advantages of the Government's devolution proposals would be that they might at least provide a way of overcoming this weakness. Moreover, the potential benefits of such a step would accrue to *all* parts of the UK.

Whatever the reason, Scotland's "track record" in studying, planning, and organising civilian medical services for its population compares favourably with that in other parts of the UK. An account of this record can be found in a document published in 1967,¹ obtainable from the BMA Scottish Office or from me.

During my 18 years as Scottish secretary of the BMA I also served as joint secretary of the Scottish Health Services Council, a statutory body under the Act. This "liaison" kind of arrangement reflected the good co-operative relations which had been built up between the central authority and the Association in Scotland from as far back as the end of the first world war.

This experience led me to the conclusion that administrative devolution is not enough. It produces a kind of independence comparable to that of a dinghy tied to the stern of a yacht. I believe it would be better for all concerned if we sailed independently as part of the same fleet.

E R C WALKER

Dalkeith, Midlothian

¹ National Health Service (Scotland) Review Committee —an historical account, 1966-67. Edinburgh, BMA, 1967.

SIR,—Like Dr Ian F M Saint-Yves (1 April, p 860) I am puzzled by the pronouncements of the Scottish Council of the BMA regarding devolution, as this body has never asked for the opinion of the ordinary members of the BMA in Scotland so far as I am aware.

The views of Scottish Divisions are not likely to be very representative. At the last divisional meeting which I attended nine doctors were present out of a possible 400; of the nine, three were actually retired. If this is the percentage of doctors attending throughout Scotland I cannot see how the Council can come to a representative view on devolution.

Since 1948 the Health Service in Scotland has been devolved and has been run from St Andrew's House in Edinburgh. There are a number of differences between the NHS in Scotland and in England as regards terms of service and administration. Are we to believe that the Scottish Council of the BMA wishes to put the clock back and do away with the devolution which we have already enjoyed since 1948? Surely it is not their intention that the Scottish Health Service should be administered from the Elephant and Castle.

A M K BARRON

Greenock Eye Infirmary,
Greenock

Hospital day nurseries

SIR,—The interpretation placed by some authorities on the draft circular on day nurseries for children of health authority staff issued by the Department of Health and Social Security in September 1977 has come as a severe blow to many women working in the Health Service who have young children. It appears that these authorities no longer consider the provision of hospital crèches necessary either to attract a stable locally resident

work force or to reduce the drop-out rate of expensively trained personnel.

Without doubt crèches are valuable for a number of very different reasons—for example, the humane one of enabling the single parent to support his or her family or perhaps to aid recruitment of trained nursing staff. However, the undersigned are particularly concerned with the plight of women doctors. Fifty per cent of medical students are now women and the majority of these will marry and have a family. The woman doctor can then choose to drop out of medicine for a few years and then attempt to re-enter the career by means of extensive retraining schemes. Others try to struggle on either part time in specially created supernumerary posts or even full time when the latter are not available. Satisfactory child care is of paramount importance if these women are to be helped to make a contribution, and most will eventually take up full-time appointments when their domestic commitments lessen. In our hospital an existing crèche is under threat of closure and the same threat is hanging over other hospital day nurseries up and down the country.

We should be interested to hear the views of other women in similar circumstances.

SHEILA HOLLINS
K FRANKLIN
GAYNOR LLOYD
URSULA LLOYD
E O'SULLIVAN
S T SCOTT

Queen Mary's Hospital,
Rochampton,
London SW15

Subconsultant grade

SIR,—I must apologise for once more trespassing upon your valuable space. However, I cannot let Dr J S M Zorab's letter (25 March, p 791) pass without comment.

He accuses Mr F S A Doran (11 February, p 385) of muddled thinking. Let him look to his own mote. What an exercise in casuistry! He is entirely mistaken in his view that all medical assistants are untrained (sic). It is this very question of training that continues to bedevil any rational approach to medical staffing.

Let him heed the letter in the same issue from Dr R T Parry (p 791). It is his generation and those after him that we as a profession should be thinking about and not how to perpetuate a system of privilege and patronage that would do credit to the French Revolution.

Those who ignore the lessons of history will be condemned to repeat them.

I M LIBRACH

Chadwell Heath Hospital,
Romford, Essex

Payment of district management teams

SIR,—I write to support strongly the letter from Dr R Wann (18 March, p 722). As a member of a district management team for the past four years I kept accurate records of the time involved in the work on this admittedly large district. Much of the time was spent in travelling—258 miles in the first quarter of last year, for example. I hope that the figures I submitted to the BMA are some help in pressing for more equitable payment to the clinical members of the DMT in future.

