Secondly, if we as doctors are concerned about the physiological health of women using medical methods of contraception, we cannot be merely consumer salesmen (or saleswomen). There are times when we need to refuse a particular method for an individual for medical reasons and at the same time explain the reasons.

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Pseudomonas cross-infection due to contaminated humidifier water

SIR,—Referring to the article on *Pseudomonas fluorescens* cross-infection by Dr Penelope J Redding and Mr Paul W McWalter (26 July, p 275), I report an exactly similar problem with an infected reservoir of humidifier water that caused chest infections and deaths in intensive care patients.

After a series of deaths (including a 31-year-old man) in postoperative surgical patients treated in intensive care (not all on ventilator therapy) we screened bacteriologically all possible sources of bacterial contamination. An 8-litre plastic container containing sterile distilled water standing outside the theatres, utilised to refill the humidifiers used to administer nasal oxygen to postoperative surgical patients, contained *Pseudomonas aeruginosa*, as did the humidifiers.

The hospital subsequently switched to Hospal Aqua-Pak disposable gas nebuliser humidifiers for all purposes for postoperative oxygen for spontaneously breathing patients intubated with a T-tube. These sets have a 500 or 100 ml water canister and a "dial a percentage" oxygen control, driven directly from the oxygen flowmeter, and are exceptionally convenient. Every 24 hours the whole set was changed. Ventilator tubing and humidifiers were changed at least daily. The Bennett cascade humidifiers were either run at 55°C or had 1% aqueous chlorhexidine (non-volatile) added to them.

In my experience this habit of using large-volume canisters is widespread, and many staff are not aware of the fact that it is so dangerous.

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Single-car road deaths—disguised suicides?

SIR,—The observed monthly variations in the recorded total numbers of deaths by suicide may possibly be appreciably affected by the extent to which deaths which are at risk of being mistaken for suicides are recorded as suicides. If there is a tendency for the total numbers of deaths from these two causes (suicide and possible suicide) to be relatively constant, there will be a negative association between changes in the numbers of the two kinds. Mr J Jenkins and Dr P Sainsbury (18 October, p 1041) seem to assume that any important association must be positive. Nevertheless, their table shows that the greatest sum of the ranks for six consecutive months occurs from September to February for single-car single-occupant road deaths and in precisely the other six months for the suicides.

Spearman's rank correlation coefficient,

computed from the ranks given in their table, is $r_s = -0.64$, for which $p < 0.025$ in a two-sided test of the hypothesis that this is a chance deviation from zero. This calculation disregards the variation in the lengths of the months, which might be expected to have a slight tendency to produce a positive association. If the ties are broken by reference to the numbers of days (for example, 44 deaths in February may be regarded as worse than 44 deaths in July), $r_s = -0.65$; but if the rankings are done on the average numbers of deaths per day r_s moves towards zero but cannot nullify the question of the relationship between the two series.

Quite possibly the number of weekends or public holidays, or of days of extremes of weather or some other factors, would be better for standardising the months. A satisfactory analysis would require much more information than could have been given in a short paper. It may be noted, however, that, very roughly, a change of 10 deaths by suicide is accompanied by a change in the opposite direction of one death in the tabulated car accidents. One possible explanation, which can perhaps easily be confuted, might be that about one-tenth of the recorded suicides are accidental deaths (perhaps associated with preoccupation, emotional stress, mental confusion, or tiredness) of a general kind, of which some of the single-car single-occupant deaths are an alternative manifestation.

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Listening and talking to patients

SIR,—In interviewing a patient the doctor must guide the topic of conversation towards those subjects which must seem to him most likely to yield a diagnosis. It may be quite natural in these circumstances that a patient may feel frustrated in his desire to enlarge on what may interest him. When a consultant recommends that patients should be given more opportunity to talk at length to the GP it is reasonable to point out that more time given to the history may mean less time available for the examination, and that other consultants recommend that patients should be examined more. It would probably be wisest to allow GPs to decide for themselves how best to apportion their time between history-taking and examination in order to obtain the best results.

B JAMES

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Perinatal practice and compensation for handicap

SIR,—Mr P Mitchell and Mr I G Chalmers's letter (27 September, p 868) on perinatal practice and compensation for handicap is timely and appropriate, as is the subsequent correspondence in the issue of 18 October (p 1067).

I agree it is a disaster that parents of severely handicapped children should be expected to provide evidence that the handicap of the child is a result of some iatrogenic cause because this may be impossible and is irrelevant. Like Professor Illingworth (p 1067), I am particularly concerned about the cases of so-called damage from whooping-cough vaccination. There is no incontrovertible evidence

that whooping-cough vaccine itself causes brain damage or convulsions. The legislation now active for compensation for whooping-cough vaccination victims was totally wrong, partly because it implicated the whooping-cough vaccination as potentially harmful and partly because it restricted compensation to a small proportion of severely handicapped children. It takes a very long time to get such compensation and much of the cost may be absorbed, as Mr Mitchell and Mr Chalmers say, by administration. The Act dealing with vaccine-damaged children has reinforced the fear of many and has contributed substantially to the major outbreak of whooping cough in our population. Probably for some 20 years I have hardly seen a case of whooping cough in our wards; we are never without them now.

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DHSS in the witness box

SIR,—You consider it laudable in your leading article (18 October, p 1023) that in a parliamentary democracy government ministers are called to account for their actions, but how much better would it be if on certain important occasions their intentions were also more closely examined. It does not require a Commons select committee to expose the present inefficiency of the NHS. This is self-evident, much of it the predictable outcome of the 1974 reorganisation. Could not the same or some other equally inquisitive and influential parliamentary committee take evidence now from those of us who are deeply concerned about the next phase of reorganisation?

In Wales the Secretary of State has produced a document frivolously entitled *Patients First* declaring in a supplement his misguided intention to retain area health authorities. In this area he will even increase its membership and the authority, in turn, will keep every element of its cumbersome central administration—including, for example, a superfluous and costly planning department with nothing new to plan. And to our dismay extra administrative offices will be built in our clinically deprived hospitals to house the next generation of district officials.

To improve "efficiency," meanwhile, when laboratory workers, medical secretaries, and other lowly but essential members of staff retire or move elsewhere they will not be replaced, regardless of the consequences in terms of service to patients. We have, of course, been involved in the ritual of so-called democratic consultation and in the fullness of time will look forward to another leisurely select committee report deploring the continued disintegration of the NHS.

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Pay of AMOs and RMOs

SIR,—The letter (1 November, p 1218) on the subject of merit awards for area medical officers (AMOs) and regional medical officers (RMOs) deserves some comment. Your readers may not be aware that the generality of AMOs and RMOs receive a supplement