Advisory Service.\textsuperscript{5} This pointed to vast problems in the care of the chronic sick for which managerial solutions only brush the surface, and there are others of that kind in the Health Service.

The area authorities are planned to have in addition to a chairman appointed by the Secretary of State about 14 members. They will include at least two doctors to be appointed by the regional authority, and it cannot be assumed that in practice they will include more. At area level as at regional the main criterion for selection will be management ability, and again the consequences of this deliberate change in emphasis away from user representation will need to be studied.

Alongside the managing committees the plan proposes to have community health councils to represent local interests and views to the managers. The councils will be consulted on the development and operation of the health services in the districts, and their members will have the right to visit hospitals and other institutions. This too is an innovation that deserves careful thought, for the need to find a satisfactory way of engaging the concern of the community in the running of the health services was brought to the fore yet again as one of the lessons of the Hospital Advisory Service’s report\textsuperscript{6}—and peculiarly sadly in the report of the tragedy at Farleigh Hospital.\textsuperscript{7} Unfortunately many people find it more attractive to sit on a committee, join a deputation, or shout in a pressure group than to do voluntary work in a hospital. The present proposals seem unlikely to improve that state of affairs.

In their discussions of the Department’s proposals doctors will inevitably have in mind the thought that what matters first in a health service is good medicine, not good management. So far from being incompatible, the two should run in harness, and expert attention can help them to do so.\textsuperscript{8} But doctors are also conscious of the fact that medicine evolves all the time in response to trial and error, scholarly study, patient application—and occasionally lucky chance. The art of management too has its traditions and its techniques. An article by Professor R. F. L. Logan and his colleagues at page 519 discusses some of them. But it remains an empirical art depending more on good managers than on knowledge tested and proved in practice. Thus to put the running of the health services in the hands of people selected by the main criterion of management ability demands more thorough questioning than the Department of Health would like to allow.

\textsuperscript{2} British Medical Journal Supplement. 1971, 2, 111.
\textsuperscript{3} British Medical Journal, 1971, 2, 477.
\textsuperscript{4} British Medical Journal, 1971, 2, 420.
\textsuperscript{6} British Medical Journal, 1971, 2, 415.
\textsuperscript{7} British Medical Journal, 1971, 2, 119.

\section*{Closed Injuries to the Duodenum}

Though the duodenum is deeply placed on the posterior abdominal wall, it is susceptible to injury because of its relatively fixed position and relationship to the vertebral column. In a recent report E. Roman and colleagues\textsuperscript{1} have lucidly reviewed their experience in the treatment of 23 blunt injuries to the duodenum treated at the Detroit General Hospital. Eighteen of their patients were involved in car accidents, with 13 undoubtedly being struck in the abdomen by the steering wheel. No fewer than 14 of them were the worse for drink. The authors classify this injury into three types: firstly, intramural haematoma or serosal tear, without perforation of the duodenum or associated pancreatic injury; secondly, complete rupture of the duodenum without injury to the pancreas; and, thirdly, damage to both duodenum and pancreas.

Intramural haematoma, producing a tense, dark blue, upper abdominal mass, may result in duodenal occlusion and bilious vomiting. D. M. Caird and H. Ellis\textsuperscript{2} have reviewed some cases in children. Preoperative diagnosis has been made on a number of occasions by barium meal examination. It shows a smooth, sharply defined, intramural mass with crowding together of the valvulae conniventes, which produces the coiled-spring effect more familiarly seen in intussusception.\textsuperscript{3} Treatment comprises evacuation of the haematoma, combined, if necessary, with a gastrojejunostomy. However, if accurate diagnosis has been made radiologically, conservative treatment may suffice.

Rupture of the duodenum without damage to the pancreas can usually be treated by simple suture. If this is impossible because of contusion and oedema, the tear may be closed by suturing the serosa of an adjacent intact loop of jejunum over it.\textsuperscript{4} Complete transection is best managed by end-to-end anastomosis, and a gastrojejunostomy is indicated for any duodenal injury if the lumen is compromised.

The most difficult technical problem is when there is an associated injury to the head of the pancreas. A mild contusion of the pancreas requires no more than placing a soft drain to the site, evacuation of any haematoma, and repair of the duodenal laceration. Severe disruption of the pancreas is treated best by excision, together with the injured duodenum, by means of a pancreatico-duodenectomy. This is an extensive and difficult operation but gives the patient the best hope of recovery.

Roman and his colleagues point out that the overall mortality rate for blunt duodenal injury is about 26\%, but the prognosis is much worse when diagnosis is delayed and when the pancreas is also injured, when the mortality may go up to nearly 70\%. Even if the patient survives the combined injury he may have a stormy postoperative course with pancreatic fistula, pancreatic fistula, or pseudocyst formation.\textsuperscript{5} Unfortunately, early diagnosis may not be easy in a patient suffering from multiple injuries and perhaps unconscious from an associated concussion or alcoholic intoxication. Repeated careful abdominal examination usually shows diffuse tenderness and guarding, which is greater in the right upper quadrant than elsewhere. X-ray examination of the abdomen may be helpful.\textsuperscript{6} Retroperitoneal rupture of the duodenum may be associated with speckled gas shadows in the right retroperitoneal space, often outlining the kidney and right psoas. Intrapерitoneal rupture usually causes a pneumoperitoneum, but this is frequently in combination with evidence of retroperitoneal emphysema. Confirmation of duodenal rupture may be obtained by performing an upper gastrointestinal examination with a water-soluble opaque medium,\textsuperscript{7} which shows spillage out of the duodenum. When typical findings are present on the plain films, this procedure is unnecessary.

