value of photic radiations) are well known, one wonders why no epidemiological survey of seasonal affective disorder has been undertaken. Presumably congenitally blind people could provide controls worth exploring, other psychological drawbacks notwithstanding. Is the condition more pronounced among the Eskimos, who probably use less artificial light than Swedes? When travelling through Peru I was struck by the paucity of artificial illumination in rural areas. Is anything known about psychiatric conditions there or is life too hard for seasonal affective disorder to flourish? What happens near the equator, where seasonal variations ought to be minimal?

Relevant expert epidemiological studies might provide a short cut to meaningful results, which might elude an apparently more direct approach.

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- 1 Lewy AJ, Sack RL, Miller S, Hoban TM. Antidepressant and circadian phase-shifting effects of light. *Science* 1987;235:352-4.
- 2 Sykes SM, Robison Jr WG, Waxler M, Kuwabara T. Damage to the monkey retina by broad-spectrum fluorescent light. *Invest Ophthalmol Vis Sci* 1981;20:425-34.
- 3 Weale RA. Age and the transmittance of the human crystalline lens. *J Physiol (Lond)* (in press).
- 4 Bone RA, Sparrock JM. Comparison of macular pigment densities in human eyes. *Vision Res* 1971;11:1057-64.

Trusting patients with case notes

SIR,—We were relieved to note that one of the conclusions of Dr David A Sandler and Professor J R A Mitchell (12 December, p 1523) was that "patients could be trusted." It is perhaps unfortunate that the authors appear to limit this trust to patients as post(wo)men by using patients to deliver their hospital discharge summaries to general practitioners in sealed envelopes.

We have recently completed two parallel randomised controlled trials in Newbury, west Berkshire,¹ and in St Thomas's Hospital, south London.² In these trials pregnant women were given their obstetric case notes to hold throughout their antenatal care (and, in Newbury, until the 10th postnatal day). The effects were compared with those under the more usual practice of giving cooperation cards. As in the Nottingham trial, we found no major negative administrative effects. To the contrary, we found that the new system brought savings in clinical and clerical time and, particularly at St Thomas's, meant that notes were less likely to go astray.

In our studies, however, women not only held their own records but also had full access to their contents. When asked for their views women showed a strong preference for this access. Those allocated to hold their case notes felt more in control of their antenatal care and felt they could talk more easily to the doctors and midwives than women allocated to hold a cooperation card.

Dr Sandler and Professor Mitchell refer to the importance of communication, but communication means more than the prompt delivery of information from hospital staff to a patient's general practitioner. In addition to communication between different health service professionals there is a need for two way communication between patients and those caring for them. One medium for facilitating that exchange may be written information, whether in the form of the full case notes or merely a discharge summary.

It might be argued that pregnant women are different from other patients as they are not usually ill. But maternal and fetal problems do arise and need to be written in the notes and discussed with

the expectant parent(s). It is reassuring that in neither of these two trials did access to their notes raise the level of anxiety felt by women under these circumstances. Nor has the experience of patient access to records been confined to obstetrics. It has been reported in such diverse specialties as general practice,³ psychiatry,⁴ rehabilitation,⁵ acute admissions,⁶ and child health.⁷

Such access to personal health information is consistent with recent guidelines from the Department of Health and Social Security,⁸ although these are at present limited to computerised data. Nevertheless, they are a step in the right direction of trusting patients to share with health service professionals in the responsibility for their own health care.

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- 1 Elbourne D, Richardson M, Chalmers I, Waterhouse I, Holt E. The Newbury maternity care study: a randomised controlled trial to assess a policy of women holding their own obstetric records. *Br J Obstet Gynaecol* 1987;94:612-9.
- 2 Lovell A, Zander L, James C, Foot S, Swan A, Reynolds A. The St Thomas's Hospital maternity case notes study: a randomised controlled trial to assess the effects of giving expectant mothers their own maternity case notes. *Pediatr Perinat Epidemiol* 1987;1:57-66.
- 3 Baldry M, Cheal C, Fisher B, Gillett M, Huet V. Giving patients their own records in general practice: experience of patients and staff. *Br Med J* 1986;292:595-6.
- 4 Stein E, Furedy R, Simonton M, Neuffer C. Patient access to medical records in a psychiatric inpatient unit. *Am J Psychiatry* 1979;136:327-9.
- 5 Golodetz A, Ruess J, Milhous R. The right to know: giving the patient his medical record. *Arch Phys Med Rehabil* 1976;57:78-81.
- 6 Stevens D, Stagg R, MacKay I. What happens when hospitalised patients see their own records? *Ann Intern Med* 1977;86:474-7.
- 7 Greene A, Macfarlane A. Patient held child health record cards—a comparison of types. *Health Visitor* 1985;58:14-5.
- 8 Department of Health and Social Security. *Data Protection Act 1984: modified access to personal health information*. London: Department of Health and Social Security, 1987. (HC(87)26/HCFP(87)9.)

