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Medical Teachers' Training College

SIR,—Was it sheer coincidence or editorial genius that enabled the personal viewpoints of Professor Dorothy Russell (27 July, p. 248) and Professor M. F. A. Woodruff (3 August, p. 311) to appear in consecutive issues? That they are covering the same themes, education and research, from different angles is illustrated in the totally different conclusions reached.

There is much truth in the reasoning that some are born to teach and some to research. Few would doubt that the dedicated people in both these categories find it hard to share their vocation, but the present system does seem to demand that many who wish to research will have to teach, and many who wish to teach will have to research. Bearing in mind that at the "publish or perish" altar only one out of ten projects ever sees the light of day, one wonders, in respect of the other nine, whether the time spent by these individuals (often not by their wish) might not be more profitably employed in learning how to teach. The benefits of being taught how to teach would far outweigh the benefits, if any, of unproductive research.

I think there is a good case for reassessment of research facilities in the medical profession, on the one hand, and on the other, perhaps, the establishment of a medical teacher-training college.—I am, etc.,

Peterborough. D. W. BRACEY.

Non-proprietary Names

SIR,—I was most interested to read of the principles governing the choice of non-proprietary names (25 May, p. 484). I heartily agree with the general concept and wish to thank the responsible committee for a long and largely successful essay in lexicography. However, my efforts to use these names have sometimes given rise to confusion and misinterpretation. I recall the plaintive tones in which an experienced consultant physician once asked me to explain the "cyanocobalamin" that I had been using for the past six months to treat his cases of pernicious anaemia. This episode merely illustrates the widespread ignorance of non-proprietary names, but the Nomenclature Committee of the British Pharmacopoeia Commission must bear some responsibility for their unpopularity and consequent widespread anonymity.

I would suggest that a primary purpose of names is to be used—and largely used, in this case, for prescriptions. It seems more important to me that the name should be easy to recall, pronounce, and spell than that its chemical construction should be paramount. My desire is not to condemn the system but rather to believe that it is capable of better things. Among my colleagues I tread a comparatively lonely path. If I am to stick to the straight and narrow, still more proselytize, I must plead for the Nomenclature Committee of the British Pharmacopoeia Commission to give much more thought to the potential use and users of their names.—I am, etc.,

I. B. HOUSTON.

Department of Child Health, University of Manchester.

Exchange of Confidential Information

SIR,—It is comforting to see your leading article entitled "Doctor or Social Worker?" (3 August, p. 365) taking up the cudgels against too free passage of information regarding our patients.

An alarming example of this came to my notice and I feel deserves airing. It is the practice in this area for copies of paediatrician's letters to general practitioners to be sent to the medical officers of health. This would seem a fairly reasonable and helpful procedure so long as the parents' consent had been sought. But as the following incident shows it can be open to question. My young patient had recurrent abdominal pains and was considered by the consultant to have abdominal epilepsy. This, I believe, is considered a likely cause in some medical circles and I am not questioning the specialist's opinion, and I expect the patient had it explained. However, some months later a very indignant mother was ringing to ask if I could explain why her child had been offered a place in a holiday home for epileptics by the local authority.

I feel sure that parents still look upon the consultation they have as a relatively private matter between themselves, the general practitioner, and the consultant. I feel strongly that some method should be evolved to make sure parents agreed to this passage of information—preferably a signed agreement attached to the relevant letter.—I am, etc.,

Brecon. C. A. M. AITKEN.

Withdrawal of Tranquillizing Drugs

SIR,—"The continuing practice of prescribing tranquillizing drugs to patients *en masse* on long-stay wards is questioned, and an appeal made for reassessment following simple experiments demonstrating individual needs."[1]

Prompted by this comment the following study was carried out at St. John's Hospital, Stone. Thirty-seven long-stay patients in one ward were submitted to a policy of gradual reduction of tranquillizing drugs. Minor changes in the ward population occurred, but new patients were submitted to the same policy. The co-operation of patients and staff was enlisted. Difficulties were discussed as they arose and the nature of the

	June 1967	January 1968	May 1968
Chlorpromazine ..	2,875	300	1,150
Trifluoperazine ..	415	82	180
Thioridazine	750	150	200
Chlordiazepoxide ..	30	—	—
Imipramine	300	—	—
Pericyazine	—	20	20
Fluphenazine enanthate	—	—	2 ml/month
Haloperidol	—	3	24
Benzhexol	154	12	12
Benztropine	14	8	12
	Dose in mg/day		