mention how such trials should be conducted. Apart from trials of cytotoxic agents or other harmful drugs, there are cogent reasons for undertaking trials in healthy volunteers provided that truly informed consent is obtained.

As to randomisation, the authors say, "It is difficult to see how a placebo and no treatment may be used with the full consent of the family member, the family doctor, and the patient." Primum non nocere is a tenet of medical practice and there are many examples where an active treatment, whether surgery, radiotherapy, or chemotherapy, may do more harm than good in some patients. There are other examples where current best therapy is of doubtful value.

In this article Professor Mathe has confirmed himself as a member of what is known as the French impressionist group of trialists. Such physicians have much to offer but in this scientific age their findings are not very well received. Clinical impressions are passé, and both drug regulatory authorities and drug firms recognise this.

There are several other contentious statements: "All physicians today recognise the need for obtaining informed consent." The Medical Research Council is one body who would disagree. "Consent must obviously be written. . . ." This is not obvious outside cancer chemotherapy, and even here there may be reasons for not obtaining written consent. In phase I studies "the existence of unknown factors . . . prohibits the simultaneous submission of more than one subject to the study" at any one time. This stricture can apply only to known toxic drugs or completely new drugs, not to a known safe group such as the cephalosporins, for instance.

Finally, the authors "believe that physicians cannot and do not wish to assume more individual responsibility" in clinical trials. I do not believe that this is true in the UK. It would be interesting to have your readers' views on this and the many other points raised.

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Contraceptives and the under 16s

SIR,—The period between the Court of Appeal's judgment in December 1984 and the reversal of that ruling by the House of Lords in October 1985 (26 October, p 1208) provided an opportunity to record the effect of the change in the law. The 1985 conception rate among 15 year olds will not be available from the Office of Population Censuses and Surveys until 1987. But meanwhile there is some evidence from Brook Advisory Centres that doctors have been severely restricted in their ability to protect sexually active 15 year olds from pregnancy because fewer 15 year olds at risk have sought advice and because fewer of those who have sought advice have obtained contraception.

Although after the Court of Appeal judgment under 16s were still allowed to obtain treatment with a parent's consent, and although the General Medical Council confirmed that doctors were still obliged to maintain confidentiality, many people believed that no under 16s could have contraception and that a doctor was now obliged to tell a girl's parents of her request.

The combined effect has been that in the first six months of 1985 Brook Advisory Centres recorded a drop of 46% in the number of new clients under 16 (219 versus 407 in the first six months of 1984; the equivalent figures for 16 year olds are 536 *v* 518 (+3·5%)).

Although our centres saw only 11% of the 17 900 under 16s seen at all family planning clinics in England in 1984, it is reasonable to expect that a similar decrease will emerge for all clinics when the DHSS publishes the figures next summer.

To examine the effect of the change in more detail we undertook a retrospective study of all the new female clients under 16 seen at the Walworth Brook Advisory Centre, London, in the first six months of 1984 and 1985. There were 83 clients in the first period and 40 in the second, a decrease of 52%. Most of the clients in both groups were aged 15, and most were already sexually active. But in the 1985 group, after the change in the law, there were proportionately more pregnant clients, and fewer of the non-pregnant clients obtained contraception (table I).

As more 15 year olds became sexually active—a cause for grave concern—the conception rate was expected to rise. However, improved access to contraception, as shown in the sharp rise in attendance at family planning clinics, has so far prevented the expected increase (table II).

If the Brook experience has been mirrored in family planning clinics and family doctors' surgeries throughout England the change in the law, together with other trends, will have produced a sad upturn in conceptions to 15 year olds in 1985.

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TABLE I—*Comparison of all new female clients under 16 seen at Walworth Brook Advisory Centre in January-June 1984 and 1985*

	1984	1985
No of clients	83	40
No (%) aged 15	60 (72)	29 (73)
No (%) sexually active	65 (78)	35 (88)
No (%) pregnant	13 (16)	12 (30)
No (%) prescribed contraception (non-pregnant clients)	74 (89)	22 (54)

TABLE II—*Conception rates (England and Wales) and rate of attendance at family planning clinics (England) of girls aged 15*

	1969	70	71	72	73	74	75	76	77	78	79	80	81	82	83
Conceptions	16	18	20	22	21	20	19	18	17	18	17	16	16	17	18
No attending clinics/1000								23	26	26	28	32	37	42	45

Sources: OPCS and DHSS.

Medical hazards from dogs

SIR,—As a casualty officer I read with interest Dr Beulah R Bewley's article (21 September, p 760) and would like to share my observations and experiences in dogbite injuries. Over five months I treated 66 patients with dogbite injuries at Newcastle General Hospital accident and emergency department. The injuries were all minor and predominantly affected the limbs, children being the most commonly affected.

