SUICIDE

Sir,
I was interested to read the article by Dr W. M. Patterson (October *Journal,* p. 616). At the risk of being anecdotal, his article immediately reminded me of the summer of 1978 when in a space of two months three female patients on my list took their lives intentionally.

The first, in June, certainly had some evidence of depression but on the day before her death was noted by neighbours to be quite composed even though a traumatic affair had just broken up. She was found two days later neatly arranged in bed with her house in apple pie order having taken a massive overdose of barbiturates.

The second, was an old lady, with chronic bronchitis and on steroids, who had lived alone for some years since the death of her husband. She, like all three of these patients, was intelligent and on developing some post-menopausal bleeding and after my suggestion of investigation, also took a large dose of barbiturates leaving letters to her friends and to myself explaining that her action was entirely intentional as she had no wish to burden the Health Service or other people with treating what was almost certainly a fatal illness.

The third, and perhaps the most remarkable, was the intelligent wife of an ex-Army Officer who having been very active, had virtually been immobilized by a stroke seven years before her death. She had questioned me on a number of occasions on the required dose for ensuring her demise and although I was circumspect she was able to deduce what was required. She carefully arranged the timing, and although I suspect her husband was aware of what was going on he did not interfere. She wrote letters to her friends, relations, and myself, and most remarkable of all, to the local Coroner explaining her actions.

Living and working as I do in an area with a large geriatric population, many of whom are intelligent, and overloaded hospital services, I cannot help thinking that this kind of action will not be uncommon as the population of this country ages.

M. THOMSON

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GIVING A DRUG A BAD NAME

Sir,
The letter by Dr M. K. Thompson (October *Journal,* p. 623) is both timely and pertinent.

The question that should really be asked is "Who stood to gain?" by the intensive campaign to eliminate barbiturates from our prescribing habits.

Let it not be forgotten that whereas barbiturates *depress* consciousness, the benzodiazapines *alter* consciousness. The latter is nothing other than thought manipulation.

The addiction and habituation rates for the latter drugs are even more rampant than for the barbiturates and for very obvious reasons.

Too many drugs are given by too many doctors for no good reason at all. *Cui bono?*

HUGH W. FORSHAW

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PRESCRIBING IN DOMICILIARY MEDICINE

Sir,
Every general practitioner has a round of elderly patients whom he visits at home on a weekly or monthly basis. The patient may be on some form of long-term therapy such as digitalis and a diuretic and on questioning the patient may produce some new symptom like headache, insomnia, or indigestion. Often these symptoms are transient and no treatment is required. However, it is difficult to explain this to the patient without spending a lot of time or appearing unsympathetic, so the usual response is to prescribe the appropriate remedy.

When the patient writes or telephones for a repeat prescription, the new drugs are added to the old so that a pharmacological snowball begins to roll. Old patients tend to get a sense of security from having a large number of bottles around them and feel that what a doctor can do for them is in direct proportion to the number of different drugs which are supplied. The doctor is in a dilemma since it is difficult to appear kind and sympathetic while declining to represcribe an old, well trusted but useless remedy.

Perhaps we should return to the old bottle of medicine remedy. The patient should have all his drugs in one capsule or one solution; the doctor could then change its constitution without the patient's knowledge. Another rule might be that whenever a new drug is prescribed it is always instead of an old drug, and only in exceptional cases taken in addition to an old drug.

BRENNIG JAMES

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AGRICULTURAL MEDICINE

Sir,
I wish to determine the potential professional interest in all aspects of agricultural medicine in the UK with a view to forming a British delegation to the International Association of Agricultural Medicine and Rural Health. Those ideally placed to practise agricultural medicine are doctors in rural areas, veterinary surgeons, and agricultural engineers, backed by toxicologists, epidemiologists, environmental health officers, work science practitioners, and others whose skills relate to occupational health on the land.

Considerable interest in the subject has already been shown in Europe, a diploma being available from the University of Tours. The International Association of Agricultural Medicine and Rural Health, founded in 1961, has held triennial conferences both in the Western and Eastern hemispheres. Thirty countries are represented and a quarterly journal is published in Japan. Important academic and clinical data have been assimilated.

In Great Britain, occupational health is represented by the Health and Safety Executive, which is an advisory service, and legislation is limited to regulations for minimum standards to control hazards, with the provision of treatment in case of illness.

Occupational health services available in industry are in general provided privately. None exist in agriculture, one of our largest single industries; nor is coordinated formal teaching available in the subject. Limited research projects of high quality have been carried out, usually in isolation, without liaison with colleagues in clinical practice.

