obtained through contact with most of the postgraduate centres in the country, that one group of doctors at least—general practitioners—are aware of the potential benefits of audiovisual training programmes. In our own limited survey carried out early last year, of 123 course organisers for vocational training replying to a questionnaire, 81% had access to video recording equipment and 65% of them used the equipment sometimes or often. Since then we have evidence of an increase in interest in this type of teaching as shown by the purchase of videotape equipment, monitors, and cameras by individual course organisers or postgraduate centres. One area in particular where these techniques are being used is in the recording and study of general practice consultations, which many trainee groups use as an aid to study of many different general practice topics.

One point which seems clear from observations we have made of the use of audiovisual equipment is that the more frequently the equipment is used the more frequently it *will* be used, since familiarity breeds competence. Admittedly, there are still postgraduate centres like the one I visited where a missing videocassette recorder, needed in an hour's time, was eventually tracked down to a cupboard in the pathology museum, but these are becoming rarer as audiovisual programme material becomes available.

The authors' recommendation that "new techniques should be introduced only after rigorous evaluation in a pilot study" ignores the possibility of a learning effect associated with the use of such techniques, an effect which is likely to be significant only after considerable consistent use of audiovisual materials. The message that does emerge from the survey is the inadequacy of current evaluation of teaching methods. Often the only measure offered is whether the particular technique is preferred by the users rather than whether it had any teaching effect. Until more time and money are put into true evaluation many of the questions raised by the variety of current teaching methods will remain unanswered.

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Gonorrhoea—a question of tactics and logistics

SIR,—During my searches of the medical literature I look for communications on venereal diseases, if only because I have become somewhat specialised in the behaviour of the spirochaetes. However, combination of medical history and gonorrhoea (22-29 December, p 1631) attracted my attention for another reason. Probably there are pathologists and medical technologists still alive who would dispute the accuracy of my tale, but they might forgive my imaginative excursion or confirm my memory.

In 1943 I was a very junior trainee technician in a military general hospital in Malta. I had but recently been promoted from washing up to the bacteriology bench, and I still wonder whether I was being honoured or whether it was that the other technicians had found adequate excuses to avoid the job. I was required to collect specimens at 6 o'clock every morning from soldiers who had, I was told, acquired gonococci resistant to German sulphonamides, which, it seemed, had

been prescribed for prostitutes in Sicily. (Maybe it was North Africa.) I was to make cultures, which I would then test against British and American sulphonamides. That was the gist of the first medical research in which I participated. I did my best, even to making Oxford cups from old glass tubing—nobody under the age of 50 seems to remember what those were. My "chocolate agar" produced the required colonies and the work proceeded successfully up to the assays.

Then one morning the chief technician came into the laboratory. "Right. Pack it all up and go back to the routine bench." I must have looked as though suffering from shock. "Oh, it's all right. You've done nothing wrong. They've flown a new drug in and it'll be pumped into these blokes and they can go back to Sicily." I dared to ask the obvious question. "What's it called?" "Ah. It's something called penicillin. Very expensive. But it'll cure them."

During my activities for 30 years in medical and veterinary research I have told often this story as a moral tale to illustrate several things. Told with a touch of bawdiness, it relieves stress or tedium. Told with emphasis on status, it provides comment on our concern for professional one-upmanship in the community of science. With technical embellishments, it may help trainees to think about what they are doing. As a tale of fortunes and misfortunes, it may help to put into proper perspective our concern for our contemporary problems.

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Pleural aspiration and biopsy

SIR,—In the article "Pleural aspiration and biopsy" (8 March, p 693) Drs P B Iles and Colin Ogilvie quite rightly open with the statement that the patient should be "as comfortable and relaxed as possible." Later on they say that "he may be either seated facing the side of the bed . . . or in bed with a bed table as a support for his arms." I submit that it is impossible for a patient to be relaxed and comfortable while leaning forward in bed with his legs outstretched. I cannot recall an occasion when it was not possible for a patient to sit beside the bed for aspiration.

It is equally important for the aspirator to be comfortable. To achieve this he should sit at a higher level than the patient so that the syringe is approximately level with his waist.

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Rotating lights on doctors' cars

SIR,—Trinity House has been made aware that the Department of Transport is to permit the use of rotating green lights on doctors' cars when answering emergency calls in an attempt to help them reach such emergency cases more quickly.

While Trinity House fully supports any action that is likely to assist in the saving of lives, we are concerned over the possibility of the meaning of this light being misconstrued in coastal areas. As an example, a doctor could be called to a ship anchored at a pier and on arrival leave his rotating green light switched on. In periods of poor visibility

a mariner to seaward of the pier may mistake the light for an aid to navigation as green lights are used for starboard hand marks under the provisions of the IALA Buoyage System "A" recently introduced throughout the waters of North-west Europe.

