ceivably be playing a part in the aetiology of other disease entities,⁹ and halogenated salicylanilides and related compounds may not be the only drugs retained in this manner.¹⁰

Dr. R. H. Champion, in the article "Diseases of the Skin: Drug Therapy of Urticaria" (22 December 1973, p. 730) states that "antihistamine drugs may, if necessary, be continued for months or years with safety." How can he be sure of this? How can we be certain that any of the photosensitizing drugs which cover a wide therapeutic range and include several antihistamines are not retained in the dermis for long periods, eventually playing a part in the production of actinic reticuloid in susceptible subjects? Promethazine, an antihistamine, and chlorpromazine, a tranquillizer, two phenothiazine derivatives, may cause persistent photodermatitis which depends upon concomitant oral administration and external application.¹¹⁻¹³ The active photocontact sensitizers cause multiple cross-sensitivities¹⁴ and it is conceivable that one or several photosensitizing drugs retained in the dermis might be immunologically activated by an external powerful sensitizer such as fenciclor, leading to actinic reticuloid.—I am, etc.,

JOHN N. BURRY

St. Peters,
South Australia

- 1 Burry, J. N., *Archives of Dermatology*, 1967, **95**, 287.
- 2 Ramsay, C. A., and Crow, K. D., personal communication.
- 3 Burry, J. N., *Archives of Dermatology*, 1968, **97**, 497.
- 4 Hillson, O. F., and Baughman, R. D., *Archives of Dermatology*, 1963, **88**, 409.
- 5 Ives, F. A., et al., *British Journal of Dermatology*, 1969, **81**, 469.
- 6 Wilkinson, D. S., *British Journal of Dermatology*, 1972, **87**, 397.
- 7 Jensen, N. E., and Sneddon, I. B., *British Journal of Dermatology*, 1970, **82**, 287.
- 8 Willis, I., and Kligman, A. M., *Journal of Investigative Dermatology*, 1968, **51**, 385.
- 9 Burry, J. N., *New England Journal of Medicine*, 1969, **281**, 620.
- 10 Cox, A. J., and Marich, K. W., *Archives of Dermatology*, 1973, **108**, 655.
- 11 Sidi, E., Hincky, M., and Gervais, A., *Journal of Investigative Dermatology*, 1955, **24**, 345.
- 12 Calnan, C. D., and Frain-Bell, W., *Transactions of the St. John's Dermatological Society*, 1962, **48**, 49.
- 13 Fisher, A. A., *Contact Dermatitis*. London, Kimpton, 1967.
- 14 Hjorth, N., and Fregert, S., in *Textbook of Dermatology*, ed. A. Rook, D. S. Wilkinson, and F. D. Ebling, Oxford, Blackwell, 1972.

Looking after Schizophrenics

SIR,—Your leading article (4 May, p. 236) is to me a sad one as you seem to support the view that our old large mental hospitals should not be closed if only because of all the schizophrenics still needing treatment in them. But is the present chronicity rate really necessary? The trouble may be that many schizophrenic patients are being inadequately treated at present. For instance, drugs remedying the affective component of a schizophrenic illness, such as lithium, trimipramine and Parstelin (tranylcypromine + trifluoperazine), are not being used enough, more electric convulsive therapy (E.C.T.) should often be given in early cases, and insulin sopor and modified narcosis with further intensive E.C.T. may be needed in resistant obsessive patients.

In 1961¹ and again in 1965² we showed at St. Thomas's Hospital that over 80% of schizophrenics treated actively with modified insulin, E.C.T., and chlorpromazine were at

home in a two-year follow-up and mostly at work. And this needed only an average hospital treatment stay of *six weeks*. In 1972³ we published the results of treatment of 74 schizophrenic and schizoaffective patients, many considered chronic, who were given modified narcosis, phenothiazines, intensive E.C.T., and the combined antidepressants all together, and many were helped who had been sent for considered leucotomy. Fifty-two of the 74 patients were still helped.

On retirement from St. Thomas's in 1972 I was able to re-establish a narcosis ward in a psychiatric nursing home and today, among other patients, 25 often considered "chronic" schizophrenics have had the full combined narcosis and E.C.T. treatment with additional insulin sopor when needed. It has sometimes needed more than 20 E.C.T.s and over two months of narcosis to bring no less than 22 out of these 25 patients into remission. Five patients had been ill with schizophrenia for 10 years or more, eight for five years or more, and 12 for less than five years.

