On ten occasions over the past 15 years she has been observed both here and elsewhere to exhibit dystonic episodes while taking certain neuroleptic drugs. Specifically these were chlorpromazine hydrochloride (Largactil) 50 mg three times a day intramuscularly; trifluoperazine (Stelazine) 5 mg three times a day by mouth; haloperidol (Serenace) 5 mg or more intramuscularly; and fluphenazine decanoate (Modectate) 25 mg intramuscularly two-weekly. The dystonia was recorded by her doctors as severe opisthotonos, torsion of the neck with deviation of the mouth and eyes, dysarthria, forced flexion of the left arm, paroxysmic rigidity and stiffness of the neck and limbs, trismus, grimacing, and oculogyric crises.

In March 1975 she was started on propranolol in gradually increasing doses as described by Yorkston and his colleagues¹ for the treatment of schizophrenic symptoms. On reaching a dose of 600 mg twice a day, despite neuroleptics having been omitted for some months, she developed further dystonic episodes. In these, according to relatives and nursing staff, her eyes rolled up, teeth were clenched, perspiration and salivation became marked, and limbs and trunk exhibited distorted postures, the legs being extended and arms and wrists flexed, with arching of the back leading to a tendency to slide repeatedly on to the floor from chair or bed. This lasted half an hour and recovered without administration of antiparkinsonian agents. Such episodes recurred at intervals over a few days until propranolol was discontinued. The mental state had not materially improved.

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¹ Yorkston, N J, *et al*, *British Medical Journal*, 1974, 4, 633.

Describing urinary symptoms

SIR,—In his article on urinary symptoms Dr Norman Jones (24 September, p 818) writes, "dysuria, sometimes described as a sensation of scalding on micturition . . ."

This phrase underlines how unsatisfactory a term "dysuria" has come to be. The prefix "dys" can mean pain, as in dysmenorrhoea, or difficulty, as in dysphagia. Unfortunately people suffering from symptoms of lower urinary tract disorders can have pain or difficulty or both so that dysuria is an inaccurate and sometimes misleading word. In order to overcome this we have recently encouraged in this department the use of the word "uralgia" specifically to apply to a condition in which the patient has pain on passing water and I would commend this word to general use. Both parts of it are derived from Greek, it is precise in its meaning, and furthermore it rolls off the tongue with a pleasing euphony.

It is worth pointing out that although Dr Jones mentions many different causes for lower urinary tract symptoms he does not mention bladder cancer. Not all patients with bladder cancer have haematuria, and the exclusion of malignant disease in patients with uralgia is always in the forefront of the urologist's mind.

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Left-handed pipers

SIR,—I bow to the knowledge of Mr M Beckett (8 October, p 961) and my other artistic colleagues. As stated, the likelihood is that it is a right-handed piper, hence the proviso, "*thought to be a self-portrait*." However, the possibility remains that it is truly a left-handed piper, a possibility strengthened by the difficulty in painting (while piping) a side view with the head looking forward. Mr Beckett asks for further evidence for left-handed pipers. With respect to the Scots Highland bagpipe, there are two further indications: a picture by David Allan (1744-96) depicts a family scene with a left-handed piper; a manuscript by Donald MacDonald (1822) states that the position of the hands and the side for the bag are dependent on the player. Angus Mackay, in his manuscript of 1838, avoids definition of hand positions.

The Scots Highland bagpipe is a late development; evidence for left-handed players of earlier bagpipes is manifold: two mediaeval knife handles from Richborough and Whitby Abbey; Gorleston Psalter illustration (c 1330); Stone carvings at Melrose Abbey (14th century), at Roslin Chapel, Midlothian (15th century), and at Davidstowe Church, Cornwall (16th century); engraving on the silver armour of Henry VII; the picture, "Southwark Fair," by Hogarth (1733); and an Albrecht Dürer engraving (1514), possibly a reversal of a right-handed piper.

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*.*This correspondence is now closed.—ED,
BMJ.

Minerva trips up

SIR,—Minerva (22 October, p 1091) must be corrected in her belief that George Gale's article on oral contraception appeared in the *Daily Mail*. It did not. It was published in another newspaper for which the *Daily Mail* has no responsibility.

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Report on first MASC meeting

SIR,—As a medically qualified preclinical teacher with nine years of experience in medical physiology I was very disappointed with the report of the first meeting of the Medical Academic Staff Committee (MASC) in the *BMJ* of 8 October (p 972). I waded through nearly three pages dealing with the problems of clinical academic staff in order to find a frustratingly small amount of information on the proceedings of the preclinical section. This imbalance seems to me to make a mockery of the serious situation which exists in the preclinical sector. The exodus of medically qualified staff from preclinical departments has been reported to be accelerating. The medical profession at large should be made aware of the present situation in the hope that remedial action can be taken before preclinical departments are denuded of medically qualified staff. I hope that in future the *BMJ* will devote space commensurate with

the seriousness of this problem in medical education.

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*.*The conference divided into two parts and the *BMJ* had only one reporter present. As the clinical academics are the larger electorate it was decided to report their part, but this does not mean that the *BMJ* is biased against preclinical teachers or unaware of their serious problems.—ED, *BMJ*.

Ethics and etiquette of doctor-managers

SIR,—Mr John Potter (15 October, p 1030) invites discussion on the ethics of doctor-managers. Like many of us he is concerned that our loyalties to our individual patients may conflict with management decisions. In such predicaments is it better to detach from the decision-making process or to contribute our professional expertise and informed opinion from inside the group responsible for making the decision?

For a variety of practical reasons, including access to current information, opportunities for developing more fruitful working relationships with colleagues in allied professions, and the creation of mutual trust between managers of different disciplines, many clinicians find that they can influence decisions more effectively from within a decision-making group. Nevertheless, we cannot expect the interests of our own patients to predominate disproportionately. A member of such a group must be prepared to be influenced as well as to influence others—whence "consensus."

Besides this, who are our own individual patients? Do they include patients whose management we share with other clinical colleagues in general practice and in hospital and patients we are going to see in the immediate or more distant future? The demarcation lines are blurred. Perhaps, after all, we hospital clinicians have some responsibility for the health care of our neighbours in the community. If so, and resources are limited and in many places diminishing, we should take a full part in discussing and deciding priorities.

The more fully clinicians are involved in these decisions the more likely it is that the scarce resources will be used to the best advantage of all the patients. We need both concern for our individual patients and commitment to the National Health Service in which we work and which provides as much care for patients as resources, management, and all our efforts allow.

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SIR,—I believe that Mr John Potter (15 October, p 1030) has raised a very important matter and one that has become increasingly important to doctors since the recent ill-conceived administrative reorganisation of the NHS. I am also sure that the profession should look very closely at the ethical problems of medical participation in NHS management. It is easy for those without responsibility for beds and patient care to make very sweeping proposals often harmful to the interests of their clinical colleagues' patients and to consider