card, which they keep; and its significance should be explained to them so that they are free of unnecessary anxiety in future pregnancies.

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Weight penalties

SIR,—Readers may be grateful to Dr J S Garrow (10 November, p 1171) for his useful summary of the use of the body index W/H^2 in relation to mortality. He asks the question "Is the excess weight fat or some other component?"

To assess desirable weight Dr Garrow suggests that values of W/H^2 from 20 to 25 are best. This range corresponds approximately to 12.0-13.7 on the scale $Ht/\sqrt{Wt}$ (in inches and pounds) and, in terms of Sheldon's somatotypes, includes almost all mesomorphs at the age of 20. Those with W/H^2 ratios above 25 would be mainly endomorphs. As age increases they blossom, as can be seen from their skinfold measures, but there is little or no evidence of increase in bone size or calf or biceps girth if allowance is made for skinfold fat. Women are notably fatter than men. In the most overweight persons diabetes is commoner in women. Does not this suggest greater association with overweight in the form of fat? In the most overweight men the mortality ratio was only 1.95, much the same as for the most overweight women (207). But the greatest disposition to coronary disease is found in mesomorphs, actually endomorphic mesomorphs, rather than endomorphs; and the mechanism, to which I have referred earlier,^{1,2} is almost certainly different.

Incidentally, genetic predisposition does not, of course, imply that environmental change is impossible or that all treatment must be ineffective.

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¹ Parnell, R W, *Behaviour and Physique*. London, Edward Arnold, 1958.

² Parnell, R W, *Lancet*, 1964, 2, 816.

³ Parnell, R W, *British Medical Journal*, 1977, 1, 1345.

Clinical practice and community medicine

SIR,—The correspondence (20 October, p 1005, and 27 October, p 1078) following Professor E D Acheson's paper (6 October, p 880) has chiefly concerned a possible clinical role for service community physicians. Many academic departments of community medicine grew out of university departments of social medicine, which contained people like myself whose training had principally been oriented to clinical medicine but who had acquired a special interest in epidemiology. A small number of such individuals now hold honorary consultant contracts in both clinical and community medicine. Despite the fact that there is a certain element of conflict concerning the distribution of research, teaching, and service in two specialties, such a possibility provides an attractive option to some and in my opinion both disciplines are likely to benefit from the existence of such appointments. At present there are probably fewer than a dozen in the United Kingdom and, so far as I am aware, they have without exception been purely personal appointments.

I find my own work combining community

and clinical medicine stimulating and I hope that the Faculty of Community Medicine and the royal colleges will consider ways in which training grades for such a career could be established.

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SIR,—I was dismayed to read Dr Frada Eskin's letter on clinical practice and community medicine (20 October, p 1005). If she is correct in her analysis I am in the wrong game, but I do not accept this to be the case.

I believe it to be a fundamental mistake to seek to separate clinical and population medicine, because they are part and parcel of the same discipline: to speak of one without the other is to leave the yeast out of the dough. A doctor's prime responsibility is as advocate for his patient; to act in this capacity in a fully informed way he needs a working understanding of epidemiology and of the relative importance of primary, secondary, and tertiary prevention in his own daily work. Unfortunately, few people are prepared to take on the challenge involved in training doctors in the medical schools, and at postgraduate level, to have a systematic knowledge of their specialty areas that includes both the population and the public health perspective and a wider advocacy role.

If we were honest about the administrative aspects of community medicine, we would admit that the reason we want doctors to do the jobs is that we do not want non-doctors to do them. The reason for this apparently dog-in-the-manger attitude is because we wish to maintain medical control over decision making and over the health authorities, which must surely constitute the biggest quango of all. The place for departments of community medicine in all this is for them to be providers of information and intelligence centres where the interfaces of medicine can be explored. In such a setting there is room for wide combinations of interests and the department is enriched by the contacts involved.

My major concern about the faculty orthodoxy as expounded by Dr Eskin is that the end result would seem to be the construction of a vessel with no sailors to man it, as those of us who refuse to be forced into the mould return to work where we are accepted for what we are, and not what some people would have us be.

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SIR,—Your leading article (6 October, p 817) and Professor E D Acheson's article (p 880) prompt me to draw the attention of your readers to the field of community liaison psychiatry whose existence is still not widely appreciated and where this dual approach to clinical work and administrative planning can be practised, as I have done for quite a number of years.

There is little doubt that a considerable number of psychiatric disabilities and problems can be and indeed are more appropriately contained in the community without referral to any hospital facility. This community psychiatric approach appears much more suited to the particular needs of many patients and clients, is far more economical in manpower and services, and additionally is often

preferred by the patients themselves and their relatives. It also prevents a number of cases from reaching crisis proportion, thereby saving scarce and expensive hospital accommodation.

Continuity of care incorporating the management and supervision of psychiatric patients discharged from hospitals back into the community engages our service to a considerable extent, as many patients are never entirely free from psychological disabilities which adversely affect their relationship with other people. Thus continuing advice and support are needed, and favourably influence a more appropriate rehabilitation and resettlement. Neither the primary health care team nor the community agencies, statutory and voluntary, either alone or even together, can effectively manage and support these cases. This is precisely where the community psychiatrist plays a key role since he not only contributes his psychiatric expertise but also brings the various agencies together and co-ordinates their work.

If I may use my own position as a model, it is essential in my view that the community psychiatrist is basically a practising clinical psychiatrist possessing a knowledge of community medicine. This combined expertise, together with his work in the community and attachment to the local hospital psychiatric units, provides him with an understanding of the local needs and enables him to advise on the administration and planning of a comprehensive integrated psychiatric service for the district.

A community psychiatrist is probably also better placed than his whole-time hospital colleagues to undertake research into the epidemiology of psychiatric disabilities, especially as these are met with in the community. In a community setting such a psychiatrist also has greater opportunities for applying prophylactic measures.

Primarily this "community-orientated multi-disciplinary psychiatric team" approach takes an active part in the management, treatment, care, and rehabilitation of patients in the community. From my own observations I consider that a full-time community psychiatrist would be appropriately related to a population of about 200 000—that is, the size of an average health district—but, depending on the extent of his hospital involvement, this may have to be reduced to 1 per 120 000 population. This does not necessarily imply an increase in recruitment for this specialised field but rather a redeployment of some suitable presently employed personnel.

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Professional standards for consultant appointments

SIR,—Mr Peter Diggory (3 November, p 1147) is quite rightly concerned that consultant appointments in obstetrics and gynaecology have been given to candidates who have not received full accreditation by their royal college. His specialty, however, is not alone, since there have been three consultant appointments in neurosurgery in the last two and a half years where the successful candidate had not received full accreditation from the Royal College of Surgeons of England. Indeed, the most recent appointment was given to a candidate whose senior registrar training in this country was at a unit that was not recognised by the Royal College of Surgeons' specialist advisory committee for senior registrar training in neurosurgery.

The royal colleges are constantly reminding us of their role in training and maintaining standards, but unless they are prepared to take a more firm line on the true role of accreditation