Deaths From Smoking

Sir,—The suggestion by Dr. Betty Wallace (25 July, p. 248) that Irish country practitioners shrink from using the word "cancer" and put down "pneumonia" as the cause of death when patients die from cancer of the lung, thus completely falsifying the published statistics, cannot be reconciled with the relevant figures. Table I shows the death rate per million for pneumonia, cancer of the stomach, and cancer of the lung, as well as the average level of cigarette smoking, for various areas of the British Isles.

The figures for cancer of the stomach show no indication of any reluctance to put the word "cancer" on death certificates in rural practices in Ireland, nor does the recorded death rate from pneumonia show the signs of inflation which would occur if it concealed numerous undiagnosed cases of lung cancer. The startling contrast between lung-cancer deaths in London and the rural counties of Ireland is obviously unconnected with cigarette smoking. This rural area, with a 1960 population of about 838,000, is taken to be the whole of the Republic with the exception of the counties and boroughs of Dublin, Dun Laoghaire, Cork, Limerick, and Waterford. Its comparatively low lung-cancer mortality is only one example of the worldwide linkage between the incidence of the disease and urbanization. Table II gives cigarette consumption, lung-cancer mortality, and population density for six different countries.

It is precisely the virtue of the therapeutic community, to which Dr. Entwistle uncomprehendingly refers, that it embodies methods of dissolving hierarchy. A democratic group requires leadership. It is convenient for a leader, as the representative of the common will of the community, to hold a symbolic office. The title of medical superintendent for this is as good or bad as any other. What matters is not the title but the way in which it is used.

Our experience is the reverse of that to which Dr. Entwistle alludes. Without medical superintendents it is doubtful whether the major developments which have transformed progressive mental hospitals could have been achieved.—I am, etc.,

Claybury Hospital, Essex.

M. J. HERON.

REFERENCES
4 personal communication, 1964.

G. C. MYDDELTON.

Correspondence

Hours of Service

Sir,—There appears in the Supplement (5 September, p. 127) an interesting memorandum with, however, one curious sentence: ‘‘To all duties arising between 8.30 a.m. to 5.30 p.m. on Thursdays, is somewhat later than the hours of work customarily expected of medical officers both in the public health service and on the staff of the Ministry of Health.” The writers of the memorandum should be aware (1) that ships are as likely to leave out-side “office hours” as within them, (2) that many health-education activities necessarily take place only in the evening, (3) that slaughterhouses and fish markets are in full operation hours before 8 a.m., (4) that mental health services and social welfare services may need the presence of a public health medical officer at any hour with no exclusion of Sundays or public holidays, (5) that the law of contract and professional ethics demand that the medical practitioner does not cease to be a doctor at any fixed hour or on any day, (6) that in many local authorities meetings of the various committees are held in the evening, and (7) that any outbreak or suspected epidemic of infectious disease demands immediate investigation and urgent action.

The false image of the public health doctor—and to some extent of his Central Government college—of a staid, starchy, and non-conformist person was malevolently created in an era of hostility between clinicians and public health medical officers; any preservation of that false image in the era of co-operation and good will is to be deprecated.—I am, etc.,

A. L. A. MACQUEEN.

Complications of Arterial Puncture

Sir,—With reference to Professor W. W. Mushin’s query regarding the safety of arterial puncture (1 August, p. 310), I would like to refer to an interesting case which has shown that femoral arterial puncture in order to perform retrograde catheter studies on the aorta involves greater risk than most would appreciate, as illustrated by the following case report.

A male patient aged 46 was admitted to the medical ward of one of the hospitals of the Derby group with hypertensive cardiac failure in June 1962. In January 1963, while investigating the cause of the hypertension, the physician-in-charge suggested a retrograde femoral aortogram. During this period the patient was receiving antihypertensive drugs and, owing to many unforeseen difficulties, the aortogram was not done until 4 November. On the same night he developed a haematomyoma in the right femoral triangle over the site of the arterial puncture. As was routine practice after an aortogram study, the catheter used had been withdrawn and manual compression applied by the consultant radiologist himself. After examining the swelling, the vascular surgeon concerned thought that the pulsation present in the patient’s right groin was being transmitted through a resolving haematoma. The patient’s progress thereafter was closely followed both by physician and by surgeon, and at the end of January 1964 it was decided to explore the pulsating swelling after a diagnosis of false aneurysm was as likely to be made. However, it was not possible to admit him until the first week of August, and at that stage an echo-cardiogram revealed the right groin to be pulsating. At first he performed a right femoral angiogram on the table under a general anaesthetic. However, no true aneurysm could be seen in the angiograms. Therefore the skin