September, p 770). The impossibility of the task of the official lies in his or her need under the Mental Health Act 1983 to perform the task without responsibility.

The Act enjoins on these second opinion doctors the exercise of final power, against which there is *no* appeal, over the decisions of other doctors. They have no subsequent responsibility other than their consciences for the repercussions. If he wishes, the commission's doctor can pronounce *ex cathedra* and simply walk out. The deep intimacy of the doctor-patient relationship which led to the decision to operate may devolve into a new relationship of mutual frustration resulting from the overruling.

In my opinion, the only way the commission's doctor can exercise his or her statutory role responsibly is by accepting that the clinician's decision results from such an intimately developed relationship of mutual understanding as should *never* be overruled unless it is clear to the commission's doctor that the psychiatrist's decision was patently mistaken, unless the error is firmly but tactfully pointed out, and unless the better strategem for the patient (worked out by the two doctors) is then constructively outlined to the patient. This might avoid that desperation leading to suicide to which Minerva alludes.

Indeed, this example is particularly one in which the medical commissioner needed to conceive his or her role in "underwriting" rather than "overruling" terms because the psychiatrist deciding to recommend operation was Dr Paul Bridges, who is probably the psychiatrist in England most experienced in the indications for brain operation. In the case in question he had reached his decision to recommend operation only after immense heart searching and in consultation with Mr John Bartlett, the neurosurgeon. Does the medical commissioner feel, in conscience, the slightest responsibility, one wonders, for the resultant tragedy? Has he or she in any way so rethought his or her attitude as to avoid a further such tragedy?

Parliament should never have enacted the offering of such a flagrant power without responsibility. The ground for it was political not medical. It offered spurious protection to patients but took no sensitive account of how the doctor-patient relationship leads to decision making in psychiatry. The commission's doctors have, therefore, to introduce this sensitivity into their statutory interferences.

SEYMOUR SPENCER

Oxford OX3 7LW

Three weeks on call for the labour ward

SIR,—Dr R N Spencer-Gregson's personal view (6 October, p 916) should have a great impact on all doctors working in the National Health Service. It contains statements of crucial importance to ourselves and our patients. Firstly, we should not allow his unhappy experience to allow us to contemplate a return to former systems in which junior medical staff were expected to work unacceptably long hours. Slave labour is unacceptable no matter if it is performed by the consultant or his juniors.

This sort of problem is, however, a strong argument for changing the administrative system and holding consultant contracts at district level. It is at this level that local problems are understood—for example, it would

have been known to Dr Spencer-Gregson's colleagues that he was being asked to assume an unacceptable burden and that the service would be potentially clinically dangerous. District management teams have three doctors serving on them, and they would realise the gravity of the problem and could attempt to resolve matters.

The district health authority through its officers is responsible for maintaining the quality of care provided, and good care involves good doctoring. An overtired doctor is not acceptable, which is well understood at district level. What a shame that consultants and the British Medical Association so strongly oppose the proposal to have consultants' contracts held by the district.

A final lesson is that it is the duty of all consultants to give adequate notice to their personnel departments of their leave plans. This is by no means always done. It is disturbing that Dr Spencer-Gregson's first appraisal of the problem seems to have happened "a couple of days" after his colleague went on holiday, as even if he had brought the matter to the attention of his district or regional medical officer there would by then have been little they could have done to help him.

MICHAEL C D HEATH

Basildon and Thurrock
Health Authority,
Basildon Hospital,
Basildon, Essex SS16 5NL

SIR,—At long last I find a consultant experiencing the symptoms of a rapidly spreading disease in the NHS which normally only afflicts junior medical staff. This disease is called "chronic constrictive personnel department failure," otherwise known as "the doctor will always cope."

I recently suffered the complaint myself when, as one of two obstetric senior house officers who normally covered the delivery suite, I was made to perform both my colleague's and my own duties over one weekend because she had become unwell earlier in the week. Despite the fact that the personnel department had been told of her absence well in advance of her weekend duties, no locum was found and it was assumed that I would cover her duties without hesitation because it was my duty (despite nothing to that effect being in my contract). The ensuing weekend (including continuing my double cover until 5 pm on the following Monday) led to all the symptoms that Dr Spencer-Gregson experienced and found so distressing. Out of the 56 hours that I was on duty I was up for 40 of them, and by the end of the Monday I felt as if I had a severe case of jet lag.

I recount my experience not as a sob story to outdo others but rather to say that this disease is spreading and that, although it is the doctor who suffers the symptoms, it is the patient who suffers most. A patient may risk serious damage being treated by a doctor (junior or senior) who is far too fatigued to make sensible decisions.

MARTIN BELL

Henleaze, Bristol

SIR,—One cannot but sympathise with Dr R N Spencer-Gregson. One partial solution to the difficulty of finding locums for consultants in peripheral hospitals might be if senior registrars in teaching hospitals were freed by their departments so that they might fill these

vacancies. There are often times in teaching hospitals when there are more than enough junior staff to fulfil the service commitments. Perhaps also so called "time expired" senior registrars could be deployed by the region to fill such posts until they find a permanent consultant post.

