CORRESPONDENCE

Correspondents are asked to be brief

Future of Mental Health Services

SIR,—For the past year or so the Department of Health and Social Security and the Manchester Regional Hospital Board have been expressing great satisfaction at the rapid development of psychiatric units in district general hospitals in the Manchester region. This week the report of the inquiry at Whittingham Hospital was published. Anyone who knows how little money has been devoted to mental health services in recent years will know that these units at general hospitals can have been created only by starving the old mental hospitals of funds. The Department has seen fit to criticize the regional board, the management committee, and the medical and nursing staff of Whittingham Hospital. In our submission the real blame attaches to the Department's own policy.

D.G.H. Psychiatric Units

Critics of the concept of the district general hospital psychiatric unit have repeatedly expressed the view that if a hospital is made into a dumping ground for chronic patients and nothing else the morale of the staff will suffer, and long term the chronic hospital will succeed in retaining only chronic staff. In the latest version of the Department's plans the old mental hospitals are to be abolished entirely. This is unrealistic for a number of reasons.

In this county so far as both mental illness and mental subnormality are concerned simple arithmetic shows that the amount of accommodation recommended by the Department is insufficient, even if the organization recommended could be made to work. The total accommodation in both hospital and local authority hostels, based upon the Department's standards of beds per thousand population, would amount to considerably less than the present number of patients in hospital and local authority care or on waiting lists.

The Department's plans appear to assume that excluding so-called psychogeriatric cases the mentally ill can be divided into acute and subacute patients suitable for care in a general hospital unit and chronic patients suitable for care in local authority hostels. In spite of all the recent advances in treatment there are still a small but significant number of patients who fail to stabilize to a degree which would be acceptable in a local authority hostel. These are, in fact, patients with chronic mental illness who show persistent behaviour disturbances. Though these patients represent only a small proportion of total acute admissions, they would lead to a progressive silting up of a general hospital unit, which would continue until the unit became unable to carry out its proper function. If we assume that only 1% of admissions follow this chronically disturbed course the accumulation of these patients would be blocking half the beds of general hospitals units after a lapse of only seven years. There are in addition serious public implications concerning the correctness of housing acutely disturbed schizophrenics, character disorders, and drug addicts in general hospital units. It is the Department's real intention that there shall be no service for these patients?

Mental Subnormality

On the subnormality side the Department assume that the severely subnormal with physical handicaps will be treated at the district general hospital, while the remainder of the severely subnormal and all the subnormal patients would be cared for in local authority accommodation. Persons of low intelligence but not clinically subnormal are apparently to be treated in mental illness units if they become mentally disturbed. This would perpetuate a deficiency which already exists in the psychiatric services. The majority of hospitals for the subnormal are very reluctant to accept patients with an I.Q. above 50. Experience has shown that any mental illness unit patients with an I.Q. below 80 do not derive much benefit from treatment. The tempo of the therapeutic community is too fast for them. There are, however, considerable numbers of patients in the I.Q. range of 50 to 80 who show behaviour disturbances sufficiently severe to require hospital treatment and to make them quite unsuitable for hostel or domiciliary care.

As usual the Department's plans appear to have been made with big cities in mind. In less densely populated areas the psychiatric unit of the general hospital will be likely to have no more than 60 beds/80 day places. One wonders whether such a small unit could provide all the therapeutic facilities required in modern psychiatry and remain a viable proposition. For instance, it would be unlikely that at any time more than half the patients would be able to attend the industrial therapy unit. Industrial therapy units can survive only if they are

large enough to be able to guarantee prompt return of work to the firms supplying the work. In a small unit of this type this would be quite inconsistent with the requirement to provide as great a variety of work as possible. So far as local authority hostels are concerned the suggestion is that these should be quite small and should not be concentrated in one place. To staff scattered small units would be very much more expensive in staff than in existing units. Has the Department really faced the financial implications of this?

