as only two of the children of the inpatient group grew at even half the expected velocity the growth retardation was considerable and the value for χ^2 was 26.87 (13 D.F., $P < 0.02$). In the outpatient group there was no difference between the observed and expected height velocities (χ^2 3.66, 5 D.F., N.S.).—We are, etc.,

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- 1 Brook, C. G. D., *Archives of Disease in Childhood*, 1971, 46, 182.
- 2 Tanner, J. M., Whitehouse, R. H., and Takaishi, M., *Archives of Disease in Childhood*, 1966, 41, 454, 613.
- 3 Marshall, W. A., *Archives of Disease in Childhood*, 1971, 46, 414.

Death after E.C.T.

SIR,—The use of muscle relaxants and short-acting anaesthetics has diminished the discomfort of electric convulsion therapy (E.C.T.), while its efficacy, especially in severe and suicidal depression, remains unchallenged. Fatalities are rare, but their incidence is uncertain. The risks are obvious in the elderly with cardiovascular or respiratory impairment, but the case here reported, like that of Malik,¹ was that of a comparatively young, physically healthy woman.

The patient a widow of 55 who had responded well to E.C.T. in puerperal depression some years before, was admitted to Springfield Hospital with psychotic depression and was prescribed further E.C.T. Apart from noticeable agitation while she was waiting, her treatment apparently proceeded normally and respiration was re-established. Some 10 minutes later she became pale and pulseless and stopped breathing, and though prompt resuscitative measures restored the heart beat and, soon after, respiration, she never regained consciousness and died two months later. At necropsy the only pathological findings were areas of cortical softening, consistent with a period of anoxia, and the terminal lung infection.

Review of this case raises the following questions: (1) What are the risks of using cardio-toxic drugs with E.C.T.? The patient had been on amitriptyline 50 mg three times a day for five days. (2) Is the usual pre-operative dose of 0.6 mg of atropine adequate? Cropper and Hughes² suggest that 2-3 mg intravenously is necessary to protect the heart from vagal inhibition. (3) What effect does acute anxiety in a situation of helplessness have upon the heart?³ Should pre-operative anxiolytic drugs be given?—I am, etc.,

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- 1 Malik M. O. A., *British Journal of Psychiatry*, 1972, 120, 69.
- 2 Carruthers, M., and Taggart, P., *British Medical Journal*, 1964, 110, 222.
- 3 Carruthers, M., and Taggart, P., *British Medical Journal*, 1973, 3, 384.

Teaching Model for Tracheal Suction

SIR,—We read with interest the letter from Dr. T. H. Howells (27 April, p. 226) regarding an endotracheal intubation trainer. We have been interested in this problem

in regard to training physiotherapy and nursing staff in the technique of tracheal suction as part of the care of the unconscious patient.

It is our experience when teaching tracheal suction techniques that the following three questions are asked: (1) Can I do the patient any harm? (2) Where does the suction catheter go? (3) How far should the suction catheter be inserted? In order to answer these questions we have constructed a teaching model which also provides an opportunity to practise sterile suction techniques.¹

The model (see fig.) is life-size and constructed entirely from transparent plastic.

Though the larynx itself has been simplified and is represented by a box, it is anatomically correct in size, as are the attached trachea, carina, and left and right main bronchi with their upper lobe bronchi. A cuffed endotracheal tube or a cuffed tracheostomy tube are easily passed into the trachea. Suction catheters are clearly visible as they pass through the tracheal tubes and their position in the trachea and main bronchi may be easily seen. The head of the model is mounted on a plastic base and may be rotated for viewing at any angle.—We are, etc.,

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- 1 Hilliar, K. M., and Strunin, L., *Physiotherapy*, 1973, 59, 14.

General-practitioner Deputizing Services

SIR,—Dr. B. T. Williams and Professor J. Knowelden (*Supplement*, 16 February, p. 9) wonder "how acceptable the public finds the treatment it receives from deputizing services."

We published a paper some months ago describing how after-hours medical care was organized in a prepaid group practice in New York City with an enrolled population of three quarters of a million.¹ As we then reported, questionnaires were sent to those subscribers who participated in the after-hours programme during a three-month

period in 1972 in order to determine the level of consumer satisfaction and thus ascertain those areas where improvement was most needed.

We found that there was an 80% satisfaction rate with the services provided. The 20% dissatisfaction was equally distributed among subscribers no matter what form of treatment they had received—house call, telephone advice, or referral to a night treatment centre. On analysing the data further we concluded that if the patient received the type of treatment which he initially requested then he would be much more likely (80%) to express satisfaction with the service rendered, no matter who the physician providing the service or what the service was. On the other hand, if the type of service rendered did not conform to his initial wish then he would be more likely to be dissatisfied (20%), no matter how appropriate or how capable the service rendered.

The logical conclusion of this analysis (in the situation where medical service is rendered by a substitute physician) was that the enrollee should be given that which he asks for if one wishes to have a satisfied subscriber. The obvious conflict which this produces between prescribing physician and consumer-recipient has yet to be resolved.—We are, etc.,

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- 1 Miles, A. I., and Goodman, L. J., *Health Services Reports*, 1973, 88, 868.

Dangerous Drugs: a Warning

SIR,—General practitioners and others should be warned about the possible consequences of the recent introduction of safety precautions at pharmacies with respect to dangerous drugs. I think it is predictable that there will be break-ins into doctors' surgeries for opiates, barbiturates, Mandrax, amphetamines, appetite suppressants, and so on. Doctors should be advised to keep stocks of these at a minimum and to dispose of any unnecessary stock they may be carrying.

As many pharmacies have already installed burglar alarms and safety cupboards it is predictable that these burglaries will soon be beginning.—I am, etc.,

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Death in Hospital

SIR,—We would be interested in the views of other readers about early notification of the death of a patient in hospital.

While we appreciate that all hospital staff are busy, we regard it as essential that a patient's general practitioner should be informed by telephone within 24 hours of a death. This task could be delegated by medical staff provided that the informant is briefed by them. The bereaved relatives often assume that the G.P. has early notification of a death, and embarrassing situations are encountered without this knowledge. Help and explanation are frequently required by the family.

This lack of early communication seems to be shared by a number of district and teaching hospitals. The need for early information