Real Education

SIR,—Mr. Patrick Trevor-Roper's article (16 January, p. 170) reviewed the irrational views and statements of apparently intelligent men throughout history and the resultant follies and postulated that we can hardly be different and must be equally unaware of our deficiencies.

Of course. Throughout history the generation of the present has been a failure and it would be the grossest conceit to presume we could be any different. But it can never be hopeless. I suggest that the first generation to realize it is stupid has the possibility of change, for it cannot be denied that in recognition lies the possibility of cure. Mr. Patrick Trevor-Roper knows this and so do I, but that makes only two. Has not the key always lain in education, and the explanation of follies in the absence of education? The answer to the question of how could such intelligent men have made such irrational assertions is simply that they were not educated.

How else to explain the follies and records of today, internationally and nationally? The only answer regarding world leaders, politicians, clergymen, doctors, university teachers, etc., can be that they are uneducated. Can it be that bishops, cabinet ministers, university lecturers are uneducated? Indeed yes, and just because they are these things, technicians in a particular calling, they are probably more likely to be uneducated than a tramp. Up to the present the universities have confused technical knowledge with education, possibly because they are staffed by historical technicians, mathematical technicians, etc. Education has always occurred by accident, as so well put by Sitwell: "educated between terms at Eton."—I am, etc.,

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Shortage of Technicians

SIR.—Drs. C. E. D. Tavor and D. A. McSwiggans in their letter (9 January, p. 114) disagree with my remarks regarding graduates in medical laboratories (5 December, p. 623). I would appreciate a final opportunity of explaining in greater detail the reasons for my comments.

A young man or woman who comes into the pathology department aged 17-18 with O or A levels, and has decided to make medical laboratory technology a career, should at the end of three years' training be a very useful member of the pathology staff, competent in the basic techniques of three disciplines. However, if we employ a freshly qualified graduate he will already be specializing in one discipline, often biochemistry, and will have little or no knowledge of basic medical laboratory techniques. He will in twelve months or so probably be a competent chemist, but will be of little value during an emergency in haematology or for other duties outside his chemical pathology experience. In a large pathology department or specialist unit the type and volume of work is such that graduates are employed not only in one section of pathology but often on a single project. In the smaller pathology laboratories the staffing is often

minimal and therefore the inability of a technically inexperienced graduate to "lend a hand" in another department does cause problems. Exactly the same difficulty will occur if medical laboratory technicians specialize too early in their careers. A-level applicants invariably specialize in chemical pathology.

It would therefore seem economically more viable to recruit the right staff at the outset, train them in a purpose-designed school closely linked to the hospital and technical college, with opportunities for higher technical and graduate qualification. Such a scheme would enable the Health Service to recruit and train an ample force of technicians, the more academic among them having graduate opportunities. The end product would, I am sure, result in better technicians and graduates. For many years now we have muddled along staffing laboratories with whatever we could get; long-term planning now would make the future position more favourable.

I hope that graduates who were upset by my remarks of 5 December will now appreciate the comparison I was attempting to make referred to the early part of their careers. My main concern is that both technicians and graduates should obtain a better theoretical and technical training, and would emphasize that I do not believe the present Ordinary National Certificate, Higher National Certificate system, or present graduate recruitment fulfils this purpose.—I am, etc.,

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Health Education for the Public

SIR.—Prevention is better than cure. There will be satisfaction that Action for Smoking and Health has been launched (see *B.M.J.* 16 January, p. 171) specifically to educate a public often ignorant or careless of health hazards. In fact the dangers of smoking were well known to doctors 30 years ago.

A gynaecologist sees need for education in regard to family planning, contraception, abortion, and in the prophylaxis against V.D. and cancer. No doubt there are many other areas where information to the public should be made available in a responsible and sensible way.

I would recommend that hospital boards should be required to spend a small proportion of their annual budget to enable a broadly based education scheme to be launched now. In the long run it could save a great deal of suffering and costly medical treatment. Must we wait a further 30 years for funds to develop this much needed service?—I am, etc.,

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Gold for Rheumatoid Arthritis

SIR.—There is now general agreement that in gold therapy the individual dose of sodium aurothiomalate should not exceed 50 mg. Dosage in excess of this could produce a high plasma concentration of gold which may

persist for many months and could predispose to, or initiate, a toxic reaction.

In view of this it has been decided to cease the manufacture of the 100 mg and 200 mg strengths of Myocrisin (sodium aurothiomalate). The 1 mg, 5 mg, 10 mg, 20 mg, and 50 mg strengths will, of course, continue to be available.

