for intraperitoneal use and preliminary clinical results with them are proving to be most encouraging.

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Barbiturate hypnotics

SIR,—Insomnia is a symptom, a complaint. The Committee on the Review of Medicines concludes (22 September, p 719) that "severe, intractable insomnia" (presumably the persistently complaining patient) provides an indication for the prescription of barbiturate hypnotics.

Pain too is a symptom. Another four years of deliberations may enable the committee to conclude that the complaint of severe, intractable abdominal pain is an indication for the prescription of daily enemas.

In the resurgence of Edwardian medicine prescriptions shall be written in Latin.

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Contamination of injections

SIR,—The inconvenient report of Blogg *et al*,¹ which confirms my own previous findings² that at least 50% of syringes have their contents contaminated by the second refill, implies that present methods of preparing thiopentone injections are unsatisfactory. Even when a single dose is prepared from an ampoule of water drawn up, transferred to the thiopentone powder for solution, and aspirated again into the syringe ready for use, this danger is present.

Obsessed by theoretical dangers of decanting in the preparation of solutions in multidose (100 ml) containers, the manufacturers—encouraged by the DHSS—now supply the water in narrow-necked bottles and advise that the solution should be prepared by syringe aspiration of the water and its injection into the thiopentone container. Clearly one cannot use one 20-ml syringe five times because of the dangers mentioned above. Should we use five fresh syringes and further syringes when the solution is injected into patients? This seems wasteful—so would the use of a disposable and cumbersome 100-ml syringe.

The alternatives seem to be to use a special transfer needle to couple the two bottles (such needles are not currently available in the UK),

or to have the solution prepared in the sterile products division of the hospital pharmacy in those places where such provision exists.

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Unwanted journals

SIR,—The issue Dr R E Simmons raises is by no means an OLVPS—a One Lone Voice Protesting Subject. I would like to support him in his criticism (6 October, p 867) of the way doctors get bombarded with unsolicited journals. He receives *World Medicine* only because last June he signed a card asking us to send it to him. We send *World Medicine* only to doctors who within the previous three years have signed a card requesting it. And many moons ago we instructed our distributors not to let our list of readers be used for distribution of other journals or promotional literature.

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Deployment of mental handicap specialists

SIR,—Dr D A Spencer (6 October, p 863) rightly draws attention to the crisis in the number of psychiatrists specialising in mental handicap, but his suggestion that consultants should be appointed to districts rather than hospitals was put forward by Mrs Barbara Castle in February 1974. She then promoted a package that also contained the National Development Group for the Mentally Handicapped and the Jay Inquiry into mental handicap nursing; this predictably caused disruptions, not least among the consultant force.

In 1973 the total number of consultants in mental handicap in England and Wales was 183.¹ At that time the Royal College of Psychiatrists said that a realistic minimum was 375 and the ideal 500. Five years later, according to the *Medical Directory*, the number has fallen to 162. Over 20% of these are from overseas and, on the basis of a representative sample, it seems that 48% are over 50 and only 4% under 40. During 1974-7 no appointments were made in 42% of the registrar posts advertised in mental subnormality and reservations were expressed about a further 18% of the successful applicants.² The assessors of the college reported that "the calibre of those interviewed seemed particularly low in subnormality." The national development team devoted less than 1% of its first report to the role of consultants and there is no evidence that its "community units" attract "new consultant blood" to their associated multidisciplinary teams.

As Dr Spencer points out, it is an impossible task for a consultant to be responsible for hundreds of inpatients, and neither is this necessary. Whether or not the patients require nursing care (and most do not), the present arrangements for nursing accountability would

make it a relatively simple matter for the responsibility for care, including admissions, to be accorded to nurses. This, however, should release specialists not to do vaguely defined consultant work in the community (unless we are looking for a declining number of preretirement jobs) but to concentrate in much greater depth on the *psychiatric* aspects of the care and treatment of the mentally handicapped.

