device. We have in fact described a device which meets these requirements in full.¹

The first part, operated by the pressure of the oxygen supply, comes into operation when the oxygen is turned on and cannot be turned off. When the oxygen pressure begins to fall the device sounds a warning, then cuts off other vapours or gases and opens the breathing circuit to atmosphere. However, after failure little or no air is drawn in because rebreathing occurs to and from the reservoir bag and this could result in asphyxia. The second part of the device is essential to prevent this rebreathing. The whole device will operate whether the system is semi-open or closed and whether the rebreathing is spontaneous or artificial. The device is manufactured by the British Oxygen Company and the first part is already freely available. However, the manufacturer cannot yet give us a supply date for the complete devices, which have been on order now for more than two years.—We are, etc.,

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¹ Rosen, M., and Hillard, E. K., *British Journal of Anaesthesia*, 1971, 43, 103.

Social Workers in Hospitals

SIR,—I would like to comment on the letter from Dr. P. E. Baldry (15 September, p. 589), which concerned my article on "Social Workers in Hospitals" (25 August, p. 443). The writer of that letter made several questionable points, the most fundamental of which was that social workers have no special expertise which would enable them to help the patient in areas of psychosocial functioning. He argued that doctors and nurses are just as well equipped as the social worker to undertake this kind of helping work. I would contend, however, that a psychosocial orientation to the patient must be based on knowledge, together with an understanding of how to apply this sensitively to each person's particular situation.

Dr. Baldry states that he does not want social workers interfering in the "delicate interpersonal relationships between doctor, ward sister, and patient." I would refer him to Dr. Ann Cartwright's research on this matter. She concludes a chapter on communication between patients and doctors by saying, "The present arrangements do not encourage a personal relationship between patients and hospital doctors. If communications are to be improved some doctors need to be more approachable people, less like inaccessible Gods."¹ Too often the patient does not have any relationship at all with the doctor. The development of such a relationship must be an ongoing concern and takes a great deal of time and patience. Do most doctors have the time, knowledge, understanding of rational and irrational forces and fears to have such a flexible and developing relationship with the patient? I very much doubt it.

Dr. Baldry also asserts that social workers would probably not become quite so out of hand if doctors "laid down sufficiently clear guidelines as to what is required from them," as they do for other ancillary workers. Firstly, social workers do not stand in the

same relation to the hospital endeavour as radiographers, physiotherapists, etc., and to put all such workers under the same umbrella shows a distinct lack of subtlety in understanding their different roles in relation to doctor and patient. Secondly it does not seem to occur to Dr. Baldry that discussion between social workers and doctors on the basis of exchange of knowledge and ideas between colleagues might yield more fruitful results for all concerned.—I am, etc.,

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¹ Cartwright, A., *Human Relations and Hospital Care*, p. 100. London, Routledge and Kegan Paul, 1969.

Excretion Urography in Acute Renal Failure

SIR,—We note with interest the letter from Dr. J. M. Vandenbroucke and his colleagues (4 August, p. 291) commenting on our paper on excretion urography in acute non-obstructive renal failure (9 June, p. 575) and reporting their own experience. Like them, we are puzzled by the considerable difference between our results. We find it difficult to attribute this solely to the number of patients studied because of the large difference between the two series in the proportion of patients with "acute tubular necrosis" showing an early dense persisting nephrogram.

While we recognize that it is not possible to give extensive details in a letter we would like to have known the clinical status of the patients at the time of excretion urography. Thus if the patients were volume-depleted or hypotensive with consequent renal circulatory failure the nephrographic pattern could well be affected.¹

We also note that Dr. Vandenbroucke and his colleagues employed the methylglucamine salt of iothalamate while we have used exclusively the sodium salt of diatrizoate. While we are still not certain of the precise mechanism of the development of the nephrogram in "acute tubular necrosis" there are theoretical reasons for believing that the sodium salt might give a better nephrogram than the methylglucamine salt because of better concentration, possibly at the proximal tubular level.² We are not aware of any study which has compared the sodium salt with the methylglucamine salt in this clinical situation.

We agree that considerable attention must be paid to the radiographic technique, and failure to obtain comparable exposures largely nullifies the value of the investigation. We do not accept, however, that it is too difficult to obtain comparable exposures and would re-emphasize that if these are not achieved the results of the investigation must be interpreted with extreme caution.

Finally, we cannot accept the statement that "unfortunately, the nephrographic patterns are not sufficiently distinctive to lead to an accurate diagnosis in non-obstructive acute renal failure." Our main conclusion was that if an early dense persisting nephrogram is observed in patients with acute renal failure, this indicates uncomplicated "acute tubular necrosis" or suppurative pyelonephritis. Dr. Vandenbroucke's results do not refute this. This observation alone is of value to the clinician. If this nephrographic pattern is not found

we would submit that the diagnosis of "acute tubular necrosis" should be reconsidered and the need for further investigation—for example, renal biopsy—be assessed. In addition to their clinical value, such studies may yet lead to more accurate definition of the pathophysiology of the ill-defined syndrome of "acute tubular necrosis."—We are, etc.,

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¹ Fry, I. K., and Cattell, W. R., *British Medical Bulletin*, 1972, 28, 227.

² Cattell, W. R., *Investigative Radiology*, 1970, 5, 473.

Psychiatric Aspects of Sterilization

SIR,—The recommendations made by Dr. Myre Sim and others (28 July, p. 220) deserve the attention of family planning authorities and psychiatrists in developing countries, where female sterilization by tubal ligation is practised on a much wider scale than in western Europe. In the subcontinent of India an increasing number of tubal ligations are done each year. This operation, contrary to what Dr. Sim and his colleagues recommend, is carried out at childbirth or during the neonatal period.

