correction of known or suspected risk factors. There is clearly no magic formula, in my experience, which can be placed across the board and applied on a mass scale. There is, unfortunately, no alternative to the careful investigation of every patient on an individual level, correcting each risk factor presented, energetically, by the safest and most acceptable means for the patient. Clearly, the correction of hyperlipidaemia by all reasonable means must be included in any treatment programme for the prevention of atherosclerotic arterial disease. Unfortunately, all large multicentre trials that I have seen seem to fail in that they do not treat the whole patient, and for this reason grave doubt must be thrown on their validity in testing the concept of the primary prevention of arterial disease by studying one factor and seeking to match all other factors.

The review article by Professor Lewis (19 July, p 177) gives a clear and positive approach to the problem without leaving the physician with no guidelines to offer the patient.

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¹ A report from the Committee of Principal Investigators. *Br Heart J* 1978;40:1067-118.

² Royal College of Physicians of London. *Prevention of coronary heart disease*. London: Royal College of Physicians, 1976:21.

Social environment and relapse in schizophrenia

SIR,—Your leading article on social environment and relapse in schizophrenia (19 July, p 173) summarised the recent excellent work of the Medical Research Council Social Psychiatry Unit. It identified the value of medication and the importance of family life for the course of the illness. It lacked, however, a clear statement of the possible value of intervention in the family interaction processes to reduce excessive "emotional involvement, hostility, and dominance," which predisposes to relapse.

At least one methodologically adequate study in the United States suggests that family therapy may be useful,¹ and work in this country has examined some details of the pathological interactions.² The only family intervention explicitly suggested is removal of the patient from the family. As clinicians know, this is often unsatisfactory or unworkable. It is not unreasonable to think that sophisticated epidemiological research may clarify the value of family therapy techniques.

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¹ Langsley DG. *Am J Psychiatry* 1971;127:1391-4.

² Scott RD, Ashworth PL, Casson PD. *Soc Sci Med* 1970;4:41.

What is "emergency"?

SIR,—I have no wish to play sword and buckler with my friend Mr W H Rutherford (26 July, p 308)—there might indeed be a casualty.

Shakespeare did *not* use the word casualty for the seriously injured—as a glance at a concordance will show.¹ Dickens's "casualty ward"² contained more than those injured. If Mr Rutherford knows of other references perhaps he will tell me.

In the sixteenth century casualty meant "a chance event" and it was used in this sense in the Rules and Orders of Newcastle Infirmary

(1751).³ In soliciting support, its founders⁴ had drawn attention to the case of a poor woman, run over by the York Waggon, who lay in a public place for six hours before she received attention⁵; and so we have in the rules, repeated by other voluntary hospitals,⁶ the phrase "casualties when patients are suddenly brought in." The use of the word casualty depended on the communal setting and the irregularity of timing, not the injury. The word casual, as "casual losses," not casualty, was used by the Army until much later than 1810.⁷ Mr Rutherford is quite correct in quoting the *Lancet* reports of 1869. It was probably the interest being shown which prompted Robert Bridges to write his now famous account of the casualty-outpatient department at St Bartholomew's Hospital.⁸ In reading this first-hand account we see that the work of Robert Bridges there was at set times and was that of a dispensary physician. The "casualties" were the third category of patients, many with far from trivial complaints, being treated by the house surgeons (and house physicians) in the corner of the room. Perhaps it was the realisation that in protesting about the number of his patients he was talking himself out of a job which made him turn to other, perhaps less frustrating, pursuits. In any case it was these patients whom all subsequent reports have tried to restrain. Mr Rutherford's "casual" patient never has been a problem; if he does not come with a flea in his ear he certainly leaves with one.

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¹ Bartlett J. *Concordance of Shakespeare*. London: Macmillan, 1927.

² Dickens C. *Sketches of Boz. The hospital patient*. London: Gresham Publishing Co, 1860:180.

³ Statute of Rules and Orders for the Government of the Infirmary for the Sick and Lame Poor, 1751. Draft, Newcastle upon Tyne Medical Library, copy presented by W A Sanderson: 23.

⁴ Hume WE. *The Infirmary, Newcastle upon Tyne*. Newcastle upon Tyne: Andrew Reid and Co, 1951:2.

⁵ *Newcastle Courant* January 1751, daily for one week.

⁶ *Rules and Orders of Nottingham General Hospital*. Cresswell, 1781:15.

⁷ Charles J. *New and enlarged military dictionary*. London: T Egerton, 1810.

⁸ Bridges R. *St Bartholomew's Hospital Reports* 1878; 14:167.

