recommend glutethimide as an alternative to barbiturates. Indeed, a strong case could be made for dispensing with it completely.

What of the other hypnotics in overdosage? Ethchlorvynol is no better—it can produce deep and particularly protracted coma; chloral hydrate and its derivatives and methaqualone (with or without diphenhydramine) are also unsafe. Safety in overdosage might appear to be an unreasonable attribute to expect of any effective hypnotic, but does seem to be the case with nitrazepam. Individuals can ingest as many as 60 to 70 tablets without becoming more than drowsy, yet a 10 mg dose is superior to a placebo in providing sleep and, more importantly, as effective as 200 mg butobarbitone.[11] There has been argument whether nitrazepam overdosage has ever resulted in death,[12 13] but, given that it has done so, the frequency with which this occurs is minute compared with the rates associated with barbiturates and glutethimide. Whether the same will be true of more recent benzodiazepine hypnotics remains to be seen.

The message is not a new one and by now should be clear to all: if doctors must prescribe hypnotics they should think twice before prescribing anything other than nitrazepam.

[1] *British Medical Journal*, 1975, **3**, 725.
[2] *Lancet*, 1975, **2**, 441.
[3] Matthew, H, Roscoe, P, and Wright, N, *Practitioner*, 1972, **208**, 254.
[4] Holland, J, *et al*, *New York State Journal of Medicine*, 1975, **75**, 2343.
[5] Jorgensen, E O, and Jensen, V B, *Danish Medical Bulletin*, 1975, **22**, 263.
[6] Arieff, A I, and Friedman, E A, *American Journal of The Medical Sciences*, 1973, **266**, 405.
[7] Wright, N, and Roscoe, P, *Journal of The American Medical Association*, 1970, **214**, 1704.
[8] Chazan, J A, and Garella, S, *Archives of Internal Medicine*, 1971, **128**, 215.
[9] Maher, J F, Schreiner, G E, and Westervelt, F B, *American Journal of Medicine*, 1962, **33**, 70.
[10] Hansen, A R, *et al*, *New England Journal of Medicine*, 1975, **292**, 250.
[11] Matthew, H, *et al*, *British Medical Journal*, 1969, **3**, 23.
[12] Barraclough, B M, *Lancet*, 1974, **1**, 57.
[13] Matthew, H, *Lancet*, 1974, **1**, 224.

Reacting to autistic children

The one pathognomonic sign of childhood autism is the sustained absence of contact with other people. This shows itself in the characteristic unresponsiveness; the fleeting eye-to-eye contact; the apparent failure of attentive, comprehending listening; the stilted quality of speech; and the absence of emotional resonance. The "alone-ness" originally described by Kanner[1] has never been fully explained, though difficulty in comprehending language seems to be important. This barrier to communication frustrates parents, therapists, and teachers—as well as other children.

In trying to establish contact with the autistic child it seems only reasonable to intensify one's approach by physical contact, by heightened vocal tone, by exaggerated gesture, and, indeed, many texts have specifically advised parents and others to do so. Recently, however, in a preliminary experimental study Richer and Richards[2] reported evidence suggesting that "less avoidance is provoked if adults are less reactive to autistic children . . ." and they concluded that adults should be relatively unreactive. This directly contradicts the approach of some behaviour therapists, such as Kassorla,[3] who work on the assumption that praise acts by positive reinforcement. In the experiment described the most encouraging response was obtained when the adult looked at the child, and when the child looked back the adult continued looking without change of expression or other gesture. This is perhaps not so surprising when we recall that Kanner's descriptive triad, besides referring to autistic withdrawal and abnormal development of speech, also referred to "an obsessional desire for sameness." A possible common denominator in the repetitive play with wheels, tops, and mechanical objects, the rote memory for jingles, the body-rocking, the precise arranging—all of which are characteristic of many autistic children—is the absolute predictability of all these activities. Perhaps this repetition is a striving for perceptual monotony, and other people are avoided because they are unpredictable.

As many investigators have come to realise it is unlikely that "autism" is a homogeneous entity. Of the eight children studied by Richer and Richards all were severely retarded, and nearly all were mute. It is not clear whether they were all residents in institutions. Nevertheless, the suggestion that over-responsiveness in others increases avoidance in autistic children is of potential importance in education and therapy and merits further study.

[1] Kanner, L, *Nervous Child*, 1943, **2**, 217.
[2] Richer, J, and Richards, B, *British Journal of Psychiatry*, 1975, **127**, 526.
[3] Kassorla, I, *Horizon*, BBC2, 24 October 1968.

Priorities and morale in the NHS

When the DHSS published its consultative document[1] on health priorities in March we argued that it should be rejected as a policy of despair.[2] Nothing that has been said or written since then has seriously challenged that assessment, and indeed at an informal *BMJ* conference organised to examine the document these criticisms were amplified and reinforced (see report p 1447).

The Government is concerned to halt the growth in public expenditure and it must, therefore, keep the total expenditure on the NHS more or less constant in the next few years. As a policy decision the DHSS has decided to allow for a small (1·8%) annual rise in current expenditure and it has found the money to do so by cutting back on hospital building. It has also decided to spend more on general practice, community services, the old, and the mentally ill, and proposes finding the necessary money by reducing expenditure on the maternity services and restricting growth in the other acute specialties.