An even greater injustice exists, however, and this is the lack of any salary at all for general practitioner members of area or regional health authorities. Mileage payment and subsistence are on the usual scale, but "loss of earnings" is limited to £10.70 per day and that is only payable on proof of actual payment to a locum tenens. The BMA suggested locum fee is now of the order of £28 per day, so that attendances at area or regional meetings involve the GP in actual loss of earnings or heavy dependence on his partners' support during his absences. Moreover, distances involved in area and regional meetings are often quite considerable. At district level many meetings can be squeezed into a relatively normal working week, and the district management teams and local medical committee meetings often take place in the evenings after normal working hours.

I have been an active participant in management and medicopolitics all my professional life and am certain that clinicians must be involved in management. I do not wish to make a profit but feel most strongly that financial penalties for participation can only deter future participants and lower the quality of candidates who are prepared to involve themselves.

May I say that since I raised this matter, I have received nothing but sympathy for the problem? I hope that we may rapidly find a solution.

J S GILMORE

Plymouth, Devon

Dental emergencies and the GP

SIR,—So another bank holiday has passed with its usual crop of dental emergencies, begrudgingly dealt with by the GP, because of the unavailability of dentists.

After years of futile discussion, is it not time we disclaimed responsibility, and left the dentists to arrange an out-of-hours service to deal with what are obviously their problems?

A HOUGH

Derby

Distinction awards

SIR,—Lord Platt (4 March, p 582) may feel able to defend the system which controls the allocation of distinction awards, although he appears to be mainly concerned to defend the secrecy which it has already been agreed to modify. He fails to meet the major criticisms of Drs S Bourne and P Bruggen (18 February, p 456). His Shakespearean quotation can only mean that in his view the reason that some specialties are deficient in distinction awards is because they are deficient in distinction.

We strongly refute this proposition, being in a position to know about the present award holders in anaesthetics at least and having no personal axe to grind. There is no doubt there are more than enough anaesthetists who fulfil the various criteria for A, B, and C awards to bring the specialty at least up to the average for the profession as a whole. Drs Bourne and Bruggen here identified one reason why they do not receive them—namely, that the crucial committees are dominated by specialties such as general medicine and general surgery which already receive an above average number of awards.

Is not comparing distinction in different specialties like trying to compare apples with oranges? One way to minimise this impossible task would be for the available awards each year to be offered initially to each specialty roughly in proportion to their numerical strength; if there were not enough meritorious individuals in any specialty to justify all the awards the surplus could be redistributed that year to specialties with unsatisfied merit. This is not a new principle in the system; awards are at present regionalised and only transferred to another region if insufficient meritorious doctors can be identified in the region. It would be quite logical to extend this to inter-specialty pooling and transfer.

Unless some revision is instituted we shall continue to be forced to try to compare apples with oranges, although in this instance, perhaps, a better metaphor would be plums with lemons, but never, we hope, breadfruit with sour grapes.

M ROSEN
M D VICKERS

Department of Anaesthesia,
University Hospital of Wales, Cardiff

Hospital practitioner grade

SIR,—To judge from Dr E B Lewis's statement to the General Medical Services Committee (25 February, p 523) I am afraid that the Hospital Consultants and Specialists Association's view on the hospital practitioner grade is being misrepresented by leaders of the Central Committee for Hospital Medical Services. We have three main objections to the grade as it is presently constituted, and the modification that has now been agreed with GMS leaders does not correct them.

The first objection is that the grade is confined to principals in general practice. It means that many doctors with the same training and responsibility but who are not principals cannot qualify for this grade and must remain clinical or medical assistants, posts that are lower paid and may be temporary. Doctors could be working side by side doing the same work yet paid different salaries. This discrimination is likely to affect women in particular, who might well wish to take up part-time hospital work of hospital practitioner grade responsibility after they have been registrars or even senior registrars in NHS hospitals but do not wish to take up general practice.

Secondly, the qualifications for this grade are too loosely defined, and sadly the new definition does not improve matters. Unless the necessary training and qualifications are clearly stated no clear standard of competence can be guaranteed.

Thirdly, it is quite wrong for the salary scale of this grade to overlap the consultant scale. Since the responsibility, experience, and training parallel those of registrars the sessional rate must be below that of the consultant, and until the salaries of senior hospital medical staff are raised to achieve this end the HCSA remains opposed to any appointments to this grade.

The hospital practitioner grade could be the grade of the future in the NHS. Consultants are beginning to realise that the present staffing structure in the hospital service must change soon, and with a sensible integration of doctors working outside hospitals—whether in general practice, the community health service, industrial medicine, or at home caring for their families—with those working entirely

within hospitals a much more unified and viable service would be produced with greater job satisfaction for all.

ALAN B SHRANK
Deputy President,
Hospital Consultants and
Specialists Association

Ascot, Berks

***The Secretary writes: "(1) The grade was proposed and negotiated specifically for general practitioner principals working in the NHS. This is why it was limited to five sessions. The extension of this principle to provide an all-purpose subconsultant career grade along the lines suggested by Mr Shrank raises important issues for hospital staffing. Meanwhile the Department is unwilling to enter into negotiations until the issues over the new consultant contract are settled.

