view this represents a complete muddle on their part about their true function and duties under the 1959 Mental Health Act.

All my professional life I have taken the view that I must be convinced by the doctors proposing compulsory admission before I will deprive a person of his civil liberties. If a doctor cannot take the time to convince me, or recognise that occasionally I may disagree, then he cannot expect my co-operation—because if a patient sues for negligence or wrongful admission the applicant is sued and not the doctor.

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SIR,—Sorrow and anger are evident in the paper on multidisciplinary teams written by Drs James Appleyard and J G Maden (17 November, p 1305) and further echoed in your leading article (p 1245) headed "Who carries the can?" It is true that many doctors feel frustrated and even outraged at the behaviour of colleagues in other disciplines. Interestingly enough, they sometimes feel the same about us. Indeed, multidisciplinary teams were evolved in order to improve communication and decision making, because it was recognised that clinical care might be threatened by inter-disciplinary misunderstanding and hostility. What Drs Appleyard and Maden are most concerned about seems to be leadership and accountability. But their argument, and yours, is one sided and shows no awareness of an extensive experience and literature on such matters.¹⁻⁵

May I make the following suggestions? (1) We as a profession should recognise that no one these days will accept medical autocracy. (2) The multidisciplinary team can be made to work appropriately if basic principles and practices are understood. (3) Leadership is made difficult and complex by a thoroughly democratic structure, but, by the same token, is rendered all the more necessary. (4) Doctors may have to "earn" their leadership status anew.

I really must also challenge the writers' statement, "It is impossible for a team to carry out any form of treatment or social work with an individual patient." In psychiatric practice this is a nonsense and ignores the imaginative and successful use of multidisciplinary teams in psychiatric hospitals and clinics all over the world.

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¹ Jones, M, *Beyond the Therapeutic Community*. New Haven, Yale University Press, 1968.

² Cumming, J, and Cumming, E, *Ego and Milieu*. New York, Atherton Press, 1962.

³ Clark, D H, *Administrative Therapy*. London, Tavistock Publications, 1964.

⁴ Morrice, J K W, in *Therapeutic Communities: Reflections and Progress*, ed R D Hinshelwood and N Manning. London, Routledge and Kegan Paul, 1979.

⁵ Miller, E J (editor), *Task and Organisation*. London, Wiley, 1976.

"Wednesday's Child"

SIR,—In his note on *Wednesday's Child* produced by the BBC's special features unit and shown on BBC2 on 1 November, Dr B M Laurance (10 November, p 1215) states, "This play should not have been shown to the public in this form. The play, which was essentially about problems of communication, could have

been just as convincing if the child had been damaged as a result of an accident in the road or at home."

While fully appreciating Dr Laurance's underlying concern about alarming parents whose child is about to have an anaesthetic, this programme was dealing specifically with communication surrounding a case of negligence. Only by inference did it deal with the broader issue of communication between the profession and the public. Thus if we were to make the transference Dr Laurance suggested and use an accident case instead, the issue of communication (or rather lack of it) would still involve a practitioner from one medical discipline or another. Then, no doubt, people could express the same concern about creating public alarm as Dr Laurance has with the case of anaesthesia shown in *Wednesday's Child*.

Would that there were a certain way of avoiding unnecessary alarm when raising contentious but important issues; but I fear that there is not.

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Placement of subnormal offenders

SIR,—Ten years ago most large hospitals for mental handicap accepted cases from the courts and prisons, usually under Section 60 of the Mental Health Act 1959. Since then there has been a noticeable and steady decline in the referral and the admission of this group of patients. This reflects an increasingly difficult and unsatisfactory state of affairs in the hospital placement of people with intelligent quotients in the 50-70 range.

The pressure to discharge the more able patients from hospitals for mental handicap, the tendency to admit only the severely mentally handicapped, and the well-intentioned recommendations to make the hospitals more home-like have all conspired to render the hospital for mental handicap more and more unsuitable for the subnormal offender. Nursing staff in the hospitals now tend to look askance at any proposal to admit a seriously disturbed or dangerous patient. Many subnormal offenders are confined in prison, which is generally agreed to be undesirable. They are out of place in the mental handicap hospital; they are not serious enough cases for special hospitals; and, because of their IQ, they are unwanted in the mental illness units.

