Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Compulsory Powers over Mental Patients

SIR,—Paragraph 5 of the report of the Royal Commission on the Law Relating to Mental Illness states that “most people are coming to regard mental illness and disability in much the same way as physical illness and disability.” The report then proceeds to recommend (paragraph 296) that “mentally disordered patients should be admitted in the same way as other hospital patients” whenever possible. There would be, however, a residue of cases where it would be necessary to use compulsory powers (the euphemism for certification), which, it is advised, should be done without reference to a judicial authority. There should be, the report says, two medical recommendations, one of which would be by a general practitioner, as at present, the other by a psychiatrist, who would replace the magistrate.

This means that society would indeed have decided that mental illness is a purely medical matter, placing the whole onus on the doctors, even allowing them to take away the patient's liberty. Splendid to have a free hand, you say. Yes, but there is a catch in it. For surely it is clear that society cannot avoid responsibility for a procedure which involves the deprivation of liberty of any one of its members: in other words, at this point, if not before, mental illness must be considered to have social as well as medical implications. The existing procedure, which includes a certificate by a magistrate who represents the law and therefore the community, acknowledges this responsibility. The new recommendation seeks to dodge it. This is just neither to the patient nor to the doctors, on whom all the odium will now descend. In cases where the psychiatrist is attached to the receiving hospital (and this is recommended) the doctor-patient relationship will be poisoned from the outset. Then the community, having in effect washed its hands of the unpleasant responsibility for certification, proceeds to justify itself *after the event* by bringing in judicial procedure. Any compelled patient will be able, within six months of admission, to appeal to a mental health review tribunal. The patient will thus be adequately protected *after* compulsory powers have been used, but the doctor is there to be shot at. The legal machinery which was thrown out of the front door has been smuggled in at the back, and the effect will be that the community, instead of safeguarding all parties—patients, doctors, duly authorized officers, and itself—at the beginning, leaves everything to the doctors, so that it is free later to range itself on the side of the patients and their relations in keeping a careful eye on these suspicious characters to whom the buck has been successfully passed. It will be the doctor who is really on trial at the tribunal.

Since compulsory powers are to be used only for the unwilling, none of whom will have agreed to the necessity for use of compulsory powers, logically 100% of those detained should want to appeal. No doubt, by one means or another, this will be whittled down to quite a small number, which unfortunately is sure to include the most awkward, difficult, and vindictive ones. By the time they appear before the tribunal it will be most difficult in some cases to produce, especially to lay people, convincing evidence of mental disorder. For example, the delusions of paranoid cases will have become less urgent or the patients will have learned how to conceal them. It is certain that many will be discharged by these tribunals and that some of these, fortified by the tribunal's decision, will feel encouraged to take legal action for wrongful detention against the doctors who ordered it. Then doctors will be unprotected by a magistrate's certificate. It will be no wonder then if the mental hospital doctors, faced with a difficult patient, a court or tribunal case with a relative (paras. 503, 504), and a prospective tribunal with the patient, sacrificed thoroughness

to speed in treatment and disposal. It would be a race to discharge the patient before he could reach the tribunal. Such slapdash psychiatry would be bad for everybody. Also, since hospitals are to be allowed to pick and choose their patients, quite a competition in dodging the undesirables could develop.

The Royal Commission's fundamental error, therefore, consists in assuming that the stigma attaching to certification will be eliminated by eliminating certification. It does not understand that the stigma resides, not in the outer world, but in the minds of the people and largely in the unconscious at that. It is therefore projected on to the most obvious and convenient scapegoat. The playing down of certification will mean that another scapegoat will have to be found. A benevolent Commission has provided one which adequately fills the bill—the psychiatrist. Instead of conniving at a national neurosis or flight from reality, would it not have been better for the Commission to have encouraged the public to face the facts and shoulder its responsibilities?—I am, etc.,

Southall, Middlesex.

C. R. BIRNIE.

Plastic Surgery of the Middle Ear

SIR,—Your leading article (*Journal*, July 13, p. 90) draws clear and timely attention to progress in plastic surgery of the middle ear, the subject of recent keen discussion at the summer meeting of the Section of Otology, the Royal Society of Medicine. British otologists have been alive to the possibilities of functional restoration with the use of free, full-thickness grafts since they were first mooted, and many have visited the Continent to study original techniques. There is now a good deal of experience available in this country from which to draw first-hand conclusions, and it would appear to me that results are by no means as uniform nor yet perhaps so optimistic as your article may suggest.

