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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Morale in mental handicap hospitals

SIR,—Hospitals for mental handicap are often criticised for the low morale of their staff. What is surprising is that morale in these hospitals is often as high as it is, having regard to the intractable problems and the constraints of staff and facilities they endure. If morale is poor it reflects a growing mistrust shared by staff in hospitals for mental handicap.

Firstly, there is mistrust of the Department of Health and its special groups for mental handicap. Staff feel that while lip-service is paid to the work done by nurses, doctors, and other staff in these hospitals there is a conspiracy to achieve their eventual dissolution, the demise of the registered nurse of the mentally subnormal and of the specialist in mental handicap, without any alternative system of care of proved value being developed other than a nebulous community care.

Secondly, non-statutory and voluntary bodies representing mental health and mental handicap are mistrusted for their apparently deliberately provocative and even abusive antihospital propaganda. Paradoxically, parents and pressure groups had relatively far more to complain about legitimately years ago when hospitals for mental handicap were more crowded and impoverished than they are today.

Thirdly, the reorganised management structure of the NHS has not obviously helped hospitals for mental handicap. Decisions, when made at all, are more remote than before and are made, without reference to the staff and patients affected, by officers with little or no understanding or knowledge of mentally handicapped people or sympathetic

awareness of the histories of hospitals and what their staff have done over the years. Planning teams behind the scenes are mistrusted as plotting teams.

Fourthly, there is mistrust of reports by the media, usually critical of hospitals which can do no right. Hospitals are accused of "locking people away" and of "unloading them on the community." Patients who work are "exploited," if not they are "vegetating." Non-statutory facilities are invariably portrayed as doing so much more for the mentally handicapped than hospitals, but it is rarely pointed out that such agencies are highly selective and the mentally handicapped people they reject find their way to hospitals.

Fifthly, staff who have for years struggled to do their utmost for mentally handicapped patients with limited resources but who felt that they enjoyed understanding and gratitude for their work from patients, relatives, and public now find themselves turned against, denigrated, and virtually told that they are no good at what they do and that they should not be doing it anyway. Even if hospitals are inadequate, staff have been willing to make the best of them if they have had the respect and support for what they do from management, relatives, and public and if there was chance of gradual improvement.

Sixthly, reports of scandals intended to stir the public conscience have done more harm than good to morale when they have been manipulated to backfire on staff.

Seventhly, there is mistrust of provision by the social services for the mentally handicapped. This may be planned and operated with little reference to the Health Service until a mentally handicapped

person presents a problem or becomes unacceptable to the social services; then hospital admission is expected.

Eighty, there has come, unfortunately, a mistrust of visiting volunteers and students in hospitals for mental handicap since some have infiltrated in a "kibitzer" role.

Ninthly, hospitals for the mentally handicapped have an increasing proportion of profoundly handicapped patients whose occupation presents an enormous challenge and whose chances of living an independent life in the community are negligible. Staff coping with such patients mistrust the idealism of armchair theorists.

Tenthly, there is mistrust of official statements, memoranda, and White Papers which present an ideal of which staff in hospitals for the mentally handicapped are well aware but which are not supported by the resources to achieve it.

If the higher echelons of the Health Service do not recognise mistrust in hospitals they are failing in their job, as they are if they are aware of it but do nothing about it. If morale is poor patients, their relatives, and staff suffer. It is ironic that the mistrust which lowers morale has arisen from well-intentioned but misguided attempts to help the mentally handicapped.

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Active management of labour: care of the fetus

SIR,—In their article on active management of labour and care of the fetus, Professor K O'Driscoll and his colleagues (3 December, p 1451) draw attention to their low rate of

induction of labour (8.7%) and to their low incidence of caesarean section (3.8%). Of equal importance is that, in addition to one perinatal death from meconium aspiration at 41 weeks, they record five late fetal deaths before the onset of labour. Details of these deaths are not presented, but it seems likely that they may represent the stillbirths associated with late placental failure which are potentially preventable by timely induction of labour.^{1,2} In our own experience we have found that an active induction policy reduced late fetal deaths to below one per thousand (5 February, p 347).

The central point of the paper from Professor O'Driscoll and his colleagues is that meconium staining is an almost constant feature of cases in which the fetus died during labour or suffered cerebral dysfunction after birth, a finding previously demonstrated by Walker in 1954.² They claim a low incidence of fetal distress, but this seems scarcely justified in the face of a 10% incidence of meconium-stained or absent liquor in labour. In a randomised prospective trial³ we found, in patients managed expectantly until 41+ weeks, that the incidence of meconium staining was 11% as compared with only 1% in those women induced electively at or about term. It seems likely that the Dublin workers might have achieved fewer perinatal deaths and less meconium staining by a more active induction policy. Their paper highlights the obstetricians' dilemma of whether to accept a relatively high incidence of obstetric intervention or face the consequences of untreated late placental failure.

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¹ Racker, D, Burgess, G H, and Manly, G, *Lancet*, 1953, 2, 953.

² Walker, J, *Journal of Obstetrics and Gynaecology of the British Empire*, 1954, 61, 162.

³ Cole, R A, Howie, P W, and Macnaughton, M C, *Lancet*, 1975, 1, 767.