Paragraph 7 of the memorandum on Parts I, IV-VIII, and IX of the Mental Health Act 1959 (published by HMSO in 1960) states that patients classified as subnormal, as distinct from severely subnormal, are intellectually dull; but their main trouble is often emotional instability. Many of them need psychiatric treatment as well as training; and it may be more suitable in some areas to accommodate them, when circumstances permit, in units associated with hospitals for medium-stay mentally ill patients, or in entirely separate units, than in the same hospitals as severely subnormal patients.

Formerly the usual practice for the prison medical officer faced with a prisoner who was apparently mentally handicapped was to refer the case to the regional health authority, which asked an appropriate consultant to see the man and arrange admission. Today there appears to be a tendency for solicitors to go "shopping around" various specialists to

obtain the report they find most favourable to their clients. This gathering of numerous reports may be a questionable use of legal aid.

If mentally handicapped offenders are to be taken out of prison and if more are to be discharged from—or not sent to—the Special Hospitals, the only solution would appear to be the provision of some special form of secure unit for these patients on a regional or area, if not a district, basis, where expertise in treatment and research could be concentrated.

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Muslims, Ramadan, and diabetes mellitus

SIR,—I was interested to read the letters by Dr S G Barber and others, (7 July, p 46) and by Dr R N Ebbing, (4 August, p 333) on Muslims, Ramadan, and diabetes mellitus.

In Qatar we have approximately 1000 patients attending the diabetic clinic, about 800 of whom are Muslims. As is customary, most do not attend the clinic during the month of Ramadan and it is difficult to judge the effect of fasting on diabetic control. Usually 300-400 patients are seen monthly but during Ramadan this year (Hajera year 1399) 164 attended, of whom only 95 were Muslims, and of these 81 were fasting. Twelve of these fasting patients were having insulin and the random blood glucose in three of these patients had fallen by 3 mmol/l (54 mg/100 ml) compared with previous attendances and in five patients it had risen by 5 mmol/l. One patient continued his usual dose of insulin and fasted alternate days and his blood glucose rose from 8 to 13 mmol/l (from 144 to 234 mg/100 ml), while another patient took his insulin on alternate days and his blood glucose, which over the last three years had averaged 10 mmol/l (180 mg/100 ml), fell to 3 mmol/l (54 mg/100 ml) during Ramadan. Two further patients had stopped insulin completely and were found to have random blood glucose concentrations of 20 mmol/l (360 mg/100 ml); both declined to have insulin or other treatment. Most patients on twice-daily insulin took their insulin before breaking their fast in the evening and in the early morning. Those on a once-daily injection took it before breaking their fast in the evening.

Of the 56 patients on oral therapy who were fasting, random blood glucose was 3-5 mmol/l (54-90 mg/100 ml) higher in 13, 3 mmol/l (54 mg/100 ml) less in 15, and unchanged in 28. Of those patients on diet, the blood glucose was higher in six and unchanged in seven. No patient was admitted to hospital during Ramadan or in the following month in either diabetic ketoacidosis or hypoglycaemic coma. As stated by Dr Barber, the poor quality of control in many patients is little affected by the fasting. The safety of fasting with or without modification of insulin and oral therapy is difficult to assess, but during 10 years I have seen only one patient admitted during Ramadan where fasting could be said to be the cause of admission. This patient, a young insulin-dependent policeman, was admitted in severe hypoglycaemic coma. He had had his usual dose of insulin but as he was on duty in public he was unable to have his mid-morning snack.

No patients were noted to have lost any weight during or after Ramadan but this is not surprising as the extra amount of food consumed is considerable. Qatar, with a total population of about 200 000 (including non-Qataris), imported 300 000 kilos of chilled beef and 45 000 live sheep in addition to the 15 000 sheep normally imported per month.¹ The fast is broken at sunset by drinking water and eating dates in varying quantities; large amounts of "halwa" sweets of various types are eaten in larger quantities than usual. The working time during the fasting hours is shortened and many spend the hours from midday until

sunset resting or sleeping, so that energy expenditure is a lot less than normal.

