almost entirely by general practitioners, and it was only the chance availability of the eight-year pool of demobilised young doctors who had been conscripted from 1939 onwards which enabled the new NHS hospital staffing structure to be established on a pyramidal basis. Although there are now schemes to make use of the skills of many highly trained general practitioners in hospitals, these will have to be intensified despite the many problems. At present the greatest difficulty appears to be the differences in pay structure between the hospital and practitioner services. I have met many practitioners who would welcome an active role in their local hospital, providing a stimulus not only to them but to the consultants who work with them. It is to be hoped that the hospital skills which the trainee GP now acquires in the many excellent training schemes can be utilised when he or she goes into practice.

Mr Williams points out that senior registrar numbers are adjusted to the numbers of potential consultant vacancies; but in the smaller branches of medicine which expanded rapidly after 1948 there is now an undue proportion of consultants approaching retirement. Before reorganisation it was relatively easy to adjust the numbers of senior registrars to allow for variations in potential consultant vacancies. This was done by discussion between a principal medical officer of the DHSS, the consultant adviser, and a senior representative of the branch of medicine concerned. Any increase in establishment was financed from central funds until the next annual budget. Now one is faced with the Central Medical Manpower Committee and the delays inherent in such structures. If, after a lapse of time, an increase in senior registrar establishment is granted to a suitable training department, this can be implemented only if money is available locally to finance the post. This nowadays is very unlikely, so that the whole costly and time-consuming exercise results only in frustration. In the meantime the many keen young men required to fill the coming consultant vacancies cannot find training posts. Time for them is running out, many consultant posts will not be filled, and with the present plethora of uninformed committees it appears to be quite impossible to alter the situation.

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Fee for service or capitation fee?

SIR,—I believe that Dr A G Dawrant (27 January, p 273) has read more into my article (28 October, p 1241) than was intended. I did not advocate the continuation of the capitation system, but believe that in the present UK politicoeconomic climate GPs are fighting to maintain their status quo. We are more likely to have a salaried service thrust upon us than receive "item-for-service" payments.

I found Canada to be a delightful but highly regulated country with well-policed regulations and laws permeating throughout the whole of society, including health care. Since submitting my article, I have received some information about the Association of Concerned Physicians in Ontario, whose level of influence and representation is not known to me. The association campaigns against the alleged arbitrary methods used by the Medical

Review Committee (MRC). It objects to the fact that the secretary of the MRC is also an official of the Ontario College of Physicians and Surgeons and a special constable in the Ontario Provincial Police Department. Thus it claims that a doctor under investigation does not know whether he is invited to a friendly discussion of his problems, a formal MRC inquiry, or a police investigation. The association claims that any doctor found not to be in breach of the regulations cannot reclaim any expenses he has incurred in the investigation, and has difficulty retrieving his medical and business records. I believe that the introduction of a fee for service at the present time would result in another level of bureaucracy without any increase in remuneration.

Dr Dawrant is forgetting that the structure and historical background of the two health services are entirely different. In Ontario 7.1% of the gross national product is spent on health care, excluding dental and optical services and most drug supplies. The NHS attempts to cover all aspects of health care using only 5.6% of the GNP. This difference is further emphasised by the fact that Ontario has less than 8% of its population over 65 years old, whereas in the UK the elderly population accounts for over 14.5%. One-half of the NHS beds are occupied by patients over 65 years. Thus I believe that the NHS gives better value for the money actually spent than the Canadian's system. The problem in the NHS is that not enough money is spent on health care, and economies have been achieved by underpaying the work force, poor facilities, and waiting lists with resultant patient dissatisfaction. There will be no improvement in the NHS until the British people are prepared to vote for more of their tax money to be spent on the NHS.

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New consultant contract and women senior registrars

SIR,—The paper by Drs Berenice Beaumont and Anne Grüneberg on women senior registrars' working pattern and their views on the new contract (3 February, p 359) omitted any figures for Wessex.

Although the Wessex RHA officials were unable to circulate the questionnaire they kindly gave me a list of senior registrars in the region. I have, I hope, contacted all women senior registrars in post at 30 September 1978 with the same questionnaire. The results will complete the national picture and are as follows:

There were 19 women senior registrars, of whom two now hold full-time consultant posts. The mean age was 36.8 years; 16 (84%) were married, of whom 14 had two or more children. Ten of the 14 with children were aged at least 27 at the birth of their first child. Of the 12 women working eight sessions or more, nine were full time. All except two were geographically tied. Eleven of the 19 (58%) were seeking full-time consultant posts, although a further three would accept an 8-clinical-session contract if there were no alternative choice. Five felt that they could not contemplate such a commitment while their children were still young. No matter what their personal preference the majority expressed the view that part-time consultant contracts should continue to be a normal part of health service hospital staffing, which would increase as the number of female graduates rose.