Myringoplasty, strictly speaking, is a simple operation reserved for large dry residual perforations without active middle ear disease, where major mastoid surgery for eradication of sepsis is not indicated. It is a direct successor of older methods of “patching” holes in the membrane such as with cigarette paper, gold foil, or human amniotic membrane. Hearing may certainly be restored to near normal in some selected cases, but I have not found a technique for “swinging in flaps of meatal skin” that gives sufficiently reliable results. Closure of a large perforation with free full-thickness graft can be achieved in a high proportion of cases provided reinfection is eliminated, and only a third of my cases have failed to gain any improvement in hearing.

Tympanoplasty embraces the concept of middle ear and mastoid exploration, eradication of sepsis, and reconstruction of the tympanum. The particular plastic reconstruction required depends on what is left of the conducting mechanism after the sacrifices necessary to eradicate chronic infection. Unless disease is eradicated there would seem no prospect theoretically, nor in my experience in practice, of obtaining a healthy “take” with the graft. It is this microscopical cleansing that is so time-consuming. Tympanoplasty is described by stages according to the conducting remnant left to build on. Stage 1 approximates to a myringoplasty, with the difference that it is applied to a case in which major mastoid surgery is contemplated if exploration reveals the necessity for it. Some opinion would go so far as to abandon the term myringoplasty in favour of stage 1 tympanoplasty.

I feel strongly that, as there is a place for attempting to close small dry perforations by the simple expedient of repeated stimulation of the edges with trichloroacetic acid, there is a definite place for attempting to close large dry perforations by the simple expedient of skin grafting, without intending to do more than close the defect, and that this operation should be designated myringoplasty. It involves the patient in little discomfort except that arising from the removal of skin from a donor site behind the ear, which, site, if properly handled, will heal with a scarcely detectable scar. The stay in hospital need not exceed two days.

(elsewhere it has been performed as an out-patient procedure), and the results are, in my opinion, sufficiently encouraging to deserve its retention.

Tympanoplasty is major surgery, and I do not find the results predictable enough to recommend it to a patient with middle ear deafness unless major surgery is already indicated for the elimination of chronic infection. If, however, active chronic disease is present it may now be considered the operation of choice.—I am, etc.,

London, S.E.5.

STUART MAWSON.

SIR,—I would like to congratulate you on the excellent summary of the principles governing the plastic surgery of the middle ear (*Journal*, July 13, p. 90). I wish to draw attention, however, to one aspect of the problem which has not been mentioned, that of cholesteatoma of the middle ear as a cause of chronic suppurative otitis media. In the present state of our knowledge this disease is not preventable.

In a series of over 150 plastic middle-ear operations it has occurred in approximately 60% of my cases. Cholesteatoma of the middle ear can now be completely cured by these new techniques without destruction of useful hearing, and it is to this type of case that these operations offer the most hope.—I am, etc.,

Doncaster.

PHILIP H. BEALES.

Sterilization of Dressings

SIR,—Dr. Hugo Grant (*Journal*, June 29, p. 1532) is undoubtedly correct in supposing that there are many chinks in the "aseptic line." But in the case of tulle gras or petroleum jelly gauze, the chinks lead in more complicated directions than he supposes.

The sterilization of these materials has been the subject of two papers,^{1,2} in which it was shown that the quantity of moisture normally present in cotton can give rise to a sufficient quantity of steam for sterilization. That it does not always do so is the result of another complication in the physical chemistry of cotton. The assumption that heating in an autoclave is only the equivalent of dry sterilization is therefore quite natural but not in fact correct. The B.P.C. "authority" must be read in conjunction with the tests for sterility, in which any method is authorized *provided that* the bacteriological results are satisfactory. There are so many chinks that nothing but such a test is really capable of dealing with the wide range of conditions which are encountered in practice. Dr. Grant would certainly be correct in assuming that the autoclaving of plain paraffin gauze dressings would succeed only in exceptional circumstances.

The balsam of Peru in tulle gras may or may not alter these circumstances. 150° C. for one hour is not necessarily a recipe for success.—I am, etc.,

Barnet.