With a continued rise in motor vehicle accidents, blunt injury to the abdomen is being seen more and more frequently.
As prophylaxis against these serious and indeed often lethal accidents the Detroit group of surgeons gives good advice—abstinence from alcohol before driving and routine use of the seat belt and shoulder harness during the journey.


Suicide Attempts

"You might as well live," wrote Dorothy Parker after listing the disadvantages of the various methods of attempting suicide and going through the catastrophic experience of trying it twice. Even if suicide rates for both sexes have fallen in the later 1960s the prevalence of attempted suicide still gives cause for concern. The term "attempted suicide" is under attack for being inaccurate, but whatever the name applied to their act the people doing it occupy a considerable number of acute medical beds, require much time from medical staff, and strain the psychiatric resources of general hospitals.

Skilled psychiatric assessment of every case is the present official policy, but the view has been expressed that this can be done only at the expense of other important work.1 Even in a teaching hospital it has been found that 22% of these patients, for one reason of another, were never seen by a psychiatrist.2 Of those treated in the Poisoning Treatment Centre at Edinburgh and recommended for an out-patient psychiatric appointment "rather less than half" attended.3

To lighten the load J. L. Crammer4 has suggested that patients attempting suicide might be screened by questionnaire and by the taking of a social history. These measures, he considered, might suffice as a basis for sensible decisions to be taken without every patient having a consultation. Now J. Birchnell and J. Alarcon5 have explored the possibilities of a questionnaire in 91 consecutive cases treated in a casualty department at Aberdeen in 1969. Two patients had cut their wrists; the remainder had taken overdoses of drugs. Only 23 became unconscious and 30 others were drowsy but rousable. The ratio of females to males was 2.4 : 1, partly as a result of the inclusion of 22 teenage girls. There was only one boy.

In their first paper4 these authors record a comparison in scores on a self-administered depression rating-scale between the sample and a group of outpatients thought to be depressed enough to need electric convulsion therapy. No difference was found between the types of symptoms in the two groups, but scores were lower in the attempted suicide group, and lower still in the teenage girls, than in the depressed outpatients. Somewhat under half the patients said that at the time of the attempt they wanted to die, and these, as might be expected, had a significantly higher score for depression. There was, surprisingly, no relation between depression score and the level of unconsciousness. In their other paper5 the authors report an interesting sex difference in the length of time the suicidal attempt had been contemplated. Almost half the men but fewer than one-third of the women had contemplated the act for weeks or months, whereas 43% of the women and girls had acted impulsively.

Other questions attempted to probe the patients’ feelings and intentions at the time of the act by offering five feelings for self-rating and four possible effects on other people that the patient could have had in mind. Feelings of shame and of having failed in life were commoner in men, whereas more women said that their prominent feelings were of being lonely and unwanted. The wish to die, long contemplation of the act, and male sex were correlated with higher scores in the “effect on others” scales. Motives such as to “show how much you love someone” or “make things easier for others” were admitted more often than retaliatory motives.

To gather accurate information in retrospect about feelings and intentions in such a crucial act as a suicide attempt is difficult even for a psychiatrist in a face-to-face interview. A questionnaire might seem a blunt instrument in comparison. The patient may deny the attempt—"I was only trying to get some proper sleep"—or he may dissemble because he fears pressure to accept admission to a psychiatric hospital. He may be sheepish about the trouble caused to nurses and doctors, or the attempt may have achieved its aim by altering the attitude of some key person and is now—he feels—best forgotten. He may refuse to admit aggressive motives even to himself, let alone to others. The hangover effect of barbiturates may intensify his depression, or the attempt cathartically may produce improvement in mood, which may only be temporary.

But, as the authors of these papers say, the blankness of a questionnaire is at least not coloured by a doctor’s preconceptions or decorated by the beginnings of a doctor-patient relationship. Doctors are inclined to feel at sea unless they can see their way to a diagnosis, and diagnosis does not emerge from the methods described by these authors. Nevertheless, their findings seem plausible: men are more reluctant than women to attempt suicide; they think about it longer; they need to be more depressed; they dwell more on past failures and less on present discontent; ultimately, more men commit suicide than women. To decide solely on the results of rating tests how to manage patients would be premature and unwise, but this is a line of research that needs extending.

1 Crammer, J. L., British Medical Journal, 1969, 1, 651.
2 Greer, S., and Bagev, C., British Medical Journal, 1971, 1, 310.
5 Birchnell, J., and Alarcon, J., British Journal of Medical Psychology, 1971, 44, 45.

Rabies Diagnosis

A rabies epizootic in foxes is spreading across France, having previously invaded a number of other European countries (Germany, Switzerland, Austria, Denmark, Belgium). It comes at a time when an increasing number of people spend holidays on the Continent, many of them camping, so it is important to bear in mind the existence of the disease.

The revised quarantine arrangements proposed by the Committee of Inquiry on Rabies in their interim report, and largely implemented by Government, should effectively pre-