In 47% of cases the dog was a stray and unknown to the patient; this contrasts with a New York study, where 84% of the dogs were unknown.[1] The patients were all asked about the breed of dog. The largest groups were Alsatians (15, 12 of them being unknown to the patient) and mongrels (15, 13 of them being unknown to the patient). These findings were expected because these breeds are the most common breed of guard dog and stray respectively. However, the third group was the terrier, which accounted for 13 cases, and in 12 incidents was known to the patient. This was thought to reflect the irritable temperament of this breed of dog.

Tighter control of stray dogs and selection of a more tolerant breed for a pet would seem to be mandatory.

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MRC trial of treatment of mild hypertension

SIR,—The routine for characterisation of blood pressure used at the Dunedin hypertension clinic and described by Dr H J Waal-Manning and others (5 October, p 972) is not readily usable in general practice. The MRC trial (13 July, p 97) was largely based in general practices precisely because most mild hypertension in the United Kingdom is managed by general practitioners, and characterisation of blood pressure was deliberately carried out by a method approximating to that normally used in general practice.

The finding in the MRC trial that blood pressure falls sharply in the placebo group immediately after entry is a common experience. The only way of ensuring that all trial participants would have pressures consistently within the mild hypertensive range as defined at entry would be to recruit from a higher pressure range. It might be thought unethical to enter people with pressures in such a range when first seen to a study in which they might be given placebo tablets. Entry pressure may well be reasonably representative of an individual's true pressure in response to the normal activities of daily life, even though it is higher than pressures recorded at subsequent follow up visits, when the element of stress has been eliminated by familiarity with personnel and procedures; certainly casual readings of blood pressure are more useful as predictors of subsequent cardiovascular events than are mean values of repeated readings.

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Topical treatment of cutaneous leishmaniasis

SIR,—With regard to our paper on the topical treatment of recurrent cutaneous leishmaniasis caused by *Leishmania tropica* with an ointment containing paromomycin and methylbenzethonium chloride (14 September, p 704) we would like to describe our further experience with the same ointment in acute cutaneous leishmaniasis caused by *Leishmania major*. Over the past four years an attempt has been made to develop a topical treatment for acute cutaneous leishmaniasis. This study included in vitro[1] and in vivo[2,3] experiments in animals.

Sixty seven patients, 19 women and 48 men, aged 4 to 66 years old and suffering from lesions of cutaneous leishmaniasis were treated topically

with an ointment comprising 15% paromomycin sulphate and 12% methylbenzethonium chloride in white soft paraffin (P ointment, UK Patent No GB117237A).

After 10 days' treatment twice daily 73% of patients had no parasites in their lesions; 14% became free within a further 20 days without further treatment, and 13% failed to respond. Pigmentation developed in 18% of the treated lesions and inflammation of varying degree was associated with the treatment. These developments did not affect clinical healing, which was generally completed 10 to 30 days after the end of treatment. In addition, 94% of the treated lesions healed with little or no scarring. No adverse clinical or laboratory side effects were observed except for a burning sensation at the site of treatment. Parasites isolated from patients who failed to respond to topical treatment were found to be susceptible to the ointment in in vitro infected macrophages and in vivo in experimentally infected BALB/c mice.

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2 El-On J, Jacobs GP, Witztum E, Greenblatt CL. The development of cutaneous Leishmaniasis due to Leishmania major in experimental animals. *Antimicrob Agents Chemother* 1984;**26**: 745-51.
3 Weinrauch L, Livshin R, Jacobs GP, El-On J. Cutaneous leishmaniasis: failure of topical treatment with imidazole derivatives in laboratory animals and man. *Arch Dermatol Res* 1984;**276**:133-4.

Does stopping smoking delay onset of angina after infarction?

SIR,—The interesting findings of Dr Leslie E Daly and his colleagues (5 October, p 935) suggesting delayed onset of angina pectoris in ex-smokers after myocardial infarction are not confirmed by unpublished data from the practolol multicentre trial,[1,2] which followed up several times the number of patients.

The table shows the expected advantage to the β blocker group for patients with severe symptoms—that is, angina induced by emotion, at rest, or by slow walking—but no significant differences between the two smoking categories within each treatment group.

The occurrence of angina in the first year or two after recovery from myocardial infarction is probably determined by the state of the coronary vessels, which are, ipso facto, extensively diseased in nearly all cases. Though aware of this, I had expected to find that symptoms would be more severe in continuing smokers because of the rises in blood pressure and heart rate which occur when smoking a cigarette. But, of course, the rises last only for a few minutes. Perhaps smokers with angina tend to avoid exercise while actually smoking and vice versa. I recall that I did when I used to be subject to both conditions.

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1 Multicentre International Study. Improvement in prognosis of myocardial infarction by long-term beta adrenoceptor blockade using practolol. *Br Med J* 1975;ii:735-40.
2 Multicentre International Study. Reduction in mortality after myocardial infarction with long term beta-adrenoceptor blockade. *Br Med J* 1977;ii:419-21.