Plastic surgery

SIR,—Plastic surgery trainees will welcome the leading article by Mr D M Davies (12 December, p 1502) and the letter by Mr B N Bailey (9 January, p 134). If the specialty is to continue without plastic and reconstructive operations being more frequently performed by surgeons of other specialties consultant numbers clearly need to be increased. The encroachment of other specialties into reconstructive surgery is likely to make it progressively more difficult for juniors to acquire training in some aspects of plastic surgery, particularly head and neck reconstruction.

The career structure for juniors in plastic surgery is being reorganised in a manner which has anticipated many of the proposals in "Achieving a Balance." There are, however, more registrars at present in training than can be accommodated in the senior registrar grade, before senior registrars begin to be appointed under the new training scheme. Many of these registrars have four or more years of experience in plastic surgery, and several have experience in surgical research.

At a time when the specialty is in urgent need of expansion there is a possibility that the surgical skills needed for expansion will be lost through lack of consultant and senior registrar posts. Mr Davies makes the point that the specialty is failing in its commitment to teaching and research. If this is so the research skills of trainees at present in the registrar grade are an asset that the specialty can ill afford to lose, especially as there is at present no

academic department of plastic surgery in this country.

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Nursing grievances

SIR,—About 30 000 nurses each year leave the NHS. Only 1500 of these join the independent sector and they will have worked for five years for the NHS, on average, before leaving. They continue to nurse British patients, who, as taxpayers, contributed to the costs of their training.

Much greater concern must arise from the 25 000 nurses who apparently abandon their profession to work in offices or shops. We need to identify why nurses leave the profession and find ways of attracting them back.

Of the 2000 nurses joining independent hospitals from all sources in 1985 K J Thomas *et al* showed that 75% had gained some special experience (not qualifications) (report to DHSS, 1987). Not unexpectedly, the largest single group were theatre nurses (11%). The NHS therefore lost about 40 qualified theatre nurses to the independent sector. This compares with 385 who completed approved theatre nursing courses in that year. The problem which the independent sector shares is a general shortage of trained and specialist nurses.

The independent sector already takes part in some basic nurse training courses and conducts some specialist courses. The Independent Hospitals Association intends to contribute further by organising appropriate courses and is conducting a study to determine how this can best be done. We want to increase the capacity for training so that more specialist nurses are produced each year.

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Hospital and community health service costs: England and Scotland compared

SIR,—Drs Alastair C A Glen and John K M Hulbert suggest (12 December, p 1566) that our claim that regional differences in private health care activity have little effect on regional differences in unmet need is not sustained by the finding of Nicholl *et al* that the private sector makes a significant contribution to acute care in England and Wales.¹ In doing so they make the fundamental mistake of equating needs with demands (and by analogy activities with outcomes). Since the NHS is concerned with maximising the impact of resource utilisation on unmet need and hence rationing services in line with greatest needs, consideration ought to be given to the effects of United Kingdom average age specific utilisation in relation to needs in both the NHS and private sectors. The simple deduction of observed private sector utilisation from estimated Resource Allocation Working Party (RAWP) targets is inappropriate, as indicated in the recent RAWP review.²

We are not surprised that Drs Glen and Hulbert take a different stance from ourselves on inter-country resource allocation for health care provision. While our concern is entirely the promotion of equal access to health care for equal needs throughout the United Kingdom, Dr Hulbert admits that, as Scottish National Party health spokesman, his concern is for his "own profession and the people of Scotland."³ Such parochial interests are responsible for the existing levels of health care provision in England and Scotland,

which, even under the most conservative assumptions made by Drs Glen and Hulbert in their original paper,⁴ are 10% greater per head of population in Scotland than in England.

In the interests of the 51.5 million members of the UK population (90%) living outside Scotland we would welcome Dr Hulbert's proposals for redressing this imbalance.

