ments now taking place in this continent, significant differences are becoming obscured. It is suggested that details of the transfusion services throughout Africa should be collected and made available in pamphlet form to each co-operating service and to workers overseas who might be interested in having this information. This simple project should prove to be of particular interest to those workers who will be engaged in the International Biological Programme which will be commencing shortly.

May I request, through the agency of your journal, that any transfusion service in Africa should send me the following information: (1) title of service; (2) address; (3) name of medical director; (4) area or region served; and (5) name of the responsible authority. It is hoped to obtain at least one address for each country. I would also be pleased to know of any organization or individual who may be interested in receiving copies of the information gathered from this survey.—I am, etc.,

G. W. D. HENDERSON.

Bulawayo and District Blood
Transfusion Service,
Southern Rhodesia.

Pleural Biopsy

SIR,—The following modification of pleural biopsy technique, using an Abrams¹ needle, has proved useful. The skin preparation, insertion, and aspiration are as hitherto described, save that only minimal fluid is aspirated. The needle is rotated downwards, and withdrawn until it bites the pleura. The

needle is not closed at this stage, as is done in the standard procedure. Instead the pleura is drawn through the window of the needle by pulling on the plunger of the syringe. Now, while maintaining the pull with one hand, the needle is closed by the other. A larger specimen of pleura is thus obtained, and thereby a greater chance of a positive result.—I am, etc.,

London Chest Hospital. J. F. FIELDING.

REFERENCE

- ¹ Abrams, L. D., *Lancet*, 1958, 1, 30.

Quinine and Cramp

SIR,—Tabs. quinine sulphate, gr. 5 (0.32 g.), appear to have been in use for some time as an empirical treatment for and prophylactic against cramp.

For some time I have been using gr. 1 (65 mg.) t.d.s. for one week followed by gr. 1 nocte or p.r.n. This I have found to be quite as efficacious as the larger dose. As a personal sufferer also, I have found it so. Moreover, gr. 1 does not increase my tinnitus or deafness; gr. 5 does both.

May I suggest the wider use of this smaller dose as both tinnitus and deafness can become quite a problem in older patients?

As the gr. 1 tablet is becoming increasingly difficult to obtain, can anyone tell me who is now making it? B.D.H. did, but I have been informed are no longer doing so.—I am, etc.,

London N.1. MARGARET O. THORPE.

Seasonal Onset of Acute Leukaemia

SIR,—The purpose of this letter is to show that there is a winter peak of incidence of clinical onset of acute leukaemia in all seven of the series reported so far in which there are adult as well as child cases.

Tables 1 and 2 show a November–February or (in one series) a December–February peak of onset in six of the seven child-plus-adult series, the sources being respectively Belgian,¹ Danish,² Italian,³ Spanish,⁴ and American.⁵ The American report also gives the month of histological diagnosis, and Table 2 shows a December–January peak of

diagnoses in males and a February–March peak in females. In all six instances the authors themselves remarked on the existence of a winter peak of onset both in their own series and in all or most of their predecessors' series, but their results have not been known to recent workers.

By contrast the many series to date which contain only child cases display great variation in seasonal incidence of onset. The form of this contrast is consistent with the successive observations of Engelbreth-Holm⁶ and Scanu⁷ that the winter peaks of onset in their respective series are, in fact, confined to the cases aged over 12 in Scanu's series and to those aged over 15 in Engelbreth-Holm's series (Table 3)—cf. Hayes⁸—and is also consistent with the data of Lee's⁹ British series. Certainly there is in Lee's

series a December–January peak of onset in the cases aged 0–19 (Table 4) as well as in those aged 20–44 (Swan¹⁰), but despite this the ratio of cases aged 20–44 to those aged 0–19 is very much higher in November–February—viz., 1.39 (827:596)—than in March–June—viz., 1.13 (792:703)—or in July–October (711:665).

TABLE IV.—*Acute Leukaemia Cases in Children and Adults (Data of Lee⁹)*

Month of Clinical Onset	Cases Aged 0–19		Cases Aged 20–44		Month of Clinical Onset	Cases Aged 0–19		Cases Aged 20–44	
	Diff.	Und.	Diff.	Und.		Diff.	Und.	Diff.	Und.
Mar.	148	59	111		Oct.	152	58	109	
Apr.	173	65	114		Nov.	123	74	101	
May	173	85	115		Dec.	169	75	158	
June	209	75	168		Jan.	165	64	156	
July	162	53	136		Feb.	139	68	131	
Aug.	187	52	111		Mar.	148	59	111	
Sept.	164	69	123						
Oct.	152	58	109						

Thus in the seven child-plus-adult series of acute leukaemia cases reported to date a winter peak of clinical onset has invariably appeared, and most of the evidence, whether direct or circumstantial, suggests that these peaks have been largely due to adult cases. It remains to be seen whether similar peaks will prove to be the rule in future series.—I am, etc.,

Royal Infirmary,
Aberdeen.