Recruitment of Staff

There are also problems of staff recruitment and training. Would the smaller general hospital units receive approval as training centres from the Royal College of Psychiatrists or the General Nursing Council? There is the further problem of career prospects in psychiatric nursing. Many psychiatric nurses fear that general nurses understand psychiatric nursing so little that the general hospital nursing hierarchy would not allow them to do their job. For instance, they ask would any general hospital matron understand that it is part of mental nursing to organize games or even to play billiards with patients? With the implementation of the Salmon structure it is unlikely that many psychiatric units would be large enough to rank an area nursing officer above Grade 8. This must inevitably deter nurses of the best calibre from entering psychiatry.—We are, etc.,

F. A. BLEADEN
J. H. PRICE

St. John's Hospital,
Lincoln

Community Medicine

SIR,—When a new concept is invented full understanding of what it means is assisted if we have in our minds a model by which to judge it. There is much talk and printed discussion just now about a new kind of medical animal, variously called the community physician or the specialist in community medicine. We all know what a surgeon is and what he does and I think we all know what a physician is and what he does. Likewise most people probably have a fairly clear picture of the M.O.H. and his duties in advising local authorities on community services which they are presently required to provide; maternity and child welfare, school health services, control of epidemic disease, food hygiene, port medical services, and many other things, and we know what the hospital medical administrator does. However, many people seem to be confused and uncertain about the detailed work which will be expected of the "specialist in community medicine" for this has not been spelt out clearly.

In the report (*Supplement*, 22 January, p. 19) of your discussion with Dr. C. D. L. Lycett, Chairman of the B.M.A.'s Public Health Committee, Dr. Lycett appears to set out some of his ideas on this subject. However, as with other similar descriptions this one tends to be couched in rather vague and indefinite phrases which do not go far enough in detail to amount to the model I seek.

It may be naive of me to seek a realistic blue-print of the future specialist in community medicine when I know of, and indeed played some small part in, the establishment of the new Faculty of Community Medicine of the Royal Colleges of Physicians of Edinburgh, Glasgow, and London, and was a member of the joint working party which produced the Brotherston report *Doctors in an Integrated Health Service*.[1] Perhaps Dr. Lycett could be persuaded to amplify the remarks he made to the *B.M.J.* He may thus help others besides me to peer into an uncertain future.—I am, etc.,

J. G. M. HAMILTON

Edinburgh

1 Scottish Home and Health Department. *Doctors in an Integrated Health Service*. Edinburgh, H.M.S.O., 1971.

Cardiac Arrythmias during Laparoscopy

SIR,—We read with interest the article by Drs. D. B. Scott and D. G. Julian on cardiac arrhythmias during laparoscopy (12 February, p. 411). Together with Professor G. R. Kelman, we have been investigating the cardiovascular effects of laparoscopy,[1] and have now completed a series of over 50 cases where laparoscopy was carried out under a nitrous oxide, oxygen, relaxant technique with endotracheal intubation and artificial hyperventilation, during which end-tidal CO_2 concentration and E.C.G. were monitored continuously in all patients and PaO_2 and $PaCO_2$ were measured in 15. When planning this study, we decided against allowing patients to breathe spontaneously via a face mask for the following reasons:

(1) The significant risk of silent regurgitation in patients in the Trendelenberg position with raised intra-abdominal pressure.[2]

(2) The increased incidence of cardiac arrhythmias in patients with hypercarbia breathing halothane.[3,4]

(3) The occurrence of hypoxaemia during spontaneous ventilation in patients in the Trendelenberg position where the diaphragm has been splinted by artificial pneumoperitoneum. Desmond and Gordon[5] quote a PaO_2 as low as 46 mm Hg in such a patient breathing 33% O_2.

In our series $PaCO_2$ rose by a mean of 5 mm Hg, and never exceeded 40 mm Hg. Mean $PaCO_2$ was 135 mm Hg, the lowest being 101 mm Hg. No cardiac arrhythmias were seen in the series.