Factor VIII supply and demand

SIR,—Dr Peter Jones (21 June, p 1531) is to be congratulated for his perceptive analysis of what is a complex and fascinating topic. He is right to conclude that nothing can be achieved in our search for self-sufficiency in blood and blood products without considerable changes in the organisation of collection and processing of blood and in our attitudes to its optimum use. Dr Aronstam's *cri de coeur* (21 June, p 1532), though understandable, was somewhat one-sided in defining where the problems lay and how they could be solved. Perhaps it would be helpful to make the following comments:

(1) There is now sufficient evidence to support the view that the calculations made in 1975 of the future factor VIII requirements in the UK were a significant underestimate. This view is fully recognised by many colleagues in the UK Transfusion Services and current forward planning is cognisant of this fact.

(2) Considerable efforts are being made to secure a position in which sufficient plasma fractionation capacity, based in the United Kingdom, will be available to meet the

anticipated demands for the future. It would be naive to conclude that the single major problem in this area is lack of finance. However, this and the other problems are being actively explored against a background assumption that the vital and sustaining quality of our voluntary blood donation services must be secured. None of these difficulties is insurmountable; but resolution will require much effort, improved organisation and business skills, active collaboration between all concerned, and a resolve to maximise flexibility and minimise unnecessary expenditure.

(3) Unlike Dr Jones, Dr Aronstam failed to mention a most important aspect of the problem of national self-sufficiency in blood products—the availability of plasma for fractionation. Although there are several outstanding exceptions, there is little doubt that unless those in charge of hospital blood banks are more successful in persuading clinical colleagues to use red-cell concentrates rather than whole blood in the management of the majority of routine hospital transfusions, the creation of major new plasma fractionation facilities will not be the salvation Dr Aronstam seeks. Each year many thousands of litres of fresh plasma are being directed away from fractionation in the United Kingdom, and it is increasingly clear that the key to preventing this loss is held by the medical profession. Here is an area in which Drs Jones and Aronstam and their colleagues can make a contribution now and in so doing reduce the necessity for the transfusion services to develop large-scale plasmapheresis programmes.

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Pre-eclampsia and eclampsia and change of paternity

SIR,—We appreciate that the printers' dispute in the spring has made a nonsense of the dates appearing on your numbers over several months. This presumably accounts for the fact that your leading article "Inheriting pre-eclampsia" (28 June, p 1557), which gives a generally excellent review of the current state of knowledge on immunogenetic possibilities and pre-eclampsia, fails to refer to the important short report from Nigeria by Mr Dozie Ikedife (5 April, p 985). This provides strong support for the idea that pregnancies by new consorts carry a higher risk of severe pre-eclampsia or eclampsia than that holding for multigravidas in general.

This information is very important in relation to immunogenetic ideas about the aetiology of this strange condition and underlines the value of collecting data from parts of the world where the condition is still relatively common. Retrospective studies in our own area^{1 2} showed that out of 34 201 deliveries there were 47 instances in which severe pre-eclampsia had occurred in multiparas who had normotensive pregnancies. Thirteen of these patients were found to have a change in paternity for the affected pregnancy compared with three matched controls.

The evidence is beginning to suggest that a pregnancy by a particular father gives the mother a degree of immunity to the condition in subsequent pregnancies by that father but that this does not cover pregnancies by other men. It would thus seem that pre-eclampsia

and eclampsia have an immunogenetic basis which, as Dr Ikedife suggests, is the reverse of rhesus disease—exposure to the relevant antigen being protective rather than the reverse. If this becomes established then the way is open to devise prophylactic immunotherapy.³

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¹ Feeney JG. In: Bonner J, MacGillivray I, Symonds EM, eds. *Pregnancy hypertension*. Lancaster: MTP Press, 1980: 41-4.

² Feeney JG, Scott JS. *Eur J Obstet Gynaecol Reprod Biol* (in press).

³ Scott JS, Jenkins DM, Needs JA. In: Bonnar J, MacGillivray I, Symonds EM. *Pregnancy hypertension*. Lancaster: MTP Press, 1980: 15-7.

Regional specialties and "Patients First"

SIR,—The 1974 reorganisation of the National Health Service failed to provide adequate financial administration of regional specialties such as neurosurgery, cardiac surgery, radiotherapy, etc. Essentially the districts or areas are not interested in these expensive specialties, and referral to the region is met with the response that the region supplies the area with all necessary finance. But further inquiry reveals that the region does not know exactly or even approximately how much money is allocated within the district or area budget to such specialties.

Neither your leading article (2 August, p 342) nor the paper *Patients First* refers to this important deficiency, although the evidence of the Society of British Neurological Surgeons to the Royal Commission on the National Health Service and the report of the London Health Planning Consortium on neurology and neurosurgery stressed the current difficulties.

May I ask through you that the Department of Health and Social Security considers ways of fairly financing regional specialties in the future? At the moment the situation is most unsatisfactory from everybody's point of view, but *Patients First* does not consider this.