R. MAXWELL SAVAGE,

Chief Chemist, S. Maw Son and Sons Ltd.

REFERENCES

¹ Savage, R. M., *British Medical Journal*, 1942, 1, 472.

² — and Chambers, W. P., *Quart. J. Pharm. Pharmacol.*, 1942, 15, 291.

Women's Footwear

SIR,—The letters from your three correspondents (*Journal*, July 13, p. 102) succeed in partially cancelling out their respective complaints. It is gratifying to read that "it is now almost impossible to get a badly shaped child's shoe," and that "the styles of men's shoes during the same period [during last year] have become much more pleasing in appearance and lighter and more comfortable in wear." To suggest that shoes are made for women, including teenagers, without regard for the health and comfort of the wearer is to fly in the face of fact. Manufacturers are neither so irresponsible nor so commercially foolish as to produce styles that are in themselves injurious. For them fit is at least the equal of fashion. They recognize, however, the primary importance of helping the customer to buy shoes that fit correctly, and welcome means of awakening the public to an appreciation of the factors that combine to

ensure beneficial wear. That the medical profession is taking a constructive interest in furthering such education will be welcomed by footwear manufacturers.—I am, etc.,

London, W.1.

A. BARKER,

Director, Incorporated Federated Associations of
Boot and Shoe Manufacturers of Great Britain
and Ireland.

Pink Disease

SIR,—We have recently had a case of pink disease in the Children's Annexe of the Luton and Dunstable Hospital, and on inquiry it was found that the patient had been given a well-known brand of teething powder five weeks prior to admission. It was felt worth while checking on the formula of this teething powder, although the firm has now altered the composition.

It was interesting to find that the powder had not been bought from a chemist but from a village shop, and samples sent to us for inspection showed that they were, in fact, old stock still containing mercury.—I am, etc.,

Luton.

GRAHAME FAGG.

Scapulo-thoracic Crackling in Youth

SIR,—It was with great interest that I read Dr. F. Parkes Weber's account of scapulo-thoracic crackling in youth (*Journal*, May 18, p. 1181). A few weeks before that date I examined a young woman who had been referred for a neurological examination following a motor-car accident. An incidental finding was obvious crackling, both audible and palpable, on rolling the shoulder-blades. The patient was quite unconcerned about it, and its presence was also noted before the accident. I could find no particular reason for it. The only other point of any significance in the patient's history was marked allergy to most of the antibiotic drugs and to many foods. It may be added that x-ray examination of the shoulder-blades was negative.—I am, etc.,

Ramat Chen,

Ramat Gan, Israel.

D. P. KIDRON.

Removing the Pump Handle

SIR,—In your annotation on public health in 1955 (*Journal*, December 22, 1956, p. 1478) you used the incident of the cholera epidemic in Soho in 1854, when Dr. John Snow's advice to remove the handle from the Broad Street pump quickly ended the epidemic, as an illustration for handling the smoking and lung cancer problem. Can you imagine the Soho local authority objecting that there was no proof, other than a statistical one, for the connexion between cholera and the water in that well? Did they require John Snow to separate the cause of cholera from the water and they would then do something about it? It was 1883 when Koch discovered the *Vibrio cholerae*, but the local authority removed the pump handle and ended the epidemic in 1854.

No one was interested in keeping the cholera epidemic alive, but unfortunately many people desire the continuance of the smoking habit. The arguments advanced demonstrate the type of interest involved. They are futile arguments, a sort of smoke-screen for the arguer and his audience. One frequently hears the objection raised that the evidence is only statistical, but what is there against this type of evidence, especially when it involves some 18,000 deaths per annum? A spokesman for the tobacco manufacturers pleaded on behalf of the cigarette that to breathe the polluted air of city streets may be as dangerous as smoking. He is ignoring the M.R.C. statistics there and substituting a guess of his own. Moreover, to give up smoking is a total gain for the smoker, while to give up breathing has obvious disadvantages. The smoker himself makes many excuses, mainly to the effect that it isn't certain that he will be one of the unfortunate ones, and, after all, one has to die of something. No one is so blind as he who refuses to see.

Sir Ronald Fisher (*Journal*, July 6, p. 43) takes you to task for advocating "all the modern devices of publicity."