fest abortions. I would therefore suggest that these differences are an indication that the elimination of abnormal conceptuses in ASB families is relatively inefficient. Since the mechanisms involved in this natural selection are unknown it is not possible to discriminate between the roles of maternal and embryonic factors in this process. However, it is perhaps significant that ASB has a relatively high survival rate compared with other morphologically less gross malformations.^{1,5}

Thus there may be at least two explanations for the apparent improvement in the reproductive performance of ASB families. The efficiency of the selective process may be improved directly or indirectly by successive pregnancies. Alternatively, the activity of the teratogenic insults resulting in ASB may fall below a critical threshold level as the number of pregnancies increases. Furthermore, the teratogenic insults may in themselves influence the efficiency of the selective process. Such an interaction is at least implied by Roberts and Lloyd,⁶ who suggested that variations in the abortion rate might account for the geographical variations in the incidence of ASB. Perhaps we should be asking why so many ASB pregnancies survive to term and how they differ from those that are eliminated in early pregnancy.

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¹ Clarke, C, *et al*, *British Medical Journal*, 1975, **4**, 743.
² Talberg, G B, *American Journal of Obstetrics and Gynecology*, 1968, **102**, 451.

³ Witschi, E, in *Congenital Malformations: Proceedings of the Third International Conference*, ed F C Fraser and V A McKusick, p 161. Amsterdam, Excerpta Medica, 1970.

⁴ Nishimura, H, *et al*, *Teratology*, 1968, **1**, 281.

⁵ Creasy, M R, and Alberman, E D, *Journal of Medical Genetics*, 1976, **13**, 9.

⁶ Roberts, C J, and Lloyd, S, *British Medical Journal*, 1973, **4**, 20.

Advisory Committee on Borderline Substances

SIR,—It has been brought to my attention that there may be some doctors, particularly among those who have entered NHS practice in recent years, who would welcome information about the Advisory Committee on Borderline Substances (the ACBS), of which I am chairman. I hope the following outline of the functions and the status of my committee will be of interest to your readers.

Most of our colleagues will recall that when the MacGregor Committee—the Standing Joint Committee on the Classification of Proprietary Preparations—was wound up in 1970 it was agreed between the professions and the Health Departments that there was a need for continuing independent professional advice to doctors practising in the Health Service about the circumstances in which certain foods and toilet preparations might be regarded as medicines. This need arises because, as I understand it, there are no powers which enable Health Service authorities to provide anything other than drugs and medicines to patients who are living at home and being treated under the general medical services. The agreement resulted in the ACBS being set up in 1971.

We are a small committee—six doctors, including myself, who between us combine current experience in general medicine, gastroenterology, paediatrics, chemical pathology, dietetics, and general practice, and a

general practice pharmacist. Members are nominated in consultation with the appropriate professional bodies, and a secretariat consisting of medical, pharmaceutical, and lay officials is provided by the DHSS. Nevertheless, we order our proceedings as we think fit and we invite whichever professional colleagues we choose to give us the benefit of their opinions and participate in our deliberations.

It is open to doctors, whether as individuals or, say, members of medical service committees, to manufacturers, or to the Health Departments to request the committee to consider any substance or product; as a rule manufacturers are asked to provide evidence in support of the contention that a product should be regarded as a drug. Naturally the committee is always ready to reconsider any of its decisions in the light of new evidence. The flow of requests fluctuates, but usually the committee meets about twice a year. Immediately after each meeting the committee's views are notified to those who requested guidance and, after an interval to enable manufacturers, for instance, to comment or request a reconsideration, they are passed to the Health Departments and published as recommendations to the profession.

The *Monthly Index of Medical Specialties (MIMS)* prints the committee's recommendation in the "Borderline Substances" section of every issue, making appropriate amendments in the edition published in the month following that in which they receive notification of new recommendations. Similarly recommendations are published in the Drug Tariff.

Irrespective of what the committee may recommend, it is nevertheless for individual doctors to decide what to prescribe. Our recommendations can never be more than advisory—they are simply guidelines which we hope our professional colleagues will find helpful and time-saving. However, although we are not a statutory body and are wholly independent, the Health Departments take account of our recommendations when formulating their policy in relation to borderline substances. All concerned accept that prescriptions which are endorsed "ACBS" by the prescribers have been issued in accordance with those recommendations; consequently, in general, neither doctors' time nor Health Service resources need be wasted on inquiries or challenges concerning prescriptions that are endorsed in that way.

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Hospital appointment procedure

SIR,—May I be allowed to reply to the letter of Dr B Lee (3 September, p 645) with regard to a hospital practice to which he takes exception. The practice to which he refers is the one in which hospital outpatient clerks do not make appointments for patients on the telephone but only after a referral letter has been "considered." This practice is not current at the Middlesex Hospital. However, I personally feel that there are considerable advantages in following this procedure and have worked at hospitals where it is current practice.

