thought the orders could only be made by a magistrate in a juvenile court. Fourteen thought such orders prevented parental access to the child unless the order was revoked or the order specifically gave parents access. Seven thought the place of safety was always a hospital if the child was under 12 months of age. Questions on the meaning of a "care order" were similarly seriously wrong.

If any lawyer feels smug about this, a solicitor can qualify without any tuition whatsoever in forensic medicine; the Council of Legal Education are, we understand, introducing forensic medicine as an optional subject in the final year for law students but without any examination. At universities known to us any facility for a law student to acquire any knowledge of medicine is haphazard or non-existent. The student actively has to seek involvement in such an activity.

The purpose of this letter is not to suggest that either law or medicine can provide remedies for the basic causes of violence to and abuse of children: but those practitioners in either profession who are going to have to deal in one role or another with individual patients and clients involved in these tragedies should surely be better equipped by proper training.

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Pressure in cuffed tubes

SIR,—I was interested to read Dr W G Notcutt's remarks about pressure on the tracheal mucosa (9 June, p 1566) but regret that he made no reference to the rise in pressure that occurs in a cuff if it is inflated with air and nitrous oxide is used as an anaesthetic agent.^{1 2}

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¹ Stanley, T H, Kawamura, R, and Graves, C, *Anesthesiology*, 1974, **41**, 256.

² Revenäs, B, and Lindholm, C E, *Acta Anaesthesiologica Scandinavica*, 1976, **20**, 321.

Emergencies and the laboratory

SIR,—Your leading article (9 June, p 1521) demonstrates a truly remarkable ignorance of the clinical chemistry "scene" on the other side of the Atlantic. For example, the number of clinical chemists per million of population is 27 in the UK and 14 in Ontario hospitals. Attempts at monitoring demand and ensuring legitimate utilisation that are possible in the UK are well nigh impossible in Ontario with this staffing ratio. Not only that—the work load per patient day can be up to 20-fold greater in a teaching hospital in Ontario than in a similar institute in the UK.

My approach¹ was subtitled "a method for improving communication between the physician and the emergency clinical biochemistry laboratory," and because of the priority form I now know exactly when an emergency test result is required. Therefore I have assured myself that legitimate requests will be adequately dealt with. Of course, many (nearly all?) priority requests are not essential, but before solving that problem I need accurate information on the extent of the

misuse. The priority form helps me to obtain this.

Since I wrote that paper last year, the number of emergency tests have increased considerably. The current ratio (June, 1979) of priority test (result required within a two-hour time period or less) to routine test is 0.97 for random glucose (n=858), 0.44 for electrolytes (n=701), and 0.73 for electrolytes with urea and creatinine (n=725). Being "more convincing" is the least of my worries.

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¹ Henderson, A R, *Journal of Clinical Pathology*, 1979, **32**, 97.

Sweet medicines and teeth

SIR,—Of the children studied by Dr I F Roberts and Dr G J Roberts (7 July, p 14), half of the patient group had chronic disorders of the nervous system and apparently most had fits. While the authors explicitly set aside consideration of any relation between specific medication and dental disease, where anti-convulsants—and in particular phenytoin—are concerned this is to set aside a most important aetiological factor.

Unfortunately, phenytoin-induced hyperplastic gingivitis and poor oral hygiene conspire by positive feedback. The degree of gingival hyperplasia found in those receiving phenytoin over a long period is inversely related to the meticulousness of oral hygiene practised, as elegantly demonstrated in an unintentional controlled trial by a patient taking the drug whose gums proliferated only on the side that she had not been careful in brushing her teeth.¹ With failure to keep gum proliferation at bay the teeth may be set at further risk as a result of sequestration of food particles behind the intruding tissue. Any sugar in the phenytoin preparation adds to this risk to the epileptic child, and here in particular the authors' call for its replacement should be heeded.

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¹ Bruun Kristensen, C, *Epilepsia*, 1977, **18**, 295.

Disposable syringes for insulin injection

SIR,—Dr A Greenough and others (2 June, p 1467) made an excellent case for the use of disposable syringes for insulin dependent diabetics.

The statement that the syringe carries the caption "Sterile. Destroy after single use" because sterility cannot be guaranteed once the syringe has been removed from the packet is correct, but this is only part of the story.

The compatibility and toxicity studies associated with such products are extensive but always assume that the product will be used once only. Any adverse effects associated with continuous contact of the syringe and its components with insulin and its vehicle and preservatives over a period of months is unknown.