The specialties which these senior registrars covered were pathology, including haematology and virology (7), radiology and radiotherapy (4), psychiatry (3), medicine (2), obstetrics and gynaecology (1), paediatrics (1), and anaesthetics (1).

The results are very similar to those obtained nationally and confirm that women will wish to complete higher training for a career in hospital medicine whether married or not. There is evidence to suggest that they delay having their families and thus approach consultant appointment at a time when children are still young. Although many will seek full-time posts there will be a wastage or misuse of trained talent if provision for less than 8-clinical-session contracts is not made possible in all specialties. These findings bear out predictions of previous studies of part-time senior registrars.¹

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¹ *Lancet*, 1976, 1, 1280.

SIR,—The article by Drs Berenice Beaumont and Anne Grüneberg (3 February, p 359) has drawn attention to a very important matter, which will not be resolved simply by re-drafting contract requirements. If it is true that half our women senior registrars expect consultant appointments of less than eight sessions, new jobs are going to have to be created specifically for them. These jobs will be unsuitable for the other senior registrars and, unless created in addition to existing posts, they are likely to be most unpopular with senior registrars who need to work full time to support themselves and their dependents. Not all senior registrars become consultants. Perhaps those looking for full-time jobs as a source of income should have priority?

The article notably begs the question of how so many part-time consultants will actually function. How will continuity of patient care be maintained? Will part-time consultants operate a common waiting list, admitting off the top of the list irrespective of the consultant who saw the patient? Will two or three consultants share the same desk, office, and secretary? How many ward rounds can junior staff attend a week and still have time to clerk their patients?

These logistical questions will have to be faced and settled before any change actually occurs and it is disingenuous of the authors to imply otherwise. It would be interesting to hear from units who have experienced such arrangements. Pie-in-the-sky paper exercises will serve only to increase disgruntlement without bringing the essential solutions any nearer.

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Safety in clinical laboratories

SIR,—Clive Jenkins's reported statement that nothing has been done in the past three years to improve safety standards in NHS laboratories is clearly an exaggeration. But perhaps it is more useful to consider whether *sufficient* has been done—that is, whether safety standards are now satisfactory. It seems unlikely that many people would say that they are, although as Dr Heather M Dick points out (3 February, p 346) the reported incidence of hepatitis has fallen.

So far as safety is concerned, working conditions in the NHS are generally unsatisfactory, as shown in the recent Health and Safety Executive study.¹ What has or has not been done about particular sources of hazard is a secondary question; the root cause is underfinancing over a long period. Successive governments have attempted to run the NHS without being prepared to pay the proper cost, leaving the individual manager to decide how best to meet the demands made on him or his department. Often the NHS manager has had to choose between meeting legitimate demand for an essential service and improving (or even maintaining) the standards of working conditions for himself and his colleagues. Inevitably safety has suffered. The trade unions and the professional societies could usefully make a joint approach to this fundamental problem.

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¹ Health and Safety Executive, *Pilot Study: Working Conditions in the Medical Service*. London, HMSO, 1978.

Trade unionism in medicine

SIR,—I was privileged two days ago to attend the honorary secretaries' conference, distinguished by its very interesting talks and gracious headquarters hospitality. Owing to my own tardiness plus a great number of apposite questions from other secretaries I was unable to raise my own query. Are we rushing too fast into professional trade unionism? A somewhat similar worry, voiced by Dr E M Jones of Stockport, was dismissed, I felt, a little summarily.

Ten years ago a meeting such as this would have seemed inconceivable, with heavy discussion of professional trade unionism by doctors at a time when the nation is being ground down by the efforts of industrial trade unions. One wonders, given the rate of acceleration into trade unionism, where we shall be in another 10 years' time. I think that the general public, not to mention many of the rank and file in medicine (to use a trade union term), will find it a difficult exercise to distinguish between professional and industrial trade unionism. The junior doctors have after all already taken industrial "inaction" and caused patients some discomfort by extending waiting lists. Thus the precedent has been set.

Place-of-work accredited representatives (POWARs) are obviously going to be of great help in sorting out the day-to-day problems of working in harmony with other NHS groups, particularly in hospitals. I wish, while supporting the POWAR concept (arrived at democratically by the Representative Body votes), to sound the warning to take matters slowly and with great thought. We shall be treated as we behave and if we play the union game too hard we shall, in spite of rapid short-term advantages, eventually cease to be regarded as a profession. We should at all times insist that people are listened to for the truths they speak, rather than the amount of trouble they cause if they turn nasty. I appreciate that these remarks will strike many readers as unfashionable and out of date.

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Points

Acute poisoning with Distalgesic

Dr W MACKEAN (Liverpool) writes: Dr Alan A Morgan (3 February, p 342) points out that there is resistance from our patients when we attempt to substitute paracetamol or another analgesic for "the DGs." . . . Nobody, however, seems to have published the simple fact that it is much easier to swallow Distalgesic than paracetamol.

