SIR,—Sometimes, the duty of confidence is against the patient's interest. A girl of 16 attended a peripheral V.D. clinic as subsequent contact of a man treated for gonorrhoea. She did not permit me to inform her general practitioner. No gonococci were found, but a routine cervical cytology smear showed cells "bordering on dyskaryosis." The test should have been repeated after six months, but the girl did not attend for it.—I am, etc.,

W. K. BERNFELD

Cardiff

R.C.S. Council

SIR,—May I as a senior Fellow of the Royal College of Surgeons make the plea that Fellows who have retired from, or are about to retire from, the active staffs of their hospitals should not, save for exceptional circumstances, apply for election to the Council. I am sure that friends and colleagues whom this may affect will realize that in making this plea I am concerned with principles and not persons. The Council would be strengthened by a decrease of its average age and by the accession of younger Fellows now at the height of their contributions to surgery.—I am, etc.,

DAVID PATEY

London W.1

Aerosols in Asthma

SIR,—I should like to reply to comments by Drs. J. W. Paterson and T. J. H. Clark (6 March, p. 557) concerning my paper (5 December, 1970, p. 579). Firstly, with regard to the aerosol producing a satisfactory bronchodilator response, Freedman¹ suggested that increases of less than 10% are probably valueless and that patients are more likely to be aware of useful improvement when the FEV₁ has increased by 20-30%. In the same paper, he also reported a mean peak response to Medihaler-duo of 36.2% increase in FEV₁.

My own criterion for admission to the trial was an increase in FEV₁ of 20% or more, and the changes reported were statistically significant ($P < 0.001$). The value for change in FEV₁ was also significant ($P < 0.05$) when the whole group of 23 patients was analysed. I consider that this can be regarded as satisfactory bronchodilatation. Of course, the paper by Pflug *et al.*² had not been published at the time my own work was submitted for publication but it is of interest that only three of his chronic bronchitic subjects fulfilled this criterion of being capable of a 20% increase in FEV₁ at the time of testing. These subjects, Nos. 17, 18, and 25 showed changes in PaO₂ of -4, +3, and +5 mm Hg respectively after Medihaler-duo.

Drs. Paterson and Clark are correct in pointing out that in two of the studies quoted^{3,4} orciprenaline was given by subcutaneous injection and not by inhalation. However, it should be pointed out that Chapman,⁵ Hume,⁶ and Bass *et al.*,⁷ in addition to Waddell *et al.*,⁸ all administered the various bronchodilators by pressurized aerosol. I know of no evidence that the effects of bronchodilators on the blood gases are dependent on the method of administration, and in my review of the literature the different methods

of administration used are clearly stated in the introduction to the paper.

It was not my intention to suggest that the combination aerosol is absolutely safe in severely hypoxic patients. The last line of the discussion clearly states that the combination aerosol—"may have an additional margin of safety if used by a severely hypoxic patient unaware of the seriousness of his condition."

It is unfortunate that this was contracted in the summary to read, "is additionally safe."

Finally, and as your correspondents suggest, I agree that a comparison in the same patients with isoprenaline alone is scientifically desirable and indeed a controlled comparison of isoprenaline, Medihaler-duo, and salbutamol given by pressurized aerosol is now nearing completion in this department. In addition, a further paper has been completed and submitted for publication elsewhere in which Medihaler-duo is compared with salbutamol given by pressurized aerosol.—I am, etc.,

L. H. HARRIS

Newsham General Hospital,
Liverpool 6

¹ Freedman, B. J., Meisner, P., and Hill, G. B., *Thorax*, 1968, 23, 590.

² Pflug, A. E., Cheney, F. W., and Butler, J., *American Review of Respiratory Diseases*, 1970, 101, 710.

³ Stiksa, J., Daum, S., and Nikodymova, L., *Arzneimittel-Forschung*, 1967, 17, 568.

⁴ Daum, S., Stiksa, J., Nikodymova, L., Petric, A., and Svorcik, C., *Arzneimittel-Forschung*, 1967, 17, 565.

⁵ Chapman, T. T., *British Medical Journal*, 1969, 4, 557.

⁶ Hume, K. M., *British Medical Journal*, 1970, 1, 173.

⁷ Bass, B. H., Disney, M. E., and Morrison-Smith, J., *Lancet*, 1969, 2, 438.

⁸ Waddell, J. A., Emerson, P. A., and Gunstone, R. F., *British Medical Journal*, 1967, 2, 402.

Self-certification

SIR,—Certificates of longer term incapacity are more likely to be objective and of value to everyone concerned. However, 70% of certificates signed by doctors relate to short absences, which manifest withdrawal from work for reasons other than incapacity. To that extent such N.H.S. certificates are *ipse dixit*, and similar private certificates are valueless.

When constituents cease to pretend otherwise, the B.M.A. will be in a position to negotiate on their behalf an alternative method for claiming short-term benefit. Patients, whether managers or employees, might then value more highly the expression of objective medical evidence and have greater respect for medical opinion in poorly defined cases.

