Improving the Psychiatric Services

SIR,—Being very interested in and committed to the task of trying to plan and provide suitable hospital services for elderly people, I think that Dr. H. Jacobs's letter (16 December, p. 681) calls for some comment.

I refer to the very popular notion of "*x* weeks in and *x* weeks out geriatric service." Such service is not necessarily the sort of panacea that many people seek. It is very difficult indeed to keep to any such timetable. One knows that shuttling the elderly from here to there will in itself very often affect them adversely and one had found that at the end of the allocated stay in hospital the patient is much worse than at the time of admission. Although one is keen to help the relatives and benefactors of frail elderly people by giving them respite, and is able to do this in selected cases, I have come after many years to believe that the primary task of the geriatrician is to treat vigorously whichever patients have tractable diseases, tempering such treatment with, one hopes, humanity and common sense.

As for day hospitals, I am completely sold on their virtues and efficacy. I am beginning to think that these, paralleled by local authority day centres, might very well reduce dramatically the expense of providing in future for the needs of the elderly.—I am, etc.,

St. Edmund's Hospital, Northampton. J. H. RAPHAEL.

Tetanus Prophylaxis

SIR,—I was very interested to read your leading article on tetanus prophylaxis (16 December, p. 635). I was pleased to see that you made it very clear that prophylaxis in the non-immune wounded patient for practical purposes rests between antibiotics and antitetanus serum. Neither of these has been proved to be 100% effective, but nevertheless clearly must be largely effective, for, as you state, the number of tetanus cases in this country is quite small.

I do wish, however, that you had made it very clear that tetanus toxoid has no practical value in the immediate prophylaxis of tetanus. We see a number of patients in this hospital who have had their initial treatment of wounds at a neighbouring hospital where the staff seem to be convinced that either tetanus toxoid alone, or tetanus toxoid plus one injection of penicillin, is adequate prophylaxis. At the recent symposium on tetanus held in Leeds in April,[1] which is referred to in your leading article, both Mr. Sharrard and I emphasized that a course of antibiotics was necessary for adequate prophylaxis. This point you have brought out in your leading article. Recently, however, my colleague Dr. J. J. L. Ablett lectured on the treatment of tetanus to a society some 40 miles from here. As a matter of interest, at the end of the lecture he inquired from all those present what method of prophylaxis they themselves used in the patient at risk. The majority of those present stated that they gave tetanus toxoid and one injection of penicillin. I am sure that Mr. Sharrard will join with me in condemning this as inadequate and in stressing once more that tetanus toxoid is of no immediate prophylactic value.

All except one of our last 10 patients undergoing treatment in our tetanus unit had been given this form of prophylaxis, emphasizing its inadequacy from a different point of view.—I am, etc.,

Tetanus Unit, General Infirmary, Leeds. M. ELLIS.

REFERENCE

[1] Sharrard, W. J. W., in *Proceedings of a Symposium on Tetanus in Great Britain*, Leeds, 1967, ed. M. Ellis.

Low Back Pain

SIR,—I was interested in Dr. W. I. D. Scott's comments on back troubles in industrial and general practice (9 December, p. 618). I would agree with him that strict bed rest in simple lumbago is impractical. Indeed, I would suggest that it may be harmful in some patients by providing yet another somatic outlet for their psychological stresses.

After all, the acute prolapsed disc is rarely seen in general practice, and most cases of lumbago-sciatica fall into the category of musculo-ligamentous strains.

These cases respond admirably, in my experience, to infiltration with local anaesthetic solutions, with or without hydrocortisone, together with manipulation and early mobilization.—I am, etc.,

Elgin, Morayshire. A. M. BLAIN.

Bromism

SIR,—We should like to point out once more the dangers of the long-term administration of carbromal, especially as the amount prescribed may go somewhat unnoticed when it is combined with a hypnotic such as pentobarbitone as in Carbrital (carbromal 250 mg., pentobarbitone 100 mg.). The danger lies in the fact that bromide (to which most of the carbromal is metabolized) is much more slowly excreted from the body than pentobarbitone and therefore has a cumulative effect. A recent case illustrates this.

A 75-year-old man who had been taking Carbrital as a hypnotic for many years, and who possibly took more than his usual dose of two capsules four days prior to admission, was admitted in a very confused state with nystagmus, marked ataxia, and generalized diminution of sensation. His serum bromide level at this time was 60 mg./100 ml. Without treatment this had fallen to 40 mg./100 ml. in five days and the above symptoms and signs had disappeared.

In the past nine years he has had five admissions to mental hospitals with episodes of confusion, delusions, and hallucinations. On each occasion these settled down without any specific treatment within a few days of admission. A number of psychiatric diagnoses were suggested, but none were consistent with the transient nature of the symptoms.

As the serum bromide was not recorded during these admissions we have no definite proof that they were due to bromism, but in view of his recent illness and the well-documented evidence of psychiatric symptoms in bromide intoxication[1,2] we consider that these were manifestations of a toxic level of bromide.