Dr L RATOFF (Liverpool) writes: With reference to the letter from Dr J A J M Critchley and others (3 February, p 342) . . . as a general practitioner, I believe that Distalgesic has no therapeutic advantage over paracetamol. . . . Over the past few months I have been making a serious effort to wean patients off Distalgesic which has been prescribed by other doctors. When a simple explanation is offered to them, I have not found the withdrawal of Distalgesic too difficult. Occasionally I have felt obliged to substitute a placebo in place of Distalgesic. A request for a repeat prescription read, "May I please have a repeat of aneurine tablets as these seem more effective than Distalgesic."

Malnutrition in infants receiving cult diets

Dr A LONG (the Vegetarian Society of the United Kingdom, London) writes: Unfortunately babies can be starved (3 February, p 296)—or overfed—on any diet. . . . The tragically bizarre diets of the starved babies and their mothers do not justify condemnation of veganism. Last June we published in our magazine *Alive* many examples of babies and toddlers thriving on vegan diets of the types we recommend. Paediatricians accept the soundness of such practices¹ and recognise their benefits, especially for babies intolerant to cows' milk, and vegan diets are now recommended for the prevention and treatment of coronary heart disease.² . . .

¹ American Academy of Pediatrics Committee on Nutrition, *Pediatrics*, 1977, **59**, 460.
² Sanders, T A B, et al, *American Journal of Clinical Nutrition*, 1978, **31**, 805.

Treatment of tuberculosis

Mr M WILKINSON (St Bonaventure's, Buckfastleigh, Devon) writes: The letter from Sir John Crofton (6 January, p 52) needs a reply. He asserts that "principles have been established . . . which are the same for all forms of tuberculosis" and then he goes on to accusations of ignorance and neglect. But the site of the disease does matter a great deal. For example, a cavity in a lung does drain via the bronchi. A visit to a ward for patients suffering from pulmonary tuberculosis before the days of chemotherapy would show that each patient with active phthisis had a sputum mug half full of purulent sputum. Similarly, a visit to an orthopaedic ward where tuberculosis of the spine was being treated would show that the response to treatment of patients suffering from tuberculosis of the lumbar spine was good, and for the same reason—namely, that pus was draining away via the psoas sheath. . . .

On the other hand, retention of tuberculosis pus in the thoracic and thoracolumbar areas of the spine is commonplace and even the most enthusiastic advocate of chemotherapy cannot claim that it is doing any good there. Quite the reverse. . . . On the other hand, if such pus is drained off by operation, recuperation of the vertebra begins within a very short time. . . .

Rugby injuries of the hand

Miss R H M ADAMS (Norfolk and Norwich Hospital, Norwich) writes: With reference to the letter by Drs R W Nutton and M J Guy (10 February, p 414), the commonest injury is almost certainly dislocation of the proximal interphalangeal joint of the fingers, sometimes associated with a boutonniere deformity. Fractures of the phalanges are not uncommon. It is because these injuries can be so disabling to a professional person—for example, doctors, dentists, musicians—that many amateurs have to give up playing the game.

Menetrier's disease

Drs J D MATTHEWS and R J WINNEY (Royal Infirmary, Edinburgh) write: A patient with Menetrier's disease (20 January, p 150) has been treated successfully with prednisolone and is still alive after eight years, with resolution of the hypertrophic gastritis and hypo-proteinaemia.¹ It would appear that prednisolone is worthy of trial in this disease.

¹ Winney, R J, Gilmour, H M, and Matthews, J D, *American Journal of Digestive Diseases*, 1976, **21**, 337.

Doctors, physiotherapists, and placebo pharmacology

Mrs I CUSHION (Department of Neurology, Norfolk and Norwich Hospital, Norwich) writes: Dr S Bourne's article (23-30 December, p 1761) highlights disturbing attitudes which exist among physiotherapists towards patients with incurable diseases, and which appear to be fostered by the medical profession. Lack of communication is an important factor, but ignorance by many doctors of the contribution physiotherapists can make, particularly in the sphere of prevention, frequently results in patients not being referred early enough. Many patients are suffering needlessly from painful contractures whereas, if they were seen earlier, relevant advice and help could have prevented contractures and reduced spasticity and many of the consequent complications. Regular standing, even when walking is no longer possible, has a beneficial effect on the circulation and on kidney function, as well as relieving pressure on the sacrum. Passive movements and careful use of spasmolytic drugs can greatly reduce the discomfort of washing, dressing, and moving spastic, paralysed limbs. . . .

Ataloia fever

Dr W ALAN HEATON-WARD (Bristol) writes: In answer to my query as to the likely course of a recent febrile illness, with gastrointestinal symptoms and vague joint pains, my general practitioner friends all nodded wisely and said "Ah! There's a lot of it about." It has since occurred to me that this is probably as