- ⁴ Fazio, A. F., *Journal of Abnormal Psychology*, 1970, **76**, 211.
⁵ Baum, M., *Canadian Journal of Psychology*, 1969, **23**, 1.
⁶ Hussain, M. Z., *Canadian Medical Association Journal*, 1970, **103**, 768.
⁷ Hussain, M. Z., *American Journal of Psychiatry*, 1971, in press.

Alopecia and Levodopa

SIR,—The side effects of levodopa administration are well known (30 January, p. 267). We report here two cases in which alopecia developed during treatment with levodopa.

A 54-year-old woman with idiopathic Parkinson's disease of long standing was treated in November, 1970 with levodopa. The dose was increased to 3 g daily over the next month, with considerable improvement, but after a further three weeks she developed choreiform movements, mental agitation, and severe flushing of the face and neck. On stopping treatment these side-effects disappeared within three days. Levodopa was then given in a dose of 1 g daily with clinical improvement. Now, however, three months after first taking levodopa, she developed a severe diffuse alopecia. No other cause for this was found. Haemoglobin, leucocyte count, and blood film were normal and serum thyroxine iodine was 5.8 mg/100 ml with a free thyroxine index of 6.4.

The second patient was a 63-year-old woman with a 20-year history of idiopathic Parkinson's disease. In November 1970 she was treated with levodopa with considerable benefit. The dose was gradually increased to 2.5 g daily and maintained at this level when she complained of mild nausea. Six weeks after starting this treatment she complained of hair loss and moderately severe diffuse alopecia was confirmed. Again there was no apparent cause for the alopecia. She had no clinical evidence of hypothyroidism, and serum thyroxine iodine was 5.5 mg/100 ml with a free thyroxine index of 6.8. Haemoglobin, leucocyte count, and blood film were normal.

Both patients preferred to continue with levodopa although it was explained that their hair loss might be associated with this treatment. In both cases the partial alopecia persists.

Between them these cases demonstrated the well-known side effects of nausea, mental agitation, and involuntary choreiform movements. As far as we know severe flushing of the face and alopecia have not been described with levodopa administration. These symptoms may be no more than coincidental to the treatment, but we would be interested to know if a similar phenomenon has been noted by others.—We are, etc.,

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Amino-acids in Fetal Fluids

SIR,—I read with interest the paper by Dr. F. Cockburn and others (26 September, p. 747). Several comments might be made. The techniques of collection, storage, and speed of quantitation are such that their data are above question. However, their final conclusion that "Inborn errors which result in altered fetal urinary amino-acid excretion might thus be identified in utero" is quite doubtful. If the offending amino-acids are metabolizable by the mother fetal homeo-

stasis will be maintained, and it is highly unlikely that amniotic fluid will reflect any aberration. Our data from paired amniotic fluid and fetal urine at term suggest that very little of the amino-acid composition of amniotic fluid is derived from urine and in an affected fetus the branched chain amino-acid concentrations of amniotic fluid from a patient with proved maple syrup urine disease were normal.¹

The reason that I raise this point is to caution clinicians who are diagnosing potential amino-acid defects prenatally. Other methods of prenatal diagnosis such as direct enzyme analysis, quantitation of a non-metabolizable product, or analysis of cultured cells has been proved of value. By looking at amniotic fluid amino-acid concentration false negative results will be given to mothers at a time when termination of pregnancy could be accomplished if that particular course of therapy was desired.—I am, etc.,

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¹ O'Neill, R. T., Morrow, G., Hammel, D., Auerbach, V. H., and Barness, L. A., *Obstetrics and Gynecology*, in press.

Laparoscopy Hazard

SIR,—With reference to the laparoscopy hazard reported by Mr. Humphrey Arthure (21 November, p. 492), I should like to make a few comments.

Laparoscopy is an extremely safe procedure, and if the methods used for creation of the pneumoperitoneum are simple there is no risk of cardiac arrest, air emboli, or shock from "impaired respiration or circulation". I follow the simple method of air insufflation with a blood-pressure bulb, and stop when the abdomen is distended sufficiently for the creation of a space between the viscera and anterior-peritoneum or when the patient complains of discomfort. We have never found it necessary to use more complicated methods or manometers, and the only complication that we have found related to the pneumoperitoneum is on decompression following evacuation of large amounts of ascitic fluid—owing to dilatation of the mesenteric plexus and hypotension. This can be avoided by a tight binder and incomplete evacuation of liquid and air.

Laparoscopy is an extraordinarily useful procedure as well as a very safe, painless, and economical endoscopic method. By keeping it simple as it has been since Ruddock's instrument became available more than 35 years ago¹ it will continue to serve its purposes faithfully and safely.²—I am, etc.,

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Guatemala

¹ Ruddock, J. C., *Western Journal of Surgery, Obstetrics and Gynecology*, 1934, **42**, 392.