Incidence of angina among smokers and ex-smokers in practolol multicentre trial. Results are percentages

	Placebo group		Practolol group	
	Smokers (n=642)	Ex-smokers (n=468)	Smokers (n=702)	Ex-smokers (n=383)
Mild angina at 6 months	24·4	21·3	23·3	24·0
Severe angina at 6 months	9·5	10·8	7·0	8·7
Withdrawn from study	4·1	7·0	2·4	3·1

Misleading guidelines on oxygen treatment in asthma

SIR,—Drs A T Elder and G K Crompton (21 September, p 823) criticise the recommendations in the *British National Formulary* on oxygen treatment in asthma. We have sought the comments of our expert contributor on section 3·6 and we would agree that if a clinician has correctly diagnosed asthma and has strong reasons to believe that the patient has not had long standing respiratory failure, and is thus not likely to have hypercapnia, then high concentrations of oxygen are safe and sometimes desirable.

The problem is, however, that in an emergency the patient may not have been seen by a doctor, and ambulancemen will have no knowledge of the medical history. Under such circumstances the diagnosis of acute severe asthma may not be easy and there are certainly many examples of patients arriving unconscious at hospital owing to high concentrations of oxygen having been delivered in transit. For this reason the comments in the *British National Formulary* are as stated. However, we have in mind adding to the statement words to the effect that in cases of uncomplicated severe asthma in which there is no evidence of preceding chronic respiratory failure, and therefore no reasonable risk of hypercapnia, higher concentrations of oxygen—for example, 35%—delivered by a conventional mask would be recommended.

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Manpower problems in psychiatry of old age

SIR,—Following the results of the 1983-4 survey of psychogeriatricians[1] and the letter from David Jolley[2] on the problems of finding enough eligible candidates for new consultant posts in the psychiatry of old age, all health authorities advertising consultancy posts in this specialty during 1984 were surveyed.

Forty nine jobs had been advertised, some several times, and replies were received about 40 of these. Only 23 of these vacancies had been filled. Nine of the posts were replacements and 31 were newly created posts. Of the new posts, 19 had been filled. The net detected gain in consultant numbers in 1984 was thus 14, bringing the estimated national total of psychogeriatricians to at least 165. One hundred and eleven health districts (or their equivalents in Scotland and Northern Ireland) were still without a specialist consultant, and several larger health districts had insufficient sessions. At the present rate of increment it will take at least eight years before the minimum of one consultant per average health district suggested by *Care in Action*[3] is achieved. If all jobs advertised had been filled there would have been a net gain of 31 posts, enough to produce one specialist per health district in four years.

In this period of increasing demographic need we are still failing to train enough senior registrars in old age psychiatry to fill available consultant vacancies. Some posts advertised may be so underresourced that they will never attract a good candidate, but the main problem is that there are too few senior registrar posts to train potential candidates. Where such posts exist there is nowadays rarely difficulty in filling them with good candidates. At one recent interview for a senior registrar post in psychiatry of old age there were four good candidates but only one appointment to be made.

If we could double, perhaps temporarily treble, the 14 satisfactory senior registrar posts identified in the 1983 survey we could probably fill all the vacancies and new posts more or less as they become available. Our situation is thrown into stark contrast by that of general surgery, where Mr N G Rothnie identified 49 "time expired" senior registrars (5 October, p 973). We are trapped at present between the DHSS's strict manpower limits on senior registrar training and the unwillingness of relatively oversubscribed specialties to relinquish posts to a specialty where they are desperately needed.

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2 Jolley D. Further developments in psychogeriatrics in Britain. *Br Med J* 1985;**290**:240.
3 Department of Health and Social Security. *Care in action*. London: HMSO, 1981.

Medical manpower: a district model

SIR,—Drs J N Todd and Ann-Marie Coyne have made a brave attempt to make practical headway with intractable difficulties (5 October, p 984). I note in passing their ingenious approach to the "on call" problem whereby senior house officers should do most of this even though they may not proceed to registrar and senior registrar posts. A truly radical system would surely declare obsolete and unnecessary the person on call (SHO) between houseman and consultant.

My purpose in writing is to note cognate issues in general psychiatry, not discussed by Drs Todd and Coyne, in which some different considerations apply. We can endorse for psychiatry their principle of trying to ensure that new outpatients are seen by a consultant or senior registrar, and we acknowledge that acute psychiatric inpatients are often not seen by consultants within 48 hours. Adequate assessment of a new inpatient often requires 2-10 hours (say about four on average) of a doctor's time and it is rare for much of this assessment to be made by the consultant personally.

The time consuming nature of psychiatric examination means that if psychiatric consultants are to take on much of this work, currently done by trainees, their numbers will need to be increased considerably. Senior psychiatrists usually have