Pioneering work on this has already been done in Dundee (and elsewhere) and there is now a chair with this title in London. Much more needs to be done in this area, however, than has been achieved in the past by lone workers, often against considerable odds. RHAs should cut out the dead wood of consultant responsibility that amounts to a charade in clinical terms, *reduce* their consultant establishments, and use the money they save to follow the example of authorities south of the Thames—that is, fund academic departments in the psychiatry of mental handicap, with senior staff having service commitments, at the local universities and medical schools. This strategy may involve sacrifices by some existing consultants, but if there is a conviction that such work needs to be done a way must be found out of the ravages that have characterised this field since the watershed public events of 1967.

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- ¹ Royal College of Psychiatrists, *British Journal of Psychiatry*, suppl *News and Notes*, December 1973, p 2.
- ² Brook, P, *Bulletin of the Royal College of Psychiatrists*, January 1979, p 7.

Clinical practice and community medicine

SIR,—With reference to Professor E D Acheson's "Clinical practice and community medicine" (6 October, p 880), when are community physicians going to realise that credibility has to be earned by the effective practice of their own specialty rather than by aping their clinical colleagues?

The role of the community physician is complex,¹ and requires a wide knowledge base and traverses a number of disciplines. A synthesis of medical knowledge and understanding together with knowledge in the field of the behavioural sciences, economics, epidemiology, statistics, etc, enables the community physician to take the broad approach to health that is his brief. It is essential for the community physician to view the total picture if he is to make an impact on health, and assuming any clinical responsibilities will diminish his ability to practise community medicine. It is his job to see the forest rather than to deal with the individual trees. If it is medical knowledge he is seeking, this is more effectively gained by reading the journals and attending post-graduate meetings.

Trainees in community medicine hankering after clinical work should question their motives for choosing the specialty and ask themselves whether they are actually committed to the underlying concepts. It may be that in seeking a clinical role they are opting out of the more difficult task that constitutes the prime function of the community physician.

As a community physician I respect my clinical colleagues for the clinical expertise that they exhibit. I am delighted when they take an interest in the wider aspects of health

service management, but their own credibility would not be enhanced by their seeking to assume a part-time community physician role. I should begin to wonder why they had that amount of time to spare, what their motives were in so doing, and whether they were operating effectively in their own clinical practice. It works both ways.

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¹ *What Should Community Physicians Be Doing?*
Occasional Papers No 2. Manchester, Unit for Continuing Education, 1979.

SIR,—I read with interest the results and conclusions of Professor E D Acheson's survey of the views of community medicine trainees with regard to combining clinical practice and community medicine (6 October, p 880).

Expanding this survey to include the views of well-established specialists in community medicine with consultant status in the NHS and academic posts, etc, would not only be useful to trainees and aspiring trainees but is also necessary to validate the conclusions reached, as the commitment of trainees to community medicine may not be as complete as those of consultant status. The important points are which specialties can be successfully combined, whether in the NHS or in medical schools, etc, and at which level—including the implications of a clinical assistant appointment if a consultant one is not feasible. Some community physicians already have practical experience of combining or attempting to combine two specialties and knowledge of their experience could be invaluable to trainees.

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Boycott of tertiary examination in orthopaedics?

SIR,—The Edinburgh College of Surgeons has now set up a third-stage examination in orthopaedics. Competition for consultant posts being severe, no registrar in the specialty can baulk this further hurdle if it becomes established. It will inevitably commit all present registrars and their successors permanently. Do we accept that it is humane and wise to impose on young men this extra obstacle? When consultant posts are scarce, the rewards moderate, the responsibilities excessive, is it fair to expect would-be surgeons to sustain yet another burden and obstacle in their climb?

Some would argue that an additional challenge must enhance the standard of training achieved. Whatever the proper place of examinations in advanced medical training, this is not necessarily so. I believe firmly that, where I have had a comparison, a recent higher examination has proved counterproductive in terms of service. The content of examinations is determined by the convenience of examiners and by prestige considerations. The subject as examined becomes the subject as taught, and thence soon the subject as practised. Examinations permit the coercion of trainees into attitudes and opinions which are merely fashionable. They excuse diversion of time and energy from provision of service and

accumulation of experience. These last are the most important aspects of the work we should require from registrars.