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- 1 Nicholl JP, Williams BT, Thomas KJ, Knowelden J. Contributions of the private sector to elective surgery in England and Wales. *Lancet* 1984;ii:89-92.
- 2 Department of Health and Social Security. *Review of the resource allocation working party formula*. London: DHSS, 1987.
- 3 Hulbert JKM. *Scotsman* 1987 Sept 18.
- 4 Glen ACA, Hulbert JKM. Hospital and community health service costs: England and Scotland compared. *Br Med J* 1987;295:207-10.

Points

The malignant neuroleptic syndrome

Dr A M P KELLAM (Whitechurch Hospital, Cardiff CF4 7XB) writes: Drs P Finucane, C Price, and K Ghose quoted the mortality for the neuroleptic syndrome as being about 20% (2 January, p 18). I have recently reviewed some 200 articles on the syndrome and pointed out that the reported mortality is decreasing steadily.¹ Importantly, death is now rare in patients treated with dantrolene or a dopamine agonist such as amantadine or bromocriptine, or both. In the cases reported in the 1980s 19 out of 69 patients treated supportively and three out of 14 treated with benzodiazepines died compared with two out of 33 treated with dantrolene. My concern that many colleagues might be unaware that there was an effective treatment for this condition was increased when, in September 1986, the Committee on Safety of Medicines said of the neuroleptic malignant syndrome, "Apart from withdrawal of the drug, treatment is essentially supportive."²

- 1 Kellam AMP. The neuroleptic malignant syndrome, so called. A survey of the world literature. *Br J Psychiatry* 1987;150:752-9.
- 2 Committee on Safety of Medicines. Neuroleptic malignant syndrome—an underdiagnosed condition? *Current Problems* 1986;18:2.

The unquiet 1960s

Dr B D M WILLIAMS (Stratford on Avon CV37 7EB) writes: It was surprising to read in Sir Douglas Black's otherwise excellent article (2 January, p 53) that the 1960s in the NHS were "years of quiet development with little political interference." In those years general practitioners drastically altered the leadership of the British Medical Association's General Medical Services Committee and collectively threatened to resign from the service. They thereby forced the government to replace a peculiarly pernicious system of remuneration with one which reversed a dangerous decrease in the number of practising family doctors. The change initiated improvements in the standard of general practice, improvements which will continue unless the government enacts one or other of the more ill judged proposals in the recent white paper.

Public Health Laboratory Service pay

Mr B GREATOREX (Public Health Laboratory, Taunton and Somerset Hospitals, Taunton TA1 5DB) writes: Your New Year message (2 January, p 1) refers to the low pay of nurses and secretaries. Medical laboratory scientific officers have been particularly badly treated since 1979 and now earn 20% less in real

terms than they did then. They are excluded from the pay review body that includes radiographers because of their so called lack of patient contact. They are voting with their feet, particularly the young and ambitious. Twenty per cent of basic grade medical laboratory scientific officers left the Public Health Laboratory Service last year. The people who are being driven out all say they enjoy their work, but £6000 a year is insufficient to attract the kind of young person required in today's high technology laboratories.

The Royal College of Psychiatrists and South Africa

Dr ALISTAIR KING (Royal Infirmary, Edinburgh) writes: In his reply to my letter about the banning of Professor Michael Simpson from addressing a meeting of the Royal College of Psychiatrists, Dr J L T Birley (2 January, p 63) claimed that the purpose of Professor Simpson's visit was achieved. Nevertheless Professor Simpson left Britain bitter about what had happened and disappointed that the kind of censorship he was accustomed to in South Africa had been extended to Britain. Until these anonymous doctors who put pressure on the college to ban Professor Simpson come forward themselves and give some good reasons for their protest, I am afraid I must continue to regard them as "bigoted extremists" who do more harm than good to the cause they claim to espouse.

Testing paternity

Mr PHILIP WEBB (Cellmark Diagnostics, Abingdon OX14 1DY) and Professor ALEC JEFFREYS (Genetics Department, University of Leicester) write: Professor Barbara E Dodd and Dr P J Lincoln (5 December, p 1435) state that traditional blood testing methods are usually adequate for testing paternity. They claim that when the father has been wrongly named such tests can provide proof of non-paternity in 97-99% of cases. This is of little comfort to the one to three men in every 100 tested whom these tests cannot exclude, who could wrongly be assumed to be the father and have to pay maintenance for up to 16 years. When the results of traditional blood grouping are inconclusive this then means taking further blood samples for DNA fingerprinting—a most traumatic experience for the child. It also means paying fees for two types of tests, whereas if DNA fingerprinting had been used first only one fee would have been payable and conclusive results assured. By providing results of such certainty magistrates will need to spend less time considering secondary evidence in cases where paternity is disputed. There will also be fewer appeals, thus saving public expenditure. DNA fingerprinting is fast being adopted by both the legal and medical professions as the test of choice in cases of disputed paternity.

