Council in 1975). It is equally simplistic to suggest that voluntary organisations could be given seats on district health authorities; they would surely run very quickly into identity problems—would they be the managers of the full range of services, or champions of their own client group's interests (a legitimate role for them on community health councils)?

Professor Klein's remarks on the monitoring of services and the alternative options open ignores completely the role of community health councils in influencing positively and progressively the development of local health services. The long-term influence of the community health council through the planning process and otherwise on the type and emphasis of evolving health services is surely its most important function. Yet Professor Klein talks loosely of an inspectorate and of community health councils as if the two were interchangeable, whereas the two functions have practically nothing in common.

To be positive, Professor Klein does acknowledge that the direct cost of community health councils is trivial as a proportion of total NHS expenditure. Not only is it trivial, but it is money which stimulates many times its worth in voluntary effort, both deliberative and practical, in support of the NHS. During the last five years community health councils have provided a users' commentary on services which has been of value to management, and that they have acted as a spring-board for new voluntary activity in many localities is well documented.

"Patients first" without community health councils does not offer the key to balancing central control and local responsiveness. Both organisationally and financially the pressure will be for district health authorities to cover large populations, in many instances the same as the areas of today. And with fewer members, less non-NHS representation, and the job of management to do it is idle to pretend that the district health authorities can or will effectively "represent the interests of the users of the service."

There is still a need for community health councils.

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SIR,—Professor Rudolf Klein (9 February, p 420) contemplates abolition of community health councils in favour of a proposal "which should, surely, be eagerly seized on and welcomed" for monitoring services at district level—that is, by an advisory group of experienced NHS officers who would report to the district health authorities, professionals, including economists, reporting to professionals; the model exists in the Health Advisory Service.

The NHS has seen two expensive adventures in the last 30 years: the construction of massive district general hospitals, which the DHSS admits it would not build again, and now reorganisation of the 1974 reorganisation. These decisions have not been costed but a modest estimate could be thousands of millions of pounds. Reorganisation in 1974 was recommended by Professor Klein's professionals—that is, senior medical, nursing and administrative staff, aided by management consultants.

The consultative document *Patients First* is not supporting its own doctrine when it questions the need for community health councils; were not these established not only

to provide community representation but also to allow patients to seek information on the use of the service? A good working relationship between officers of community health councils and the NHS can provide awareness of its limitations yet be constructive in approach and able to dispel public ignorance of what is and what is not possible with limited resources.

Health Advisory Service officers arrive from afar and have not the intimate knowledge of local problems, often seemingly trivial but none the less vital to the public (car parking at our local district general hospital is a current one) and which cannot always be known to them, as is possible with day-to-day public contact with community health councils.

It is not only district health authorities who will be responsible for health care problems. Local authorities are increasingly concerned with community care concepts and community health councils provide an independent yet co-operative link both with health authorities and with voluntary organisations generally. Community health councils are acknowledged by Professor Klein as trivial. Can the "public voice" caution against "eagerly seized" enthusiasms, past and present?

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Phenobarbitone and epilepsy

SIR,—I would like to support in the strongest possible terms, the letter from Dr Alan Richens and Dr Jolyon Oxley (16 February, p 482) concerning the proposed legislation on disubstituted barbiturates.

While I agree that the widespread use of phenobarbitone in epilepsy has been superseded by more modern antiepileptic drugs, there are still an appreciable number of patients with epilepsy who are well controlled without side effects by phenobarbitone, and in whom attempts to reduce or remove phenobarbitone lead to breakdown in the control of the epilepsy. Once this breakdown has occurred it can be difficult to regain control. I think this is particularly true in the more severe epilepsies such as one sees at a special centre. I have had considerable difficulty in some patients in withdrawing phenobarbitone for a number of reasons, both here at the David Lewis Centre and also in outpatient practice at the university departments of neurology in Manchester. I think that there is a very real danger to certain patients with epilepsy if phenobarbitone is included in the Misuse of Drugs Act, for the reasons given by Drs Richens and Oxley.

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Plasma concentrations of paracetamol

SIR,—Recently we have received inquiries from hospital departments of clinical chemistry about the need to provide, at short notice and throughout the 24 hours, facilities to measure plasma levels of paracetamol. In the recent letters in your columns by Dr J A Vale and others (1 December, p 1435) and by Dr L F Prescott and others (5 January, p 46) about the mode of treatment for this type of poisoning this question has been overlooked.

From our point of view clinicians seem to be

divided into three camps in their attitude to the treatment of paracetamol overdose. There are (i) those who turn immediately to oral methionine and are content with this so long as the patient does not vomit; (ii) those who regard intravenous *N*-acetylcysteine as the treatment of choice; and (iii) those who have not yet made up their minds but are considering ease of administration, therapeutic efficacy, and economy.

In a hospital where the first of these policies is adopted there is no need for an emergency laboratory service to estimate plasma paracetamol concentrations. Provided that no more than 10 hours have elapsed since ingestion, there is confidence that even in patients who present with very high levels the oral antidote will be effective. On the other hand, if the overdose is not in this dangerous category, no harm will be done by the methionine and a negligible sum of money will be wasted in unnecessary treatment.

In cases where vomiting is troublesome, the physician may well turn to *N*-acetylcysteine without waiting for a plasma paracetamol assay. However, the course of the infusion extends in total over 20 hours and the cost is by no means insignificant. A plasma paracetamol measurement obtained as soon as possible could therefore indicate whether this intravenous therapy needs to be continued for a full course. The same reasoning applies in hospitals where there is a forthright preference for intravenous *N*-acetylcysteine.

When clinical indecision prevails, this will not in itself be resolved by turning to the laboratory in the first place and so losing valuable time. It is suggested, therefore, that in such circumstances the physicians discuss the problem with those in charge of the clinical chemistry department to settle on course of action (i) or (ii) and so have the plasma assay facilities organised accordingly. Alternatively, it would seem reasonable to administer methionine immediately in the knowledge that it is an effective treatment, while allowing time for the laboratory to measure the blood paracetamol concentrations. At this stage the physician will have the fullest possible indication of the potential risk to his patient without having delayed treatment. He can then, bearing in mind such factors as cost, convenience, and the lack of overwhelming evidence in favour of either treatment, decide on his course of action.

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SIR,—Dr L F Prescott and his colleagues (5 January, p 46) quite reasonably question the low incidence of vomiting (16%) reported to the National Poisons Information Service as the result of telephone inquiries. We are aware that such reporting may well be biased in several ways and in particular that the information on the presenting symptoms may not be complete. For this reason we formed a group to undertake a prospective survey of the presentation and management of all cases of analgesic poisoning admitted to our several hospitals. The information on each case was collected on a standard questionnaire, which was in turn sent to the National Poisons Information Service for checking and processing by computer. That study is now completed and we are in the process of writing a full report, which we hope to publish later.