Post-pill amenorrhoea

SIR,—Our experience leads us to support Professor R P Shearman's view (26 November, p 1414) that oral contraceptives may be responsible for secondary amenorrhoea. He drew attention to the report¹ that 20 of 25 patients with definite evidence of a pituitary adenoma gave a previous history of oral contraception and we have observed a relatively high incidence of hyperprolactinaemia in patients with ovulatory dysfunction after stopping oral contraception, which points to the likelihood of some pituitary change. Serum prolactin estimations were performed on 100 consecutive patients complaining of amenorrhoea or infrequent menstruation. Of 29 patients with a history of oral contraception immediately preceding the menstrual disturbance, 11 (38%) were found to have hyperprolactinaemia (prolactin >40 mg/l), compared with only 10 (14%) of 71 women without such a history (χ^2 test, $P < 0.025$), the overall incidence of hyperprolactinaemia being 21%.

Since ingestion of oestrogen/progestogen preparations in the mouse is associated with hyperplasia of the pituitary chromophobe cells and in susceptible strains adenoma formation² it seems wise to keep in mind the pos-

sibility that on occasions women taking oral contraceptives may get similar effects.

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¹ Chang, R J, et al, *American Journal of Obstetrics and Gynecology*, 1977, 128, 356.

² *Carcinogenicity Tests of Oral Contraceptives*. A Report by the Committee on Safety of Medicines, London, 1972.

Return to work

SIR,—The paper by Drs D A Brewerton and P J R Nichols (15 October, p 1006) and the letter from Professor R C B Aitken (12 November, p 1284) raise two important issues concerning the resettlement of disabled people into work and, in particular, the links between the medical and employment services.

Firstly, they contend that the resettlement problems of disabled people are dealt with by organisations whose main interests lie elsewhere, the NHS being concerned with health care and the Employment Service Agency (ESA) with the working of the labour market, with the result that the employment problems of disabled people fall between. These comments give an entirely misleading picture of the services which ESA and the Training Services Agency (TSA) provide for disabled people. The importance which the Manpower Services Commission (MSC) (our parent body) attaches to this work is reflected in the very substantial resources devoted to its resettlement, rehabilitation, training, and sheltered employment services—in 1977-8, £64m and about 3000 staff, some 10-12% of resources. For us, therefore, this is not a peripheral activity but an important and integral part of our services involving positive discrimination on behalf of disabled people by giving them extra support in the labour market.

Secondly, Drs Brewerton and Nichols propose that the employment problems of disabled people should be handled by staff with appropriate skills (I agree) and that this service should be in the mainstream of the NHS (here I disagree). What skills are necessary? While doctors and paramedical staff in their treatment of patients must take into account the problems of employment caused by disability, I believe, like Dr Felicity C Edwards (3 December, p 1474), that the skills and knowledge required are not primarily medical. When disabled patients face a change of occupational direction or a modified job with the same firm they need above all an assurance that they will get help to make the best use of their residual abilities; information about the occupational options to them, about the requirements of jobs, standards of entry and rates of remuneration, etc; when appropriate, employment rehabilitation and training programmes provided against a background of vocational opportunities; and finally help into jobs from people who know the labour market and can introduce them to suitable employers. These forms of help are no different in essence from those which ESA staff provide every day of the week to thousands of job-seekers. In my view there is only one way to provide a service to meet the employment needs of disabled people and that is to provide it as part of a good employment service for everybody. And, as many of your readers will know, the ESA has been under-

taking a major programme of improvements to its employment services.

But staff helping disabled people need extra knowledge—in particular, about the employment implications of disabilities and about the social and psychological problems of disabled people—and extra skills—how to persuade employers to give suitable employment opportunities to disabled people. That is why our disablement resettlement officers (DROs), after training as employment advisers and acquiring the knowledge and skills relevant to the normal labour market, are given additional training at our new national DRO training centre at Leeds. Over half our 500 DROs have now received this training. And DROs are not clerical staff, as suggested, but executive officers who have acquired extra skills. Furthermore, they are increasingly involved with industry and commerce in efforts to improve employment opportunities for disabled people in these times of high unemployment. All the time we are developing the expertise of the DRO service, though of course there is always room for improvement.

Drs Brewerton and Nichols mention the major changes in educational, medical, and other services for disabled people in recent years. Our employment services have been changing too—for example, the appointment of a substantial number of senior DROs; closer working links with our medical advisers in the Employment Medical Advisory Service (EMAS); a more flexible service at our 26 employment rehabilitation centres, catering for a wider clientele; a new employment rehabilitation research centre to evaluate and improve our service; experiments with hospital DROs, to be evaluated further with the Department of Health and Social Security and EMAS; publication of our new magazine *Outlook* aimed in part at the medical world. And, turning to the future, the MSC will shortly be publishing a 5-10-year development programme of our services for disabled people.

Co-operation between medical and employment services depends largely on communication and understanding. At national level we have regular contacts with the Health Departments. At local level we fully acknowledge the value of detailed medical advice before resettlement and the need to work closely with both general practitioners and hospital staff. Despite serious efforts over the years, however, levels of co-operation vary considerably. We see the need for a further review of liaison arrangements and we shall be undertaking this shortly along with our National Advisory Council on Employment of Disabled People (which has several distinguished medical members), with the Health Departments, and with EMAS.

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SIR,—All contributors to this subject in the *BMJ* during recent months are agreed that resettlement into a useful and satisfying occupation is the correct aim of management of members of the working population who are disabled, either temporarily or permanently. All are also agreed that there is a deplorable gap between the NHS and the Manpower Services Commission. This gap has always existed, although it was shown quite clearly at the Royal National Orthopaedic Hospital that, at least in the special circumstances