than an objectively demonstrable entity. Research has been rightly directed to demonstrating the variables which influence the relapse of acute schizophrenia with productive symptoms. What is also needed is an objective assessment of the variables which may influence the development or resolution of schizophrenic defect. Have changes in institutional management changed the development of defect or merely where a schizophrenic lives? Do long-term phenothiazines influence the postacute course or merely productive symptoms? Is defect inevitably associated with an organic brain lesion?

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¹ Cheadle, A J, Freeman, H L, and Korer, J R, *British Journal of Psychiatry*, 1978, **132**, 221.

² Kraepelin, E, *Dementia Praecox*. Edinburgh, Livingstone, 1919.

³ Huber, G, *Fortschritte der Neurologie, Psychiatrie und ihrer Grenzgebiete*, 1966, **34**, 409.

⁴ Johnstone, E C, et al, *Acta Psychiatrica Scandinavica*, 1978, **57**, 305.

⁵ Mellor, C, *British Journal of Psychiatry*, 1970, **117**, 15.

⁶ Spitzer, R L, Endicott, J, and Robins, E, *Research Diagnostic Criteria*. New York, New York State Department of Mental Hygiene, New York State Psychiatric Institute, Biometrics Research, 1975.

⁷ Bleuler, E, *Dementia Praecox or the Group of Schizophrenias*. New York, International University Press, 1950.

Patients' responses to barium x-ray studies

SIR,—Maureen Reynolds's first-rate paper about communication in hospital (24 June, p 1673) explored ground similar to the paper by Dr Jenifer Wilson-Barnett on patients' responses to barium x-ray studies published a few weeks earlier (20 May, p 1324). I have been astonished that this earlier paper did not provoke a flood of correspondence.

This trial showed that patients who received explanation and information about a barium meal or enema were less anxious than those who did not. Why on earth was such a trial necessary? Can there really be anyone anywhere who is surprised that explanation reduced anxiety? For those who cannot believe their common sense without a scientific paper to quote in their support there are already the equally unnecessary papers quoted in the introduction to the later paper.

However, what is most disturbing is the use of a control group. Can it be ethically and humanly acceptable to give procedures like barium studies to a group of patients and deliberately withhold explanation? Perhaps the simple and cheap innovation of subjecting each doctor to the common investigations that he or she uses would make us kinder and more humane doctors.

D HASLAM

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* * * We sent a copy of this letter to Dr Wilson-Barnett, whose reply is printed below.—ED, BMJ.

SIR,—Far from there being a flood of criticism over this short research report the correspondence, both personal and published (24 June, p 1699), has been wholly complimentary.

This experimental study assessed the degree of anxiety evoked by barium x-rays and examined the effect of giving patients a

full explanation of the procedures and sensations involved well before screening. The fact that this explanation would alleviate anxiety was not accepted as common sense by staff, many feeling that explanation might have an adverse effect on patients.

The suggestion by Dr Haslam that information was deliberately withheld from control subjects was not the case. Control patients were subject to the routine and normal preparation for barium x-rays by staff. However, in other studies,¹ including that praised by Dr Haslam, patients were found to receive very little information about what to expect during investigations. Many staff members excuse themselves by saying, "Patients would rather not know." It may well be that they also do not have detailed knowledge about the ever-increasing number of diagnostic tests. Is there a better way to convince them that patients benefit from such explanation than to produce objective evidence?

If, as seems to be the case, information-giving to patients is neither common sense nor common practice in hospital, and if Dr Haslam believes that withholding information is unethical and unacceptable, is he suggesting that much of what goes on in hospital care is therefore unethical and unacceptable?

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¹ Wilson-Barnett, J, and Carrigy, A, *Journal of Advanced Nursing*, 1978, **3**, 221.

Economising on drugs

SIR,—Your leading article "Freedom to prescribe—in ignorance" (17 June, p 1573) comments on the various activities of hospital therapeutic committees.

It is not only in hospitals that the attempt to produce a basic list of drugs has been made. I am one of a group of six dispensing doctors and the need for ever-increasing economy in maintaining our drug stock led us to review the drugs we use with the aim of producing a basic stock list. This does take relatively as much time as you describe in hospital, and what started as an exercise to achieve financial savings has become a valuable educational exercise. Justifying a particular drug choice to one's colleagues, including trainees, concentrates the mind wonderfully, and we have even managed to produce a practice policy for the use of some categories of drug.

I am sure other people are working along similar lines and I would be interested to hear of any conclusions as an aid to our own efforts.

I R WALLACE

Newmarket, Suffolk

SIR,—In attempting to deal with this problem (leading article, 17 June, p 1573), I hope that both doctors and the Department of Health and Social Security will attempt to limit our ignorance and not our freedom. In an attempt to control prescribing habits Australia has four categories of drug. The result is more paperwork for everyone and the need to get special permission from the Department of Health to prescribe a drug such as flucloxacillin; and at the same time the prescribing

in some practices is as haphazard and irrational as any I have heard of in Britain. No amount of regulation will guarantee good prescribing.

