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