and satisfactory declaration on the subject to date.

There is a diversity of opinion upon the status of the haematologist. It should, however, be clear that the bulk of laboratory investigations are performed by technicians, whose proficiency at fulfilling routine investigations is far superior to most medical graduates. If the haematologist is to contribute more than gratuitous observations of anisocytosis, with a signature to give them authority if not meaning, then he needs the incentive of knowing he has a real job to perform. It is absurd to limit his function to that of an adviser sitting by a desk piled high with journals as the source of his authority. This authority may best come from experience of clinical medicine, laboratory work, responsibility for treatment, and follow-up. If any one of these components is denied it is to the detriment of all.

Haematology is an attractive subject precisely because some latitude of activity has been preserved. Whatever the arguments for more stringent definition of its boundaries, it should be borne in mind that many younger haematologists entirely endorse the claims of your leading article, and might respond bitterly to having the ground cut from under their feet.—I am, etc.,

MICHAEL S. ROSE.

Guy's Hospital,
London S.E.1.

Oral Contraceptives and Hypertension

SIR,—It is true that as yet the mechanism of the pressure rise which occurs in some women taking oral contraceptives is as yet unknown (16 May, p. 378). However, your leader failed to mention some recent experimental evidence which suggests that progestins may be involved.

In rabbits hypertension can be consistently produced by treatment with progesterone.¹ The rise in arterial pressure can be prevented by giving the animals an increased salt intake.² This may possibly act by reducing renin, angiotensin, and aldosterone levels. In work done during the past few months we have demonstrated that in rabbits pretreated with progesterone intravenous infusions of aldosterone cause a rise in pressure of more than double that seen in untreated animals. These results suggest that the progestin component of the pill should not be ignored when considering the mechanisms of contraceptive-induced hypertension.—We are, etc.,

D. F. HORROBIN.
I. J. LLOYD.
P. G. BURSTYN.

Department of Medical Physiology,
University College Nairobi, Kenya.

REFERENCES

- Horrobin, D. F., *Lancet*, 1968, 1, 170.
- Horrobin, D. F., Lloyd, I. J., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, 77, 253.

Safety of Oral Contraceptives

SIR,—As a practising gynaecologist, I am most concerned that my colleagues and I do the best we can for the safety of the numerous patients for whom we are prescribing oral contraceptives.

It is unfortunate that the Committee on

Safety of Drugs chose to depict in graphic form (25 April, p. 231), the results of the study by Dr. W. H. W. Inman and colleagues (p. 203). There are anomalies which will be retained in the mind of the reader, whereas the careful justification by the authors (p. 206) may not register.

Dr. Inman and colleagues indicate that cases of thromboembolism are better reported on the newer oral contraceptives than on the long established high dose products. This may lead to the anomaly of Conovid E being well below the observed/expected ratio despite the fact that it contains 100 µg. of oestrogen. The authors state that they base their figures on market sales excluding those from F.P.A. clinics. It may have escaped their attention that much of the general practitioner and hospital reporting of thromboembolic episodes must include patients taking F.P.A.-prescribed pills. It is conceivable therefore that the products prescribed to a greater extent in F.P.A. clinics, such as Norinyl-1 and Volidan, may be unfairly chastised.

If the inclusion of F.P.A. sales for these products produced one more expected case, the observed/expected ratio would fall below the mean line of the histogram.—I am, etc.,

JOHN FRANKENBERG.

Hillingdon,
Middlesex.

Who Should Do Psychotherapy?

SIR,—Your leading article on "Who should do Psychotherapy?" (13 June, p. 617) may risk being unnoticed in the welter of present medico-political events. Its importance is seen in the figure you quote that about 250,000 new outpatients are seen each year by psychiatrists in England and in your guess that more than 20 people need help for every one who is receiving it. If this refers only to psychotherapy I think your guess is optimistic, for it is available for very few patients indeed outside London and even there N.H.S. waiting lists are enormous; naturally not all psychiatric patients need formal psychotherapy, but many on physical treatment still need psychiatric supervision.

This is a very serious situation in purely medical terms and in any other branch of medicine would bring an outcry. It has considerable applications in industrial efficiency and in other problems of society—for example, crimes of violence, road accidents, and drug-taking. Psychiatrists, not surprisingly, would like to tackle the situation and must welcome the careful review made by Professor J. K. Wing and Dr. Lorna Wing,¹ who estimate that 480 more psychiatrists are needed to supply specialized and supportive psychotherapy in England and Wales.

This is, of course, a shocking figure—shocking, that is, for anyone who has to pay for it—and very likely we cannot afford it, though the future cost of not affording it must also be counted.

Of course nearly all psychiatrists would agree that more assessment of the value of psychotherapy is needed. But who is to do it? The trouble is that most psychiatrists now are already so overworked that they have no time for research; and worse, they have had to lower their standards of treatment in an attempt to do what they can for

more people; and naturally their reputation and that of the treatment has suffered. Even to assess psychotherapy, therefore, more psychiatrists are needed.

You also suggest that psychotherapy should be done more by general practitioners, priests, and social workers. This may well be useful and has, indeed, been advocated by some of us for years, but the value of this needs assessing just as much as the value of psychotherapy; and experience has shown that, if non-psychiatrists are doing work of this kind, they quite soon demand more help and supervision from psychiatrists if their work is to be efficient and not dangerous. This, too, therefore, will need more psychiatrists to make it work.

Some may be misled by your leading article into thinking that because psychotherapy still needs assessment, and because sometimes it needs no psychiatrist to do it, we do not need more psychiatrists. This would be a grave error. Many are needed now; more should be in training now. If only some of the increase recommended by the Wings could be granted, we could do something more at once, and plan more effectively for the future.—I am, etc.,

ROGER TREDGOLD.

University College Hospital,
London W.C.1.

REFERENCE

- Wing, J. K., and Wing, L., *British Journal of Psychiatry*, 1970, 116, 51.

Drip Set Hazard

SIR,—Air embolus is an obvious hazard of intravenous transfusion. We recently noticed a mistake with a commonly used drip set which might have led to such an embolus if the drip had not been stopped in time.

The Baxter BS-1 set consists of a broad plastic outlet needle leading via a filter chamber to the drip tubing, and an air inlet needle some 17 mm. longer than the outlet needle. By pushing home the air inlet fully into the bottle its mouth is normally well above that of the outlet (Fig. 1). In the case described, however, a nurse had failed to push it in to the full extent and had also

FIGURE 1

FIGURE 2