No longer obstructed by spurious medical authority now implied, both sides of industry might then make progress towards the understanding of, and the appropriate remedy for, the individual who finds the work situation temporarily intolerable.—I am, etc.,

JOSEPH L. KEARNS
Medical Adviser,
J. Lyons and Co. Ltd.

London W.14

Physicians for Chest Diseases

SIR,—Dr. F. Ridehalgh (16 January, p. 161) in pointing out the lack of trainees in chest diseases illustrates the changing pattern of work by figures from the chest department in Oxford. It would be unwise to regard these as typical of what has happened in the rest of the country. Change in Oxford

seems to be gentle and comparison with the figures from my unit in Mansfield illustrates what has been achieved in many places up and down the country.

1969	Oxford	Mansfield
Population	430,000	220,000
No. of Consultants	3	1
Admissions		
Tuberculosis	87	33
Lung Cancer	161	84
Other Malignancies	20	15
Acute Infections and Cardio-respiratory Failure	182	181
Asthma	28	64
Pulmonary Embolism	10	22
Other C.V.S.	—	82
Other Respiratory	—	71
Non-thoracic	—	64
Other	92	—
Total	580	616
Cases per bed	7.5	19.6

In this area the chest department deals with nearly one-third of all "medical" admissions. This concentrates many difficult problems into a department geared to deal with them while leaving the general physicians with an adequate interest in chest diseases. The figures also show that the chest physician gets reasonable experience in a wider range of medicine. I believe the Mansfield figures give a more accurate idea of the work load of most chest physicians these days.

Trainees are required to replace these physicians as they retire. The Sheffield region is without a senior registrar in chest diseases, and vacancies in recent years have had to be filled from elsewhere. Because further retirements are expected in the fairly near future the Chest Diseases Advisory Committee of the Board recommended in 1968 the establishment of a senior registrar post. The Senior Registrar Committee, however, seems to be so poorly in touch with the service needs of the National Health Service that it has taken two years to agree to such an appointment, before forwarding the recommendation to the Department of Health. Months later we are still waiting for a decision.—I am, etc.,

D. DAVIES

Ransom Hospital,
Mansfield, Notts

Hypertension during Chlorimipramine Therapy

SIR,—May I be permitted to comment on the letter by Dr. I. Hesso (13 February, p. 406)?

Since January 1968 I have been carrying out a research project with chlorimipramine involving the treatment of severe depressives and obsessive compulsive states with intravenous infusions of this preparation. Over 50 patients have been treated so far, and their ages range from 19 to 75 years. Doses of chlorimipramine up to 250 mg have been given by intravenous infusion together with oral therapy, and the results on the whole have been most promising.

It is true that the known contraindications have been scrupulously observed—namely, existing liver damage, cardiovascular insufficiency, prostatic enlargement and urinary obstruction, patients with a convulsive tendency, and also those with glaucoma. Care has also been taken not to prescribe during the first three months of

pregnancy or within 14 days of cessation of treatment with a monoamine-oxidase inhibitor drug.

During the intravenous infusions, which were originally given over a period of three or four hours, but are now reduced to 45 minutes, the blood pressure was recorded every 30 minutes and in no case was there any evidence of hypertension. If anything, a slightly hypotensive action was more commonly observed.

In view of Dr. Hesson's letter, I thought it might be helpful to record these observations on patients treated with large doses of chlorimipramine.—I am, etc.,

G. H. COLLINS

St. Thomas' Hospital,
Stockport, Cheshire

Family Doctor Booklets

SIR,—Recently I have had an experience that may caution others. The Editor of B.M.A. Family Doctor Publications asked if I would write a booklet. There was no formal contract. The booklet was written and published. I later discovered that it had been serialized in a week-end publication of the cheaper tabloid variety, distinguished only by an abundance of near-naked nymphs and cartoon jokes.

The gorgeous girls I gladly could forgive but cannot acquiesce in the fact that my name, degrees, and occupation were splashed in boldest type across the page, whereas the acknowledgement of B.M.A. Family Doctor Publications' copyright could only with difficulty be found.

The Editor of B.M.A. Family Doctor Publications does not share my qualms. He might be asking other members of the profession to write for him, and it may be that they would wish to act with circumspection.—I am, etc.,

IAN OSWALD

Department of Psychiatry,
Edinburgh University

* * * We showed Dr. Oswald's letter to Dr. Trevor Weston, Editor of Family Doctor Publications, who replies below.—ED., B.M.J.

SIR,—I wrote to Dr. Oswald over two months ago to say how sorry I was that he was displeased by the serialization of his booklet in the newspaper to which he refers. I added that, while I appreciated that he might have preferred to have seen it in another sort of paper, we were pleased that this particular journal wished to carry it since it would bring it before an audience who would be unlikely to purchase the booklet and who probably stood in greater need of health education than other sections of the community.