NICHOLAS HOLLIS

Melton Mowbray,
Leics LE13 0QY

SIR,—There is a need to recognise that doctors have responsibilities to home and family as well as to patients. Many marry and have children just after qualification. In the early years of a relationship unrealistic work stresses lead to maladaptive patterns of relating and coping styles. Instead of the relationship being supportive it may become yet another drain.

The real issue which must be grasped by doctors is that few people, if they are honest, like working nights and weekends in addition to the standard working day. There are a number of practical alternatives to the present arrangements. I sense that before these can be seriously considered the problem needs to be stripped of all the psychological rationalisation that surrounds it. When this happens it will be to the benefit of patients, doctors' families, and doctors' mortality from self destructive activity.

ANDREW MACAULAY

St George's Hospital,
London SW17 0QT

Effects of treatment for hypertension on cerebral haemorrhage and infarction

SIR,—Dr D G Black and others are to be congratulated on undertaking an analysis of the types of stroke based on present day modes of investigation (21 July, p 156). Unfortunately they then proceed to use these data to draw conclusions about the effect of antihypertensive treatment on the causes of stroke. For instance, they state that antihypertensive treatment has failed to reduce the frequency of stroke on an atheromatous basis. Without knowing what the frequency of atheromatous stroke would be in the population without treatment there is no way that they can arrive at their conclusion.

Moreover, we mention in passing that the two references that they used to state that antihypertensive treatment has not reduced the frequency of ischaemic heart disease cannot be used to arrive at such a conclusion. The sample size of the Veterans Administration study on hypertensive agents was too small to address the question,¹ and the Breckenridge study,² although it has its prospective components, also suffers in the lack of a control group.

The study of Dr Black and others falls into the category of a "trohoc" analysis—that is, a flawed type of cohort study, where the cohort is defined retrospectively by case identification.³ As well as the grave disadvantage of selection bias inherent in a retrospective study the temporal relation between cause and effect cannot be established with certainty; neither can the risk factor state of patients be accurately determined after the fact. In the present case many non-random selection processes could have intervened before admission and diagnosis, disturbing the statistical relation between hypertensive state and the type of stroke. For example, one cannot exclude the possibility that haemorrhagic stroke increased the probability of being classified into the untreated hypertension category rather than vice versa. Moreover, the accuracy in identification and quantification of hypertensive state is highly questionable. Systematic bias would be hard to eliminate: it seems more

likely that more subjects with unidentified hypertension would tend to be classified as normotensive than the reverse, tending to inflate the normotensive group at the expense of the untreated hypertension group.

Given all these uncertainties little can be concluded—for reasons which Dr Black and others may well understand but to which little lip service is paid. They acknowledge uncertainty in the prospective categorisation of stroke by reserving an “unknown” category but apparently are confident that retrospectively they have been able to identify patients’ blood pressure state (normotensive, treated, or untreated hypertensive) with accuracy and without bias. (Even prospectively, how much risk to assign to a known blood pressure measurement and how to measure the adequacy of treatment are difficult questions.)

One further criticism is that having determined that there was an excess of cases of haemorrhage and a deficit of cases of infarction in the “untreated hypertension” group the finding of the converse in the “treated hypertension” group is not unexpected on the basis of chance alone given the limited number of degrees of freedom remaining—and as such carries no additional information.

For these several reasons it is wrong to make any conjectures at all about the incidence of cerebral infarction in the treatment of hypertension. Such a question could only be settled prospectively—optimally by a randomised controlled trial including both normotensives and hypertensives. Modern methods of clinical examination such as computed tomography must be matched with modern design to answer the questions which the authors address to themselves.

JOHN D ABERNETHY
HERBERT G LANGFORD

University of Mississippi
Medical Centre,
Jackson, Mississippi 39216,
USA

- 1 Veterans Administration Study on Hypertensive Agents. Effect of treatment on morbidity and mortality: results in patients with diastolic blood pressure averaging 115 through 129 mm Hg. *JAMA* 1967;202:1028-34.
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- 3 Feinstein AR. Clinical biostatistics—XX. The epidemiological triad, the ablative risk ratio, and “retrospective” research. *Clin Pharmacol Ther* 1973; 14:291-307.

*. *Dr Black and others reply to this and other letters below.—ED, BMJ.

SIR,—As we emphasised, our study was hospital and not community based. Although the study was a prospective one, blood pressure classification was of necessity retrospective unless patients were known to have been receiving antihypertensive treatment before hospital admission.

Dr D H Barer and Professor J R A Mitchell (1 September, p 560) comment that our patients were “atypical and unrepresentative” compared to those reported in studies from Minnesota¹ and Oxford.² Indeed, it would be surprising if patients admitted to hospital in Leicester were typical of quite different populations. It would be equally surprising if, as Dr Barer and Professor Mitchell imply, their unpublished hospital based study could be extrapolated to the population at large. We pointed out that a hospital study would inevitably select out more severe disease. The patients with hypertension were not defined merely on blood pressures at the time of admission: blood pressure was monitored throughout the stay in hospital and evidence

of other target organ damage was sought. We were all aware of the acute effect of a cerebrovascular accident on blood pressure. As we pointed out in our paper, misclassification of some patients may have occurred, but it is difficult to see how it could have introduced a systematic error into our conclusions.