T. M. ALLAN.

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- Engelbreth-Holm, J., *Klin. Wschr.*, 1935, 14, 1677.
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- Scanu, A., *Rif. med.*, 1954, 68, 449.
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- Hayes, D. M., *Cancer (Philad.)*, 1961, 14, 1301.
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Longer Training for Radiographers

SIR,—May I comment on the letter of Mr. R. F. Farr (18 July, p. 191)? The pre-registration year will cause much trouble to x-ray departments, and therefore to the hospital service as a whole, in the transitional year, if not longer. Those students who remain at their training schools will not be available for the other hospitals (the majority), and those who go to other approved hospitals will be much less useful than if they were registered and fully "operational." We have experience of employing radiographers from before their final examination results were known and then, after it was known they had failed, keeping them on as unqualified radiographers, unable to take full responsibility, not being able to take charge of a small sub-department, and not being able to do their share of unsupervised night duty. Thus, they are better than nothing but much less valuable than when qualified. In this transitional year it would be a question of having the third-year students not as well as qualified radiographers but instead of, if the hospital concerned were approved. That the third-year student could not undertake unsupervised night duty would be, especially, a nuisance. More night duty than usual would have to be undertaken by the others, and this at any time, but especially when there are shortages from sickness, annual leave, and unfilled vacancies, would make it excessive

TABLE I.—*Acute Leukaemia Cases of All Ages (Data of Various Authors, 1934–54)*

Months of Clinical Onset	Lambin and Gerard ¹	Engelbreth-Holm ²	Storti and Brotto ³	Scanu ⁴	Guasch ⁵	Total
July–Oct. Nov.–Feb.	11 26	23 45	17 20	34 41	21 36	106 168
March–June	17	28	12	33	31	121

TABLE II.—*Acute Leukaemia Cases of All Ages (Data of Hayes⁸)*

Months of Clinical Onset	No. of Cases	Months of Histological Diagnosis	No. of Cases		
			M.	F.	Total
June–Aug. Sept.–Nov.	30 41	Aug.–Sept. Oct.–Nov.	12 11	14 8	26 19
					45
Dec.–Feb.	66	Dec.–Jan. Feb.–Mar.	27 23	11 22	38 45
					83
Mar.–May June–Aug.	50 30	Apr.–May June–July	18 18	14 8	32 26
					58

TABLE III.—*Acute Leukaemia Cases in Children and Adults (Data of Engelbreth-Holm² and Scanu⁴)*

Months of Clinical Onset	Cases Aged Under 12 or 15			Cases Aged Over 12 or 15		
	Scanu's Cases Under 12	Engelbreth-Holm's Cases Under 15	Total	Scanu's Cases Over 12	Engelbreth-Holm's Cases Over 15	Total
July–Oct. Nov.–Feb. March–June	14 9 15	8 9 9	22 18 24	20 32 18	15 36 18	35 68 36

for the others. Night duty is particularly unpopular and an increase would tend to drive women out of radiography.

The student having spent her third year in a training hospital or at one or more non-training hospitals will not be appreciably more competent, if at all, than the radiographer who qualified after the second year and spent the third year with full responsibility. Radiographers, like doctors, only begin really to learn when they are up against problems alone. Mr. Farr writes of the increasing complexity of radiology, but the more advanced techniques tend to be left to the more senior radiographers, and one more year as a student will not make the newly qualified radiographer more competent to deal with neuroradiography, angiocardiology, and the like. Mr. Farr suggests that the third year will make it easier to attract students, but this is questionable and anyway unnecessary. It has been shown¹ that by a simple programme of lectures by a suitable lecturer accompanied by slides at schools and demonstrations in x-ray departments students can be easily recruited. Mr. Farr suggests

that this third year as a student will lead to more radiographers staying on to become seniors. Surely he knows that the bulk of the wastage of female radiographers is due to marriage. Indeed, this is a reason for letting students start at 17 and qualify at 19, to give as much useful service as possible before they give up. As for men, much as we appreciate those already in the hospital service, in their own interest they should keep out of radiography, for the salary is too small for maintaining a family and will remain so in the foreseeable future.

The third year is unnecessary for the radiographer and would be a positive nuisance to the hospital service, in the transitional year if not later. The ancillary departments find it difficult to keep going on account of staff shortages. It is to be hoped that the Society of Radiographers will abstain from rocking the boat.—I am, etc.,

Whittington Hospital,
London N.19.

G. OSBORNE.

REFERENCE

¹ Osborne, G., *Lancet*, 1960, 1, 96.

Practice Expenses

SIR,—The Tables supplied by the Minister (*Supplement*, 22 August, p. 121) are scarcely worthy of a man who not so long ago served a diligent apprenticeship at the Treasury. I think all would agree that in order to achieve tax relief one has first to achieve a reduction in net income either by earning less or incurring higher expenses. If we take the first example quoted we see that an expenditure of £300 would incur a direct reimbursement of £200 and tax relief of £30. The inference here is that the difference between £300 and £200 would be paid from the doctor's own pocket, reducing his net income by £100 in order to achieve a tax relief of £30. This would be clearly an entirely new departure from the previous policy of reimbursing the doctors as a whole for all the practice expenses which between them they incur.