Lactose absorption and milk drinking

Dr JEFFREY J SEGALL (London NW2 2PX) writes: Drs M Lember and A Tamm (9 January, p 95) have confirmed in a case-control study my epidemiological findings of an association between a high intake of fresh milk and myocardial infarction.^{1,2} They also implicitly accept the view that the association may not be due entirely to the saturated fat content of milk.³ I agree with them that "lactose absorption does not seem to be a risk factor for myocardial infarction by itself" but suggest that their reported findings do not exclude lactose malabsorption as a risk reducing factor since their adjustments for the other potential risk factors cannot logically be applied to reduction of risk. If so, the observed statistically significant difference in lactose malabsorbers between their two groups, not the estimated relative risk for lactose absorbers and malabsorbers, is relevant: 12 (17%) lactose malabsorbers in the myocardial infarction group compared with 22 (31%) in the control group and 24-32% prevalence in the Estonian population. This subject could be investigated further in London by a study of myocardial infarction in West Indian, white, and

Asian subjects in relation to lactose absorption state and consumption of whole and skimmed milk.

- 1 Segall JJ. Is milk a coronary health hazard? *British Journal of Preventive and Social Medicine* 1977;31:81-5.
- 2 Segall JJ. Hypothesis: is lactose a dietary risk factor for ischaemic heart disease? *Int J Epidemiol* 1980;9:271-6.
- 3 Freed DLJ, ed. *Health hazards of milk*. London: Baillière Tindall, 1984: chapters 10-12.

Mattress contamination

Mr PETER LOWTHIAN (Watford, Hertfordshire WD1 4AJ) writes: Dr Eirian Williams (9 January, p 130) is justifiably scathing about the mattress contamination problem which he has highlighted. From the photograph the mattresses seem to be foam and made to Department of Health and Social Security specifications. It has been known for at least nine years that there is a hygiene problem with these mattresses as the covers become porous after 18 months to two years of regular service. When this happens the foam mattress core may become contaminated.¹ This problem was just one reason for the development of the Vaperm mattress system,² which uses short life water vapour permeable (but waterproof) mattress covers. The recent announcement by the government that certain types of upholstery foam are to be banned from March 1989 suggests that all general purpose hospital mattresses will need redesigning. Is this not an opportune time for an improved DHSS mattress specification which overcomes the hygiene problem and, like the Vaperm, is designed to reduce the incidence of pressure sores?

- 1 Stead S. Contact. *Nursing Times* 1979;75(36) (suppl):18.
- 2 Scales JT, Lowthian PT, Poole AG, Ludman WR. Vaperm patient-support system: a new general purpose hospital mattress. *Lancet* 1982;ii:1150-2.

Sexism in medical writing

Dr FRANCIS SANDOR (Hartlepool, Cleveland TS26 0AR) writes: In the Hungarian language there is no "der, die, das" no "le, la." English became my favourite language because "the" precedes any kind of noun, as in Hungarian. My difficulties were in the opposite direction. I could not understand why in German a child is neutral (das Kind). I turned to the French—who have no neutral. To my horror I then noticed that in French all neutral Latin nouns became masculine without exception. They really are "male chauvinists" (also a French word). In Hungarian the same word is used whether it is a he or a she or only an it, which avoids inadvertent "sex biased" heretical writing without distorting the language. Would Sue Burkhart like to take up Hungarian studies to find out how this sexist habit developed naturally? This would be preferable to those artificial hybrid words mentioned in her paper (19-26 December, p 1585), which have the opposite effect to that recommended by the "publication manual," being irritating and causing "momentary interruptions." The English George Bernard Shaw quotation is more grammatical than these words.

Hemlock poisoning

Dr A HOLLMAN (Pett, East Sussex TN35 4EQ) writes: It is wrong to describe poisoning by hemlock water dropwort (*Oenanthe crocata*) as hemlock poisoning (19-26 December, p 1657). Hemlock is *Conium maculatum*.

Correction

Response to deoxycofomycin in mature T cell malignancies

This letter by Dr A D Ho (5 December, p 1483) should have had the names of Dr Pierre Stryckmans, Brussels, and Professor Robert Zittoun, Paris, included as authors.