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

experienced is becoming common practice since the reorganisation of local government services, and I am concerned that although the report was with the permission of the individual and I was to be paid for the examination and the report, my findings could be read by a whole host of non-medical officials of the education department. I feel that it is necessary to comment on this erosion of the confidentiality of medical information.

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Consultants' ballot results

SIR,—The cause for future professional freedom, an issue which completely transcends the more immediate one of private practice, has suffered a severe setback as a result of the fearful and flabby response of the consultants to the BMA ballot (*Supplement*, 12 February, p 475).

The Goodman proposals, bristling as they do with loopholes and avenues for political exploitation, do little, in my opinion, to allay the fears of doctors concerning Mrs Castle's consultative document; fears which were sufficiently strong to produce an immediate and united rejection of it by all interested branches of the profession, in the form of the memorandum of reply (*Supplement*, 4 October 1975, p 54). Yet the ballot results clearly indicate an acceptance (by the majority who bothered to make a return) of the Goodman "compromise," a Government device put forward to test and try our mettle. We have been tried and found wanting. Mrs Castle must surely feel, with some justification, that recent events have culminated in a significant advance for left-wing ideology.

The only hope we have of regaining our rapidly diminishing prestige and credibility (with Government and public alike) would appear to lie in giving support to—and being supported by—our junior colleagues. For they, unlike us, have long since learnt that the only way to make progress in negotiating with the Government is to present a posture of determined unanimity. The capacity for independent thought, so essential to our patients' welfare, is a great disadvantage when placed in the context of political negotiation: it predisposes to an attitude of intelligent compromise, inevitably interpreted by politicians as one of weakness.

The distinction between consultant and junior hospital doctor is quite artificial when considered in the context of the future of medicine. It would appear that our juniors, in their growing opposition to the Goodman proposals, have, as future consultants, already realised this fact. Is there any possibility that we too can realise it and, in so doing, give ourselves and our patients some chance of freedom in the future?

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SIR,—“The fault, dear Brutus, is not in our stars [nor in the BMA] but in ourselves that we are underlings.” The result of the ballot is clear. The vast majority of consultants have faith in Lord Goodman's “reasonable” pro-

posals. The Prime Minister's support for Mrs Castle's policy is vindicated. The Secretary of State has been assured that, no matter what she proposes, she has nothing to fear from the consultants. The groundwork is laid for the introduction of a full-time NHS. One can but hope that the general practitioners (next in line), and the lawyers will be able to offer a united front and thus preserve some semblance of professional freedom.

We consultants have shown ourselves to be a poor lot. We deserve to lose our status and become, like our colleagues in Eastern Europe, State employees, mere hospital specialists, fulfilling our daily norm, having little influence in the conduct of our affairs, centrally directed and locally administered, and bereft of the yardstick of private practice against which to measure future remuneration. Registrars and senior registrars must feel badly let down by their senior colleagues. The future for them is bleak. Two of my children are doctors. One leaves for New Zealand at the end of this month. What inducement is there for the other one (a senior registrar) to stay?

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Fair allocation of resources

SIR,—At the meeting of the Manpower Committee of the North-west Thames Regional Authority last week we were given to understand that there was to be a very considerable reduction in the available money to the area for both junior and senior staff. This was confirmed by a member of the Central Manpower Committee who was present. I think it is absolutely important that all doctors remember their ethical duties and recall that these were laid down some thousands of years ago.

Firstly, we must look after our patients and take every step that we need to take to take care of them, and if we are members of committees then we must take such steps as will take care of patients in the areas served by such committees. We must not therefore shrink from telling authorities that ideas of theirs or ideas of a central government which would hinder the wellbeing of the patients or the development of the Health Service will not be accepted in any way. If a government chooses to attempt to spend the country's money in ways which are to the detriment of the NHS, then we must make it quite clear that we will not tolerate such action. We cannot sacrifice the wellbeing of the nation's health for the benefit of political ideas or, of necessity, even the wellbeing of a particular industry.

The second duty is to our junior staff and to those whom we may be training, and we again must see that any restrictions in finance do not jeopardise the future training or the development of our juniors' careers. The so-called shortage of some particular disciplines is due to the general lack of financial incentive to the average young consultant and the necessity for many suitably trained doctors to emigrate because of the Government-imposed restriction on the necessary expansion of the Health Service.

There may well be a tendency therefore for the Government to suggest that senior registrars at the end of their terms of contract should be disposed of. This must be stopped entirely. Pressure must be brought on the

Government to make the consultant programme follow through relative to the needs of the Service, and if there is any degree of difficulty in this respect the senior registrars should be maintained in their jobs so that their training, which might have been expensive to the country or to their parents, should not be wasted.

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SIR,—As consultant physicians in the far periphery we welcome the approach of Mr J H Rickard (31 January, p 299) in attempting to relate resource allocation more accurately to needs. We are not surprised that our area's expenditure on general hospital services is above average, despite obvious inadequacies in our facilities and consequent deficiencies in the services available to our patients. Mr Rickard has outlined two of our particular problems—the provision of services outside the geographical boundaries of our area and the high morbidity rates found locally—but has taken a rather simplistic view of the relationship between costs and bed numbers. Our own district is adequately supplied with beds, but their distribution among 17 hospitals, some of which are in an advanced state of dereliction, makes their efficient use impossible. Maintenance and housekeeping costs in this plethora of ancient buildings are high, but conversely we are unable to afford some of the parallel facilities required to give an efficient service to our patients. We hope that the provision of an adequate district general hospital will not only improve the service to our patients but also do so in a more economic fashion.

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Devolution to Scotland

SIR,—The BMA Scottish Council's brief comments (*Supplement*, 7 February, p 354) on the White Paper on devolution¹ are at least a start to the debate on the imminent changes in health care in Scotland, and it is good to know that the BMA will defend the present level of funding of the NHS in Scotland. However, the BMA's view that separate salary scales in Scotland and England are self-evidently bad must be questioned. As the Scottish Council knows to its cost, members of the Scottish profession, both senior and junior, do not share their English colleagues' views on their type of contract and declined to join the recent industrial action. I suspect that the consultants in Scotland, largely on full-time contracts, would have accepted the principle of the Government's original proposals (and be financially better off today) and that the trainees would prefer to go back to an (adequately) salaried service. If this is in doubt the facts can be obtained, since the many questionnaires put to the profession recently can be looked at again for guidance on Scottish attitudes to remuneration, and the BMA should be urged to do so. A separate salary system in Scotland, reflecting our own attitudes, is an entirely reasonable outcome of devolution. This diversity is taken for granted in other countries with a federal