In your article you stress that genitourinary medicine should not be confused with urology, and would not encroach on the realm of urology. In spite of this you immediately state that the work of genitourinary physicians could "expand to include infertility and other diseases of the genitourinary tract when appropriate." This could only be seen as an encroachment on the realm of the urologist. May I stress again the deep concern which the council and members of the British Association of Urological Surgeons feel regarding the change of title. In a recent issue of the *B.M.J.* a junior post in genitourinary medicine was advertised under "Venereology." Surely this is an anachronism.

It would appear that the time is now opportune for the whole subject to be discussed logically not only by the Royal College of Physicians but in association with the Medical Society for the Study of Venereal Diseases, and more particularly with the British Association of Urological Surgeons.—I am, etc.,

R. A. MOGG

President,
British Association of Urological Surgeons

London W.C.2

Television Programme on Induction of Labour

SIR,—The main theme of the B.B.C.2 "Horizon" programme of 27 January was induction of labour. On this controversial subject I am not qualified to comment. However, epidural analgesia in obstetrics was also referred to and several misleading or frankly incorrect statements were made.

The information leading to these statements did not come from discussions between the "Horizon" production team and the anaesthetists working at the John Radcliffe Maternity Hospital, where much of the programme was filmed, as none took place. In particular, one patient's recollections of her care after an epidural analgesic were quite at variance with established theory and practice at this hospital. She was also allowed to state that the epidural was the direct cause of her emergency caesarean section for fetal distress. In fact, at that operation the reason for the fetal distress was found and it was in no way related to the epidural.—I am, etc.,

L. E. S. CARRIE

John Radcliffe Hospital,
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Leeds Infirmary Blues

SIR,—Your correspondents Mr. R. A. Elson and Dr. R. H. Townshend (22 February, p. 455) raise two points in regard to your leading article (8 February, p. 297) on the threatened disruption of the development of the Leeds medical school and General Infirmary. Mr. Elson questions why the Leeds situation is unique. The answer is simple. About £12m. has been committed already in relation to the project and the Hospital for Women at Leeds has been demolished as the first part of the "development." Tolerating failure to improve hospital facilities is one thing, but to live with their destruction through administrative incoordination quite another. Dr. Townshend suggests that the local population might find the necessary

capital and this raises an issue which deserves the closest consideration, but any policy decision could not be applied to Leeds in isolation.

We are very conscious of the parlous financial state of the nation, but it is in this light that the problems which have arisen are particularly serious. The detailed planning of an integrated hospital-medical school complex began as you say in 1962 with the enthusiastic support and encouragement of the Department of Health and the University Grants Committee—the bodies ultimately financially responsible. The first serious setback arose in the late 1960s, when the U.G.C. reneged on its side of the integrated plan. Subsequently a fresh plan was devised involving separate, but closely related hospital and medical school buildings. At all stages the closest liaison was maintained with the two administrative bodies concerned. Now, after more than 12 years of work, when the U.G.C.'s side of the joint plan is well on the way to completion, it seems possible that the D.H.S.S. might fail to produce its part of the scheme. It is the great financial waste which would occur in this eventuality—attributable to lack of co-ordination between two Government bodies—that is so serious from a national point of view.

Locally the implications are rather different. The initiation of the scheme occurred with demolition of the Hospital for Women, which was sited adjacent to the General Infirmary and relied upon its wide range of ancillary resources in emergency situations. Its "temporary" replacement is miles away from these resources and this involves a deterioration in patient safety standards. Apart from the patient welfare aspect, perpetuation of this on a semi-permanent basis would serve along with the £5m. energy-generating complex as memorials to the massive waste of public funds which has achieved nothing but deterioration in the local medical facilities.

It will be no surprise that, faced with such a situation, medical staff morale is on the point of collapse; problems of contracts and the like are of little significance by comparison with having to work in the shadow of this chaos. Those like ourselves who have not made a major contribution to the planning are aghast that the dedicated work of our colleagues—some part-time, some whole-time N.H.S., and some university—might at this stage be squandered. These consultants have given this effort without stint at the prime of their lives and at the cost of developing their own practices and research. To maintain dedicated doctors of the best quality in this country it must be shown to them that, whatever the financial state at any time, millions of pounds are not wasted through lack of co-ordination of expenditure from the left and right Government pockets and that their talents and enthusiasm will not be exploited.—We are, etc.,

J. C. GOLIGHER
J. S. SCOTT

General Infirmary at Leeds,
Leeds

SIR,—May I congratulate you on putting the unfortunate position of the Leeds General Infirmary complex into such clear perspective in your leading article (8 February, p. 297). As a past student I have

a deep interest in its fortunes. There are perhaps two points which could be made with the benefit of local knowledge.

