that that of the defence societies is but a logical extension of that of the CMO.

As to whether defence societies should seek to influence individual doctors in their clinical judgment, the question, I suggest, does not arise in this context. Where there is no medical reason for a procedure, there can be no clinical judgment regarding it. On the question whether the defence societies should circulate all doctors setting out their decisions, they have made no decisions but only recommendations to members who, being aware of the medicolegal hazards and anxious to protect their patients and themselves, have sought their medicolegal advice.

Dr Jones and I are in complete agreement when he says that the defence societies do not say that they will not cover doctors who insist on vaccinating. We have never said this in respect of any procedure.

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SIR,—Dr D T Jones's letter (11 October, p 1004) is a welcome reminder of the dangers—both to the vaccinated and to the vaccinator—of smallpox vaccination. Unfortunately, the pressure on general practitioners to vaccinate is still considerable, particularly from large international trading companies, whose staff may be redirected at a short notice to countries still requiring vaccination and must carry valid certificates with them all the time. It seems to me that the simplest solution of this problem would be to stop supplying vaccine to the profession and to restrict smallpox vaccination to government centres on the same lines and preferably at the same places as for yellow fever. It would save a lot of unnecessary embarrassment and responsibility, both for doctors and for medical defence societies.

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Management of acute stroke in the elderly

SIR,—We read with interest the report by Dr W M Garraway and others (27 September, p 827) of the follow-up of their controlled trial of the management of acute stroke in the elderly. They offer two hypotheses to account for the disappearance of differences between stroke unit and medical unit patients during the follow-up period. The first hypothesis was that following discharge stroke unit patients received more help from relatives, thus decreasing the number of "independent" patients. The second hypothesis was that more medical unit patients were discharged before their rehabilitation potential had been realised.

As analysed, their data do not, however, distinguish between these trends, although the data presented do enable one to do this. If we analyse results for the "independent at discharge" and "dependent at discharge" categories separately, the results for the two units appear as in the accompanying table. The differences between units are not significant for "independent at discharge" patients ($\chi^2=1.48$) but are significant for "dependent at discharge" patients ($\chi^2=4.85$, $df=1$, $p<0.05$).

Thus with respect to the differences between units, there is no result to be explained in the case of the number of formerly independent patients found to be dependent at follow-up. The number of dependent patients is still higher than that assessed at discharge by the

Dependence and independence at follow-up in patients from the two units

	Stroke unit	Medical unit	Total
	<i>Independent at discharge</i>		
Independent at follow-up	54	41	95
Dependent at follow-up	13	5	18
Total	67	46	113
	<i>Dependent at discharge</i>		
Independent at follow-up	2	11	13
Dependent at follow-up	32	34	66
Total	34	45	79

team and the possibility of working more closely with relatives is a major area for exploration. However, we do not have to explain any differences between outcome for the units.

With respect to the number of "dependent at discharge" patients achieving independence at follow-up, their remarks about length of stay in medical units being shorter for this group are clearly pertinent. It is by no means clear how far this artefact affects the results of the preliminary report (12 April, p 1040). Since assessments were made "when discharge was imminent or at a cut-off period of 16 weeks," this artefact will presumably have heightened the differences found initially.

Finally, we would concur wholeheartedly with the conclusion about the need for management of stroke to continue beyond the in-patient phase and for the involvement of carers of stroke patients. One analogy which might prove useful in this respect is the "Portage" schemes for developmentally delayed children¹ and the controlled evaluation of such approaches will, no doubt, be of great value.

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¹ Shearer MS, Shearer DE. *Exceptional Children* 1972; 36:210-7.

Mental health review tribunals

SIR,—Dr Henry Rollin (27 September, p 872) expresses dismay with the review of *Representing the Mentally Ill and Handicapped*, which I co-authored with Elaine Rassaby, while saying that he has not actually read the book. The review was indeed in error in two respects.

