becomes a useful research tool for comparing analgesic drugs double-blind. We believe this method can bring us closer to the much desired goal of effective postoperative analgesia.

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¹ Rosen, M, in *Pain—New Perspectives in Measurement and Management*, ed A W Hargreaves, R Smith, and B Whittle. Edinburgh and London, Churchill Livingstone, 1977.

Altered bile in diabetic diarrhoea

SIR,—I was interested to read the article by Anne M Molloy and Dr G H Tomkin (25 November, 1978, p 1462), in which they report increased faecal bile acid excretion in diabetic diarrhoea. This finding is at variance with our study using the ¹⁴C-glycocholate test as an indicator of bile acid malabsorption.¹ We found increased faecal ¹⁴C excretion in only one of seven patients with diabetic diarrhoea. In contrast, in a similar study of postvagotomy diarrhoea all the patients had increased faecal ¹⁴C excretion and responded to cholestyramine.²

In the present series the daily faecal volume is not given. Clinically important bile acid malabsorption is unlikely when the stool output is less than 200 g.³ It would also be interesting to know whether cholestyramine was used in these patients. I have found it to be generally disappointing in diabetic diarrhoea.

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¹ Scarpello, J H B, *et al*, *British Medical Journal*, 1976, **2**, 673.

² Scarpello, J H B, and Sladen, G E, *Lancet*, 1977, **1**, 646.

³ Fromm, H, Thomas, P J, and Hofmann, A F, *Gastroenterology*, 1973, **64**, 1077.

Prophylactic co-trimoxazole in biliary surgery

SIR,—The study "Prophylactic co-trimoxazole in biliary surgery," by Dr C Morran and others (12 August, p 462), raises many more questions than it answers. Possibly the most important observation from their paper is that the majority of their wound infections grew staphylococci, an unusual organism in the biliary tract, as their bile cultures show. The authors state that wound sepsis is more common in patients with infected bile yet the data in their paper can scarcely be said to support this claim since of the nine patients in each group with a positive bile culture only three of the controls and none of those treated with co-trimoxazole had wound infections. We have no dispute with the central thesis of the paper that perioperative single-dose co-trimoxazole reduces the incidence of wound sepsis in elective biliary surgery. However, it seems to us that the effective prophylaxis has been against staphylococci, most of which have not been introduced from infected bile.

Two further matters are worth a comment. The first is that 10 of 47 patients undergoing elective cholecystectomy without antibiotic cover developed a wound infection (could it be that Dr McNaught did the surgery and Mr McArdle the bacteriology?). This infection rate of 21% is far too high and preventive measures are certainly justified. Nevertheless,

the cause of this high infection rate needs to be established and dealt with; on the data presented infected bile is not the culprit.

Wound infection rates in elective biliary surgery without antibiotic prophylaxis appear to be very high (16.9-22%) in recent studies reported from the United Kingdom.¹⁻³ Studies reported from the United States indicate a lower wound infection rate (1.4-11%)⁴⁻⁶ and in this hospital the wound infection rate in 200 consecutive patients undergoing elective cholecystectomy was 6%. It is interesting to speculate on the reasons for these differences.

We are also surprised at a mean duration of stay of 10 days in patients with an uncomplicated postoperative course when this is 6 days in this hospital (200 patients) whether or not their course was complicated. There are obviously many reasons for these discrepancies and it would be useful for comparative purposes if papers of this nature could include data on patient characteristics, especially that of age distribution, so that useful comparisons could be made.

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¹ Keighley, M R B, *et al*, *British Journal of Surgery*, 1975, **62**, 275.

² McLeish, A R, *et al*, *Surgery*, 1977, **81**, 473.

³ Strachan, C J L, *et al*, *British Medical Journal*, 1977, **1**, 1254.

⁴ Stone, A M, *et al*, *American Journal of Surgery*, 1977, **133**, 285.

⁵ Stone, H H, *et al*, *Annals of Surgery*, 1976, **184**, 443.

⁶ Cunha, B A, *et al*, *Lancet*, 1978, **1**, 207.

Function of the community physician

SIR,—I refer to your leading article "Epidemiology and the Potteries" (9 December, p 1590), in which certain remarks attributed to Professor E D Acheson may be misconstrued by those who are not familiar with the specialty of community medicine and the role of the community physician.

In order to clarify the issue it is vital to distinguish between the "administration" and "management." Administration is the day-to-day running of established services, usually the responsibility of non-medical administrators, whereas management is concerned with the planning and development of future services. While it may be true that some community physicians may be involved with some administrative duties, in general community physicians are neither interested in nor concerned with administration. Their training and orientation is in relation to their management function—that is, intimate involvement in planning and policy making in the field of health service development.

