the other hand may consider that because of inadequate nursing staff in the hospital he should not be admitted, as this would mean inadequate nursing not only for this patient but for many others. The latter judgement means that I am performing a *nursing* management function rather than a medical one.

It would do a great deal for the morale of nurses—and thus for their efficiency—if consultants (sic) insisted on acting as *advisers* to nursing staff rather than as *directors* of them. Many nurses would have initial difficulty in accepting this responsibility, of course, but they can only learn if given the opportunity.

Until our profession is prepared to relinquish its defensive fantasies of omnipotence in hospitals, the difficulties which lead to the present discussion of a code of nursing practice are likely to continue.

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DEAR SIR,

I am writing in response to the invitation of the President for views about recent suggestions that there should be either 'Guidelines' or a 'Code of Conduct' for psychiatric nurses, with special reference to the problem of handling violent patients.

Something closely resembling such a code of conduct is to be found in Chapter 5 of the First Edition of the R.M.P.A.'s 'Red Handbook', which was published in 1885 with the title, 'Handbook for the Instruction of Attendants on the Insane.' As successive editions of the 'Handbook' appeared, the method of presentation changed to that of a modern text-book of psychiatry for nurses, and the problem of handling violence was dealt with by showing that good methods arose logically and naturally from a proper knowledge and understanding of mental illness. It seems then that any attempt today to produce either 'Guidelines' or a 'Code of Conduct' for nurses must ignore the direction in which progress has been made, and indeed is simply to put the clock back for nearly a century.

Such action would be doubly unfortunate, as the point requiring most urgent attention has been stressed again and again in the 'Red Handbook'. This is that if a nurse anticipates violence on the part of a patient, he or she should ensure that adequate help is summoned. Overwhelming superiority in numbers usually results in avoiding violence; even if it still occurs, it can in these conditions be overcome with the least possible risk of injury to the patient. If, however, there is a shortage of staff, the nurses are deprived of the most important help they require in handling potentially violent patients, and the real responsibility for this rests with Management.

Indeed, as the Farleigh Report suggests that the tragic events there were the end product of years of mismanagement, perhaps 'Guidelines' or a 'Code of Conduct' should be prepared for the benefit of those responsible for management in the Health Service.

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## ANOREXIA NERVOSA

DEAR SIR,

According to Wright *et al.* (1969) one of the most consistent symptoms of anorexia nervosa is the presence of lanugo. Lanugo is characteristic of intra-uterine life from the fourth month until term, reaching a peak in the seventh and eighth months and falling off thereafter. Most hair growth is controlled by steroids; the steroids present in abnormally high concentration in the foetal placental circulation are dehydroepiandrosterone (DHA) and its sulphate (DHAS), also 16oH-DHAS, oestriol and progesterone. The last two of these continue to rise until parturition, but the others probably decline towards the end of pregnancy because the foetal zone, which produces DHA, decreases relatively to the rest of the adrenal as pregnancy advances. Also DHA is found in the urine of premature babies but not in that of full-term ones (Birchall *et al.* 1961). Since lanugo declines in the same way towards the end of pregancy it seems possible that it is caused by DHA. (DHAS and 16oH-DHAS are less likely to be responsible because conjugated steroids have relatively little biological activity.) Since DHA is thought to be produced only by the adrenals this would seem to implicate the adrenals in the causation of anorexia nervosa.

Against this are the facts that it is practically confined to teenage girls, and is associated with amenorrhoea and also with low oestogen levels, all of which suggest an ovarian disorder. Typically it starts a year or two after menarche (Crisp, 1965). For the first few years after menarche the menstrual cycles are anovular, i.e. there is no luteal phase; so it looks as if anorexia nervosa is associated with the onset of ovular cycles, which would incriminate the corpora lutea. This supposition is strengthened by the fact that the low oestrogen levels (Russell, 1965) are almost wholly due to low levels of oestriol,

https://doi.org/10.1192/bjp.119.549.227 Published online by Cambridge University Press