On the other hand, if the Ministry argue that the £100 would be returned, more or less, from the Pool, or what remains of it after the fixed amounts have first been paid, then the reduction in the practitioner's income would not occur and the tax relief would not occur either. You can't have your cake and eat it.—I am, etc.,

Doncaster.

W. E. McPHILLIMY.

SIR,—Am I to understand that the Minister of Health's magnanimous practice allowances are to be taken from the Pool and that we must endure a "reduction in capitation and other fees . . . that may . . . be only temporary (22 August, p. 463)?"

I hope that we, the G.P.s affected, are going to be allowed to decide (by postal ballot, if necessary) whether we accept the proposal or not; or is it to be another example of the "leadership" under which we have suffered so much for so long?—I am, etc.,

Leeds 8.

P. A. BROWN.

SIR,—The current proposals from the Minister of Health to reimburse part of the cost of ancillary help in general practice

directly (all, of course, indirectly as previously) may well be accepted by the profession. It should be pointed out, however, that this is simply another step in the control of the type of "medicine" to be provided by general practice. Whereas in the present system there is a measure of natural control persuading towards the employment of ancillary help (good doctors to-day cannot usually practise satisfactorily without it) the proposed system will be imposing artificial control directing towards that end.

Despite the fact that it is encouraging the type of medicine which I try to practise; despite the fact that I, personally, shall not lose financially and may well gain something; despite the fact that for once bureaucratic direction may be directing along the right path, it should be resisted as strongly as the present system has been condemned. Indeed, in principle, it should be opposed with greater vehemence.

This is one more step in directing how general practice shall be practised and not, in fact, an encouragement allowing general practice to develop according to natural needs even though at the moment the two may coincide.—I am, etc.,

Boston, Lincs.

R. K. ALLDAY.

SIR,—The Minister's proposal is very welcome, but I do hope the B.M.A. will take all steps to see that the doctor's wife is not still "unpaid labour." I have paid my wife for 17 years, but am not prepared to do so in the future.—I am, etc.,

Castle Cary,
Somerset.

ARTHUR PATENALL.

SIR,—Am I dreaming? Compulsory continuing deductions from my remuneration to help pay for the receptionist employed by my competitors, with a promise of possible further deductions to help towards the cost of enlarging and renovating their premises. No, Sir! —I am, etc.,

Larne, Co. Antrim.

W. B. JAMISON.

Hierarchies in Mental Hospitals

SIR,—I am writing with regard to a peculiar state of affairs in psychiatry.

There is a general consensus of opinion that psychiatric cases should be treated and cared for as any other type of illness. However, the psychiatric consultant is not receiving the same treatment as other consultants in other specialties. I refer to the continuing appointment of medical superintendents and, even more sinister, of psychiatrists who are called "medical directors." Surely this is a very anomalous situation. Psychiatrists and their administrative colleagues are showing an alarming tendency to perpetuate rigid hierarchical staffing structures which are totally out of date since the Mental Health Act, 1959.

There can be little doubt that the greatest hindrance to progress in British psychiatry has been the medical superintendent. I have little doubt that most have been and are well-meaning, but what damage they have wrought. They have more or less prevented the clinical consultant psychiatrist from realizing his full potential in the clinical field. This is shown in hospitals where consultants run their own firms unhampered. The great change that is being brought about is due in many of its features to the breaking down of rigid hierarchical staffing structures, of which the medical superintendent is the main monument.

There is no need for the continuing appointment of medical superintendents or of medical directors. The Medical Advisory Staff Committee can function fully in the guidance of general medical policy, and the trained administrators who are the hospital secretaries can get on with the general administrative work. I would also say that the imposition of hierarchies within the consultant staffing of psychiatric hospitals is out of date and is separating psychiatry from the general practice in other specialties. Each consultant should run his own unit and get on with the job of treating his patients. Some are using the concept of the therapeutic community to further out-of-date hierarchies. This constitutes a dishonest act. The therapeutic community can well do without superintendents and medical directors. I would go as far as to say that the therapeutic community cannot develop under a hierarchical medical staffing structure and the two concepts are quite opposed. If psychiatrists want to progress in stature and be taken seriously by other groups in the medical profession then they must cast away for ever their all-powerful, all-knowing superintendents and directors. The consultant psychiatrist must stand on his own feet and be allowed to act as a responsible consultant, as is the practice in every other branch of medicine.—I am, etc.,

Rubery Hill Hospital, CHARLES ENTWISTLE.
Birmingham.

Treatment of Neurotic Illness

SIR,—Dr. R. Giel and others (18 July, p. 160) provide another brick for the solid edifice of fact relating to psychiatry with their follow-up study of neurotic illness. However, although they may be correct in saying that any new treatment must produce a better than 70% improvement rate before a significant advance can be claimed, they