The British Standard 5081, to which all products sold in the UK must conform, specifies that sterile hypodermic syringes and needles for single use are not intended for

containing injectable fluids or samples over extended periods.

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Direct debit payments

SIR,—The letter from Dr P J Hirsch (23 June, p 1714) contains one serious error of fact. He stated that, "there is no legal redress and once a mistake has been made that is just unfortunate." Before the Association was permitted to introduce the direct debit system, our sponsoring bank, the National Westminster, insisted that we entered into an indemnity in the form prescribed by them and this was lodged with the Committee of London Clearing Banks. Under this indemnity any mistakes have to be made good by the Association.

Dr Hirsch also stated that "the old banker's order could easily be changed when sending out notification of subscription changes." This can, of course, be done but in practice proves inconvenient to many of our members as we cannot do it for them. The variable direct debit is not only convenient to the member as it always ensures that his subscription is up to date, but is also highly economical for the Association.

Finally, there is no question of the Association being given a blank cheque. Our members are advised annually of the current subscription scale and our computer is programmed so that it cannot collect more than the standard subscription rate for any year. If for some reason too high a subscription is collected from a member, we are bound under the terms of our indemnity to refund it. In practice this is extremely rare.

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Functional budgeting

SIR,—We are concerned at some of the implications of Mr P J E Wilson's letter (2 June, p 1485) on the subject of functional budgeting. There appears to be a basic misunderstanding of what this is and attempts to do. "Functional" is a rather curious term which in the context means departmental. It can be applied only to identifiable departments with responsible department heads who will be budget managers. Clinical units manifestly do not fall within this definition because they use services supplied by many departments. The question Mr Wilson seems to raise is whether departmental budgeting will restrict resources available to clinicians and thereby affect their freedom of action.

Clinicians must be aware that they do not have unrestricted resources at their disposal; budgetary control has been around for a long time and has manifested itself as much in financial systems as in physical control of resources: allocated beds, clinic sessions, staff, equipment. This control has usually been exercised at district or area management team levels, resulting in frustration to departmental managers and clinicians alike, who may be unable to exercise full control over their own resources. The introduction of departmental budgeting will help to alleviate this problem because it allows the manager discretion in the use of his resources within a negotiated overall total. He will thus have flexibility to respond to

clinical requirements without the need to go through a long rigmarole of committees.

Mr Wilson refers to the standard accounting system. This is one of the products of the NHS financial information project and is a computerised accounting and budgetary control system available to all NHS authorities ("standard" means able to be run on any of the NHS standard ICL computers). Its object is to enable finance offices to produce prompt information comparing budgets with expenditure so that budget managers can switch money to different uses and respond more effectively to demands put upon them. Improvements to the responsiveness of departmental budgetary control systems, however, will provide only some of the answers looked for from the production of financial information and its use in reviewing use of resources. Budget managers can make effective decisions when they control the work load of their departments. Sixty per cent of hospital expenditure occurs in patient treatment departments, in which the work load is effectively controlled (or not controlled?) by clinicians.

What financial control is wanted on this 60% of expenditure? Certainly not the sort that stops people having what they need to carry out their jobs. Everyone in the NHS wants to see money put to the best use. Clinicians and the departmental heads of patient treatment departments need to be able to respond to the needs of patients. They need to be able to purchase new equipment and to adopt new practices as they become available. Clinicians need to discuss to which priorities scarce additional resources should be allocated. All this requires financial information to assess the cost of proposed developments and to review the use of existing monies so that resources can be freed from wasteful or inefficient use. This is all the more necessary if any progress is to be made over coming years, when the increase of resources allowed to the NHS is likely to be minimal.

The NHS financial information project is researching the type of information that needs to be put into the hands of clinicians to enable them to make these decisions. It is unlikely that specialty budgeting will be the answer. We cannot imagine that patients will be treated on the basis of the money left in the budget. Other approaches are probably essential and are currently being developed.

The project's research is being conducted nationally and the aim is to set up field trials to enable clinicians to experiment with different types of information and the use that they can make of it. Introductory information has been sent to every management team and additional copies can be obtained from us, by request.

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Future of clinical medical officers

SIR,—The report of the Annual Conference of Community Medicine (30 June, p 1809) could be misleading and is certainly incomplete in so far as it has omitted any reference to the "Scottish view" expressed at the conference.