We hope that this action will help to reduce the incidence of toxic reactions and so extend the undoubted benefits of gold therapy.—I am, etc.,

H. J. A. RICHARDS

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Long-acting Phenothiazines in Schizophrenia

SIR.—It was recently suggested (23 January, p. 189) that long-acting intramuscular injections of fluphenazine are no more efficacious than equivalent oral preparations taken regularly and reliably. The implication was that fluphenazine injections merely overcome problems caused by psychiatric patients failing to consume prescribed tablets. In contrast with this view, recent combined biochemical and psychiatric studies suggest that failure to absorb orally-administered phenothiazines may be a major factor contributing to the value of intramuscular injections.

Twenty-four female long-stay patients were studied. All were deteriorated, institutionalized schizophrenics, treated with phenothiazines over many years. During the study, the patients were first treated for 28 days with oral chlorpromazine on a thrice daily regimen (average dose 75 mg; range 25-200) and on the 28th day blood samples were collected at the time of the morning dose, and two, four, and seven hours later. Oral medication was then continued for seven days, and on the seventh day the usual morning dose was replaced by an intramuscular dose of the same magnitude. Four blood samples were collected at zero, two, four, and seven hours after this second dose. After this, 15 of the patients (already considered satisfactorily treated) continued to receive oral chlorpromazine, and the other nine (in whom some improvement could be anticipated) received fluphenazine decanoate. The blood samples were examined for plasma chlorpromazine content, and the 24 patients were evaluated for general change in condition during a three-month period.

The 15 patients who received chlorpromazine throughout the study and five of the patients treated with fluphenazine decanoate showed no changes in condition. The mean plasma chlorpromazine concentration in these 20 patients after the intramuscular and oral doses differed by only 2%. The four other patients, who received fluphenazine decanoate, showed changes in condition. One was treated for a short period only before a deterioration in condition occurred, and restoration of oral chlorpromazine became necessary. Plasma chlorpromazine was more than 50% higher after the oral dose compared with concentration after the intramuscular dose. The other three showed varying degrees of improvement. The mean plasma chlorpromazine concentration after the oral doses was about 10% less than the mean concentration after the intramuscular dose. The most extreme difference (a mean

concentration of 15.5 ng/ml after the oral dose, and a mean concentration of 81.5 ng/ml after the intramuscular dose) was seen in the patient (case 2, see later) showing the greatest improvement. Brief descriptions of the three patients showing improvements are as follows.

Case 1.—Woman aged 62. Continuously in hospital since 1927. Uncommunicative, with florid psychotic episodes, fatuous, lacking initiative and interest. Treatment with fluphenazine decanoate (75 mg weekly) has been followed by an increase in communication, mobility, and activity. She has recently displayed considerable initiative, participating in ward activities of her own accord, and become increasingly aware of, and concerned about, personal hygiene and appearance. She has insisted that she be allowed to work in the hospital industrial unit. There has been no recent evidence of florid psychosis.

Case 2.—Woman aged 51. In hospital since 1949 with previous history of hospital admissions. Leucotomized in 1945. Generally considered one of the most bizarre cases ever seen by the hospital staff, with eccentricities of dress and appearance. Always solitary and asocial, grossly deluded and hallucinated, and preoccupied with ruminations and fantasies. Occasionally antagonistic and uncooperative. Treatment with fluphenazine decanoate (75 mg weekly) has been followed by improvement. While still eccentric and bizarre, she is now more co-operative and able to sustain conversation. She is less antagonistic than previously, but still refuses to participate in various rehabilitative programmes.

Case 3.—Woman aged 38. In hospital since 1964 with previous history of hospital admissions. Of central European extraction, she appears to understand little English, although it is probable that she knows more English than she admits. Impulsive and unpredictable behaviour, with a history of violence, suggests continuing florid psychosis. Treatment with fluphenazine decanoate (75 mg weekly) has been followed by improvement. She is less impulsive, more amenable and more interested in ward activities, although this improvement has not been as prominent as the improvement in patients 1 and 2.

These results appear to indicate a relationship between the success of fluphenazine decanoate treatment in certain patients, and the ability of the patients to achieve high enough concentrations of orally administered chlorpromazine in plasma. The one patient who relapsed when treated with intramuscular injections was the one who showed evidence of slow absorption of intramuscular injections of phenothiazines, and the three who improved showed evidence of impaired ability to absorb the unchanged drug from the intestine. Results of separate studies have suggested that this impaired ability is brought about by drug decomposition in the intestinal wall.²

It is quite possible that other orally administered phenothiazines also undergo this decomposition, and that intramuscular injections of phenothiazines other than fluphenazine would be of value in susceptible patients. Analytical problems, however, prevent comparisons with any compound other than chlorpromazine at present. Further studies of clinical status in relation to phenothiazine absorption are still in progress, but at this stage it would appear prudent not to exclude from assessments of long-acting phenothiazine injection, the possibility of their value in patients failing to effectively absorb drugs given in the form of conventional tablets.

We are grateful to Drs. Bradley, Maddocks, Spencer-Peet and Coombes, and to the nursing

staff, all of St. Bernard's Hospital, and to Mr. Mould and Mr. Riddall of the London Hospital Medical College, for assistance with the project.