We would like to thank Dr. J. E. G. Pearson for his permission to report on this case.

—We are, etc.,

Bristol Royal Hospital, Bristol. A. F. BOYLES. D. J. MARTIN.

REFERENCES

[1] Andrews, S., *Med. J. Aust.*, 1965, **1**, 646.
[2] Wuth, O., *J. Amer. med. Ass.*, 1927, **88**, 2013.

Cause of Death

SIR,—Why in the obituary notices of doctors published in the *British Medical Journal* is the cause of death never stated? In the *Journal of the American Medical Association* it invariably is.

The American practice is, I suggest, more seemly. After all, the *British Medical Journal* is written by doctors for doctors, and deals mainly with disease and death; and it would be easy to make provision for that very small minority of deaths in which a public statement of the cause might distress relatives. Certainly a changed practice in this respect would have the incidental advantage of reminding us in a most direct way that we too are mortal. And lastly, one task of medicine is to discover and to set forth the truth, and reticence of the kind in question would seem to be at variance with it.—I am, etc.,

Little Missenden, Amersham, Bucks. S. BRADSHAW.

Hospital Management

SIR,—In your leading article (28 October, p. 187) you draw attention to the report on *The Shape of Hospital Management in 1980* by the King Edward's Hospital Fund.[1] The report of the joint working party set up by the Joint Consultants Committee and the Ministry of Health on the "Organization of Medical Work in Hospital"[2] has also just been published (4 November, p. 252). These two documents form an interesting comparison and deserve careful study by members of the medical profession who work in hospitals.

Considerable attention has rightly been given to the question of remuneration and to hospital buildings, but the administration of hospitals has tended to be considered of less importance. This, I think, is a mistake. Given a reasonable standard of remuneration and freedom from financial worry most doctors can put up with considerable difficulties as regards their buildings, provided that the administration of the hospital satisfies them. In my view one of the causes of frustration and the so-called "brain drain" is the administration of hospitals. Members of the medical staff have difficulty in getting their views made plain and in getting their needs carried out efficiently, quickly, and economically. Although the consultant medical staff are not trained administrators they do have to make many decisions quickly and under difficult circumstances. It therefore causes them irritation when they see what appears to be quite a minor decision being shelved or wrongly made. Committee structure and multiplicity is often wrongly blamed for this when the trouble is the shortage of trained administrators of adequate calibre. Decisions are put off and shelter taken behind committee procedure.[3] I would like at this point

to specifically exclude the administration of my own hospital group, for which I have a high regard.

There are certain issues that need to be clarified in the Joint Working Party's Report. The first and most important is the method of appointing the chief of staff, and the second is what his exact responsibility and powers would be. It would seem that they are really intended to be advisory. However, I think in the view of many this would not be sufficient. An executive committee needs executive powers and is not purely advisory. Economy can best be achieved by delegating the responsibility for estimates and budgets to the department head concerned. The question of the divisions needed would be a problem. In the development of hospital services many of the new specialties have already developed departmental set-ups with secretarial services. The older service specialties such as *x*-ray and pathology also have these arrangements. Anyone who has worked in a specialty which has a department with secretarial services and methods of keeping their own statistics knows how valuable this is and would be very loath to lose them to a broader divisional network.

Clarification is also needed about where the manpower, the secretarial services, and the space for them are going to come from. Unless these were very quickly provided this suggested administrative network would be doomed from the start. Consultants have suffered from lack of secretarial help for too long. Only recently has it been recognized that they should have secretaries of personal secretary grade. This is one of the reasons why I think they have given up many of the old administrative functions that they used to carry out and why hospital statistics and hospital activity research are not often done.

Business analogies should not be pursued too far where hospitals are concerned. The fundamental purpose of a hospital is to care for and to treat sick people. The consultant staff have the ultimate responsibility for ordering the expenditure of the very considerable sums that are now necessary to treat patients. To my mind, therefore, it is essential that the consultants should be able to take part in the management of hospitals at the highest level. They need to be involved in more than an advisory capacity and be given both executive and financial responsibility. There are many difficulties to be ironed out, but, given the sympathy and support of the consultants and proper secretarial backing, I think the suggestions of the Joint Working Party would be a great start towards a more efficient and human administration of hospitals. It is to be hoped that the Joint Working Party will consider the total administration of hospitals in addition to the medical side, as it would seem to me, from the point of view of the medical staff, an alternative to the present situation, and the "Shape of Hospital Management in 1980" is badly needed.—I am, etc.,

Bury St. Edmunds, Suffolk. J. WEDGWOOD.

REFERENCES

1 *The Shape of Hospital Management in 1980*, King Edward's Hospital Fund for London, 1967, London.
2 Ministry of Health, *First Report of the Joint Working Party on the Organization of Medical Work in Hospitals*, 1967. H.M.S.O., London.
3 Robinson, G. A., *Hospital Administration*, 2nd ed., 1966. London.