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Appointment of consultants

SIR,—While Dr James Andrews (9 August, p 457) is commenting on the question of regional appointment of consultants I feel it would be of value to reconsider the actual wording of the Appointment of Consultants Regulation 1974. Statute 1974 (No 361) 7.2 states: "The committee shall consider all applications so referred to them and they shall select from the applications the person or persons the committee shall consider suitable for the appointment." This is to say that the members of the advisory appointments committee decides which applicants for a consultant post they wish to interview. It follows that there can be no guarantee that any individual doctor, no matter how good his qualifications or experience, will be selected for interview for a post for which he has applied as this is solely a matter for the committee to decide. This specious Act in fact gives great scope for local manipulation.

In my opinion some form of amendment is required—for example: "They shall select for interview up to six persons with the greatest experience in that specialty and thereby recommend one person for appointment. Experience shall be judged independently by the external consultant for the relevant specialty (schedule 1.2b ii) and he shall answer to the lay member at the time of interview and to his college for any queries concerning any person who has been discounted." In this way a committee should be accountable for its action and appointments would be made on the basis of experience and not simply to suit the flavour of local politics.

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Consultants and responsibility

SIR,—Having been increasingly concerned for many years about the surplus registrar problem,¹ described in a *BMJ* leading article last year as a "scandal,"² I have read in detail the great amount currently being written and reported about it.

One point never seems to be mentioned, yet it is probably one of the most fundamental of all aspects of the organisation of medical work: that is, the individual consultant's responsibility for the individual patient. If my name is on a patient's case record as a consultant, albeit honorary, then I feel I owe that patient a very great deal of responsibility. It is a source of anxiety to me if that patient receives unsatisfactory treatment from myself, but much more so if an assistant is involved.

Accordingly, it seems to me that a consultant must minimise his delegation of responsibility rather than maximise it. The latter seems to be the aim of much current practice and many plans for the future, including the reintroduction or expansion of the permanent subconsultant grade. The best that can be said of them is that they are economically inefficient.

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¹ Phillips CI. *Lancet* 1973;ii:33-5.

² Anonymous. *Br Med J* 1979;i:1299-1300.

Reimbursement for related ancillary staff

SIR,—It appears that related ancillary staff after all are going to be included in the reimbursement scheme. The excuses emanating from the DHSS when it failed to put right this gross injustice have been countered.

The "new" excuse is lack of money. This is no excuse at all—and if it can be called an excuse it is the lamest of the lot because we all know that if I chose to employ someone in my surgery other than my wife, reimbursement would be immediately forthcoming; or if I was reprehensible enough to divorce my wife and employ a girl friend cash would be available.

The latest advice to the profession is that we must adopt a responsible attitude; I entirely agree. Responsibility works both ways, in other words we should show a sense of responsibility to those people who should be paid for working and who have worked hard in the profession for 14-odd years for nothing.

The final delaying tactic of the DHSS is that something has "got to be worked out." This again is a poor excuse. All the DHSS have got to do is to agree to pay those wives who are acting as ancillary staff in exactly the same way as non-related ancillary staff. There is a scale known as the Whitley scale for nurses, and there are scales of pay laid down for medical secretaries and all Health Service workers. It would be ludicrous for any government department to suggest that it is going to take two years to work out pay.

One wonders if the Department running the Health Service has any sense of fair play at all? How many of its employees are working for nothing?

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Review of social service organisation needed?

SIR,—Dr H A F Mackay's strictures (26 July, p 313) are unfair. He bases his indictment of the role and operation of social workers on three sketchy anecdotes for which, he says, there are explanations "within the system." Why does he not reveal these explanations? Could they include a shortage of part III accommodation in his district? If so, it is every bit as unreasonable to blame the social service departments as it would be to blame clinicians for under-provision in the Health Service.

Social workers are here to stay and, whether we like it or not, they are not an ancillary profession. It is in our interest and, even more, in the interest of the public that we should have a good working relationship with them. To this end, Sir, what is needed, especially in the medical press, is less expression of King-Canute-type sentiments and more fairmindedness towards another caring profession.

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Vocational training for general practice

SIR,—The reports from the National General Practitioner Trainee Conference in Exeter and the letter from Dr A R Rogers (9 August, p 457) reveal the naivety of many trainees, who believe that because trainers are paid £2550 per annum all trainees should receive, personally, £2550-worth of teaching each year. The idea has mistakenly arisen that because this payment is equivalent to two clinical assistant sessions a trainer is obliged to give seven hours of teaching a week to his trainee.

It is important to remember that the payment made to trainers is a grant and not salary. This grant is paid to compensate the trainer for the time that will be spent away from his usual practice duties. In addition to the teaching of the trainee, the grant is designed to compensate the trainer for the time that he spends attending trainers' courses and meetings. There is also time spent travelling to organisational meetings with the course organiser and other trainers within a training scheme. There will be time spent attending the various half-day or day-release courses. There will be additional practice expenses to cover extra secretarial time, telephone costs, stationery costs, advertising and interviewing costs, and the purchase of books for a practice library.