We agree that classification of individuals into hypertensive and normotensive is arbitrary, but it is also a regrettable necessity. Dr Peter Sandercock and others (6 October, p 920) present interesting data apparently in conflict with ours, but it is, as they emphasise, a community based study; even so blood pressure data before stroke were available in only 75% of their sample. Moreover, their definition of hypertension (160/90 mm Hg) (which differs from that employed by the World Health Organisation) is not the same as ours, and one third of the patients were seen later than one week from the onset of their strokes: small cerebral haemorrhages become increasingly difficult to detect on computed tomography as the delay in testing lengthens. Cerebral haemorrhage, as Dr Sandercock and others state, was increased in the untreated hypertensive group, although not attaining statistical significance: the very small numbers of patients with cerebral haemorrhage in their study make further conclusions impossible.

Professor Abernethy and Professor Langford conclude by advocating a prospective study of this area using a “randomised controlled trial including both normotensives and hypertensives.” Such a trial would, however, clearly be unethical including as it surely must a group of untreated hypertensive patients. The results of our study indicate a high incidence of cerebral haemorrhage in our patients with strokes with untreated hypertension, a finding recently confirmed.³ Not all patients who sustain strokes survive long enough to reach a hospital, and not all patients need admission to hospital. Our study reflects only those patients who survive and require admission to hospital. We certainly would not claim that our data throw light on the prevalence of cerebral infarction in relation to the treatment of hypertension. Nevertheless, hypertension and antihypertensive treatment seem to have profound effects on the types of stroke seen in our hospital, and one explanation would appear to be a selective benefit from treatment on the incidence of cerebral haemorrhage.

D G BLACK
A M HEAGERTY
R F BING
H THURSTON
J D SWALES

Department of Medicine,
Clinical Sciences Building,
Leicester Royal Infirmary,
Leicester LE2 7LX

- 1 Garraway WM, Whisnant JP, Furlan AJ, et al. The declining incidence of stroke. *N Engl J Med* 1979; 300:449-52.
- 2 Oxfordshire Community Stroke Project. Incidence of stroke in Oxfordshire. *Br Med J* 1983;287:713-7.
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Advertising alcohol: does the Advertising Standards Authority exercise any control?

SIR,—The Advertising Standards Authority was created as a watchdog from within the advertising industry. One of its functions is to monitor advertising for alcoholic beverages

and to ensure among other things, to quote its own regulations: “Advertisements should not give the general impression of being inducements to prefer a drink because of its higher alcohol content or intoxicating effect.” This statement is followed by: “Factual information for the guidance of drinkers about such strength may, however, be included.”

I recently referred an advertisement to the authority which included the statement: “This makes [the product—Kaltenberg Diät Pils] a little stronger than most other Pils and a lot stronger than most other beers.” Although this would appear to be a clear contradiction of the authority’s own rules, it was considered that the complaint did not break the code. The authority said that the statement was “acceptable as product information.” It referred me to the statement I quoted at the beginning of this letter and to a section of the code which says: “The industry believes that it is proper for advertisements for alcoholic drinks . . . to provide information on products.”

As it is generally accepted within the advertising industry that advertising campaigns are an important factor in the increase of sales of alcoholic beverages, should doctors not join the growing number of consumer groups which are sceptical of the usefulness of an advertising watchdog which appears to be unwilling to bite the hand that feeds it.

Surely if a government seriously wants to exert restraint on the advertising of alcohol it should set up a properly independent authority to monitor this and other advertising.

T WEBB

West Suffolk Hospital,
Bury St Edmunds,
Suffolk IP33 2QZ

Chlamydial perihepatitis (Curtis-Fitz-Hugh syndrome) after hydrotubation

SIR,—Mr Jay N L Simson (1 September, p 544) highlights some of the problems associated with interpreting the consequences of infection with *Chlamydia trachomatis*, but there are four dubious claims in his article.

Firstly, the patient does not fulfil the criteria for the Curtis-Fitz-Hugh syndrome. Secondly, definitive diagnosis of chlamydial infection cannot be based on serology alone. Thirdly, the use of oral tetracyclines may have had nothing to do with the change in symptomatology, and, lastly, the incidence figures quoted are not from England and Wales but from Sweden.

The Curtis-Fitz-Hugh syndrome is an anterior perihepatitis in association with a genitourinary tract infection. No data were given to show that the patient had an active genitourinary tract infection at the time of hydrotubation, and, furthermore, subsequent laparotomy showed no perihepatic adhesions or inflammation. In the acute phase the anterior liver capsule should be inflamed,¹ and in a chronic form (as suggested by the episode in 1978) “violin string” adhesions should be present.^{2,3}

Chlamydial antibody detection by the micro-immunofluorescence test is well proved, and if high titres of IgG are found acts as an indicator to the probable presence of an active chlamydial infection but does not provide a definitive diagnosis.⁴ The patient was known to have chlamydial cervicitis in 1981 which was untreated, and if this progressed to salpingitis it could account for the serological results.

Even presuming that the serological results