While it is appreciated that the likelihood of this occurring is remote the consequences could be very serious and Trinity House has asked the Secretary of State to consider adding a suitable note to the relevant instructions, when they are issued, that the light should be used with caution in the vicinity of navigable waterways.

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Disputes between branches of the profession

SIR,—The East Sussex Local Medical Committee has noted the letter by Mr Nigel Harris, the London surgeon, to the *Daily Telegraph* concerning communication problems between hospital doctors and general practitioners in the metropolis.

We regret publication in the lay press of letters by medical practitioners of one branch of the profession criticising those in another. This can, we feel, only serve to bring the profession as a whole into disrepute—these matters of difference within the profession should surely best be considered in the medical press.

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¹ Harris N. *Daily Telegraph* 15 February 1980:16.

Doctors and compulsory procedures

SIR,—The review of the use of Section 47 of the National Assistance Act 1948 by Drs D P Forster and P Tiplady (8 March, p 739) leads them to question its justifiability in present times. On the basis of my national survey, which will be published this year, I share their conclusion that Section 47, in its present form, is inappropriate and should be amended. This is a matter for the Central Ethical Committee to debate. However, I do not believe that it should be repealed.

As the DHSS does not record the number of removals, I sent a questionnaire to all responsible community physicians in England, 90.8% of whom responded giving data on 830 cases. In 94% of cases the powers of immediate removal of the 1951 Amendment Act¹ were used; in 97% of cases the individual was over the age of 65 and in two-thirds of cases admission was to a hospital, most of the remainder being to old people's homes. On the assumption that those who did not reply used their powers at a similar rate, about 225 people are removed using these powers each year in England, compared with 240 a year in the years 1949-55, during which time the numbers were recorded in the annual reports of the Minister of Health. (It is an interesting example of bureaucratic wish fulfilment that the 1955 report stated that "it is to be hoped that . . . the need to invoke this Section will gradually diminish"—following which no further reference to Section 47 was made.)

The range is considerable. Thirty-five out of 141 community physicians made no use

of the powers and there was a sixfold difference in the rate of removal among those who did. There was no significant difference between North and South, between retirement areas and non-retirement areas, or between urban and rural areas. I believe that the main reason for the difference is the attitude of the responsible community physician.

I asked for evidence of abuse in six professional journals, as well as in newspapers and radio broadcasts aimed at the public; but concern was voiced in only one area, which the community physician has now left. My conclusion is that the powers are neither overused nor abused: in fact, I believe that they are underused and have evidence of many cases from different parts of the country in which the elderly person was deceived, coerced, or (a favourite professional term) "persuaded" when it would have been more honest to have used statutory powers. As with psychiatric admissions, it should not be assumed that "non-statutory" or "informal" is synonymous with "voluntary".²

One final point is of particular interest if Parliament decides to retain the powers: should a community physician be responsible? Those who are responsible at the moment are capable of assessing the case even though they do not have the power or influence which the medical officer of health had when these powers were first drafted as Section 56 of the Bradford Corporation Act of 1925,³ because of their experience before 1974; but what of tomorrow's community physicians? The Faculty of Community Medicine has no policy on Section 47 training, and there is little evidence that trainees are being properly prepared to act as proper officers.

There will always be a small number of people, not all of them elderly, who refuse hospital care or domiciliary care yet are neither depressed nor severely affected by dementia. Although I appreciate that some will be harmed by removal, I believe that compulsory removal is—sometimes—justified and that individuals have a right to be protected by legislation, for I regard the law as a means of protecting the liberty of the individual even when it permits his removal from his home. Section 47 is a useful law of contract setting out rules of conduct when two parties disagree. Old people more than any group need a formal Bill of Rights, a legal definition of their rights—including their right to be sectioned.

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¹ Anonymous. *Br Med J* 1979;ii:1289.

² Gray JAM. *Community Health Council News* 1979; No 45:2.

³ Gray JAM. *Community Care* March 8 1979.

SIR,—As Drs D P Forster and P Tiplady (8 March, p 739) point out, the use of Section 47 of the 1948 National Assistance Act is not open to scrutiny in the same way as are the compulsory procedures of the Mental Health Act. In these circumstances disturbing inconsistencies in its application are free to develop: Drs Forster and Tiplady's annual Section 47 committal rates of 2.8 and 19.3 per million for all ages and for 65-plus populations in the Northern RHA in 1978 contrast strongly with comparable Liverpool AHA(T) rates of 32.8 and 210.2 during 1974-5.¹

Nine (45%) of the 20 community physicians involved in Section 47 committals in the Northern RHA considered the legislation to be an infringement of human rights according to their table III, and indeed concern has recently been expressed regarding a number of areas where the activities of community physicians as agents of social control are similarly sheltered from the public gaze. The application of legislation involving immigrants² and old people³ is particularly notable in this context. However, other such community medicine roles—for instance, in medical rehousing schemes and in confirming slum clearance areas and in providing medical employment advice to police, fire, ambulance, and local authorities—would similarly benefit from the careful monitoring advocated for the use of Section 47.