Prior to the craft conference the Scottish Committee for Community Medicine balloted all clinical medical officers in Scotland on the Preston working party proposals and, while there was a significant number who welcomed

the general tenor of the report, the overall opinion was that clinical medical officers should be organisationally linked with the appropriate clinical divisions. Accordingly the view of the SCCM reported to the craft conference was that the range of duties of clinical medical officers should not consist of a varied collection of duties carried over from the former local authorities. Instead they should be permitted to specialise in their particular specialty and should have organisational links with the appropriate clinical division—those in the child health services with an enlarged paediatric division, those in family planning with the maternity services division, and the relatively small number in geriatrics with the geriatric division.

In this context it was reassuring to have confirmation from Dr Preston at the conference that there was nothing in his report to preclude this sort of development provided the doctor and his or her employing authority are in agreement. So far as Scotland is concerned the service has in some places already begun to develop along these lines and, provided a satisfactory career structure is obtained, this can be expected to continue.

M MURCHISON
Chairman, SCCM

Inverness

Community medicine

SIR,—I am grateful to Professor R W Smithells for his attempt (9 June, p 1568) to clarify the meaning of the word community, at least as applied to medicine. Community medicine is, as he suggests, that branch of medical practice which is concerned with the promotion of health and the management of health disorders of human communities, while, as he quotes from the Court Report, hospital activities are but one aspect of the overall activities of a total community within which any particular hospital is sited. The terms "community child health," "community paediatrics," and "community hospital," used to describe certain types of medical activity not based in district general hospitals, indicate some muddled thinking on the part of those who coined these expressions.

As far as child health clinical medical officers are concerned, these doctors are expert practitioners of certain areas of paediatrics which are indispensable to a complete child health service. As clinicians, however, their activities should be integrated with those of all other specialist paediatricians. It is my contention, furthermore, that some of the current practices of child health community medicine specialists are not properly part of community medicine. Epidemiology and surveillance of the state of child health, as well as the planning and monitoring of child health services, are properly within the province of community medicine (as in the case of other risk groups besides children), but the day-to-day administration of clinical services lies outside this province.

Thus, when more consultant paediatricians with experience of preventive paediatrics have been appointed, provided sessions are allocated within their contracts for this new work, and provided they are prepared to accept this extended role of the consultant paediatrician (including giving all necessary consultant direction and back-up to school health services), there is no reason at all why the activi-

ties of child health clinical medical officers should not become the responsibility of extended paediatric cogwheel divisions in each district, on which they would, of course, be represented. Hospital paediatricians are the natural colleagues of these doctors, and they will best guarantee the future development of appropriate preventive paediatric activities by recognising this and developing their professional relationships accordingly. I am sure that in this way they will discover in many hospital paediatricians powerful potential allies.

I accept, however, that until such appropriately trained paediatricians are appointed in adequate numbers, it may be necessary to maintain community physician direction of the misnamed "community child health services."

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Inertia at the Elephant

SIR,—I was intrigued to see (7 July, p 56) that the DHSS had asked 14 "good men and women" to advise about orthopaedic waiting lists and that they hoped that they would report in about 18 months.

Given a minimum of six months for the Elephant to ruminate over their recommendations, this gives a lead time of at least two years to deal with a problem that has been obvious for a decade. The inability of the NHS to react to variations of supply and demand has always been one of its fundamental weaknesses, but surely it ought to be able to do better than this. All that will now happen is that protesters against the lengthening orthopaedic list will be told to wait for the Godot of Duthie.

Why cannot they appoint four people to report in three months and promise action?

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Haemochromatosis and the sicca syndrome

SIR,—May I emphasise another facet to the dry mouth and eyes (sicca syndrome) associated with haemochromatosis as recorded by Dr R L Blandford and others (19 May, p 1323)?

Some years ago I was examining in the MRCP examination and noted that my coexaminer, a former chief, used his pen in a peculiar way. He lay it across the palmar aspect of the four fingers of his right hand and held it in position with his thumb. Everytime we left the ward where we were examining I noticed that he engineered it so that I always went first and had to open the door by turning the slippery, well-polished, round brass door-knob.

Observing my, I hope, unobtrusive interest, my old boss said on the third day of the examinations, "Do you know the earliest symptom of haemochromatosis?" I muttered something about impotency or diabetes, to which he replied, "Deposition of iron in the sweat glands. My hands are so dry that I have difficulty in holding a pen in the ordinary way and I simply cannot grip these door-knobs."

He died of liver failure a few months later.

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