failed to implement it. Why then is Dr C Joan McAlpine (15 September, p 646) able to transfer patients so quickly when many of her colleagues in geriatrics cannot do so?

Dr McAlpine points to one cause of delay—absolute shortage of geriatric beds. But shortages can also be relative, and delays can be disastrously long even when the total bed provisions in a hospital group are fairly generous. To put the matter very simply, if a well-bedded hospital group has 600 beds for geriatrics and medicine, there is a world of difference between a distribution of 400:200 and one of 300:300. Where the bed ratio is 2:1 or more in favour of geriatrics, this type of misplacement should not occur. Dr O'Brien and others,¹ whose group had 297 geriatric and 91 medical beds, achieved a high turnover: only 10.6% of patients in medical wards were over 65 years of age and only six medical patients needed to be transferred in a year.

It is an entirely different matter when the number of beds in geriatric and medical (including general practitioner acute) units are roughly equal. Then potentially long-stay elderly patients will tend to be diverted to the medical side. The geriatric service, presented with mainly, chronic illness² from home and hospital, will have a relatively low overturn; and, whatever its desired or stated policies, it will be unable to arrange expeditious transfers after meeting the reasonable needs of its community. Similar considerations influence exchanges between geriatrics and orthopaedics, psychiatry, and residential homes.

Where misplacement is unacceptable, its causes should be looked for in the balance of beds and other resources between specialties; and, given sound clinical work and organisation, it is the relevant policies of hospital authorities, not of consultants, which determine the rate and volume of transfers. There is every indication of important differences in bed ratios in different areas, and it is surely time for central departments to undertake careful and sophisticated studies of the allocation of beds and make their findings freely available.

LESLIE A WILSON

Woodend General Hospital,
Aberdeen AB9 2YS

¹ O'Brien, T D, Joshi, D M, and Warren, E W, *British Medical Journal*, 1973, **4**, 277.

² Wilson, L A, and Levy, M G, *Age and Ageing*, 1979, **8**, 152.

Cost of treatment in the NHS

SIR,—Congratulations to Dr R A Keable-Elliott (22 September, p 749) on his very sensible article on the cost of drug treatment in the NHS. What a pity there were not more people of his ilk on the Royal Commission.

One important point he omitted was the necessity of bringing home to both patients and doctors the cost of treatment prescribed. If patients knew the true cost of the drugs they take, this would result in a much greater compliance and fewer valuable drugs left on the shelf or thrown down the toilet.

A year or two ago we were asked by the DHSS to send suggestions for containing costs in the National Health Service. I wrote suggesting that all prescriptions should be labelled with their true cost for the reasons mentioned above. I received a reply saying that, firstly, the pharmacists would require payment for this and, secondly, some patients might be put off having repeat prescriptions

by the high cost of the drug they had been taking free. Truly it is said that "against stupidity the Gods themselves fight in vain."

J C SMITH

Department of Urology,
Churchill Hospital,
Headington, Oxford

Health centres apparent

SIR,—I should like to commend to all doctors caught up in the conundrum of whether or not to build or go into a health centre the sensible solution arrived at by Drs Harvey Gordon and R A Bennett at Bookham (29 September, p 811). Their "health centre apparent" is a group-practice centre with clinics attached. This is precisely the solution we arrived at in Harlow in the 1950s and 1960s, when, with Nuffield Trust money, we were trying to provide an ideal "extra-hospital health service" for a town of 80 000 people. We found that it was essential to guarantee the autonomy of both the GPs and the public health services. This we achieved by building six group-practice centres with clinics attached, on almost precisely the same lines as those which Drs Gordon and Bennett have followed. These buildings were described in the *Lancet*.¹⁻³

The major lessons we learnt were the following. (1) It is essential to separate physically the GP and the public health wings. (2) There must be a "back door," so that doctors called out urgently can get away without walking through a full waiting room. (3) The number of GPs should not exceed four (with approximately 10 000 patients). (4) The waiting area should be big enough to do its job. (5) There must be adequate parking space for patients' cars, and reserved space for doctors, nurses, and health visitors.

The Bookham centre is perfect in the first three respects. I suspect that the waiting area may prove to be on the small side if all three consulting rooms are in use at once. In every other way this is a splendid job: it combines efficiency and economy with autonomy. What more could one wish for?

TAYLOR

Glyn Ceiriog, Clwyd

¹ Taylor, S, *Lancet*, 1952, **1**, 253.

² Taylor, C, *Lancet*, 1955, **2**, 863.

³ Bach, H E, et al, *Lancet*, **2**, 1055.

Points

Prediction of fetal sex: a cautionary tale

Dr J A NUNEZ (Park Hospital, Manchester M31 3SL) writes: . . . I am on Dr A J Williams's side if he implies (29 September, p 767) that the sex we should accept in an individual with the testicular feminisation syndrome is the one shown by the phenotype, which is the one accepted by the patient, the family, and society. But we should bear in mind that what we aim at when predicting the sex by amniocentesis is the genotype. In this sense the prediction is always certain, and it proved correct in Dr Williams's case.

Familial appendicitis

Dr MONTAGUE SEGAL (Halifax General Hospital, Halifax HX3 0PW) writes: . . . With

reference to the paper "Is appendicitis familial?" (22 September, p 697), Bailey and Love's *A Short Practice of Surgery* points out that the generally accepted fact of familial susceptibility "can be accounted for by an hereditary abnormality in position of the organ, which predisposes to infection. Thus the whole family may have a long retrocaecal appendix with a comparatively poor blood supply." . . . Most practitioners, whatever their special interest, sooner or later are asked for an opinion, whether by relatives, friends, or patients, and awareness of this possibility in history taking in atypical cases may be crucial. . . .

Easy-rider sling

Dr TESSY K HANID (Kingston Hospital, Kingston upon Thames, Surrey KT2 7QB) writes: I am afraid the point of my letter (4 August, p 335) has been missed by Dr J R Gillespie (1 September, p 555). The advantages of using the sling are numerous and in no doubt. But the technique of carrying the babies in the front is hazardous and care should be taken if people still choose this method despite the warning.

Remedy for excessive salivation

Mrs ROBERTA A BUTLER (Merton, Sutton, and Wandsworth Area Health Authority, London SW12 0AD) writes: I was interested to see your items about reducing excessive salivation in the mentally handicapped (5 May, p 1200; 19 May, p 1355). Speech therapists are at present undertaking programmes to control excessive salivation by the use of battery-operated vibrators.¹

¹ McCracken, A, *American Journal of Occupational Therapy*, 1978, **32**.

Photographing slides during scientific presentations

Dr R T JUNG (Dunn Clinical Nutrition Centre, Addenbrooke's Hospital, Cambridge CB2 1QE) writes: I would wholeheartedly agree with Dr S Mann (29 September, p 798) that it is impolite of delegates to photograph slides during scientific presentations and it is about time this growing practice was curbed. At the World Nutrition Congress in Rio de Janeiro last year I was shocked to find that the organisers had allowed professional photographers to take flash pictures not only of the speakers but also of individual delegates during the actual lectures and symposia. This, as you can imagine, was most disturbing and should also be prohibited. . . .

Art and audacity

Dr H G EASTON (Glasgow G12 0XX) writes: In Dr Alex Paton's fascinating account of the achievements of that eminent medical truant Dr Tom Honeyman (22 September, p 711) there is a slip. The title of Honeyman's autobiography is not *Art and Authority* but *Art and Audacity*. The difference is important, for Honeyman, who despised the official mind, had the audacity to defy authority all his days.