Firstly, if there is a waiting list for patients to attend outpatient clinics it is possible for a consultant to examine the letter and decide

whether the patient should be given an immediate appointment at the next clinic, a fairly urgent appointment, or just a routine appointment at the end of the long waiting list.

Secondly, it is also possible for the consultant to ensure that a patient is being referred to the right clinic. In these days of increasing specialisation it is more frequent for patients to attend the wrong clinic at their initial visit. Over the past few months it has been my experience that it is a rare day when at least one or if not more patients attend the general surgical outpatient clinic when in fact they should have been given appointments for the urology clinic, the vascular clinic, or even the orthopaedic clinic. By examining the letter in advance such errors can be avoided and even if the letter is personally addressed to the consultant, surely the general practitioner would not take offence on receiving a reply from him that he thought that the patient concerned would be better treated by one of his colleagues.

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Medical manpower

SIR,—In response to Mr P R J Vickers (10 September, p 708) my estimates of the UK supply of newly qualified doctors (20 August, p 530) were based on University Grants Committee intake figures to the medical schools, with allowance for those who fail to complete the course or to take up a preregistration appointment. The estimates therefore included Conjoint students and I apologise for the loose employment of the word "graduates." The Irish situation was analysed by Oscar Gish in 1971¹ and continues to cause concern in the Irish Republic. However, the total annual output of the Irish Republic's medical schools is approximately 500; even if all the 50% who allegedly emigrate were to enter the United Kingdom this would not be a major factor in relation to other inflows from abroad. For the purposes of a model Irish doctors entering the UK can be regarded either as part of the total inflow from overseas or as part of the UK contribution. I agree that the second alternative would be the more logical, although for simplicity I had regarded their inflow *and outflow* as part of the approximate overseas totals.

Actual Department of Health and Social Security figures for 1976 show that in England and Wales there were 32 preregistration house officers born in Ireland—1.3% of the total. Irish-born senior hospital officers and registrars represented 1.7% and 2% of the respective totals (243 doctors altogether) and these figures included doctors born in Northern Ireland. This gives an indication of the actual current inflow and turnover of Irish doctors; I cannot see the extra 1000 doctors *a year* that Mr Vickers ascribes to his sources and I should not accept a 2% error in estimating the available work force as a factor which invalidated my conclusions. In any case validity is a relative term in this context; the more people are willing to experiment with testing the effects of different assumptions, the wiser we shall all become.

Professor S C Frazer's point about allowing in such models for part-time work (3 September, p 644) is very important. It can be done in various ways—for example, by estimating

a "whole-time career equivalent" of the number of years of full-time employment that a given doctor's contribution would represent. The main practical difficulty again, however, is getting good enough data in a constantly changing situation.

J PARKHOUSE

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¹ Gish, O, *Doctor Migration and World Health*. London, Bell, 1971.

Levy on the self-employed

SIR,—Dr Martin Lawrence implies (3 September, p 645) that our negotiators are unaware of the problems caused by the introduction of class 2 contributions for the self-employed and that we have not taken sufficient steps to deal with it.

We gave substantial publicity to the Bill which introduced these contributions in 1974 and published in the *BMJ* accounts of the effects which it would have on general practitioners. We urged GPs to contact their members of Parliament to recommend that tax relief should be permitted on that part of the self-employed contribution which corresponded with the employer's contribution class 1 (on which tax relief is available). Since then we have maintained close contact with a working party set up by the Opposition to examine contributions for the self-employed.

In evidence to the Review Body we have repeatedly drawn attention to the extent to which the introduction of, and later increases in, class 4 contributions have eroded the net remuneration of GPs. However, the Review Body has always replied that the contribution "is a personal liability that provides entitlement to personal benefit and any relief on it is a matter for the Government."

The Government's replies to our repeated representations consist of a mass of contradictory attempted justifications of their actions in this matter, many of which are referred to in Dr Lawrence's letter and all of which we have rebutted. We have, however, been successful in getting the Government to introduce a number of changes in the procedures for collecting these contributions, in particular measures to avoid overpayment.

These measures are explained in the notes on National Insurance contributions (for salaried doctors as well as GPs) which we produce annually for BMA members and which are widely publicised.

E GREY-TURNER
Secretary, BMA

BMA House,
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Disillusionment with area medical advisory machinery

SIR,—It was very refreshing to read Dr S G C Harrison's lucid and balanced account (3 September, p 645) of the administrative problems caused by reorganisation in the Suffolk Area Health Authority.

I believe that the majority of administrators support his views and the method of trying to improve the system in Suffolk. Contrary to the opinion of some doctors, administrators are just as frustrated by reorganisation as other staff working in the NHS. Dr Harrison's recognition of this fact will help to effect a

change to a realistic system of managing and planning our health services.

