and after treatment are compared we believe that physical activity performed must be comparable at each time and that consideration should be given to variation in the time of waking.

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- ¹ Littler, W A, and Watson, R D S, *Lancet*, 1978, 1, 995.
² Floras, J S, et al, *Clinical Science and Molecular Medicine*, 1978, 55, 395s.
³ Jeffers, T A, et al, *British Journal of Clinical Pharmacology*, 1977, 4, 523.
⁴ Wilcox, R G, and Mitchell, J R A, *British Medical Journal*, 1977, 2, 547.
⁵ Wilcox, R G, *British Medical Journal*, 1978, 2, 383.

Retroperitoneal fibrosis after treatment with atenolol

SIR,—The report from Belfast City Hospital (23-30 December, p 1786) implying that atenolol may have been the cause of retroperitoneal fibrosis in a 68-year-old woman deserves comment. There are several reasons for supposing that the suspicion of a cause-and-effect relationship is not well founded.

The authors state that this case was reported "because of the established relationship between the earlier beta-blocker practolol and similar types of sclerosing fibroblastic reaction." However, in more than 200 cases of practolol sclerosing peritonitis, which principally affects the visceral peritoneum of the small bowel, no cases of retroperitoneal fibrosis have been identified. Moreover, the early onset of symptoms (six months of atenolol therapy in the Belfast case) is not in keeping with a median time of onset of 36 months (range 15-96) for sclerosing peritonitis caused by practolol.

Perhaps of greater importance is the fact that usage of atenolol to date is similar to that of practolol when it was withdrawn and no validated reports of the specific oculomucocutaneous syndrome have arisen with atenolol. Finally, it is known that a group of 16 patients who suffered from practolol toxicity have now been taking atenolol for up to five years without any suggestion of recurrence of adverse reactions of the oculomucocutaneous type.

On balance it seems unlikely that atenolol may have a propensity to cause "similar types of sclerosing fibroblastic reaction."

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Longest-stay patients

SIR,—The leading article "Who cares for the mentally handicapped?" (18 November, p 1386) pointed out that of the 50 000 citizens of Britain living in hospitals for the mentally handicapped, 20 000 have lived in hospitals for 20 years or more. Many of today's hospitals for the mentally handicapped were opened as institutions for mental deficiency after the end of the first world war. In them there are still some residents who were admitted as children in the earlier decades of this century. They have lived out their lives within these hospitals and have passed their golden jubilees, and some are about to reach their diamond jubilees of residence in hospital.

For example, at Meanwood Park Hospital, Leeds, first opened as a mental deficiency

colony in 1919, one man achieves 60 years of residence this year. Altogether there are 35 (15 men, 20 women) out of 530 residents (6.6%) who have been in that hospital for over 50 years. They have a total between them of 1924 years in hospital, an average stay of 55 years. Some mental handicap hospitals with histories dating back before the 1913 Mental Deficiency Act may have residents with longer periods of stay than 60 years. This prompts the thought of where is the longest-stay resident in this country.

As might be expected, these longest-stay patients represent mainly the more intelligent group of residents, who would never be accepted in hospital today. In a sense they are a lost generation of their time, people who have spent a lifetime in hospital, which should never happen again. They were the victims of a system which society now acknowledges to have been wrong.

For this reason these longest-stay patients are particularly in need of recognition. The nursing staff at Meanwood Park Hospital have suggested that it would be appropriate to acknowledge in some way these longest-stay hospital residents. It is likely that all hospitals, and perhaps their communities, will be interested in honouring such patients. They have been in hospital so long that now few of them want to leave. Their remaining years in hospital will have to be made as happy as possible. Hospitals might ensure that longest-stay patients' wards are as pleasant and comfortable as possible. There is plenty of scope for volunteers to work with these patients. All who show concern about mental handicap can find common ground in giving them special consideration.

D A SPENCER

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Staging of carcinoma of the pancreas

SIR,—The surgical treatment of cancer of the pancreas is now based on staging of the disease. This principle was set out in your leading article (10 December 1977, p 1497). We have followed the steps advocated, and so after a careful laparotomy with palpation of the liver and assessment of local operability we proceed to frozen section examination of the regional lymph nodes to differentiate stage III from stage I and II disease. Recently, however, we have modified this policy by extending the use of frozen section to include an examination of a wedge liver biopsy.

Six months ago a small nodule was noted on the anterior surface of the liver in a patient who was otherwise stage I. The nature of this lesion was not clear. It was therefore biopsied. Immediate section showed that it was a small cyst, but the pathologist reported the presence of a micrometastasis of adenocarcinoma within the same biopsy. This transferred the patient to stage IV. As a result of this experience routine biopsy has now been performed and in four patients examined since that time one other who had no macroscopic evidence of spread has been shown to have micrometastases in the liver.