Compulsory admission to hospital is not a "sentence of indeterminate length." None the less, formal compulsion under section 26 or 60 of the Mental Health Act 1959 is renewable by the responsible medical officer for one year and for periods of two years thereafter; the composite effect is a potentially open-ended period of confinement. To cavil at the word "indeterminate" is to make somewhat heavy weather of the point. It is, of course, true that the great majority of patients are compulsorily detained for shorter periods of time, either for 72 hours or 28 days. It is also true that the 1959 Act does not make it explicit whether the procedures relating to compulsory admission also

authorise compulsory treatment. Nevertheless, Dr Rollin's unsupported assertion that treatment is given without consent "only in situations of dire necessity when life itself may well be in danger" does not accord with evidence in recent hospital inquiries,¹ in the White Paper on the Mental Health Act,² or in MIND's case files. Moreover, the oft-repeated statement that "psychiatrists are singled out for censure because they behave like other doctors" is incorrect in so far as the law is concerned. The common law does not permit any physical treatment without effective consent, save in cases of urgent necessity. To the extent that psychiatrists are singled out, it is for the purpose of allowing them to impose treatment in circumstances where other doctors could not do so.

Dr Rollin's more general observation that the 1959 Act is in intent "the most humane charter yet devised" is, again, made without justification. The Act is concerned almost exclusively in withdrawing rights which other citizens enjoy, including the right of unimpeded access to the courts and the right to send and receive unopened correspondence.

Representing the Mentally Ill and Handicapped concerns itself with the one safeguard provided in the Act, which is the right of access to an independent mental health review tribunal. Dr Rollin accepts the point that less than 10% of those compulsorily admitted have a statutory right of appeal to a tribunal. Yet he finds it difficult to conceive of an administrative machinery that would allow patients, say, on 28-day orders the right to a tribunal review. Such a possibility is not discounted in the Mental Health Act White Paper and, if one accepts that the loss of individual liberty even for a benevolent purpose is a serious matter, then the right to an independent review would be warranted. Nor would the increase in tribunal hearings place too heavy a burden on the tribunal system. Interestingly, the Percy Commission anticipated 8000-9000 tribunal hearings each year. In fact there have never been more than 1515 and the current figure is about 750. Many tribunal members hear only one or two cases each year, which also means that they lack the experience and familiarity with a wide breadth of cases needed to make consistent and informed judgments.

Dr Rollin personally supports the concept of representation at tribunals, but for the least important of reasons—"if only to preserve the time-honoured principle of justice being seen to be done." Representation has more than ornamental value. The patient's mental illness or handicap and the effects of institutionalisation and medication make self-advocacy invariably difficult. Further, the unrepresented patient is frequently denied the full reasons for his confinement; medical and social inquiry reports may be withheld from the patient as confidential. More important is the ability of a representative to examine provision in the community for housing, care, and support.

Finally, Dr Rollin vouches for the serious and expert deliberations of tribunal members. No doubt considerable care is taken in every case. However, the most recent and authoritative research on tribunals (an unpublished dissertation by J Peay of the department of psychology, University of Birmingham) demonstrates significant positive relationships between the attitudinal approaches of members and their discharge rates. Deference to psychiatric opinion and disregard of the legal criteria for discharge indicate a significantly lower chance of discharge in any particular

case. More importantly, decisions were taken on selective aspects of information and members were highly influenced by the hospital authority's report. The results indicate a need for tribunal members and representatives to receive advice and training, which is the principal objective of *Representing the Mentally Ill and Handicapped*.

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¹ South-east Thames Regional Health Authority. *Report of the Committee of Enquiry into St Augustine's Hospital*. London: HMSO, 1976.

² Department of Health and Social Security. *A review of the Mental Health Act 1959*. Cmnd 7320. London: HMSO, 1978.

Early intervention in Down's syndrome

SIR,—May I challenge a report in your "Views" column (21 June, p 1541)? Minerva cited a study by Piper and Pless,¹ which claimed to show that early intervention had no significant effect on infants with Down's syndrome and she ended by saying that such negative results, though disheartening, were welcome evidence of a more rigorous approach. Unfortunately you overlooked a much larger study, by my mother and a colleague,² which reached the opposite conclusion but appeared too late to be considered by Piper and Pless. As I was involved in the statistical analysis of my mother's data I would like to comment on the discrepancy between these studies.

