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