² Herrera-Llerandi, R., *British Medical Journal*, 1961, **2**, 661.

General Practitioners and Medical Television

SIR,—It is disappointing to find that Dr. C. M. Fletcher and Dr. R. Ll. Meyrick (13 March, p. 607) regard the content and conclusions of our paper "General Practitioners and Medical Television" (13 February, p. 392) as destructive criticism of this form of post-

graduate education. This was certainly not our intention as careful scrutiny of our results would have revealed.

In comparison with previous biased studies our (validated) random sample contained a very high proportion of regular viewers who appreciated the topics dealt with in the programmes and their relevance to general practice. We intentionally did not differentiate between Independent Television and the B.B.C. except so far as advance publicity was concerned. Drs. Fletcher and Meyrick have misread our findings in this section. We said that 67% of our sample knew of I.T.V. programmes only, 4% of B.B.C. only, but 26% of both—a total of 30% for the B.B.C.

Rather than ignoring other forms of post-graduate experience one of our major objectives was to relate individual patterns of more conventional education to medical televising. Our results show that the enthusiastic televiewer is likely to be equally enthusiastic about clinical assistantships, medical journals, refresher courses, and other forms of continuing education.

An obvious conclusion, therefore, is that medical television reaches those doctors already stimulated in other ways, and we suggested that programmes aimed at groups meeting in postgraduate centres might be more effective than when the solitary doctor at home is the target. We are delighted that 30 of these groups report regularly to A.S.M.E. but they cannot be regarded as unbiased for this very reason. Equally we are intrigued by the certainty of your correspondents' belief in the existence of groups of which they have not yet heard. (Is this statistically significant?)

Our ultimate question was whether available television time was being put to the most effective use. We proposed a national or regional curriculum of short provocative programmes directed towards doctors in postgraduate centres, and, in addition, because health education of the public might be more profitable, more programmes on smoking, obesity, accidents, exercise, and so on aimed at the patient rather than the profession.—We are, etc.,

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Heel Cushion on the Operating Table

SIR,—It may be as Dr. A. J. Jouhar suggests (23 January, p. 229) that the value of heel cushions in preventing thrombosis has not been proved statistically beyond all reasonable doubt, but I believe there is such strong evidence in favour of them that their use is essential. Many years ago, before the last war, I think, the late Professor Lambert Rogers advised the raising of the calf off the table by something under the heel, and since adopting the practice at that time, I have had no deaths from pulmonary embolism after abdominal surgery. I have tried to teach that the most important part of a gynaecological operation is the preventing of pressure on the calves and soles.

There is no need for a special pad which may be bulky and possibly expensive. Either a small flat sandbag or the Langton Hewer

rest is sufficient. In vaginal surgery the position is less satisfactory, and I must admit having had two deaths from embolism—one in a patient with a stiff leg, and the other in a patient over 80. With the usual lithotomy supports, pressure on the calves is unavoidable, and they should be modified so that the legs can swing inside them.—I am, etc.,

BRYAN WILLIAMS

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Uneasy Relations

SIR,—I read with interest the contribution of Dr. A. Paton (6 March, p. 554). His observations on the responsibilities to each other of consultants of differing disciplines are wise and deserve to be widely read. However, I cannot let pass his strictures on members of my own specialty—anaesthesia. "Notorious expanders of empire" we may be labelled, but expansion has occurred to fill a therapeutic vacuum, and not as a result of clashes with medical and surgical colleagues. Our involvement in intensive care units is in part due to their evolution from respiratory units and postoperative wards, but also because members of other specialties have been reluctant, in many hospitals, to accept the increased workload which can seldom be confined to office hours.

Anaesthetic out-patient clinics are another thing. But here again we have a contribution to make, and we are able to relieve some of the acute pressure on surgical out-patient clinics. In my own clinic I see upwards of 500 patients each year. Therapeutic procedures are confined to treatment of simple iron deficiency anaemia, reduction of obesity, referral for dental treatment, physiotherapy for chronic chest disease, and simple psychological support. We are also a second line of defence in that we offer the patient a further chance to ask questions. Many do not ask the questions they wish at the surgical consultation because of shortage of time, fear, or inability to think of them at short notice. In the outpatient clinic the observant and tactful anaesthetist can do much to smooth the preparation of the patient for surgery.

As anaesthetists, I believe that our main duty is to provide safe and competent clinical care for patients undergoing surgical operations. In this the technical side of anaesthesia is of paramount importance. But we must not neglect areas of legitimate interest outside the operating theatre which make us the modern anaesthetist today.—I am, etc.,

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A Psychiatrist in Space?

SIR,—Your leading article (30 January, p. 245) raises some vital issues regarding the place of psychiatry in society and the function and potential of psychotherapy.