SIR,—It is sad to note in the letter written by Mr. J. Blundell and Dr. J. Lowry (9 December, p. 617), regarding the subject of managing the hospitals, that they confuse opinion with fact in dealing with the hoary old chestnut of the takeover of the running of the hospital by lay administrators.

As a member of the King's Fund and Institute of Hospital Administrators Working Party on *The Shape of Hospital Management in 1980* I bore certain responsibility for the issue of its report.[1] I have a copy before me as I write, and it is very clear that the general manager envisaged would, without question, be the best manager available, whether medical, lay, or nursing, or from other sources. The report made it quite clear that the manager could be a doctor, nurse, or lay administrator with the appropriate management attributes—these are the facts.

Taking this further the report itself stresses that all persons, medical, nursing, and administrative, who in future would hold managerial appointments in the hospitals should have received both training and experience in management and management needs to be able to measure performance. It also provides training posts for this to be achieved in each sphere of activity. Good management must be done and be seen to be done in the future so that we may run our hospitals more efficiently for the benefit of our patients as well as the satisfaction of the staff.—I am, etc.,

King's College Hospital Medical School, London S.E.5. JOHN ANDERSON.

REFERENCE

1 *The Shape of Hospital Management in 1980*, 1967. King Edward's Hospital Fund for London.

Approval of Emergency Treatment Service

SIR,—Dr. W. P. Fitt (9 December, p. 623) questions the need for the Emergency Treatment Service in a well-organized general-practitioner service. Since he suggests that a four- or five-partnership rota is desirable, why not also the next logical step of an efficiently organized larger rota, the Emergency Treatment Service, particularly as it has been proved successful in practice?

The other question, "Are doctors really happy about State-registered nurses answering the phone?" would be answered with an emphatic "yes" by those of us lucky enough to have had the chance to use such a service. It is certainly to be preferred to the previous alternatives, ranging from non-medical secretaries to au pair girls. But perhaps of greater importance than the satisfaction of the subscribing doctors to the Emergency Treatment Service is its acceptability and indeed popularity with the patients whom it serves.—I am, etc.,

St. George Health Centre, Bristol 5. A. DOWLING.

SIR,—It is interesting to note that in the opinion of Dr. W. P. Fitt (9 December, p. 623) I, along with over half the general practitioners in Glasgow, belong to a service (the E.T.S.) of which there is need, and also by so belonging we are failing to provide a service "in keeping with the traditions of our profession."

Let us look at some facts. An analysis of my patient contacts in the past month has shown that less than 4% of my patients seen at home and 0.8% of total patient contacts were by an Emergency Treatment Service doctor. My off-duty, however, has been increased by 48 hours per week over what it was in our three-doctor practice prior to using the Emergency Treatment Service. It has been our experience that patients urgently requiring medical aid wish in the first place their own doctor, but if he is not available then they do not care particularly if it is one of a large group practice or another doctor provided he copes adequately with the situation, and provided he arrives promptly. Dr. Fitt talks about increasing efficiency. Is it more or less efficient to have nine doctors actually working with two-way radios in their cars so that always at least one is available for an urgent call, or to have 200 doctors tied to the phone or on call from the golf course? As for his point about nurses answering the phone, a ring round his colleagues will show that it is much more likely that the phone will be answered by the doctor's wife, an unqualified receptionist, or a Robophone than the doctor himself.

I am firmly in support of the value of a personal doctor, but his real value is in coping not with an acute appendix but with medical, emotional, and social problems of a more long-term nature. To cope adequately with these it is essential in the long term to have adequate time off call, and this can be done by allowing an efficiently run deputizing service like E.T.S. to cover urgent out-of-hours calls.—I am, etc.,

Bearsden, Glasgow. KENNETH HARDEN.

Points from Letters

Casualty Staffing

Mr. J. W. WILSON (Belfast City Hospital) writes: It appears from the report of the proceedings of the Central Committee for Hospital Medical Services (4 November, *Supplement*, p. 36), and the more recent letter of Mr. G. Rigby-Jones (11 November, p. 360), that the staffing of casualty departments is again the subject of interest, if not possibly of the anxiety that it merits. This problem is not one that can be dealt with in isolation; decisions taken here affect the whole hospital beneficially or adversely. The whole question of the department's responsibilities to the public, and equally to its nursing and medical staffs as regards teaching and career possibilities, must be fully appreciated before any acceptable decision on its staffing can be made. . . . It is to be hoped that when the Central Committee for Hospital Medical Services sets up its subcommittee to study this question it will seek the advice of, or, better, co-opt, consultants with wide experience in this very important hospital department.

Anaphylactic Reaction and Soap Enema

Dr. TORGILS AANELAND (Baerum, Norway) writes: In the very interesting article by Dr. Donald Smith (28 October, p. 215) there is no information about former contact between the patient and the "proprietary brand of soap-flakes," or a similar one. As long as this important information is lacking the soap allergy will continue to be a "foggy" problem in the future too.