Fortunately pregnant diabetics are usually quite willing not to fast, so their control is not affected during Ramadan. Many patients ask to be allowed to stop their insulin, and where this is not allowed it is difficult to be sure whether the patient is obeying instructions or not.

I think that it may in theory be dangerous to fast during Ramadan but in practice the patients seldom seem to get into any trouble.

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Mycoplasma pneumoniae infection and neurological complications

SIR,—The case reports of Drs J Aidan Twomey and M L E Espir (6 October, p 832), and Dr A B Jones (3 November, p 1144) prompt me to bring to your attention a survey carried out in this laboratory to investigate the association between *Mycoplasma pneumoniae* infection and neurological disease.

We tested sera from 800 patients, presenting with a wide variety of neurological syndromes, for complement-fixing antibodies to *M. pneumoniae*. Three patients had rising titres and a further 14 had high (≥ 256) static titres suggesting a current or recent infection with the organism. Of these 17 patients (2.1% of the total), 13 were 14 years or younger, and the remaining four were 17, 23, 42, and 49 years old. Six of these patients had meningism; in one case echovirus type 6 was isolated from the faeces and in another there was a measles complement-fixing antibody titre of 256. Four of the 17 patients had aseptic meningitis (one with echovirus type 4 isolated from the faeces) and two others possible aseptic meningitis. The table relates the cases by year of illness to the total cases of *M. pneumoniae* serologically diagnosed in this laboratory.

The percentage of *M. pneumoniae* infections associated with neurological disease is small (6.7% of the total) and is a constant fraction of the total for each year except in 1973, when we diagnosed only 22 cases. Because only 2.1% of the 800 "neurological" patients showed evidence of infection, it appears unlikely that *M. pneumoniae* contributes significantly to the causation of serious neurological disease; in three of our patients there was also evidence of current or recent infection with potentially neurotropic viruses.

An aetiological association with minor neurological illness remains to be proved. Seven of our 17 patients had meningism, for which the causes in children are numerous, and it is not necessary for the organism to infect the central nervous system directly to cause it. In the 10 cases of actual or possible aseptic meningitis causation cannot be proved,

but attempts to isolate the organism from CSF would help to resolve the difficulties of interpreting these serological findings. In any case it appears that if *M. pneumoniae* does affect the CNS it does so infrequently and in our experience is associated only with mild disease.

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SIR,—We wish to add a further case report of neurological complications of mycoplasma infection to those already reported in your columns (6 October, p 832; 3 November, p 1144).

The patient was aged 16 when she presented in February 1977. In December 1976 she had developed a sore throat with swollen lymph nodes in the neck. She was treated with a short course of ampicillin, with complete resolution of her symptoms. In mid-January her symptoms recurred and again resolved with a short course of ampicillin. Her illness responded within 72 hours. In early February she complained of headache and neck stiffness and over a few hours developed nausea and photophobia and became irritable. At this time she was given a course of septrin. Two days later she complained of a "funny sensation" in her right arm and leg and had a grand mal seizure with a focal right-sided onset. Because of this she was admitted to a peripheral hospital, where she was found to be irritable with neck stiffness and a positive Kernig's sign. The cerebrospinal fluid examined at that time was reported as normal. During the following 48 hours she had further grand mal seizures and became comatose. She was subsequently transferred to the neurology unit. At that time (18 days from the onset of her illness) she was comatose, responding non-purposely to painful stimuli. Horizontal nystagmus was present on central gaze with intermittent opsoclonus. The brainstem reflexes were preserved. She was hypersalivating and showed forced trismus. Tone was symmetrically decreased and the plantar responses were extensor.