Planning services requires epidemiological studies and epidemiology is that science which, although not exclusive to the specialty of community medicine, occupies a large part of the training curriculum. Because of this the community physician has a unique depth of knowledge and expertise in this field. Clinicians must, of course, concern themselves with trends and developments in their own field of practice, but judging by continuing correspondence in medical journals the majority of today's clinicians are far too busy dealing with an ever-increasing case load to have either the time or the energy to cope with the exacting intricacies of accurate and effective epidemiological methodology.

It is in the field of epidemiology that the community physician and the clinician may most usefully combine their joint skills in furthering the understanding of the aetiology and prevention of disease processes. It would be a pity if the skills of community physicians in this important field were to be dismissed through a misunderstanding of their role and function in the Health Service.

FRADA ESKIN

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Opportunity in health visiting

SIR,—We, health visitors of the future, take exception to Dr Michael Hall's letter (9 December, p 1646). Our own experiences over the past year in trying to enter the health visiting profession have proved that it is extremely difficult to obtain selection: motivation is strongly questioned as well as academic ability and suitability for health visiting.

Concerning the review of training requirements of those working in the health professions, we feel the Briggs Report has either been misinterpreted or read with bias by your correspondent. The historical reference is relevant but incorrect, as medical and nursing qualifications have long been required for entrance to this profession.

We refute the implications about motives for moving from nursing to health visiting. Many of us entered nursing in order to become health visitors, and the increased interest in health visitor training has resulted in the combined course. Many health visitors in training bring a wealth of experience from their years in all branches of nursing, which also enables them to appreciate fully the value of preventive medicine.

We should be grateful if Dr Hall could suggest an alternative course for school leavers which would provide them with the expertise in human relationships, development of powers of observation and detection which are gained through nursing training, as well as, of course, a knowledge and understanding of other health professionals, which Dr Hall seems to lack.

1974 saw the integration of health visiting with the National Health Service. Gilmore found then that a high proportion of health visitors' functions were misunderstood and not fully appreciated by general practitioners. It appears, sadly, that this may still apply.

We agree that the role of the health visitor has never been so important as it is today in our stressed society.

JILL THORNTON
and 34 other health visitor students

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Staffing of accident and emergency departments

SIR,—It is sad to think that we are as far from solving the problem of medical staffing in accident and emergency (casualty) departments as we were in the early 1950s, when senior casualty officers like myself were first forced on to a reluctant profession, and, if Dr D M Bowers (9 December, p 1648) is right, there is not going to be much improvement in the next 25 years.

At least 75% of the work presenting in the

casualty department of the average district general hospital is surgical. By far the most important part of this is related to orthopaedic surgery, and it is for this reason that the orthopaedic faculty has consistently opposed the idea of an independent casualty department. Had the orthopaedic consultants been able or willing during the past 20 years to take an active part in the running of casualty departments and in supervising the work of casualty officers the idea of an independent casualty consultant would never have arisen.

At the present time it is fashionable to emphasise the medical side of casualty work and to underrate the importance of the much larger surgical side. This is due, I think, to the determination of orthopaedists not to allow the independent casualty department to take any part in the orthopaedic care of accidents and to the wish of the casualty surgeons to appease the perennial opposition of the orthopaedic faculty to the casualty department's independence. This train of thought, on the part of both orthopaedists and casualty surgeons, has resulted in a number of unsatisfactory casualty consultant appointments in recent years and is at the present time resulting in the spectacle of appointments committees going around the country and failing to make appointments at all.

The independence of the accident and emergency department under its own consultant staff has clearly come to stay. But I cannot see these consultant posts being rewarding or attracting the right type of applicant unless the appointee has an orthopaedic background, is accepted as competent by the local orthopaedic department, and is welcomed by them to take a part in the care of fractures and allied injuries. I do not think there is any prospect of improvement in the accident and emergency service unless these two complementary hospital departments work together and the casualty consultant is regarded as one of the orthopaedic team.

K G PASCALL

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General practice records

SIR,—A close reading of the article about our record system (25 November, p 1510) will answer some of the points raised by Dr N M Maclean in his letter (9 December, p 1646). For example, the continuation cards are punched and held together by treasury tags and the four special cards are tagged on the front in strict order. Consequently, it is impossible for them to be misfiled. The problem lists (fig 3) and analyses of problems are written in capital letters and are therefore legible.

