are not only esoteric but conducted from inflexible viewpoints, making it unlikely that either side can be persuaded of the merits of the other's case. (Not that I would wish the HJS Conference to be deprived of such debates; after all, they provide healthy exercise for the participants and splendid pyrotechnics for the spectator.)

The corollary of his attacking me for something which I did not say is that he omits reference to the main theme of my letter, which was that negotiations for juniors are conducted by the Hospital Junior Staff Committee which the minority organisations—the Junior Hospital Doctors Association and the Medical Practitioners Union/Association of Scientific, Technical, and Managerial Staffs—believe to be BMA-dominated. As a result they seek separate negotiating rights, threatening fragmentation of the juniors' negotiating machinery if successful. Better then to devise a formula which would involve them in the HJS Committee, allowing it to be the sole negotiating voice. As stated in my letter, such a formula would be difficult to devise; but unless the BMA has a crystal ball telling it that the Advisory, Conciliation and Arbitration Service will deny negotiating rights to the minority organisations it would be of benefit to it (as well as to junior doctors and the JHDA and MPU) at least to explore the possibility. I should add that I have no personal axe to grind; I belong to neither of the minority organisations and though I value the different contributions which they make to junior politics, it is my personal view that their structures consign them to numerically minor though, I hope, continuing roles.

In conclusion, may I reiterate the hope expressed in the conclusion of my letter that the brouhaha surrounding the allegations of filibustering will not prevent objective assessment of Motion 104 when it reaches the HJS Committee—that is, the feasibility of juniors so organising themselves that they deal in unison with the Health Departments in future negotiations?

TOM MCFARLANE

Manchester

Primary care in inner cities

SIR,—I entirely endorse Dr R A Keable-Elliott's call at the Annual Representative Meeting (29 July, p 371) for more flexible assistance by the Department of Health towards the provision of practice premises. Apart from anything else health centres are quite the most costly means of housing general practitioners and I am far from convinced that it is necessary, except for attached nurses, to locate the other health authority services in the same buildings as medical practices.

I would go further and question whether group medical practice with attached nurses and appointment systems, which is suitable for most of the country and particularly so for middle-class, settled, favoured areas, is the most appropriate way of providing primary health care in inner cities with their shifting populations. Clinics or dispensaries akin to the old casualty departments can be more accessible to deal with acute episodic illness and to act as a filter, possibly supported by specialist teams for groups of patients with longer-term disabilities. Casualty departments evolved over many years in response to need and it may be that they are more suitable for inner

cities than present conventional wisdom suggests.

Bury St Edmunds Health
District,
Bury St Edmunds, Suffolk

GEOFFREY PATEY

BMA and social workers

SIR,—The report of the Annual Representative Meeting debate on social workers (5 August, p 446) is remarkable for the arrogance it demonstrates in the medical profession. Who else would discuss another profession at length in the absence of any representatives from that profession? It is typical of doctors to assume their own importance and to need to be in command. It is obvious from the reported discussion that the majority of the representatives know little about the social work task, and have taken little trouble to find out (a notable exception being Dr Joan StV Dawkins).

These are two professions whose areas of common interest, though of undoubted importance, are small compared with the range of knowledge and expertise in each. What we would all like to see is an increased number of social workers (paid in accordance with their responsibilities), so there would be time for non-statutory work, and improved facilities in the community for them to use. Why doesn't the Council of the BMA ask the Department of Health and Social Security for this?

B PAUL

Leeds

Points

Confidentiality of medical records

Dr O TROUGHTON (Pontefract, Yorks) writes: Dr A O Staines (15 July, p 206) may like to know that parental consent is not needed for a paediatrician to send copy letters to the district community physician "provided this is done in the interests of the child." This was the opinion given in October 1976 by a well-known medical defence organisation.

Dirt by any other name

Dr G I WATSON (Peaslake, Surrey) writes: Your informative leader on "Breathing other people's smoke" (12 August, p 453) was interesting but tailed off like a damp squib, only asking British Rail to segregate smokers from normal people on long-distance trains. I use the word "normal" advisedly, rather than "non-smoker" which you use, because the majority of the population does not smoke. I am no more a non-smoker than a non-spitter or a non-shoplifter. Let us call a dirty habit dirty rather than non-clean.

Assessment of severity of paraquat poisoning

Mr J KNEPIL (Biochemistry Department, Gartnavel General Hospital, Glasgow) writes: . . . Dr N Wright and his colleagues (5 August, p 396) state that "until a rapid, easy, and reliable blood [paraquat] assay is available, urinary excretion rate is the only way of assessing severity of paraquat

poisoning." A method for measuring plasma paraquat concentrations has been described¹ and is of sufficient rapidity, ease, and sensitivity to provide a guide to the assessment of severity of paraquat poisoning.

¹ Knepil, J, *Clinica Chimica Acta*, 1977, **79**, 387.

Scope of surgery for intracranial aneurysm in the elderly

Mr E J GIBNEY (medical student, Mater Misericordiae Hospital, Dublin) writes: In their article on this subject (22 July, p 246) Mr R P Sengupta and his colleagues state that "a 24% incidence of recurrent haemorrhage with increasing morbidity after antifibrinolytic treatment cannot be regarded as very effective." Further on in the same paragraph they state: "The surgical outcome in this series confirms that at least three-quarters of patients in the 60-65-year age group can be made safe from future haemorrhage without inflicting major neurological deficit." Food for thought. "At least three-quarters" means "at least 75%." But what does at least 75% mean in comparison with 76% (100-24)?

Diagnosis of retrobulbar neuritis

Dr V L IRWIN (Ware, Herts) writes: General practitioners often lack both the equipment and the time to carry out the full field of vision examination and as a result may find it difficult to diagnose retrobulbar neuritis. I have recently suffered an attack of unilateral retrobulbar neuritis and noticed a symptom that could form the basis of a simple test for this condition. If the affected eye is looked at in a mirror in a good light and the unaffected eye is then closed the iris of the affected eye appears to disappear or blend with the pupil. As the condition begins to resolve details of the iris of the affected eye begin to become visible again.

Male sterilisations

Dr J A MCEWAN (King's College Hospital, London SE5) writes: In a Parliamentary answer by the Social Services Minister (15 July, p 213) giving the number of vasectomies carried out in NHS family planning clinics in the various regions in 1976, South-east Thames is shown as having achieved 126 vasectomies. This is a mysterious figure, since the 1976 annual report of the family planning department at King's College Hospital indicated that no fewer than 533 NHS vasectomies had been carried out. Any advance from other clinics in the region?

Unexpected encounter

Mr M G GOTTS (Commonwealth Bureau of Animal Health, Weybridge, Surrey) writes: I saw with regret the note from Dr G D Oakley (*Materia Non Medica*, 22 July, p 261) revealing the location of a peregrine nesting site. Although it is to be hoped that egg collectors, would-be falconers, and illegal dealers in birds of prey are not among the readership of the *BMJ*, this rare bird is not helped by the publication of an account of the disturbance of a breeding pair and the name of the breeding site.