Certainly there are fewer births each year now than five years ago (though the numbers are expected to rise again in the early 1980s); and no doubt, too, the proportion of the elderly in the population will continue to increase. But these demographic changes are not the sole basis for the priorities chosen by the DHSS: there is a strong impression that the acute hospital services have been singled out for attack simply because they are the big spenders. Hospitals take the lion's share of NHS expenditure, and there seems to be an assumption that there must be some extravagances that could be curtailed.

In fact, the opposite is the case. The last decade has seen a rapid expansion of the social services, much more spending on community medicine and primary care, and an enormous bonanza of new offices and extra staff for the administrative departments. Money has been channelled in these directions,

while hospital building (which reached its peak at the end of the 1960s) has been gradually slowing to a complete halt. Accident and emergency services are still understaffed and underfinanced: and—as the clinicians at our conference agreed—the quality of the care given to the average citizen in Britain taken suddenly ill has probably declined in the last decade. In many areas the acute services have failed to keep abreast of technological advances and new methods of treatment, so that many patients are condemned to second-class care. Some with end-stage renal failure are denied the possibility of life-saving treatment, while waiting lists for major and minor elective operations are lengthening month by month.

This gap between DHSS thinking and reality is clearly shown in the suggestion that expenditure on maternity services could be cut by 2% per annum. Despite some criticism by correspondents[3 4] of our claim that perinatal mortality could be cut by the wider use of fetal monitoring, last week we were strongly supported by the Royal College of Obstetricians and Gynaecologists. "Rather than agree to a reduction in the services," said the college, "we would make a plea for more money to be spent in many areas of the country where resources are still inadequate so that they can be brought up to the level of those well-equipped and well-staffed hospitals which get better results and save more babies." There is indeed no logic in a decision to spend more money on the mentally handicapped and less on the maternity services, which, if improved still further, might well reduce the amount of mental handicap in the community.

The Department seems not to understand that there are some absolute standards in medicine. If a diagnostic aid or a new drug or procedure has been proved to make substantial difference to mortality or morbidity then the doctors working in the specialty will not be content until they use the new treatment on their patients. They will accept lack of money as an excuse for delay, but only for so long: if there is no prospect of a hospital providing its staff with the means to give their patients optimum medical care then many of them will look for work in a medical setting that can provide those means. That—not greed for higher pay—is the reason that many dedicated young doctors, nurses, and technicians are looking for jobs overseas; and the widening gap between medical care as described in reports from the best units and that offered in many NHS hospitals is the explanation for much of the decline in morale among staff in day-to-day contact with patients. Yet there is no easy source of money to modernise and re-equip our acute hospitals. No one expects an overnight transformation, as in a Christmas pantomime; but the despair among hospital doctors is caused by the apparent belief at the DHSS that most of the hospital service can be left to stagnate while such money as is available is diverted to the services for the old and mentally ill and to primary care. Of course, the community services have been neglected for far too long, but it is a dangerous error to believe that the hospital services can be starved of money in order partially to correct that historical error.

If, then, we have rejected so many of the DHSS recommendations for cuts or freezes in expenditure, what can we suggest in their place? What is needed is a more positive attitude, not one based (as cynics have seen the priorities document) on a blanket excuse for administrators to say no. One of the arguments advanced for the reorganisation of the NHS was the greater freedom that would be given to regional authorities to show initiative and to manage their own affairs. Regions and areas should be allowed freedom to innovate, to rationalise, and to benefit from any savings made (supraregional specialist units, at present starved of an income, need special consideration). Once functional units within the NHS are convinced that they will themselves benefit from any savings they make, there would be a real incentive for economies. As the priorities document says, this money can be saved in many ways—in particular by the greater use of 5-day wards, outpatient investigation, and preadmission units. Medical audit was introduced in the USA as a means of controlling expenditure, and the profession should urgently look into proposals for its own control of the quality and cost of clinical care. Big economies could be made in prescribing—and paradoxically one change that might help would be abolition of prescription charges (part of the manifesto on which this Government was elected), which would make it easier for doctors to prescribe small quantities of expensive drugs.

Medium-term savings could be made by health education and screening in cases where the procedure has been shown to be effective. In the United States epidemiologists are being cautious in their interpretation of the apparent downward trend in mortality before the age of 65 from heart disease and stroke. Nevertheless, it is unlikely to be coincidence that the prevalence of unrecognised and untreated hypertension has been halved in the last decade, almost certainly in response to repeated health education campaigns in the press and on television.[5] Saving could also flow from Government campaigns against smoking and alcoholism, which at present still seem less than fully committed, while the case for fluoridation of water supplies remains overwhelming.

Yet in the end so much comes back to morale. Surely the DHSS should be on the side of doctors and other health workers, and not seen as a hostile "them." Furthermore, the Government must tell the public why NHS standards may fall. Otherwise doctors and other health workers will take the brunt of patients' inevitable discontent, which will further erode morale. Cost-saving schemes require well-motivated staff to set them up and see them through, and for the last year or two the necessary enthusiasm has been lacking. It could be restored by a Government that was seen to give more priority to clinical medicine and to improvements in the care of patients and less emphasis to political hysteria about private practice and the pharmaceutical industry.

[1] DHSS, *Priorities for Health and Personal Social Services in England*. London, HMSO, 1976.
[2] *British Medical Journal*, 1976, **1**, 787.
[3] Campbell, H, Lowe, C R, and Cochrane, A L, *British Medical Journal*, 1976, **1**, 1013.
[4] Kirke, P, *British Medical Journal*, 1976, **1**, 1014.
[5] Stamler, J, *et al*, *Journal of the American Medical Association*, 1976, **235**, 2299.