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Points from Letters

The sleepless child

Dr CHRISTINE A LEE (London SW15) writes: I was amazed to read Dr J M Wilks's treatment of childhood insomnia (10 September, p 704). It is disturbing that a general practitioner has given this advice to his patients. His hypothesis will never be proved—no ethical committee would pass such inhumane treatment. . . . The "self-confident authority" of the Victorian privileged class is well illustrated in the bedroom episode in Charlotte Brontë's *Jane Eyre*. I would suggest that Dr Wilks reads this to remind himself of the effect on a child of being locked alone in a room. . . . Nobody has proved that loving attention does a child harm. Since most of us adults choose the comforting warmth of a double bed at night why shouldn't we be prepared to behave humanely toward our children at that time?

Dr ROBIN DAVIES (St David's Hospital, Bangor, Gwynedd) writes: Dr J M Wilks (10 September, p 704) . . . writes "what oft was thought but ne'er so well expressed." I have used this approach of failing to reward waking at night by children—nay, even making the waking episode a rather unpleasant one—with great success too.

Monitor spares wanted

Dr D EYRE-WALKER (Staffordshire General Infirmary, Stafford) writes: Owing to series of take-over bids in the medical electronic field the intensive care unit at this hospital is equipped with a monitoring system spare parts for which are now available only from America at inflated cost and considerable delay in supply. The make of monitor is Corbin Farnsworth, which was a subsidiary of Smith, Kline, and French. I would be grateful if . . . any person or department who has this equipment no longer in use would contact me with a view to us purchasing spare parts.

Running away from accidents

Dr D D'AURIA (Upton, Oxon) writes: May I loudly applaud Dr P A Lawrence's comments on road accidents (20 August, p 518)? Like Dr Lawrence, I consider aid to a road crash victim a duty, and have always offered what help I could. Legal consequences against car drivers who fail to stop and help are commonplace in certain European countries. Having just returned from a spell of working abroad, however, I can only describe such a philosophy as unwise, bearing in mind the times I have removed tourniquets from uninjured limbs or prevented evacuation of an unconscious victim in a supine position on the back seat of a car. First aid is not an intellectually taxing subject. It can be readily included in school curricula from a very early age, as is usual in Norway. Many leading authorities have added their voices to the case for first aid and its con-

tribution to good citizenship. What have our leaders done towards achieving education of our schoolchildren in such a worthwhile field? . . .

General practitioners' prescribing costs

Dr R R DRURY (Swindon, Wilts) writes: Yet again I see that suggestions for reducing the prescribing costs of general practitioners have been put forward—namely, cash limits with any excess deductible from practice expenses. One wonders if any of the individuals putting forward these ideas have seen the look of disbelief by patients when advised that they do not "just need a prescription for Panadol," that antibiotics are not indicated for the common cold, or that their pregnancy test is not necessary. . . . It is quite obvious that it is the Government's intention to allow the profession to carry the can for the cuts in the NHS. . . . If health resources are to be rationed let the Government tell the public why.

Population control

Dr A T COLEMAN (Sully, S Glamorgan) writes: With reference to Dr J A Loraine's article (10 September, p 691) . . . why has not even a whisper of the word "chastity" appeared in the credo of the Doctors and Overpopulation Group? Has the wisdom of the Chinese escaped the British group? Does not the present-day religious worship of the false god of sex strike the Doctors and Overpopulation Group as rather contrary to their aims? Why not a word against the strong commercial pressures calculated to arouse strong reproductive desires in the young? Indeed I would have thought that prevention in its true sense was Dr Loraine's field.

Screening children for visual defects

Dr MARY K BELTON (London E11) writes: With reference to your leading article (3 September, p 594) may I say that my pellet or biscuit crumb test detects poor vision in either eye at one year. The accuracy with which the crumb in the doctor's hand is picked up with finger and thumb by the child is very informative. Then, as a game, cover one eye and offer the crumb again. If this is impossible in the surgery ask the mother to try it at home, explaining to her how this will show equality or otherwise of vision in both eyes. . . .

The placenta and twins

Dr R B WILLIAMS (North Staffordshire Central Pathology Laboratory, Stoke-on-Trent) writes: Dr A J Bradbury (3 September, p 613) states in his article on "Congenital malaria in one non-identical twin" that "the placenta and membranes were normal and consistent with the twins being binovular." This statement, in itself, is correct but when taken in conjunction with the statement that the twins were "non-identical twins" is not so. . . . A dichorionic diamniotic placenta is not diagnostic of twins being binovular except when the twins are of different sexes. If they are of the same sex they may be binovular or they may be monovular, with early separation of the blastomere. . . .