Both the General Infirmary at Leeds and the medical school are buildings of unusual, and in the former case distinguished architecture. This quality is one which endears itself to those using the buildings and cannot be replaced when building in current styles. Both buildings are basically sound and, though attention would be required to bring them up to present needs functionally this would cost little compared with the task of rebuilding. The site which you mention is behind the infirmary and is available to enlarge the hospital backwards as far as is needed. Current plans are to retain only the facade of the present building and to demolish everything behind this. The medical school is to go in its entirety. Is it possible that the enforced pause in reconstruction might give time for second thoughts?

With regard to the increase in the intake of students, 80 per year ideally suited the personal teaching methods used at Leeds. With the further expansion of teaching at St. James's Hospital this number has been increased modestly without impairing the standards in any way. Should medical schools, however, go on increasing their intake to make up for losses in medical manpower which are the direct result of the policy of present and past governments?—I am, etc.,

D. J. RODGERS

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Fibrinolysis and Venous Thrombosis

SIR,—Your leading article (16 November, p. 365) and subsequent correspondence (25 January, p. 208) relating to fibrinolysis and deep vein thrombosis suggest that drugs which increase blood fibrinolytic activity may be valuable in the prevention of deep vein thrombosis. An assumption basic to the arguments put forward in your article and by your correspondents is that a considerable and prolonged reduction in blood fibrinolytic activity usually follows surgical trauma. We believe that this is open to serious doubt.

Accurate measurement of blood fibrinolytic activity after operation is complicated by the marked rise in fibrinogen concentration that invariably occurs. Fibrinogen forms the substrate for the lysis time methods of measuring fibrinolytic activity and it has been shown that an increase in fibrinogen concentration alters the lysis times of plasma and whole blood clots both *in vitro*^{1,2} and *in vivo*.³ We applied an isotopic method⁴ for the measurement of fibrinolytic activity in 50 patients after operation. This method was used because it has been shown to be independent of alterations in the level of plasma fibrinogen.³

As we reported last year,⁵ the results showed, in contrast to previous studies using lysis time methods, that no consistent sustained decrease in fibrinolytic activity or "fibrinolytic shutdown"⁶ occurred. Indeed, by the sixth postoperative day activity was actually significantly greater than mean pre-operative values. Postoperative fibrinolytic activity was reduced only on the first post-operative day and this reduction reached statistical significance only in patients who developed venous thrombosis.

It is our contention that, though there is some evidence that venous thrombosis after operation and impaired fibrinolysis are related, the link is still only tenuous and unlikely to be of major importance. This would explain on the one hand why prophylactic regimens such as phenformin and ethyl-oestrenol (which increase fibrinolytic activity) have not been effective in preventing post-operative venous thrombosis⁷ and on the other hand why a powerful fibrinolytic inhibitor E-aminocaproic acid, administered during the perioperative period was not associated with an increased incidence of deep vein thrombosis.⁸—We are, etc.,

I. C. GORDON-SMITH

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London W.2

J. A. HICKMAN

The London Hospital,
London E.1

- 1 Blix, S., *Acta Medica Scandinavica*, 1961, 169, 495.
- 2 Gallimore, M. J., and Shaw, J. T. B., *Thrombosis et Diathesis Haemorrhagica*, 1969, 22, 223.
- 3 Hickman, J. A., et al., *Journal of Clinical Pathology*, 1973, 26, 189.
- 4 Hickman, J. A., and Gordon-Smith, I. C., *Journal of Clinical Pathology*, 1972, 25, 191.
- 5 Gordon-Smith, I. C., Hickman, J. A., and Le Quesne, L. P., *British Journal of Surgery*, 1974, 61, 213.
- 6 Chakrabarti, R., Hocking, E. D., and Fearnley, G. R., *Journal of Clinical Pathology*, 1969, 22, 659.
- 7 Fossard, D. P., et al., *Lancet*, 1974, 1, 9.
- 8 Gordon-Smith, I. C., Hickman, J. A., and El Masri, S. H., *British Journal of Surgery*, 1972, 59, 522.

Prisoners and Their Health

SIR,—Your leading article on this subject (1 February, p. 232) makes a number of misleading assumptions.

There is now considerable evidence in criminological research that crime is more accurately seen as a variable political and social construct and not an aspect of social pathology, as suggested by your phrase "symptom of social malaise." One would therefore expect the official prison statistics to be a poor indicator of either health or actual behaviour trends within society and to be more expressive of variations in the operation of the penal system and penal policy. For example, drug dependence "in the community at large" is not necessarily reflected in the number of drug abusers admitted to prison—it has been shown to have a higher correlation to differential police activity.¹ Similarly, the rise in those remanded for psychiatric reports may merely reflect a trend within society to reclassify deviance as illness.

The suggestion that shortage of staff in the prison service is inhibiting the development of new and more therapeutic facilities shows a lack of understanding as to the real conditions opposing innovation in a mechanistic bureaucracy.² However, it is your final paragraph that stretches credibility beyond reasonable limits. Can we really accept that incarceration in prisons is taking "good care" of over 35 000 people per year or that we are really taking "good care" of about another 120 000 patients in mental hospitals? In whose interest and to what end do these "vital if unglamorous services" function?

