Meningococcal Infection

SIR,—We are concerned about the recent upsurge in meningococcal infection in the London area and have been impressed by the severity of the disease and its fulminant course. We would like to emphasize the importance of early diagnosis and prompt treatment in reducing mortality, which still remains unacceptably high.

Indications for chemoprophylaxis are debatable, but when this course of action has been decided upon the choice of drugs rests between a sulphonamide, minocycline, or rifampicin. We suggest that rifampicin should not be used because of the rapid development of drug resistance in vitro. Of the remaining alternatives sulphonamide, which has been well tried and has given good results, is preferable unless local strains are known to be resistant. The overall incidence of sulphonamide-resistant meningococci in the United Kingdom appears to be 10-15%, but our experience in London suggests that such resistance is unusual. Minocycline has been shown to be of value in prophylaxis, especially when there is a high proportion of sulphonamide-resistant strains, but experience with this antibiotic is limited and further critical assessment is necessary. Penicillin, which is essential in treatment, is not effective in prophylaxis.—We are, etc.,

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Attitudes of Relatives of Mentally Handicapped Patients

SIR,—Implicit in present trends and future plans in the mental health service is the belief that it is best for the patient, whenever possible, to live in the community rather than in hospital. In spite of publicity and propaganda this view is still not always shared by the relatives of the patients in mental hospitals.

For example, it is the experience in this area that a majority of the relatives of mentally handicapped patients in hospital have no desire for the patients to go elsewhere. Proposals that patients should move from the hospital to hostels, lodgings, flatlets, and other accommodation have aroused reactions of fear and hostility from many parents and relatives. Even transfers of patients to other wards in the hospital intended to prepare a patient for more independent living have raised objections from relatives, who often claim they were told years ago that the patient would never be improved. It is apparent that paediatricians, family doctors, and social workers have in the past created problems for the future by telling parents that their mentally handicapped children would live only a few years. When the mongol whom the doctor said would die before his seventh year is dominating his ageing parents at 27 their faith in the medical profession is shaken to such an extent that they are disillusioned and sceptical of what other members of the profession may say. In a minority of relatives a "martyr syndrome" is recognizable. This occurs in parents whose whole life and thinking become devoted to a mentally handicapped person in hospital. One mother cried, "he no longer needs me" when her son, now an adult, had at last learnt partly to dress himself. In such cases the more independence the patients achieve the less the parents feel they have to live for, as the patient appears no longer to need them.

No doubt financial stringency in the immediate future will delay the dissolution of the psychiatric hospitals. This could be advantageous as it will allow more time for popular attitudes to change and for a balanced appraisal of how mental health care should evolve. There is a wide gap between sociological, psychological, and psychiatric idealism and the views held by a large proportion of the population.—I am, etc.,

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Distribution and Supervision of Oral Contraceptives

SIR,—It is with some trepidation and no little regret that, though I agree with their general assessment, I find myself totally opposed to the proposals of the distinguished panel of signatories of the letter advocating the extension of delegation to allowing nurses to prescribe oral contraceptives under medical cover (19 October, p. 161). Their proposals seem to me to threaten to extend to an intolerable point the dangers inherent in delegation which exist at present. Today delegation in family planning is no longer at the discretion of the individual doctor. It is a matter of clinic procedure. He is involved in a situation where he is made responsible not only for his own medical decisions but for those of others who are not doctors, occasionally without even being consulted. It is responsibility without authority.

The feared image of the "sausage machine" in family planning clinics has in some places become largely a reality. A harassed doctor under pressure has to make quick decisions on problems as presented to him by his nurses. He is pressed by the lay staff to fit in cases which often prove complex problems on which he has then to make immediate and sometimes hurried decisions. He is for ever at the mercy of the pressure of those for whom he alone must take the full medical responsibility. But medicine takes time and cannot be driven in this way at the whiplash of financial or social expediency.

Of course, in the urgency of what is in reality an immensely pressing social and population crisis something must be done to facilitate contraceptive advice and distribution on an adequate scale. But in this as in some other, similar problems referred to in your leading article "A Rose by Any Other Name" (19 October, p. 126) it seems to me that a more honest solution should be faced than the extension of delegation. Let us end this appearance of medical care by delegation which now afflicts so many aspects of the medical situation. If nurses as well as doctors *are* to carry out medical examinations and prescribe oral contraceptives, and this is an open question, then let it be on their own responsibility and answerable to their own professional disciplinary bodies and not on that of covering doctors. Let the doctors be there for proper consultation but only answerable and responsible for patients other than their own when they accept their further care by being called in in this way.

But before considering reducing the level of care in family planning by dangerously extending this treacherous bridge of delegation the profession might usefully explore a further approach to the Minister towards securing such a fee for them as would mobilize *doctors* directly, the thousands of general practitioners now available, for this essential work. Certainly within the clinics the crisis between lay and medical interests must be met. But never at the price of the doctor becoming virtually a rubber stamp.—I am, etc.,

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SIR,—The letter from Dr. M. V. Smith and others (19 October, p. 161) may be inspired by great concern over the world's population problems. On these grounds it seems justifiable to increase the availability of oral contraceptives. The stated reason that "the health benefits of their use almost certainly outweigh the risks of use in nearly all cases" is more difficult to substantiate.

The hoped-for decrease in side effects due to lowering the oestrogen dose does not appear to have happened. With a full range of doses to choose from I found a first-year drop-out rate for any reason of 19% (50 out of 260 analysed). Herzberg *et al.*[1] found that of 272 women in Family Planning Association clinics using three low-dose oestrogen pills, only 37% were known to be still taking their original pill at the end of one year compared with 74·1% still using an intrauterine device. In 1973 it was reported that 82% of women who had used oral contraceptives considered they were dangerous to health.[2] In 1974 the survey of the Royal College of General Practitioners[3] found that 34·3% of 6,324 new users discontined the pill for any reason within their first year and this figure may be higher, as 28·4% of the total women surveyed were lost to follow-up or withdrawn. In this survey the average age of users was 28·79 years and the average number of cycles completed was 17·8. During this time a large number of conditions, some serious, increased in incidence. The annual mortality rate can be calculated as 86 per 100,000 woman-years.[4]

The overall mortality rate for women aged 35-44 on combined oestrogen-progestogen pills has been estimated previously[5] as 34 million users, nearly three times as high as the death rate in those aged 20-34. The risk of pregnancy in the older age group was estimated as 576 deaths per million births in 1966.[5] It can be seen that the mortality rate in the R.C.G.P. report is higher than these other estimations. In the report most deaths in takers were listed under the headings of "violence" and "vascular."

It is indisputable that oral contraceptives can increase mood changes and migraine. Such complaints tend to be widely regarded as subjective or psychological, though recent literature abounds with evidence of biochemical alterations from the normal in these conditions, the main changes reported being of amine metabolism, especially serotonin, adrenaline, noradrenaline, and the enzymes which inactivate them. It is difficult to imagine why a woman who experiences such