"(2) Details of qualifications and experience for a particular grade are best left in the hands of the profession to be decided in the light of the requirements of the post to be filled. We do not agree with Mr Shrank's view that they should be determined by the Department of Health.

"(3) The fact that the consultant scale has been artificially depressed by the arbitrary imposition of discriminatory pay restraints should not be allowed to delay the introduction of a grade which is needed by the hospital service. It is unrealistic to expect general practitioners to carry out hospital sessions for less than they receive in general practice."—Ed, *BMJ*.

Points from Letters

Coughing and huffing

Dr H E SCHABLIN (Stolberg, Rhineland) writes: "Is English the only language to have a word for forced expiration without prior glottal closure?" asks your contributor to "Words" (18 March, p 705). He suspects that the German "*Hauch* (breath, in the sense of exhalation)" may be related to huff. However, *Hauch* is the result of forced exhalation and thus is not the same as breath (*Atem*). Surely we cough with the glottis closed, we blow with the glottis open and the lips nearly closed, and we huff with glottis and lips open (although according to the *Concise Oxford Dictionary* "to huff" and "to blow" appear to be synonyms). The German anatomical equivalents of these three verbs are *husten*, *blasen*, and *hauchen*. . . .

Dr P SKRABANEK (Dublin) writes: Your "Words" correspondent (18 March, p 705) errs in stating that the Slavs are "huffers." They are all "coughers." For example, Russian *kashel* (a cough), Czech *kašel* (a cough), or Bulgarian *kashlitsa* (a cough). In fact, even the Germanic words *husten* and *hoste* are reflexes of a Proto-Indo-European verbal root for "cough" that had an initial k-. The change of k- into h- is part of the famous First Germanic Sound Shift (Grimm's law). . . .

Who discovered the circulation of the blood?

Dr S AL-DABBAGH (Oxford) writes: To the question "Who discovered the circulation of the blood?" asked and partially answered by

Mr E G Tomich (1 April, p 852), may I add the fact that Ibn al-Nafis (AD1210-88), an Arab Muslim physician from Damascus, later Chief Physician of Egypt,¹ discovered, by theoretical reasoning, the lesser or pulmonary circulation of the blood 300 years before William Harvey discovered the greater circulation by experiment.² Ibn al-Nafis, in his commentary on the anatomy of Ibn Sina, in striking contrast to Ibn Sina and Galen, described the lesser or pulmonary circulation almost correctly nearly three centuries before the European discoverers of it, Michael Servetus and Realdo Colombo. . . .

¹ *Arabic Concise Encyclopaedia*, p 59. Cairo, 1965.

² *The Legacy of Islam*, ed J Schacht and C E Bosworth, 2nd edn, p 4. London, Oxford University Press, 1974.

Postcoital test

Dr J SLOME (London W1) writes: May I congratulate Mr G T Kovacs and others (1 April, p 818) on their study, which places the value of the postcoital test (PCT) in true perspective? Nearly 10 years of experience with artificial insemination (donor) (AID) led me to the same conclusion some time ago—that the number of sperms present in cervical mucus following AID (and therefore normal intercourse) bore no relationship to whether or not the patient became pregnant. It occurred to me that if there are many sperms in the cervical mucus X hours after intercourse (or artificial insemination), then one could postulate that there is something preventing the sperms from swimming away from the cervical canal into the uterus—that is, that finding many sperms in the PCT was a bad sign and not a good sign as is traditionally taught. I suggest that the only value of a PCT is that it can show if agglutination of sperms has occurred since being placed in the cervical mucus. If the problem is one of male infertility the PCT is not a substitute for a proper semen analysis and it should never be used as a substitute for analysis. . . .

Posts in the Middle East

Dr M DODDRIDGE (Riyadh, Saudi Arabia) writes: I would like to add another point to Dr P E Conen's letter (11 March, p 652). When a contract ends or is ended the employer can issue a "no objection" letter enabling the employee to seek employment with another employer—that is, change his sponsorship without the three-year rule applying—but this is entirely at the discretion of the employer. This was originally introduced to prevent employees from changing employment for higher salaries in an effort to curb the wages spiral and is applied to all non-Saudi workers who have to be sponsored before they can obtain a work permit to work in Saudi Arabia.

Errant suffix

Dr J M HENDERSON (Hoylake, Wirral, Merseyside) writes: I seem to recall being taught, many years ago, that Lauder Brunton introduced amyl nitrite for the relief of angina pectoris—not amyl nitrate as stated in your leading article on Harvey (1 April, p 803). The reason for the errant suffix may be either a printing error or the fact that amyl nitrite has now largely been replaced by glyceryl trinitrate.