Treatment was started with epanutin 300 mg daily and prednisone 120 mg daily. The only abnormal finding at that time was the presence of symmetrical delta activity on the electroencephalogram. A lumbar puncture on day 20 of her illness showed 12 lymphocytes with normal sugar and protein concentrations. Over the next 21 days she slowly recovered. She had no recollection whatsoever of her illness. A repeat lumbar puncture on day 37 showed protein of 0.64 g/l, 1 lymphocyte, and normal sugar. The EEG returned to normal apart from the presence of moderate bilateral theta and delta components, most marked posteriorly. Titres of complement-fixing antibodies to *Mycoplasma pneumoniae* were (for blood): day 20—1/20; day 37—1/160; December 1977—1/160; June 1978—1/160; December 1978—1/80; (for CSF): day 37—1/20; December 1977—1/20.

Over the two and a half years since she was discharged from hospital, the patient has continued to have grand mal seizures. These were frequent in the first 18 months, but in the past year reasonable control has been obtained with a combination of valproate and carbamazepine. Recent computed

tomography scans have been normal. Within a month of her discharge from hospital, however, it was apparent that she had sustained major intellectual impairment. Ten months after her illness her verbal IQ (89) was still only within the dull normal range, even though she had passed five O levels, including English literature and language. Wide variations in subtest results were seen, low scores being noted on general knowledge, attention span, and mental arithmetic. The subtest scores for reasoning and vocabulary were within the normal range. The performance IQ (99) was found to be average, though this was considered low given that she had been receiving a sixth-form education. Again variations in subtest scores were noted, relatively poor results being found in relation to speed of visual perceptual-motor functioning and visual associative reasoning. Although the patient did not display short-term memory deficits she experienced great difficulty when attempting to learn new material. Her incidental retention of material from short-term memory was similarly extremely poor. The Halstead-Reitan neuropsychological test battery provided evidence of widespread cortical dysfunction, with moderate abnormalities noted bilaterally in the posterior cortical areas. No dysphasic symptoms were encountered. Repeat neuropsychological investigations 24 months after her illness showed no significant or consistent improvements.

In this patient the persistent intellectual difficulties and postencephalitic epilepsy contrast with the favourable outcome of neurological damage resulting from mycoplasmic infection previously reported in the *BMJ* and elsewhere.^{1,2}

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¹ Taylor, M J, et al, *Journal of the American Medical Association*, 1967, **199**, 149.

² Jachuck, S J, et al, *Postgraduate Medical Journal*, 1975, **51**, 475.

Stress and premature labour

SIR,—I would like through your columns to answer the questions raised by Drs Judith Lumley and Robin Bell (10 November, p 1222) about our paper (18 August, p 411).

We are well aware of the difficulties involved in gestational assessment and we drew evidence from a variety of sources, considering the uterine size on booking, subsequent biparietal diameter on ultrasound scans, bone age, and assessment after delivery before allocating the baby to a particular study group. We demonstrated a continuous trend through three study groups (not merely a difference between two groups), linking prematurity with higher levels of maternal stress. It is unlikely that an error in assessment of a week either way would interfere with this trend.

About 25 women at term were excluded as their labour was induced. In the preterm groups we excluded four women who were sporting Shirodkar sutures, three with multiple pregnancies, and three Asian ladies from Manchester who spoke no English. No other woman in the preterm group had an obvious "obstetric" cause for premature labour and there seems to be little scope here for a control group as suggested by Drs Lumley and Bell. Besides, we were relating levels of stress to duration of pregnancy and a control group of mothers with "obstetric" causes for preterm labour would be quite inappropriate to this question.

***M. pneumoniae* infection and neurological disease 1970-4**

Year	No of "neurological" cases tested	No (%) positive	Total No of <i>M. pneumoniae</i> cases diagnosed	% positive neurological cases out of total diagnosed
1970 (Oct-Dec)	32	2 (6.3)	33	6
1971	216	7 (3.2)	98	7
1972	216	3 (1.4)	40	7.5
1973	214	0	22	0
1974	122	5 (4.1)	62	8
Total	800	17 (2.1)	255	6.7

"Positive" and "diagnosed" = fourfold or greater antibody rise or high titres (≥ 256).