So far as the contractual aspect of the matter is concerned Dr. Oswald's cheque for the manuscript of the booklet was accompanied by the customary statement that it represented payment for full rights in the booklet to become the property of the B.M.A.—I am, etc.,

TREVOR WESTON

Editor, Family Doctor Publications

London N.W.1

Ulcerative Colitis

SIR,—In his article on the medical management of ulcerative colitis, Dr. S. C. Truelove (20 March, p. 651) recommends, for the severe attack, intravenous therapy with a combination of tetracycline and either prednisolone 21-phosphate or hydrocortisone sodium succinate.

It is stated in a number of recent articles¹⁻⁴ that when tetracycline hydrochloride and hydrocortisone sodium succinate are mixed in solution precipitation occurs. We confirmed that this was so at concentrations used clinically by adding 100 mg of hydrocortisone sodium succinate to a solution of 250 mg of tetracycline hydrochloride in 500 ml of normal saline. An immediate fine milky precipitate was produced which after two hours had coagulated to form a coarser precipitate which would not pass through the filter of an intravenous giving set. The addition of 250 mg of tetracycline hydrochloride to 500 ml of normal saline reduced the pH from 5.8 to 3.1, and after addition of the hydrocortisone the final pH was 3.25. It is likely that at this pH hydrocortisone sodium succinate is converted to the sparingly soluble hydrocortisone succinate.

It therefore seems probable that some of the hydrocortisone will be lost if given in this way, and that Dr. Truelove's alternative combination using prednisolone 21-phosphate, which is not precipitated in acid solutions, would be preferable. Alternatively, of course, hydrocortisone can be given intermittently through the drip tubing.—We are, etc.,

LINDA BEELEY
R. H. LEACH

Department of Medicine,
and the Pharmaceutical Department,
Queen Elizabeth Hospital,
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¹ Patel, J. A., and Phillips, G. L., *American Journal of Hospital Pharmacy*, 1966, **23**, 409.

² Webb, J. W., *American Journal of Hospital Pharmacy*, 1969, **26**, 31.

³ *Drugs and Therapeutics Bulletin*, 1970, **8**, 53.

⁴ Grayson, J. G., *Pharmaceutical Journal*, 1971, **206**, 64.

School Health Service

SIR,—Your readers will have observed from comments in the press that the local authority associations have put out a closely reasoned statement on the importance of the school health service, and the necessity for it to work in close relationship with the education service and individual schools. The Public Health Committee would accept this premise, and we are glad to see this expression of the local authority associations' concern for school health. However, the local authority associations are expressing doubt as to whether this close relationship can be maintained and developed with an integrated Health Service outside local government. On this aspect of the matter we would wish to say most emphatically that we see no difficulty in the school health service being maintained as part of the future unified National Health Service, staffed by doctors and other professional staff who would be within the N.H.S. and working in close relationship with the schools, and in it being organized by community physicians who would be fully knowledgeable of the health needs of the education service and able to advise education authorities and to co-operate with chief

education officers. In fact, within the concept of a unified National Health Service we would press for the preservation and development of such relationships.

It is futile to imagine the child health service for school children divorced from the service for preschool children and the service for young people. All should be together and in the main stream of medicine and this would result in a better service, both preventive and in the interests of handicapped children.

The local authority associations are suggesting a study to define and evaluate the existing and prospective functions of the school health service, "... before embarking on the more complex study required in respect of future relationships between local government and the National Health Service as a whole," and if the results of the study were in their view unsatisfactory might wish to reserve the right for education authorities to appoint "such staff as may be necessary to ensure an effective school health service." On the other hand we are convinced that the interests of the children and the school health service itself would be best served by its full inclusion within a unified National Health Service and would wish to see clear proposals for this from the outset.—I am, etc.,

C. D. L. LYCETT

Chairman,
Public Health Committee,
British Medical Association

London W.C.1

Secrecy over Hospital Closures

SIR,—In our Army days there was a story of a man who sent out a letter in an envelope marked "Top Secret. Not to be opened". In the Health Service we are all familiar with receiving letters marked "Confidential" but containing information which is common knowledge far and wide.

I am concerned about the secrecy in regard to the closure of hospitals. The officials are admittedly in a difficult position when it has been decided to close a hospital and naturally reticent for several reasons. Under the terms of the Act they are to provide a Health Service for the public in a given area and naturally they are afraid of staff leaving the hospital. If it is bruited abroad that the hospital is to close, there is often a public outcry with petitions and so forth.

I am quite sure that this attitude of the officials, which I think is imposed by Whitehall, is absolutely wrong. During the war it is true to say that every effort was made to be reasonably near to the truth in our propaganda; it was for this reason that our propaganda was successful. As soon as the cloak of secrecy descends all sorts of surmises occur to people, which give rise to rumours, unrest, and discontent.

When this situation arises the morale of a hospital disintegrates. It is perfectly all right for the older members of the staff, but for younger people there is added anxiety. It is true to say that the Health Service is not compelled legally to guarantee so many sessions to any individual, though no doubt officials would feel under a moral obligation to offer sessions to replace those that were lost. The question is whether the sessions would be as good as the others or as satisfying professionally. The official may find it very difficult to find any suitable sessions because all the other hospitals may be fully staffed.