Popularity of specialty careers in the hospital service has understandably fallen, so unkindly have we dealt with our registrars. Academic misconceptions have long since made an abuse of research, probably of training systems—and now, surely of examinations. The prospect of following the low-pass-rate primary and final fellowship with another such test, in a system liberally provided with additional opportunities for failure, will alienate many young people who should join us.

It is long past time to call a halt to the abuses of the system by which we staff our senior hospital positions. Simple humanity, as well as every consideration that is not facile, requires that this false step by the Edinburgh college should be annulled. I can see only one way in which this can occur. Action is urgent and imperative. The junior staff, for their own sake and that of their successors and for the potential well-being of surgical services, should ensure a 100% boycott of this tertiary examination at Edinburgh.

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Postgraduate dental general anaesthesia

SIR,—The undergraduate teaching of general anaesthesia has been a topic of conversation for a number of years. Ever since 1965, when a joint subcommittee on dental anaesthesia led by the Standing Medical and Dental Advisory Committee reported that a need existed for a training scheme to be available for dental graduates, little has been done to fulfill this need, although a few organisations and individual practitioners scattered throughout the United Kingdom have contributed much in the educational field.

The working party set up by request of the deans of the faculties of dental surgery and of anaesthesia under the chairmanship of Dr W D Wylie again endorsed this recommendation. I was fortunate to be the first postgraduate appointed as house officer in anaesthesia at the Sheffield University Dental School. The full-time post uses the guidelines laid down by the Wylie report to provide experience in general anaesthesia in the hospital environment, together with outpatient anaesthesia and sedation in general practices in and around the Sheffield area.

I found these six months of such benefit that I would like to add my voice in encouraging those who are considering the implementation of the recommendation of the Wylie report.

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Ethics in occupational health

SIR,—I have been very interested in the correspondence initiated by Dr J W Todd's letter (11 August, p 391).

I am not at all sure that it is unethical for an occupational health physician to advise management that a prospective employee is a worse-than-normal risk medically, even if

the risk is in the future (and maybe concerning a general medical condition) rather than an actual (and perhaps obviously job-related) present incapacity. If disability should develop, possibly prolonged or recurrent periods of sickness absence may result; and this is obviously uneconomical to the organisation, and likely to impose added strain on the disabled employee's workmates.

It is not unethical for an insurance company medical officer to act in this way, and I do not see why it should be so regarded in respect of an occupational health physician. His allegiance is primarily to his organisation and to the people already employed; and taking on a bad risk is likely only to increase the problems of work and health for existing employees, both workmates and management.

In conclusion, let me say that in practice it must be only very exceptionally that a man found medically unfit for the particular job for which he is applying can be easily offered alternative employment within the organisation, and I do not think that this is a viable answer to the problem.

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Secrecy and the health of Soviet prisoners

SIR,—Dr Michael Ryan, in his "Letters from the USSR" (25 August, p 480, 8 September, p 585, and 15 September, p 648) has performed a valuable service in describing the pressures that are exerted on the individual doctor when he practises in the Soviet Union. The intense secrecy surrounding all activities of the monolithic state inevitably causes distrust of any statements it may make regarding the state of the public health, or in the case of those in its closer charge.

I refer to the case of Anatoly Sharansky, the Jewish human rights leader, who is now in Christopol Prison serving a 13-year sentence for alleged spying for the USA. There is now grave concern for his health, particularly after the prison visit by his mother, the only one after 12 months of incarceration. His general condition was described as appalling and he told her that he was suffering from severe pain in his eyes and sinuses on attempting to read or write, and that he had been refused a consultation with an ophthalmologist. This confirms the report of similar symptoms in previous letters from Sharansky from prison, and also reports from a fellow prisoner.

Bland assurances from the authorities that Sharansky is in good health cannot be accepted, and there is no possibility of obtaining, inside or outside the prison, any medical opinion on his real state of health. Unfortunately it is not possible to accept the word of the Soviet authorities, including that of their medical establishment, so long as they maintain their wall of silence, and give information to serve only political ends.

In the meantime Sharansky's friends, inside and outside the Soviet Union, will continue to make every effort to see that his health is preserved in captivity, and that every step is taken to ensure that he receives all medical treatment that may be indicated.

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