Ergotamine tartrate overdose

SIR,—At the Charing Cross Hospital Migraine Clinic and the Princess Margaret Migraine Clinic we have seen a number of patients who, in our opinion, are suffering from ergotamine tartrate overdose. These can be divided into two groups; those who habitually take one or more milligrams a day and who suffer daily headaches and nausea, the characteristic of the headache being that it is relieved only by further doses of ergotamine; and a very much smaller group who have signs of ergotism. In our experience ergotamine headache may occur with doses as little as one milligram daily of ergotamine tartrate by mouth or 0.25 mg daily by intramuscular injection.

Our work at the Charing Cross Hospital and Princess Margaret Migraine Clinics has led us to think that an antiemetic such as 10 mg of metoclopramide followed 15 minutes later by an effervescent preparation of aspirin or paracetamol is the best treatment for most acute attacks of migraine.

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Folic acid deficiency during intensive therapy

SIR,—Recent reports^{1 2} have stressed the importance of careful haematological monitoring of intensive-care patients for the onset of acute megaloblastic change. Dr C A J Wardrop and his colleagues (8 November, p 344) state that the majority of their patients with this condition have been treated with amino-acid/ethanol intravenous nutrition. It is generally recognised that ethanol may interfere with folate metabolism so presumably the administration of alcohol played a significant part in the pathogenesis of the acute megaloblastic change observed by them.

However, ethanol is not an essential aetiological factor in many cases of acute megaloblastic anaemia seen in patients in need of intensive care. Over the past 20 months we have seen 18 patients with this condition, but only six had received amino-acid/ethanol intravenous nutrition before developing these changes.

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¹ Wardrop, C A J, *et al*, *Lancet*, 1975, 2, 640.

² Ibbotson, R M, Colvin, B T, and Colvin, M P, *British Medical Journal*, 1975, 4, 145.

Getting postgraduate education right

SIR,—Your leading article on this subject (17 January, p 116) was most welcome. Although you were mainly concerned with the continuing education of doctors, you rightly conclude by emphasising the primacy of teaching in medical schools, which we take to include postgraduate institutions. Moreover, you stress that "students must learn to recognise the limitations of their own knowledge

and abilities, and to admit their areas of ignorance." It seems, however, a little unfair to put this burden on the student; after all, he is the product of the educational system. It is the system which hampers the recognition of limitations of knowledge.

It was ideas similar to yours that led us, last year, to hold a symposium on post-graduate education as related to surgery and the field of orthopaedics.¹ Experts in sociology, psychology, psychiatry, education, and statistics participated with members from several disciplines of our institute. As a result of this cross-fertilisation of ideas we concluded that logical analysis and doctor-patient relationships should be included in the curriculum as subjects for group discussion and that the nature of the skills required for orthopaedic practice and the enhancement of their acquisition should be analysed. Our contact since then with specialists in group discussion, doctor-patient relationships, and the training of skills has been most encouraging. It is far too early to measure success or failure, or the resistance to change.

As medical teachers we are not trained in pedagogic expertise and our teaching is based largely on our own experience as students. Lightly equipped, we face the conundrum of constraining students, with their complex individuality, within a mould without at the same time destroying intellectual initiative, which is important not only for the student's personal education but also for future development. More needs to be done than simply to introduce new techniques such as audio-visual aids and group discussion. Thoughtful questioning of medical education must continue, particularly of the role and effects of didactic authoritarianism.

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¹ Kessel, L, and Byers, P, *Some Observations on Post-graduate Medical Education*. London, Institute of Orthopaedics, 1976.

Medical manpower

SIR—Your series of articles on medical manpower and the subsequent correspondence raise some interesting points. Much is made of the difference between specialties designated as "major," "popular," "demanding," or "requiring total commitment" and those which are called "minor," "dull," "unpopular," or "shortage" and are considered to be "less demanding" with a "lower academic standard requiring a lesser degree of training and expertise" and "less than total commitment." This division is unrelated to numbers either helped or employed and a better description would be whether or not the specialty is considered to be "glamorous" or "prestigious," the exact status being a combination of attitudes inculcated during undergraduate teaching, newsworthiness to the media, and a memory of the respective earning capacities in private or pre-NHS medicine.

Dr W J Appleyard's comment that "many jobs in medicine may be dull because of their confined nature" (10 January, p 80) is one of the greatest truths about work, equally applicable to medicine as to the assembly-line system in industry. This confining of a job leads to the apparent inconsistency between Dr Anne Savage's statement

(3 January, p 29) that she would be "unhappy at the thought of doing nothing but anaesthetics in the same hospital of the next 40 years" and the claim by Dr C F Scurr (24 January, p 225) that anaesthetics provides a satisfying career. However, Dr Savage is visualising, as many administrators do, that the anaesthetist's only valid work is administering anaesthetics in the operating theatre (are any surgeons expected to do nothing but operate?) whereas the concept envisaged by Dr Scurr and Dr T B Boulton (17 January, p 152) is that of an anaesthetist as a physician contributing to many aspects of total patient care within the hospital.

Flexibility of contract would allow not only movement between one part of the country and another as suggested by Mr F S A Doran (17 January, p 137) but would also allow for changes in emphasis in health care plans not only in concept—for example, a swing to preventive rather than curative medicine—but also in detail as to who is considered competent to do a particular job—for example, as more theatre suites are built the possibility of employing properly trained nurse-anaesthetists would increase. Flexibility is inhibited not by the willingness of doctors but by administrative rigidity both as to training programmes and to contractual commitment. The administration can adjust posts to meet the requirements of women doctors and apparently it is considered right for women to have two part-time jobs—that is, medicine and domesticity, either of which many consider to require total commitment. Why should it not be right for men to have two part-time jobs—for example, physician and community medicine specialist or anaesthetist and intensive care physician or occupational medicine specialist?

Finally, if women doctors should have qualms of conscience about not doing clinical work, however well qualified they may be (Dr Anne Savage, 10 January, p 79), or if these women should be eliminated before admission to medical schools (Dr Freda Eskin, 24 January, p 225), I would suggest that the same criteria be applied to those men and women who opt out of clinical work for politics or administration.

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Confidentiality of medical reports

SIR,—Over recent months much has been said and written about the confidentiality of medical reports and the need to retain it.

I recently carried out a medical examination on a member of the staff of a hospital in which I am employed as occupational health officer for a post as lecturer in one of the north-western conurbations at the request of the director of education. To my astonishment I noted that the report, with full medical details, was to be sent to that official and not to the appropriate area medical officer or one of his staff.

At working party discussions to clarify various aspects of medical examinations, questionnaires, and reports on county council and area health authority staff in this county (Cumbria) it had been agreed that no one but the community physicians or their deputies should have sight of such documents and that the forms and the envelopes to contain them should have this very clearly indicated on them for very obvious reasons. I therefore refused to forward my report to the director of education, and it took 10 minutes of expensive telephone time before I could be given the name of a medical colleague to whom I could send the report with an explanatory letter.

Inquiries have shown that what I had