One of us (JSW) has used both systems but does not share Dr Maclean's overwhelming conviction that A4 records are superior to our modification of the existing medical record envelope (MRE). He found that the style of recording on A4 tended to revert to that of hospital note-taking, being more detailed but not necessarily more helpful. Note-taking in the surgery demands an approach that takes into account the limited time available for writing during the average consultation. Use of the MRE has encouraged the habit of thinking before writing instead of thinking while writing. The limited space of MREs is,

we think, not a disadvantage in the context of the usually brief consultation in general practice, particularly when the front of the record is structured.

We agree with Dr Maclean on the importance of this structuring, whichever record system is used. It was the lack of progress in introducing A4 folders that led us to evolve our simple and *inexpensive* system. We have found it to be viable and a considerable advance in our management of patients. It, or something similar, could be introduced by GPs now, without much expense or waiting for more years of discussion, delay, and disappointment.

C H MAYCOCK
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J S WRIGHT

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*.*This correspondence is now closed.—ED, BMJ.

Redistribution of registrars

SIR,—The stand taken by the Trent Regional Manpower Committee on the distribution of senior registrar and registrar posts (16 December, p 1729) is one of fundamental importance within the Health Service. The present impasse between regions makes the position of deprived areas within a "donor" region even more parlous. In supporting Trent's claim for equity it is reasonable to expect that the same principles be applied at sub-regional level. It is not acceptable that, for instance, Kent Area on 31 December 1977 had only 12 senior registrar posts in all the clinical specialties (that is, 1:120 675 population) within the South-east Thames Region, which has an overall ratio of 1:21 567. Just to reach the 1977 national average provision of 4.62 whole-time equivalents per 100 000 population Kent could expect an additional 55 senior registrar posts.

At registrar grade the problem is equally grave. The Kent level of provision (1:15 913 population) is disproportionately low against the regional standard of 1:9787—and again this implies in Kent a shortfall of 62 registrars below the 1977 national average level of 10.55 whole-time equivalents per 100 000 population. Adequate hospital staffing is a key factor in the quality of health care which an authority can provide. It is naïve not to accept that senior training posts also have a service function—and indeed it is essential as part of training that they do so.

In the conflict between career structures and service provision which underlies these shortages it is incumbent upon the profession to recognise the practical consequences of the present situation. "Centres of population" with too few doctors may well take a different view from "centres of excellence" with too few patients.

GILLIAN MATTHEWS

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Honorary registrar posts in the NHS

SIR,—Professor L P Le Quesne's reply (2 December, p 1575) depicts my letter (4 November, p 1374) as outrageous. Yet its main point was simple enough and so self-evidently just as to be barely contentious.

Entrée to consultant posts (and academic

equivalents) comes, in the main, through two training systems, the NHS and the academic. The former is subject to numerical control (and indirectly to quality control) by the Central Manpower Committee; the latter experiences no better numerical control than that imposed by the vagaries of university budgets, and in many cases there is no control of content (and until all such posts have control of content Professor Le Quesne's second paragraph may be dismissed as mere obfuscation).

I can think of no more damning indictment of his views than his comment that "to fetter the development of the work of academic departments by constraints concerned entirely with the manpower requirements of the Health Service would be a damaging restriction of their freedom and of their obligations." As "manpower requirements" could read "career prospects for trainee specialists" he displays a reprehensibly dismissive attitude to the relevance of the underling. If the work of academic departments is of such enormous importance, then it should be accommodated by an expansion of career, not training grades.

The universities are naturally reluctant to countenance restrictions on their empires, but control of manpower is essential, being a *sine qua non* for proper staff structure and career planning. They, like the NHS, must move to a situation in which the numbers in training are reduced to a level which gives reasonable career prospects, the resulting extra service work being done by expanded service grades. The Central Manpower Committee is the appropriate instrument, though it will obviously require minor modification to allow the universities to be represented when their posts fall within its remit.

TOM MCFARLANE

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Private beds in Westminster area

SIR,—The St Marylebone Division is concerned about the availability of private beds in the Westminster area for routine and emergency patients. With the closure of private beds within NHS hospitals and the influx of foreign patients to Harley Street there would appear to be a problem. We would be pleased to hear from any consultant or private family doctor who has experienced such difficulty.

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Correction

Immunisation of adults against diphtheria

In the letter from Dr R Mitchell and Mr A Barr (11 November, p 1371) the sentence beginning on the 22nd line should have read: "In this second series we found that only 4.9% of donors had anti-toxin levels over 0.1 IU/ml and only 0.58% over 2.0 IU/ml."