlord" control of hospital staff. In this an agglomeration of Department officials and our own inveterate politicians will decide the staffing structure.

We are now in the phase of a dwindling freedom to manage our own affairs in the periphery and must accept progressive central control. The regional consultants, comprising 70% of the total consultants,

hitherto more concerned with their clinical responsibilities, are now demanding greater representation in the central committees (*Supplement*, 4 July, p. 15).

The traditional control by the London-based consultants of the college and state committees is now seen as unacceptable. Active participation of consultants throughout the country is essential if their practical views are to be heard, and more to the point taken into account. The stampede of the Elephant and Castle to effect further control is now a major anxiety for British medicine.—I am, etc.,

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Smoking in Postgraduate Medical Centres

SIR,—The second report of the Royal College of Physicians re-emphasizes our profession's responsibilities in the matter of health education about the hazards of smoking. Unfortunately recent communications¹⁻⁵

ally (smoking is pollution); and it is bad medical psychology (the obligation of self-discipline is forgotten). Surely the time has come for all postgraduate medical centres to accept their anti-smoking and "clean air"

TABLE I

Date of Circular	Total Circulation	Replies Received	No Comment or Comment Incomplete	Questionnaires Analysed	Centres with "No Smoking" in Meetings
November 1967	228	170	24	146	19 (13%)
May 1969	228	183	9	174	35 (20%)

TABLE II

Smoking in Meetings 127	Smokers: Non-smokers at the various centres	↓ or less ↑-↑ Over ↓ Unknown	74 25 8 20
Smoking in the presence of patients 46			

have shown that medical students receive very inadequate anti-smoking instruction. Is it possible that our rapidly-improving postgraduate medical facilities are being used prophylactically to remedy the situation? To assess this possibility questionnaires had been circulated to all known postgraduate medical centres in England and Wales in November 1967, and again in May 1969. The quantitative responses are shown in Table I. Table II indicates the prevailing practices as recorded in November 1967 in 146 centres.

Table III shows the low priority accorded to reconsideration by postgraduate medical centres of their policy (regarding smoking in meetings) during the 18 months between the two questionnaires.

TABLE III

Reconsideration: Smoking prohibited ..	8
Reconsideration: Smoking permitted ..	16
No Reconsideration: Smoking prohibited ..	27
No Reconsideration: Smoking permitted ..	123

It is evident that during two-thirds of meetings at postgraduate medical centres two-thirds of the doctors did not smoke, yet four-fifths of the centres still permitted smoking. This paradoxical situation is trebly inappropriate: it is bad public relations

educatively (the patients and lay staff get to know); it is bad public health environment-responsibilities, and acknowledge that smoking is "sociable" only among consenting adults in private?—I am, etc.,

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Taunton, Somerset

¹ Bynner, T. M., *Medical Students Attitudes Towards Smoking*, 1967, London, H.M.S.O.

² Curran, A. P., *The Smoking Habits of Medical Students*, Paper to Society for Social Medicine, Glasgow, 1969.

³ Arva, O. P., and Bennett, F. J., *East African Medical Journal*, 1970, 47, 18.

⁴ Anderson, J. P., *British Medical Journal*, 1970, 4, 120.

⁵ Ball, K., *British Medical Journal*, 1970, 4, 367.

Independent Contractors

SIR,—Will someone explain how the profession managed to discharge its duties during the postal strike without instruction from all those Government and other pamphlets which tell us how to do our job? Very well, I guess. It will be interesting to see the morbidity and mortality statistics during the next few months.—I am, etc.,

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