You ask "what is so special about psychotherapy from a doctor"? In my view the special quality emerges when psychotherapy is of a supportive nature, depending upon the patient's belief in the omnipotence of the doctor—to use Balint's phrase, his "apostolic function". This is a positive

transference technique which parallels a child's total belief and trust in his parents. It is easy to understand under these circumstances the value of being a doctor, and how this quality lends itself to a "special relationship". With analytically-orientated psychotherapy, the aim is not to support a dependent relationship but to examine it openly. It is necessary to interpret the dependency and allow ambivalent feelings to be expressed; in other words, the negative transference must be dealt with. Under these circumstances, the "special" quality of psychotherapy from a doctor is of less importance. What is more relevant is the training and experience of the psychotherapist, be he a doctor or from a different discipline.

Last summer you published a leading article entitled "Who Should Do Psychotherapy?" (13 June, p. 617). The main choice appeared to be between the appointment of 480 more psychiatrists (Wing's estimate) and opening the field of psychotherapy to non-medical disciplines. I think the problem is reflected in your present leader when you state that "the voice of mission control" was psychotherapy itself. I would agree completely with this view; in which case the contribution of psychotherapy would be to help mission control in coping with the conflicts that arise in relationship to astronauts in space. Obviously, the psychiatrist could take over the problem and try to deal with it himself, but this would imply the inability of mission control to cope with the various stresses. To my mind, the situation is very similar to that of a hospital trying to function as a therapeutic community. I have no doubt that the main function of a psychotherapist in a hospital setting is to offer himself to staff of all disciplines, to help them with the stresses and conflicts that arise in the course of everyday work. The psychotherapist's skill should be used to impart to others the better understanding of psycho-dynamic principles and understanding of the complex relationships that occur.

You ask "Can psychiatrists by the nature of their training and experiences ever be of help under such circumstances?" I believe that the answer is "yes" and would focus on the value of group psychotherapeutic techniques. People working with groups have invariably to face stress and tension resulting from inter-personal relationships. It is really of little importance what the specific nature of the conflict is, and the emphasis should be upon the dynamics of the relationships surrounding the conflict. In terms of space flight, it would seem that the astronauts depend upon the skill and experience of mission control, rather in the same way that a patient will become dependent upon a doctor working with a positive transference technique. On the other hand, you state that "astronauts are essentially self-selecting individuals . . . whose ability to complete the training programme excludes the possibility that they may not be able to cope under pressure." Surely this is an area of conflict in which it would be reasonable to explore the problem in depth. Perhaps this is where psychiatrists trained in group dynamics would be of potential assistance?

To return once more to the hospital setting and the whole question of who should do psychotherapy, I am convinced that the immediate task should be that of helping people of all disciplines to improve their skills. At Halliwick Hospital, for example,

there are some twelve outpatient psychotherapy groups in existence of which half are being run by non-medical staff—that is, nurses, psychiatric social workers, and occupational therapists. All staff meet with one of the consultant psychotherapists once a week to discuss their work. We consider it essential that this work continue and grow, and I can see no alternative at this time to the problem of the psychotherapeutic needs of the country as a whole. I am convinced that we have to get away from the "special" quality of psychotherapy from a doctor, and turn to non-medical staff whose potential in this field is unlimited. The focus should be the improvement of training facilities in psychotherapeutic techniques for all staff, rather than to collude in the belief of the omnipotence and omniscience of "the doctor".—I am, etc.,

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Accident and Emergency Services

SIR,—In recent letters on the problems of staffing accident and emergency departments it has been stated that the appointment of "one consultant surgeon will not solve the problem of providing a doctor on duty in the department" (16 January, p. 177), and that "Those who advocate a full-time consultant working in the accident and emergency department still fail to realize that the majority of patients attend outside the 9-5 day of the consultant" (27 February, p. 506).

Of the first 10,000 new patients to attend the accident and emergency department of the Leeds General Infirmary this year, 5,036 attended during my working hours. During this period (1 January to 27 February) there were 5,277 return visits, of which 4,829 were made during my working hours.

If these figures are representative they show that half the new patients and 90% of the return visit patients attend an accident and emergency department while the full-time surgeon-in-charge is available for consultation. Listed among the "return visits" are a number of patients who originally attended during the previous evening or night and who, after their initial treatment, had been asked to return the following morning for me to see them. I was thus able to examine them and review their treatment within a few hours of their first visit.

However, there still remains the problem of patients who arrive outside "working hours" and who require immediate treatment. The consultant's contribution to the care of these patients is made through the training of his junior staff, by making sure that essential equipment is available, and by establishing lines of communication so that expert help can be called for when necessary.—I am, etc.

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Treating the Mentally Subnormal

SIR,—The concept behind the Mental Health Act 1959, was to place psychiatric patients on the same basis, as far as possible, as