We conclude that with the technique used by us cardiac arrhythmias can be avoided during laparoscopy, when carbon dioxide is the insufflating gas. Even when nitrous oxide is used for insufflation Alexander and Brown[6] recommend maintaining adequate positive pressure ventilation to prevent excessive rises in the arterial PCO_2.—We are, etc.,

NANETTE L. M. GORDON
IAN SMITH
G. H. SWAPP

Royal Infirmary,
Aberdeen

1 Smith, I., Benzie, R. J., Gordon, Nanette, L. M., Kelman, G. R., and Swapp, G. H., *British Medical Journal*, 1971, 3, 410.
2 Seed, R. F., Shakespeare, T. F., and Muldoon, M. J., *Anaesthesia*, 1970, **25**, 223.
3 Hodgson, C., McClelland, R. M. A., and Newton, J. R., *Anaesthesia*, 1970, **25**, 382.
4 Scott, D. B., *Anaesthesia*, 1970, **25**, 590.
5 Desmond, J., and Gordon, R. A., *Canadian Anaesthetists' Society Journal*, 1970, **17**, 378.
6 Alexander, G. D., and Brown, E. M., *American Journal of Obstetrics and Gynecology*, 1969, **105**, 1078.

SIR,—Dr. D. B. Scott and Dr. D. G. Julian (12 February, p. 411) are to be complimented on studying cardiac arrythmias during laparoscopy and on a total of 1,000 laparoscopies a year at Edinburgh. Though interested to learn that the incidence of arrythmia is reduced by the substitution of nitrous oxide for carbon dioxide as the insufflated gas, we suggest that the technique of anaesthesia could not have been bettered with maximum production of arrythmia in mind.

Pneumoperitoneum and a degree of head down tilt undoubtedly embarass respiration in the anaesthetized spontaneously breathing patient. Also regurgitation must be more likely. These difficulties are solved by endotracheal intubation and controlled ventilation. The essentials of our technique are: oral premedication with nitrazepam and droperidol, 10 mg of each given as early as possible, induction with a small dose of any short acting intravenous induction agent, gallamine 100 to 140 mg to provide muscular relaxation and to facilitate endotrachael intubation, and controlled ventilation with nitrous oxide and oxygen supplemented with pentazocine 60 to 90 mg. After reversing the gallamine with neostigmine and atropine the patients are returned to the ward awake and able to raise their heads on request. Many go home the same day. In these day-cases the premedication is halved.

The intra-abdominal pressure will not be raised above 20 mm of mercury unless excessive amounts of gas are introduced into an unrelaxed abdomen. The common instruments in use do not limit the pressure but only allow its measurement. The point of measurement is frequently distant from the abdomen and may bear little relation to the intra-abdominal pressure. The amount of gas to be used, usually at least 3 litres, can best be estimated clinically by observation and palpation of the abdomen.

We do not see arrythmias. In fact we have long since given up looking for them. We would like to emphasize that with this sort of technique laparoscopy is easier for the gynaecologist, the patient, and the anaesthetist.—We are, etc.,

PATRICK STEPTOE
F. N. CAMPBELL

Oldham, Lancs

Spontaneous Fracture of Pelvis in Rheumatoid Arthritis

SIR,—Dr. R. T. Taylor and colleagues (11 December, p. 663) described the occurrence of spontaneous fractures of the pelvis in rheumatoid arthritis. Subsequently Dr. J. Dequeker and others (29 January, p. 314) drew attention to the low serum calcium levels in four of the six cases and described a further patient who had definite osteomalacia. In the case reported below there was also a low serum calcium, and like two of the Westminster Hospital patients she has done very well on conservative treatment.

The patient is a 64-year-old woman suffering from definite rheumatoid arthritis of five years' duration with typical *x*-rays but a negative agglutination test. She was treated initially with salicylates and only changed to indomethacin and ibuprofen three months prior to her admission. She has never had corticosteroids. One day she was relatively well in the morning and went