objective confirmatory tests are not available. Such cases substantially affect comparison of sickness rates related to diseases, and comparison between reports by different authors.

In sickness absence which is difficult to comprehend in terms of organic or overt psychiatric disability, my impression is that there is frequently overcommitment of the individual's time and energy. Married women are particularly vulnerable in this respect; they may have domestic responsibilities constituting a full day's work and yet (often in response to great economic pressure) contract to do a second job outside their homes. This job may be part or full time; if the patient goes sick after discovering that she cannot do two full time jobs in one day, is the diagnosis 'anxiety state' or 'battle exhaustion'? If she leaves work because of an accident and finds that her Injury Benefit is as much as the wages for her part time job, and that she has time to cope comfortably at home, her convalescence may well be prolonged.

At the risk of apparent self interest may I suggest that Dr Semmence's statement in the third and fourth sentences of fifth paragraph on page 134 ("Although studies have shown unnecessary use of medical services, descriptions of unnecessary sickness absence are largely anecdotal and its extent unknown. The close correlation between social class and occupation and mortality and sickness absence statistics suggests that it may be small."), seem to me at variance with the figures he gives on page 140 under the heading 'Supervision of sickness absence' (which show that 42 per cent of 536,000 cases ceased to claim Sickness Benefit following referral to a medical referee) and may invalidate the third paragraph on page 141 where he doubts the need for the control doctor!

Of course before an estimate of the effect of the medical referee system can be made we need to know the rate at which a comparable group of 536,000 patients 'sign off' in absence of a request to attend for RMO examination.

SCOTTISH RMO.

A College exhibition display

Sir,

The Yorkshire Faculty now possesses a display suitable for exhibitions consisting of three panels. These deal with the founding and early history of the College and include a very interesting collection of photographs of well-known pioneers. The exhibit is readily transported in its purpose-built container and, though heavy enough to need two men to lift it, will fit into the back of a medium sized car. (The size with packing case is length 41¾ ins. x 30 ins height.)

The Faculty displays this exhibit on various occasions and will be pleased to arrange to loan it to other faculties when required. For this a charge to cover expenses would be made. Any who are interested are asked to correspond with: **Dr D. H. Judson, 39 Low Ash Road, Wrose, Shipley, Yorkshire.**

Harrogate. G. W. C. JOHNSON

The college journal

Sir,

Owing to the postal strike the January, February and March issues of the *Journal* came together. I must confess I find little of clinical interest in our *Journal* these days. Only one article and that came from Rotterdam (March issue) was found to be of any interest. Statistical papers seem to overload each issue.

It is felt that more emphasis should be placed on some clinical subjects from family doctors in active practice.

I wonder if other doctors feel the same as I do.

Wallasey. M. Macleod.

Fluphenazine

Sir,

At the present time there are two long-acting injectable phenothiazines (L.A.P.) available in the United Kingdom, Moditen Enanthate (fluphenazine enanthate) and Modecate (fluphenazine decanoate). Both these preparations are metabolised in the body to free fluphenazine or fluphenazine hydrochloride. The pharmacological action is, therefore, identical to *oral* fluphenazine, a drug which has been in use for some years. It is essential to appreciate that there is no evidence that the specific action of fluphenazine differs from other phenothiazines. The potential benefits of long-acting phenothiazines come from their duration of action, the mode of administration, and the associated administrative regime of management.

The side-effects of fluphenazine are shared equally by all other phenothiazines, although the sedative effects may vary. It is true that once injected the drug remains active for several weeks, but this need not increase the risks to the patient provided that care has been taken to stabilize the patient on oral medication *before* transfer to the long-acting injectable form. All the side-effects listed in Dr West's letter (December, 1970) are known to occur with oral phenothiazines. It is well recognized that only 50 per cent of outpatients take their medication regularly and it is likely that any recorded increase may simply be a reflection of the higher percentage of patients receiving regular medication or the increased frequency that patients are seen. A possible additional hazard is a peak rise in the serum level of the long-acting phenothiazines between the second and sixth day after the injection. In our experience (Johnson and Freeman) there is quite likely to be a cluster of Parkinsonian side-effects during this period. A smaller dosage given more frequently overcomes this problem.

Depressive mood swings in patients on long-acting phenothiazines may be aetiologically associated with the drug, as it may with any phenothiazine (Johnson 1969, Dally 1970), but affective changes occur frequently during the