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¹ Rubin SG, Scott-Samuel AJR. *Health Soc Serv J* 1976;86:64-5.

² Avebury (Lord). *Lancet* 1979;ii:1085.

³ Norman A. *Rights and risk: a discussion document on civil liberty in old age*. London: National Corporation for the Care of Old People, 1980.

Industrial action by ASTMS

SIR,—Scrutator (8 March, p 729) suggested five explanations why the continuing industrial action is apparently causing little overt upset. Some of his explanations deserve comment, and other factors should be mentioned.

There has been a radical change in out-of-hours requests for procedures in many hospitals. Instead of most requests being initiated by house officers and SHOs, and made directly to the medical laboratory scientific officer (MLSO) on-call or on standby, requests are now being made by consultants or senior registrars to pathologists or other senior graduate members of laboratory staff. As a result, requesting patterns have become much more selective and more clearly confined to genuinely emergency requirements.

Many laboratories employ Whitley Council PTA staff—that is, scientific officers such as biochemists and microbiologists. It is important not to confuse these PTA staff with MLSOs, the group of PTB staff at the heart of the present dispute led by the Association of Scientific, Technical, and Managerial Staffs (ASTMS). Many emergency duty rosters, especially in clinical chemistry laboratories, are now depending heavily on their PTA staff, a responsible action on their part for which they have been roundly abused by ASTMS.

Some laboratories have never taken industrial action—these have been mostly laboratories where ASTMS's influence has so far gained little foothold. Some others have accepted the ministerial authorisation of interim payments (£5.00 for being on-call or on standby and £5.40 for a call of up to two hours) and have gone back on to out-of-hours duty rosters. Some laboratories have, all along, had a cadre of responsible MLSOs—usually the senior staff—who have continued to undertake emergency duties, unpaid—thereby risking the wrath of their junior and more militant colleagues, among whom ASTMS recruiting efforts have been more successful.

Surprisingly, Scrutator did not mention the use of group O rhesus-negative blood. Where

blood transfusion MLSOs have withdrawn their services recourse has had to be made to this on several occasions, and at least one health authority has laid in stocks of dextran. Scrutator also failed to mention "coke machines" such as automatic blood gas analysers or simple blood glucose meters, operated by clinical staff. As the present action drags on, health authorities will probably become increasingly interested in these, as one way of helping to reduce future dependence on groups of MLSO staff who claim that emergency laboratory work is their right.

Local agreements were negotiated with ASTMS representatives by many health authorities. Now that these agreements have been declared illegal, some hospitals that were hitherto protected from the effects of MLSO action have begun to feel the effects of ASTMS militancy. The union's publicity in Scotland stresses that these staff have withdrawn from rosters because they can now only be paid less than under the local agreements (for example, £5.40 instead of £7.00 a call)—naturally, the union does not mention that the interim payments all represent an increase on what was previously legally permissible.

The Government cannot afford to condone illegal local agreements with ASTMS, or it will be faced with similar demands from other Health Service unions. Some of the ways at present adopted to mitigate the effects of ASTMS action are less than ideal, but I believe that clinical staff have the will and determination to help health authorities and responsible laboratory staff to resist the widespread withdrawal of some MLSOs from out-of-hours emergency duty rosters.

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London's medicine

SIR,—It is too much of a coincidence that I am one of the few medically qualified members of the Flowers clan, and that I am a Westminster graduate, to pass up the opportunity of commenting on this rather curious document¹ or rather those parts which have become easily accessible (8 March, p 731). I wish to comment not on the proposal to abolish Westminster Medical School but on the concept of super-market medical training.

I consider that Lord Flowers has made a number of assumptions inevitable from his association with Imperial College which may not be valid when applied to the training of medical students and specialists. Firstly, the savings are likely to prove illusory—and I note that the proposed amounts are quoted variously at £6 million and £1 million. The proposed amalgamations will be costly in both initial and revenue consequences unless they are carried out without any sensitivity, courtesy, or good staff relations (shades of NHS reorganisation). Secondly, the small savings must be offset against increases in transport and other mobility costs, if the amalgamations are to be honest and not merely a papering over of cracks. I have no access to proposals, but unless they are both detailed and imposed with vigour all the savings will be dissipated in "ad hoc-ery."

Thirdly and most important, Lord Flowers has fallen into the trap, inevitable in his