By all means update the *British National Formulary*. By all means persuade the Association of the British Pharmaceutical industry to put page numbers in the index of approved names in their *Data Sheet Compendium*, which, despite its limitations and your doubts (3 June, p 1435), is a most useful handbook. By all means bombard us with advice in the *Prescribers' Journal* and the *Drug and Therapeutics Bulletin*. But let us resist the apparently simple solution of regulations and restrictions.

CHARLES A WEST

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Surgical approaches and drug treatment in the carcinoid syndrome

SIR,—Your leading article (17 June, p 1572) on the treatment of the carcinoid syndrome suggested that before hepatic artery ligation a course of cytotoxic drugs should be given. This would cause some release of vasoactive substances from the tumour and prevent a "carcinoid crisis" occurring with the more major necrosis that would follow ligation of the artery.

We have recently studied the 24-h urinary excretion of 5-hydroxyindole acetic acid in a patient with carcinoid syndrome and liver metastases (reported to the Royal Society of Medicine, Section of Endocrinology, Cambridge, May 1978) and found that after a bolus injection of cytotoxic drugs (cyclophosphamide, methotrexate, and doxorubicin (Adriamycin)) the excretion increased at least 25-fold. This presumably reflects a similar (or greater) release of pharmacological mediators from the tumour into the circulation, with the possibility of precipitating a crisis. Before any medical or surgical interference with a carcinoid tumour it is safer to try to inhibit the synthesis and effect of these substances by the administration of agents such as *p*-chlorophenylalanine and cyproheptadine.

The latter drug was very useful in controlling this patient's severe skin symptoms and it is surprising that no mention is made of its use in your article, as it appears to be relatively non-toxic and effective.

PAUL SIKLOS

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Replacement therapy in Turner's syndrome

SIR,—The report by Drs J L Margo and K E Hawton of the association of anorexia nervosa with Turner's syndrome (1 July, p 15) highlights what is, in my view, regrettable but common practice. Here a girl was diagnosed as having Turner's syndrome when she was a child, but it was not until the age of 18 that she began treatment with oestrogens to induce female secondary sex characteristics. I do not suggest that this delay precipitated her anorexia nervosa, but it must have provoked considerable and avoidable anxiety.

There is no evidence that the time of starting oestrogen replacement therapy affects the final height of these patients.¹ Accordingly

oestrogens should be given to keep their sexual development level with that of their peers. In this way, much unnecessary extra stress can be avoided.

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¹ Brook, C G D, *et al*, *Archives of Disease in Childhood*, 1974, **49**, 789.

Urinary incontinence during treatment with depot phenothiazines

SIR,—I was most interested to read the letter from Dr A Shaikh (24 June, p 1698) on urinary incontinence in women under treatment with depot phenothiazines. In 1967 Brocklehurst and Dillane¹ reported that anticholinergic drugs had been shown to increase functional bladder capacity by 50 ml or more in individual women suffering from urinary incontinence.

In view of the fact that anticholinergics such as orphenadrine hydrochloride are widely used to control the extrapyramidal reactions sometimes associated with the use of major tranquillisers it may well be that this use could be extended to include the control of urinary incontinence where this is a problem.

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¹ Brocklehurst, J C, and Dillane, J B, *Gerontologia Clinica*, 1967, **9**, 182.

Who decides? Patterns of authority

SIR,—Of all the contributions to your journal to mark the 30th anniversary of the NHS, that of Professor Rudolf Klein (1 July, p 73) goes to the heart of the matter. Professor Klein mentions that the medical profession has always insisted on participation. The re-organisation of the Health Service with its three-tier system was simply a response to trends in greater participation for workers in decision-making. Further, if the Royal Commission were to respond to further demands for worker participation, surely more tiers would have to be added rather than deleted to encompass the proliferation of consultative committees which has already slowed the process of taking decisions (leading article, p 1).

This is, of course, only one of the problems that face the NHS, but it is one that the medical profession can do something about at once. Are its members prepared to resign from their positions in the non-statutory consultative committees to bring about the collapse of the tyranny of rule by committee? Ah, the deafening silence!

SURINDERJIT S BAKSHI

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Negotiating rights for hospital junior doctors

SIR,—It is a matter for considerable regret that the excellence of Mr J N Johnson's performance in the chair at the Hospital

Junior Staff Conference (8 July, p 144) should have been marred by charges that he was party to preplanned filibustering to prevent debate on Motion 104. Whether the alleged filibustering was real and whether he and the other officers of the conference were party to it will doubtless be the subject of rancorous reverberations in the medical press and, worse, another source of division among juniors. As chairman of the North-west Regional Hospital Junior Staffs Committee, where Motion 104 originated, I write to explain why this region believed the motion to be important and opportune.