Neither study was completely satisfactory. The Griffiths scale development quotients decline most rapidly over the first two years, at about eight points per year² and this decline is not linear, being more rapid at first. Consequently children should be tested at exactly the same ages to be comparable, but that is not practical. The resulting errors in pooling data from children even two months apart are appreciable and make the study of treatment effects particularly difficult in infants. Piper and Pless confined their attention to infants, whereas Ludlow and Allen followed their children through for up to eight years. In neither case were the ages of testing synchronised.

In addition, Piper and Pless studied rather a small sample (21 experimental and 16 control children). From the standard deviations in their table 2 it is possible to calculate the smallest difference between controls and experimental children which would be statistically significant. These turn out to be rather large (5.67 to 10.44 points on the Griffiths scale) and differences as large as this could not have developed within six months unless the treatment had completely arrested or even reversed the usual decline in development quotients. In other words, given their sample size and the observed variation in children, Piper and Pless could not have shown a significant effect of early intervention unless the treatment had been totally effective. Sadly, no one is able to make that claim.

The non-statistical reader may be surprised that Piper and Pless detected no difference at all between groups, but this is a perennial problem in statistics. Even a biased coin may come up the "wrong" way more often than not unless the sample is very large. That is precisely why statistical tests are necessary. Piper and Pless were aware of this and did not claim that early intervention was useless. They were careful to point out that their results disagreed with those of previous studies and discussed possible explanations. Indeed, their careful scientific work deserves better than the scant report you gave.

One of their suggestions was that a longer period of observation might have produced different results. This seems likely since Ludlow and Allen found the largest differences at about 4 years.

Piper and Pless also pointed out that the experimental group was assessed over the autumn and winter, while the control children were studied over the spring and summer when more frequent play outdoors with other children may have been as beneficial as the therapy they missed. It is also possible that the control group children in Canada were less deprived or better counselled than the corresponding group in England, with the result that treatment was less necessary in Canada.

Ludlow and Allen studied 192 children, with 77 in the treated group and 82 and 43 in two control groups. They found highly significant differences between the groups although two features of their study might be criticised. The initial assessment of the stimulated children took place two or three weeks after the first counselling session, since an academic study was not then envisaged. By the time of the assessment, therefore, the children had already received some treatment. More importantly, the experimental group children were younger than the control group when first tested, and therefore scored higher. However, the final test results did not suffer from this problem and in other respects the groups were well matched. Piper and Pless do not say whether their control group received any counselling.

A second point of concern is that many of the tests were done by the authors, although numerous independent tests agreed closely and there was good correlation between Griffiths and Stanford Binet results. However, neither of these criticisms can be levelled at the final result of the study, which showed that the proportion of children placed by independent assessors in normal schools or schools for moderately educationally subnormal children was overwhelmingly greater in the treated group than in the controls. A χ^2 test shows that there was about one chance in 3 000 000 that this was a spurious difference.

While Ludlow and Allen have done one of the largest and most rigorous studies, they are also supported by many earlier authors and there is every justification for the view that early intervention is extremely beneficial to children with Down's syndrome. As Piper and Pless themselves say, the Griffiths scales measure only some of the possible benefits of such intervention. Others are less tangible but may be even more important, and I hope that your report did nothing to alter that view.

Finally, I trust that you will quote sample size in all future reports on research. That would be welcome evidence of more rigorous reporting.

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¹ Piper CM, Pless IB. *Pediatrics* 1980;65:463-8.

² Ludlow JR, Allen LM. *J Ment Defic Res* 1979;23:29-43.

Can insulin-treated diabetics be given beta-adrenergic-blocking drugs?