Surely the way forward is to recognize that the size of those institutions is not an immutable reality but represents a complex

interaction process within society in which doctors play a key role. A first step would be to request more appropriate information and less haphazard classification. The most obvious obstacle to this is the Official Secrets Act and its administration, as we have recently been reminded.³—We are, etc.,

PATRICK DAY
TIM BELL

University of Nottingham

- 1 Young, J., *The Drugtakers*. London, McGibbon and Kee, 1971.
- 2 Burns, T., and Stalker, G. M., *The Management of Innovation*. London, Tavistock, 1961.
- 3 Cohen, S., and Taylor, L., *New Society*, 1975, 31, 253.

** We did not say that "incarceration in prisons is taking 'good care' of over 35 000 people per year. . . ." We commented, "What stands out . . . is the degree to which the prison medical service takes care—and takes good care—of substantial numbers of society's sore thumbs. . . ."—Ed., *B.M.J.*

SIR,—I am writing to congratulate you on your liberal and forward-looking leading article on this subject (1 February, p. 232). However, I must take you to task in that you have left out a number of other groups of "society's sore thumbs" and mentally ill people. As we all know, the ranks of the homeless and those in various kinds of poor accommodation have many such members. There may even be more "sore thumbs" lurking unsuspected in other quarters. Are they to be denied the benefits of the new policy you propose of pooling both personnel and premises to look after them? The obvious place to set up these joint premises is in the psychiatric hospitals. They have grounds for new buildings not usually available to prisons.

I can see that there might be a few snags ahead in getting things properly under way. In the first place the courts may not yet be sufficiently enlightened to abandon the outworn distinction between those who have committed offences and those who have not. They might demand an overall increase in security which could place strains on the psychiatric hospitals. Perhaps we could borrow from the greater experience of other countries where there has traditionally been less distinction made between mental hospitals and prisons.

The second difficulty is that the economic consequences of our social malaise, which have unfortunately not yet been subjected to rigorous medical investigation, mean that new buildings may well have to wait for a time. The question of security that I have mentioned already suggests that prisoners would have to be kept in the hospital buildings and perhaps present patients be put up in temporary accommodation in the grounds. Tents should certainly be considered. The most serious snag likely to be encountered is the reactionary attitude of mental hospital psychiatrists. They are often weary and cynical men who have come to doubt their capacity to cope with the wide range of social ills that are now quite correctly seen as a proper object for medical study. I feel sure that they would argue that, while there is a clear need to reassess the relative places of hospital and prison, the notion of pooling premises as it appears in your article is not

only fatuously grandiose but perhaps even undesirable. Of course you are right in saying that mental hospital psychiatry is an unglamorous service, and it does not attract our best graduates. Perhaps these back-woodsmen could be appeased by the prospect of doing their ward rounds on horse-back while the padre intones psycho-therapeutic maxims over the public address system.—I am, etc.,

J. CHRISTIE BROWN

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London N.11

Misleading Drug Advertising

SIR,—On the inside front cover of your issue of 18 January you published an advertisement for Sotacor (sotalol), a new beta-blocking agent promoted by Bristol Laboratories. This latest addition to an already overcrowded field was described as "the new leader of the leaders in hypertension" which "international opinion endorses" and "a purpose-structured molecule for predictable reduction of blood pressure." The advertisement "highlighted the need for a beta-blocking agent specifically designed for the management of hypertension." The unmistakable message is that sotalol was designed specifically for the control of hypertension. This seems to be most unlikely and I am unaware of any particular pharmacological action of sotalol which makes it more effective for the treatment of hypertension than any other beta-blocking drug (practolol excepted).

The advertisement also claims that the product "restores a remarkable feeling of well-being in most patients" and that it "controls blood pressure even during exercise." The first point is difficult to accept since most patients with hypertension are asymptomatic anyway, and control of blood pressure during exercise is certainly not a unique property of sotalol, or indeed other beta-blocking drugs.

This advertisement is, in my opinion, grossly misleading and falls far short of the standards expected of a reputable journal. The whole subject of drug company promotion requires urgent investigation. Until very recently, there were no colour advertisements in the *British Medical Journal* and the *Lancet*. Now we have advertisements in glorious Technicolor extending to two or even four pages for a single product, and no doubt they are very effective. At a time when the N.H.S. is desperately short of funds doctors are being "conned" into prescribing more and more expensive drugs. The drug bill would probably be reduced to 10-20% of the present level if drugs were used with sense and discrimination.—I am, etc.,

L. PRESCOTT

University Department of Therapeutics,
Royal Infirmary,
Edinburgh

Women Doctors in the N.H.S.

SIR,—I wholeheartedly agree with Dr. Dora Black's (15 February, p. 393) observations on the expenses incurred by the married woman doctor with children that deter her from working. I consider that the present system of personal taxation is to blame. No