—We are, etc.,

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¹ Curry, S. H., *Proceedings of the Royal Society of Medicine*, 1971, **64**, 285.

² Curry, S. H., D'Mello, A., and Mould, G. P., *British Journal of Pharmacology*, 1970, **40**, 538.

Benign Prostatic Enlargement

SIR,—Although I enjoyed the article on benign prostatic enlargement by Professor J. P. Blandy (2 January, p. 31), which I thought was lucid and amusing, I regret the implications contained in the paragraph referring to specialist urological clinics (and specialists) versus the occasional prostatectomist, to which Mr. R. J. Luck (16 January, p. 175) quite understandably objects.

If a one-time occasional prostatectomist may venture to question a professor of urology may I say I was somewhat surprised to note the omission of any reference to the importance of routine cystoscopy as an aid to differential diagnosis and assessment in these cases. Of course, even occasional prostatectomists, if properly trained, customarily make the sort of investigations indicated in Professor Blandy's article, but the omission of cystoscopy—particularly where haematuria has been a symptom—will sooner or later catch you out when a small neoplasm or other lesion does not show up in an excretion pyelogram. This has happened on at least one occasion in my experience.

Personally I do not believe that the referral of all cases of any particular variety to specialized clinics is necessarily in the public interest, besides being generally impracticable. The construction and staffing of the numerous special clinics to treat all cases of a common illness are needlessly expensive and quite unnecessary for the treatment of the vast majority of sick people. Moreover, in the past a multiplicity of self-styled specialists did not always provide the best professional standards available as compared with the work done by consultants with a more generalized outlook on their cases.

The real test of the value of a specialist in any particular surgical field is that by his experience and results he is able to command the confidence of other surgeons, who will wish to refer their difficult cases to him when they feel that these patients will stand a better chance by so doing. These remarks apply to all branches of surgery, and while ordinary surgical consultants should be able to deal competently with the vast majority of cases referred to them there are generally some cases of all varieties which the honest surgeon will wish to transfer elsewhere, but the decision to do so should be his and should not be dictated by "policy."

In these days of mass publicity concerning medical matters, which tends to foster the growth of morbid interest and anxiety among potential patients, it seems more than ever desirable that those of us who hold responsible positions should avoid making any criticisms of other consultants' work. Such implied criticisms are liable to undermine the confidence of patients in those who are perfectly capable of exercising proper professional judgement in their best interests.—I am, etc.,

JOHN C. NICHOLSON

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Henry Norman Bethune

SIR,—I am involved in research on the life and career of the late Henry Norman Bethune, M.D., F.R.C.S.Ed. (1890-1939). Dr. Bethune, a Canadian thoracic surgeon, became well known in North America during the early 1930s for his development of surgical techniques and his invention of various surgical instruments. In 1936 he went to Spain, then in the midst of the civil war, where he established the Canadian Mobile Blood Transfusion Service. By transporting refrigerated blood to the wounded Bethune saved many lives. Early in 1938 he left for China to serve with the Eighth Route Army against the Japanese. Even before his tragic death (ironically from septicaemia) in November 1939 he became a legend in China. During his two years in that war-torn land he trained doctors, established mobile hospitals, and taught improvisation in the manufacture of medicines. During most of this time his operations were constantly a few miles from the advancing Japanese forces.

Between 1920 and 1923 Dr. Bethune was in London where he worked in the Hospitals for Sick Children, Queen Mary's Hospital for the East End, the West London Hospital and the London Fever Hospital. I am anxious to correspond with any of your readers who may have known Dr. Bethune or possess documentation relating to him. It is my intention to produce a documented analysis of Dr. Bethune's career.—I am, etc.,

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Cameron Fund

SIR,—Through the courtesy of your columns I should like to draw your readers' attention to the fact that, as from 1 April, the Cameron Fund (*Supplement*, 13 February, p. 45) will be in a position to receive and consider applications for assistance from general practitioners and their dependants who are in financial difficulties.

Full details concerning the Fund and also application forms will be available on 1 April from the Secretary, Miss Hazel C. Pullen, at the Fund's office in Tavistock House North, Tavistock Square, London WC1H 9JP, telephone 01-388 0796.—I am, etc.,

B. HOLDEN

Chairman, Cameron Fund Ltd.

Democratic Direction

SIR,—Sir James Howie is one of the few medical statesmen. His lecture (26 December, p. 793) on the way decisions are reached should make us all ask who makes National Health Service policy, and what are their reasons? The silence which has followed its publication makes one realize that the whole training and outlook of medical men is to solve the problems of individual patients, not to formulate, or even to discuss intelligently, the policy of a health service. The purpose of the Service is to treat the largest number of patients in the most efficient way, consistent with reasonable economy. Is this being done?