In Great Britain eighty per cent of land is used for different kinds of agricultural work in areas of low density population. Those who work in it have an excellent record of productivity, producing two thirds of our food requirements. Nutritional health of the whole population depend on farming methods, as they affect biological microprocesses from soil to food.

Morbidity of those in rural areas gives rise for concern, particularly in the very young and the old. In 1978, 73 people died, of whom 16 were children under 16 years of age.

The newly formed Rehabilitation Trust of Great Britain has given agricultural medicine its first official recognition. A short-term objective is to study the rehabilitative needs of the agriculturist, and a long-term one to found an Institute of Agricultural Medicine, in order to correlate and encourage research, provide an information service, and to teach.

If those who are interested would please write to me, a meeting will be arranged to discuss these proposals.

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NIGHT CALLS

Sir,
Dr M. F. O'Ryan (October *Journal*, p. 623) is right to take me to task for classifying childhood croup as a "reasonable but not unnecessary" night call.

I agree that it should have been placed in the "genuine emergency" group.

DERRICK MORTON
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DECEPTION IN MEDICAL PRACTICE

Sir,
The problem of deception in medical practice, which I personally feel is important, has been sadly neglected in your *Journal*. However, it has been dealt with extensively and admirably by Naish (1979). He points out that deception may be conscious, partly conscious, or subconscious and often involves the patient's family in addition to the doctor.

Doctors, as he says, are flattered by large attendances and for this reason may actually encourage the playing of manipulative games. Neuroticism is often just such a ploy and, if it were recognized for what it is, far fewer tranquillizers would be prescribed.

Financial considerations are also, of course, of considerable importance and not only in compensation cases. The 'sick' certificate represents an entitlement to an income while unemployed and I have often found that if I agree to have a patient registered as "Disabled" so that he is officially unfit for any work that he is likely to be offered, he will cease to attend the surgery and to demand certificates once he realizes that he is getting as much from 'Social Security'.

In conclusion, I would urge all my colleagues to read Dr Naish's article.

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Reference

Naish, J. M. (1979). Problems of deception in medical practice. *Lancet*, **2**, 139-142.

URINE MICROSCOPY IN GENERAL PRACTICE

Sir,
Your issue of February 1979 has just reached me. I was delighted by Dr J. M. Wilks' article (p. 103) confirming the validity of urine microscopy in general practice, and would like to make three comments.

First, the value of such microscopy in children with dysuria and frequency is emphasized by the report of Dickinson (1979), who found that only 18 per cent had bacterial infection. He also mentioned the common association of such symptoms with concurrent upper respiratory tract infection—50 per cent in his series.

Secondly, I can recommend the Cooke-MacArthur microscope for the doctor's bag. This small instrument can readily be set up and used when visiting patients in their homes.

Thirdly, a cross etched with a diamond on the upper surface of the microscope slide helps speedy focussing with the high power lens on specimens which are relatively free of suspended matter.

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Reference

Dickinson, J. A. (1979). Incidence and outcome of symptomatic urinary tract infection in children. *British Medical Journal*, **1**, 1330-1332.

A4 RECORDS

Sir,
Dr Acheson (October *Journal*, p. 622) asks what happens to A4 folders when patients transfer from a practice which does use them to one that does not.

In fact, the folders are not transferred but the contents are forced back into standard EC6 envelopes. In the process they are always muddled, often damaged, and sometimes bits appear to have been lost. In short, the notes are converted into some of the most useless records in the country.

As this matter is of some practical importance and there are sometimes delays in publishing letters in the *Journal*, I am also going to write to Dr Acheson privately. I am surprised he has not met this comment previously.

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BOOK REVIEWS

THE UNDER FIVES IN HOSPITAL 1979

Dermod MacCarthy

NAWCH
London
20 pages. Price £1

Although the care of children in hospital has improved significantly during the past three decades, the fact that Dr MacCarthy's report was thought necessary should alert us to the dangers of complacency.

The report concentrates on the stresses suffered by the under fives in hospital, and the practical commitment of the author to their welfare is evident.

Family doctors will, I am sure, readily subscribe to the author's view that in hospital highly skilled medical care must be supplemented by equally skilled attention to the social needs of children, especially those under five.

Whilst I feel that on the whole the book is for hospital-based nurses, doctors, and administrators, few general practitioners will fail to benefit from reading it. After all, most children enter hospital on the advice of their family doctors and it does us no harm to remind ourselves of the potential for causing emotional trauma which our decisions carry.

For such an easily read booklet, £1 represents a very modest investment.

C. WAINE