With a really skilled and intensive physical treatment approach there could be many fewer recent schizophrenics going into our old asylums and many are now recoverable in them.—I am, etc.,

WILLIAM SARGANT

London W.1

- 1 Rohde, P., and Sargent, W., *British Medical Journal*, 1961, **2**, 67.
- 2 Kelly, D., and Sargent, W., *British Medical Journal*, 1965, **2**, 147.
- 3 Walter, C., Mitchell-Heggs, N., and Sargent, W., *British Journal of Psychiatry*, 1972, **120**, 651.

Confidentiality in Medicine

SIR,—“Whatever I shall see or hear in the course of my profession . . . I shall never divulge, holding such things to be holy secrets.” On this Hippocratic principle many of us were taught and so have practised. Until recently the public were justified in expecting and respecting our ability to vouchsafe any statements made at consultation.

One of the few disadvantages of group practice is the fact that medical records are now largely kept in a central office to which ancillary workers have ready access. In my opinion the doctor is the patient's confidant and in order to remain so these notes must really not be so generally available to all and sundry, however discreet they may be. To my consternation the other day I learned that some of my colleagues actually encourage the perusal of their files by these very folk. It is surely a very grave matter that should be seriously considered by the profession. Some of our patients are beginning to ask, “Is everything confidential?” Years ago it was taken for granted and I think the decline in standards is sad.—I am, etc.,

JOHN TAYLOR

Guildford, Surrey

Screening—G.P. or Family Planning Doctor?

SIR,—In taking the medical history in the ordinary family planning session factors come to light from time to time—such as a history of hepatitis, a familial history of diabetes, or the possibility of sickle-cell anaemia—in which laboratory investigation

is desirable. Conditions requiring further investigation and treatment must be referred to the patient's general practitioner and, ideally, perhaps all such matters should be so referred. But this is often cumbersome, certainly delaying, and unfortunately not always followed through by every G.P. This raises the question who should be primarily responsible for such screening.

G.P.s have direct access to outpatient pathological services. I consider that family planning doctors to have an obligation to arrange certain screening investigations directly as an integral part of advice on oral contraception. If similar outpatient pathological facilities were available to them, provided these were used sensibly and only where indicated, I believe this would greatly improve the work of the family planning doctor and could relieve the load on the G.P. if this procedure is agreeable to him. Where direct referral to the G.P. is not done for any reason he should, of course, always be informed of the results.

It would be interesting and helpful to hear the views of G.P.s (and pathologists) on such direct screening being arranged routinely by the family planning doctor.—I am, etc.,

N. CHISHOLM

London N.W.3

Encroachments on the Patient's Responsibility

SIR,—There seems to be a tendency for doctors, and surgeons in particular, to accept responsibility for matters that are not primarily their own concern and, even more alarmingly, to exclude the patient in a somewhat dictatorial manner from any say or responsibility in the matter.

Two recent examples are the question of surgery and the birth control pill and the 10-day rule for x-ray examinations. I suggest that it is the responsibility of the prescribing doctor to point out the risks and complications of the pill, and thereafter it is the patient's responsibility whether she takes it or not. While the reasons for the 10-day rule for x-ray examinations are appreciated, I see no reason why the patient should not be allowed to waive the rule herself by signing on the request form. To refuse to allow this is an alarming interference with a patient's independence and will cause unnecessary inconvenience and even anxiety.

There is an increased morbidity after surgery in overweight patients, cigarette smokers, etc. The next step could be to refuse these patients the right to surgery rather than the present system of giving strong advice and leaving the final decision to the patient.—I am, etc.,

R. F. N. DUKE

Warwick Hospital,
Warwick

Acute Brucellosis Presenting as Epididymo-orchitis

SIR,—The letter (27 April, p. 221) by Dr. D. J. H. Payne prompts us to report an unusual presentation of acute brucellosis in which, happily, the serology was helpful.

A dairy farmworker, aged 32 years, presented to his general practitioner on 7 February 1974 with fever and signs of a right epididymo-orchitis.