It is interesting that Bender and Brennan¹ have recently noted the value of liver biopsy. They perform a percutaneous needle biopsy, but their report relates to a group of cases who had already undergone a bypass to relieve jaundice and were being considered for

palliative radiotherapy. Such an approach would not be appropriate in a jaundiced patient, but we have found no contraindication to operative biopsy. It is accepted that a small piece of tissue will offer only a small chance of picking up metastatic spread; but if the frozen section is positive, as in two of our patients, it clearly alters the staging and makes any resectional procedure inappropriate.

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- ¹ Bender, R A, and Brennan, M F, *American Journal of Surgery*, 1978, 135, 207.

Abortion and the NHS: the first decade

SIR,—The review of "Abortion and the NHS: the first decade" (27 January, p 217) is a superficial look at a vexed problem. It appears to be written on the assumption that an abortion is in itself a good thing and its performance is thus to be encouraged. The authors say that the effectiveness of an abortion service may be indicated by (a) the mortality rate; (b) the complication rate; (c) the proportion of abortions performed after 13 weeks' gestation; and (d) the concurrent sterilisation rate. They tell us the mortality rate but give us no figures for complication rate.

This, however, is only one side of the coin. We judge the effectiveness of a treatment or a service not only by the deaths or complications arising from that treatment, but by what good the treatment produced. The authors present no data on this subject at all. Before suggesting that "the number of abortions performed may be increased without any increase in running costs" the authors might care to ponder the suggestion that 102 675 abortions per year is already too many.

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Good general practice

SIR,—I read the Personal View by Dr J A R Willis (3 February, p 339) with considerable interest. Having qualified in the 1950s, I had similar feelings of bitterness about the low opinions held about general practice. This particularly applied because there were three general practitioners in my own family.

Undergraduate secondment to general practice is now a mandatory requirement by nearly all medical schools—except, unfortunately, my own. With the implementation of the Vocational Training Act, general practitioners should be properly trained, and we have our own royal college to help us do this. In general practice, there is a greater variation of standards between practitioners than in the consultant field. In this latter field, there is a fully integrated training programme with the appropriate royal college membership (or fellowship) examination as an essential part. With vocational training and the Royal College of General Practitioners it is to be hoped that the variation of standards in general practice will narrow.

Surely the MRCGP examination must be used as a tool to ensure that vocational training in general practice is working effectively?

Although an elected member of the college, I took the examination at the age of 46. I found the examination to be very realistic, and I felt it gave me a good appraisal of how I practised. To remain a member of the college, one is committed to a maintenance of standards and to continue to receive postgraduate education. I took the examination with this aim in view.

Dr Willis's idea of periodic inspection of the practices of the members of the college is regrettably quite impracticable. I have the privilege of being a member of a three-man team which visits and assesses practices' suitability for training. This takes up to two hours per practice including travelling, visiting the practice, and the inevitable paperwork to follow. (I must acknowledge at this point, with gratitude, the tolerance of my partners in allowing me to do this.)

In the West Midlands, there are a total of approximately 100 teaching general practices, which is about 5-10% of the whole number of practices. With the number of doctors passing the MRCGP at present, it would be totally impossible for fellow members of the college to visit other practices to assess efficiency. I wonder also what would happen if a fellow consultant were to visit a colleague to assess standards in his department, other than in the "approval for training" situation.

Dr Willis states that the college is elitist. I feel that all the royal colleges must, to some extent, be elitist, in order to be maintaining the effectiveness in their own speciality. The RCGP is no exception, and it has to cope with the largest speciality of all.

In the RCGP many doctors are committed to the college maintaining good general practice. If these doctors work hard for the college, being college tutors (which are unpaid appointments), course organisers, or trainers, is there any harm in their being recognised by the college by election to fellowship for their efforts? The proportion of fellows to members in the RCGP must inevitably be considerably lower than in the other specialities, where election to fellowship would appear to be only a matter of time.

Finally, Dr Willis must be congratulated on his most stimulating contribution to the Journal.

J D W WHITNEY

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Group practice allowance

SIR,—I should like to direct the attention of your readers and also of our pay negotiators to the problem of the group practice allowance.

This allowance has been with us a number of years—I forget how many. But each time the Review Body makes an award their habit seems to be to up grade it pro rata with other allowances, so it is at the present day worth over £500 per partner in the practices which are privileged enough to receive it. The conditions for getting this allowance are well known and state that the partnership must be one of three at least, practising from the same premises for minimum hours per week, and providing ancillary help and 24-hour cover for the practice. These are not really very onerous provisions and it is possible that a number of the practices receiving the allowance are actually employing answering services for their night calls. There must be very few practices now which do not employ ancillary help. I must now come to the question whether these particular benefits to the public are worth the

money that is being paid out for them—bearing in mind partnerships of two or single-handed practices are not allowed to have this payment, however good the services they provide for their patients.