In India during the last decade a Government-sponsored campaign with financial inducements resulted in indiscriminate male sterilization without adequate screening and caused psychiatric sequelae in a substantial proportion of those operated upon. Similarly, intrauterine loop contraception was introduced on a wide scale in the villages without proper selection and with equally poor explanation of its side effects. Sawhney *et al.*¹ reported that 21.6% of the population who underwent vasectomy or tubal ligation or were fitted with an I.U.C.D. suffered from psychiatric sequelae.

In a follow-up of 82 subjects who underwent vasectomy for family planning Wig *et al.*² reported that 36.5% of them complained of symptoms attributable to the operation. "Post-vasectomy syndrome" is a common referral in many psychiatric and urological clinics in India. Poor selection and inadequate explanation about the possible side effects and long-term consequences of family planning procedures have resulted in the spread, mainly by word of mouth, of exaggerated and at times fanciful reports of side effects among the unsophisticated population of rural India.

It is now abundantly clear that whatever method of contraception is advised the physician must not only be aware of the psychiatric sequelae of the various procedures but also take into account his patient's premonitory personality, social background (to recognize cultural factors), and religious beliefs, and most of all appreciate his client's emotional and intellectual capacity to cope with the contraceptive method recommended.

In developing countries population control is now a matter of the utmost concern to politicians and administrators alike. Considerable pressure is being brought upon physicians to implement the Government's

decision to reduce the birth rate, irrespective of the consequences such measures may have on the life of an individual. When advising procedures which "permanently" deny procreation, it is important that the physician be not carried away with his own enthusiasm for the operation and by his public-spiritedness. The paramount concern, as always, should be the future happiness and emotional stability of his patient.—We are, etc.,

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¹ Sawhney, N., Nathawat, S. S., and Sethi, B. B., *Indian Journal of Psychiatry*, 1970, 12, 155.

² Wig, N. N., Singh, S., Sahas, G., and Isaac, P., *Indian Journal of Psychiatry*, 1970, 12, 169

Antibody Response to A/England/42/72 Influenza Vaccine

SIR,—Dr. Marguerite Pereira and others (23 December 1972, p. 701) reported that a commercial influenza vaccine containing A/Hong Kong/68 virus stimulated a good antibody response to both the homologous strain and to the variant A/England/42/72. The reverse cross-reacting response has been evaluated by us in the experiments here reported.

Fifteen subjects ranging in age from 24 to 40 years and never treated with influenza vaccine were given two doses of inactivated influenza vaccine at two weeks' interval. Each dose contained A/England/42/72 400 IU and aluminium phosphate 1.75 mg. Sera were tested for antibody content to the homologous and to A/Hong Kong/68 virus

using the standard haemagglutination-inhibition test. The distribution of antibody titres for both viruses before and after each of the two vaccine injections is shown in the figure.

Fourteen days after the first dose a satisfactory increase in the antibody level against A/England/42/72 was observed in all the subjects and only two out of 15 did not show any increase in the antibody level against A/Hong Kong/68. The geometric mean titres were 1/114 and 1/68 respectively. The second dose elicited only a moderate further antibody response to both viruses; the mean titres rose to 1/173 and 1/84 respectively.

The results suggest that A/England/42/72 virus possesses a good antigenic potency; the first dose of the vaccine provokes a booster-like effect which might be due to preexisting A/Hong Kong/68 virus in circulation. The cross-reacting response suggests that the drift in antigenic content between A/Hong Kong/68 and A/England/42/72 viruses is moderate, at least from an immunological point of view.—We are, etc.,

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Lavatory Doors

SIR,—I was interested to read Dr. M. D. Begley's letter (29 September, p. 697) about

a patient trapped behind a lavatory door. Living on the Costa Geriatrica, I have come across this problem on numerous occasions, and so solid are the doors on old lavatories that they seem to have been built to withstand an elephant charge and can present a very real problem to the attending doctor.

I can assure Dr. Begley that there is no problem in having doors rehung so that they open outwards, and I have had altered all the lavatory doors in our 80-bedded convalescent home in which many of these unfortunate incidents have occurred. They are secured by a rotary latch operated from inside which also works a dial moving from "vacant" to "engaged." These can easily be opened from the outside with a small coin or a screw-driver. This method has been in use for some years and the expense of the alterations has been more than compensated for by the saving in broken doors. For doors as yet unmodified I keep available a 14-lb (6.4-kg) sledge-hammer. Three carefully aimed blows dislocate first the hinges, then the lock, so that the door can be removed bodily over the collapsed patient with the maximum speed and dignity.

I can recommend both these methods with confidence.—I am, etc.,

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SIR,—Dr. M. D. Begley (29 September, p. 697) raises a real problem to which insufficient attention has been given. I fear that if we knew the number of lives that have been lost through delay in obtaining access in the circumstances he mentions, we should be very disturbed. Doors opening outwards are considered by many to be a serious hazard, but one wonders if a few bumps are not preferable to one lost life.

The problem of overcoming this difficulty at home is appreciated but surely, as a first step, good standard practice should be observed in hospitals and similar institutions. Alternatives are: (1) Door to open with conventional "engaged" bolt which can be operated by a small instrument or a coin from the outside. (2) Door opening inwards of stable-door type with a connecting bolt on the outside allowing entry over the lower half in an emergency. (3) Two-way hinge with removable jamb on the outside which can be lifted off and the door opened outwards. This system has been used in the new building at this hospital and we consider it to be the best method though it is comparatively costly.

Should not all of us look at this problem in existing buildings in an effort to remove this serious but avoidable hazard to life?—I am, etc.,

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SIR,—Dr. Felix Post's letter (29 September, p. 693) commenting on my paper (15 September, p. 574) can be answered with figures which are reasonably accurate, but because they were not precise they were not quoted in the original paper.