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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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