The motion read: "That the national HJSC should offer to the Medical Practitioners Union/Association of Scientific, Technical and Managerial Staffs and the Junior Hospital Doctors Association a number of voting seats on the HJSC (to be filled by hospital junior doctors), a number of non-voting seats (to be filled by principal officers, advisers, or full-time officials), and a role in the servicing of the committee if they will in turn accept the HJSC as the negotiating body."

The HJS Conference's rejection of the Review Body was widely anticipated. Its sequel is uncertain, but is likely to be direct negotiations with the Department of Health and Social Security. Juniors would then require to confront the Department in concert, not as diverse warring factions which could be played off one against the other. Add to this the likelihood of the Advisory, Conciliation and Arbitration Service awarding negotiating rights to the JHDA and MPU/ASTMS and it is clear that juniors are almost certain to need some kind of joint negotiating machinery in the very near future. If this cannot be achieved within the HJSC a new structure will be necessary—a joint negotiating body comprising representatives from the different organisations. This structure would be less efficient than the negotiating rights being contained within the HJSC as it would involve much coming and going between the negotiating body and the HJSC and its equivalents in the JHDA and MPU/ASTMS to thrash out a common policy.

How are the JHDA and MPU/ASTMS to be persuaded to abandon their claims to separate negotiating rights? Perhaps it will prove impossible (and there are cogent arguments for their staying aloof as critical ginger groups, as the Liberals have found through their involvement in the Lib-Lab pact); but if it is to be achieved, it will only be through real involvement in the HJSC. Motion 104 was intended as a basis for further discussion, nothing more.

It is natural that the BMA is reluctant to share the power it now has and perhaps run the risk of improving the competitive position of its rivals, but if the result is to strengthen the HJSC and make it more representative of juniors the gains might well outweigh the losses. In addition, if the BMA gives real substance to the proposed strengthening of its peripheral structures it will become more meaningful to the average junior doctor and, ipso facto, a colossal threat to its rivals.

As Motion 104 will now be referred to the HJSC for consideration I hope that the above will help to reduce the emotion now surrounding it, allowing it to be evaluated on its own merits in that forum.

TOM MCFARLANE
Chairman,
NW Regional HJSC

Manchester

"Proceed with the pricing"

SIR,—As you rightly say in your leading article (1 July, p 4), new contracts require pricing. It must be remembered what we as consultants are giving. We are now going to give a full 3½ hours' work as a session as opposed to what is for the majority of present consultants a session which includes travelling time to work. I would think that at a reasonable estimate most consultants so affected (which is all except the comparatively young) would now be working only a 3-hour session. Under the new contract, therefore, they would be giving 16%, extra time.

In regard to the full-timers, their standard working sessions are going to be 10, apart from the negotiable extras, instead of 11, which is a reduction of only 9%, so that every full-timer except comparatively few recently appointed is going to give the Health Service 7% extra work under the new system. Therefore the rating for the new contract compared with the old full-time payment must be that 7% extra. Obviously the part-timer, working 10 sessions instead of 9, will also have to get a corresponding percentage increase if the new contract is going to mean anything.

Furthermore, the on-call work in the evening as opposed to the on-duty daytime work and the other regular sessions does not seem, so far as I read the contract, to be mandatory, although it is obviously essential to the service. Obviously, therefore, unless the pay for the work done shows a satisfactory increase in relation to other types of work done under contract, there is going to be very little enthusiasm on the part of anyone to do the work, and as on duty does not apply after 7 pm it must be up to the management side to indicate suitable remuneration for this extra work.

Overall, the new contract must not be regarded as benefiting only the consultants. It can be, I think, of very considerable benefit to the service, and I think it might very well very considerably improve, in many instances, emergency care.

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New consultant contract

SIR,—The euphoria surrounding the Central Committee for Hospital Medical Services at the moment seems to be well exemplified by its chairman's address to the Senior Hospital Staffs Conference on 27 June (8 July, p 148).

How he glimpses his "ray of hope" for consultants based on his observations I find very difficult to understand. He attributes the Review Body's recommendations of a percentage salary increase to the influence of the CCHMS on the Prime Minister's thinking. Virtually every pay award to all groups has for some time been percentage-based and there is a hint of presumption in his thinking that the CCHMS played any significant part in this. The new contract proposals accepted by the "overwhelming majority" of 50% of consultants apparently also constitutes an "enormous success." Where he finds the hope that "the proposals would undoubtedly lead to greater financial rewards and greater freedom and independence for consultants" is again difficult to understand.

The most disturbing conclusions which one must reach from this optimistic euphoria is