SIR,—The article by Dr Anthony H Barnett and others (5 April, p 976) makes the broad statement that any beta-blocking drug can safely be used in diabetics prone to hypoglycaemia. The study, however, only related to a relatively rare, albeit important, aspect of hypoglycaemia—namely, hypoglycaemic coma. The major causes for concern in using beta-blocking agents in diabetics prone to hypoglycaemia are: (1) an increased risk of hypoglycaemic coma; (2) masking of the major hypoglycaemic warning signals; (3) a delayed rate of recovery from the hypoglycaemia; and (4) an altered haemodynamic reaction to hypoglycaemia.

(1) The article by Dr Barnett and others shows that beta-blocking agents are not a major cause

of hypoglycaemic coma, with which we fully agree. However, in our experience a non-selective agent (propranolol) can indeed change the hypoglycaemic response and produce sudden unconsciousness.¹ Neither placebo nor a cardio-selective agent (metoprolol) produced this response despite similar or lower blood glucose levels.¹ We have in our subsequent studies seen another patient treated with propranolol react in an identical fashion. Although this reaction may indeed occur in diabetics without any medication, Dr Barnett and his colleagues also found that one of their five patients treated with beta-blockade attributed the occurrence of hypoglycaemic coma to the institution of propranolol therapy. Since this effect of propranolol may be due to its effect on the haemodynamic reaction during hypoglycaemia, as discussed below, it would be of interest to know if this patient improves by withdrawing therapy or by switching to a cardioselective drug.

(2) The finding of similar incidences of hypoglycaemic symptoms in the untreated and beta-blockade groups does not mean that beta-blockade leaves the hypoglycaemic symptoms unchanged. Additionally, it is possible that some true hypoglycaemic attacks are not recorded as such. In our experience the main hypoglycaemic symptom on a non-selective drug such as propranolol is increased sweating. However, tremor or palpitations were not experienced by our patients. It is surprising that Dr Barnett and his colleagues found a higher incidence of palpitations in the beta-blockade group (26% v 17%) during the alleged hypoglycaemia. This raises the questions whether all patients were indeed hypoglycaemic when they reported hypoglycaemia, and whether they had adequate beta-blockade. We have recently finished a prospective, double-blind study where five insulin-dependent diabetics were in a cross-over and random fashion treated with placebo or a cardioselective agent (metoprolol) for totals of 71 and 77 weeks, respectively. The patients were asked to record possible hypoglycaemic episodes and symptoms. One of our patients noted that with metoprolol the hypoglycaemic symptoms were less pronounced and not as sudden in onset. The remaining patients noted no clear difference. Thus we feel that a cardioselective agent may be used in insulin-dependent diabetics, but some caution should still be exercised and patients should be informed that the symptoms may be mitigated.

(3) Most studies,¹⁻⁵ but not all,^{6,7} show that a non-selective agent will delay the recovery from hypoglycaemia, probably by reducing hepatic glucose production. Although a selective agent may also influence the rate of recovery this effect is less pronounced than that of a non-selective drug.³⁻⁵ Insulin-dependent diabetics have an already reduced rate of spontaneous blood glucose recovery from hypoglycaemia.^{1,6} Any additional attenuation is obviously unwanted.

(4) The normal haemodynamic pattern during hypoglycaemia (tachycardia, reduced diastolic pressure, and raised systolic pressure) is changed by a non-selective agent to bradycardia, which may be pronounced and lead to heart rates below 30 beats/min, and elevated diastolic blood pressure.^{1,8} Ventricular arrhythmias have also been reported.⁸ We have previously reported¹ that the blood pressure in a diabetic patient during hypoglycaemia and propranolol treatment was changed from 110/70 to 200/120 mmHg. When we consider the increased incidence of cardiovascular disease in diabetics this is certainly a potentially hazardous change. In addition, the bradycardia produced by hypoglycaemia and a non-selective agent is probably one reason for the hypoglycaemic coma we noted with propranolol. A cardioselective agent influences the normal haemodynamic pattern less than a non-selective agent¹ and does not lead to bradycardia during hypoglycaemia.

Thus a non-selective agent influences the hypoglycaemic symptoms, attenuates the blood glucose recovery rate, and leads to a more alarming haemodynamic reaction during hypoglycaemia. A cardioselective agent influences these aspects less and should there-