Recent figures for doctors with main surgeries in the county of Wiltshire and on the list of the Family Practitioner Committee for Wiltshire are as follows: out of a total of 224 doctors, 187 are receiving group practice allowance, and they are members of 45 groups of three or more doctors. The remainder of the doctors in the county, comprising five groups of two, one group of three, and 22 single practitioners, receive no payment.

I, and other colleagues I have spoken to, regard this as unfair payment for which the recipients have to do very little, and I now question whether the time has not come either (a) to freeze this payment so that if inflation continues it becomes a less important part of remuneration; (b) to scrap it altogether, and add the money to the basic practice allowances; or (c) to make new conditions for acquiring it which would reflect more the efficiency and benefit to the patients, if the Department of Health think that it is necessary.

I suspect that this payment has been kept in being because the Department favours larger group practices regardless of merit. Since those who receive the payments are in the majority they are not particularly worried about the minority who do not receive them.

MICHAEL PYM

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Thoughts on hospital staffing

SIR,—I would like to comment on the article of Mr I K Mathie (2 December, p 1581) and the subsequent letter of Mr M V L Foss (27 January, p 273).

My personal belief is that consultants *should* be in active physical control of labour wards, except in those few "centres of excellence" where high-grade junior staff are available. A modern labour ward is a form of intensive care unit, and the process of birth is too important to be designated to inexperienced junior staff. The Government has backed the Year of the Child and increased grants for long-term handicap care but, inexplicably, aims at cutting back on labour ward spending.

There is also a saying that "if you can't beat them, join them" and we are approaching that situation in the NHS. The DHSS in its wisdom has made it impossible to obtain registrars even in expanding units. Many consultants might complain that to act as "registrant" is demeaning, exhausting, and unjustified under the current poor rates of pay. I would point out that registrars are rare beings outside these hallowed shores, and no consultants find it demeaning to handle their private patients in labour. Family doctors manage to get up at night until retirement. Something must be done, however, to compensate financially and in terms of time off duty.

This is obviously complex but the alleged new off-duty recall payments, scheduled for April 1979, must be made reasonable. More difficult would be the question of off-duty. Traditionally the consultant is permanently on call in a low-grade capacity—always available for administration and clinical questions from hospital and general practitioners, together with the claims of private

patients. Some sort of rota, strictly kept, would be needed and maybe telephone unavailability, as used by many family doctors.

I suspect that this will appeal to about 5% of British consultants in obstetrics and gynaecology (or any other speciality), but I believe it will come whether we want it or not, unless we are prepared to see standards fall and neonates in jeopardy, with all the lifelong consequences this would entail.

And what other specialty trains a man for 10 years (as in labour ward management) only for him to give it all up to become a gynaecologist on achieving consultanthood?

ALAN PENTECOST

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"Time-expired" senior registrars

SIR,—Concerned with surgical registrar training programmes, I write to ventilate a particular injustice that some of our senior registrars are being exposed to. When they have become "time-expired" after their four-year contract, pressures are being mounted to the effect that if they do not secure a consultant appointment then employment in their current job will cease.

There is a disparity between the number of senior registrars leaving the training programme at the end of their four-year contract and the number of consultant posts available for them in some specialties, notably surgery. If there were multiple vacancies for consultant surgeons then perhaps pressure to leave would be justified but these vacant jobs do not exist. Perhaps those who argue that employment should cease would like to spell out clearly what they think that a senior surgical registrar at the age of 35 should do. Surgical care in this country is predominantly administered by our monopolistic employer, the Department of Health and Social Security; there is no alternative therefore for the unemployed surgeon. To suggest that he should change specialty at that stage is ridiculous in the majority of cases. Emigration is no longer feasible.

An important point is that if senior registrars are thrown out of their jobs yet more registrars will be taken into the system, thus making the problem worse. It follows therefore that one way or another we must absorb most, if not all, of our fully trained senior registrars within the United Kingdom. It may be undesirable, but the one way to try to match trained surgeons to consultant posts is to allow the training period to extend, at least in some cases, and so to maintain flexibility. To dismiss a fully trained surgeon who has nowhere to go and no other reasonable way of earning his living is unnecessary, administratively wrong, and, I submit, callous.

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Short listing for senior house officer posts

SIR,—The discourteous behaviour complained of by Drs C H Cheetham and D H Garrow in their letter (27 January, p 202) cannot be excused but I believe the other side of this disagreeable coin should also be examined.