jected subcutaneously one inch (2.5 cm.) above the symphysis pubis. One end of the catheter, with three or four side-holes cut in it, is threaded through the hub of the needle and partly down its lumen. The needle point is now thrust obliquely downwards through the anaesthetized part of the skin and into the distended bladder. Urine immediately starts to flow down the catheter, which is quickly threaded along the needle until an estimated four to six inches (10-15 cm.) lies inside the bladder. Taking care not to dislodge the catheter, the needle is now withdrawn from the bladder and abdominal wall. A piece of adhesive strapping will hold the catheter in position and its distal end is inserted into a drainage bottle.

After 24-48 hours of drainage, oedema of the prostatic urethra will have settled and a further attempt at urethral catheterization can be made; or a prostatectomy, if now indicated, can be performed.

—I am, etc.,

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REFERENCES

- 1 Hey, H. W., *Brit. J. Surg.*, 1945, 33, 41.
- 2 Riches, E. W., *Lancet*, 1943, 2, 128.
- 3 Aird, I., *A Companion in Surgical Studies*, 1949, p. 957. Livingstone, Edinburgh.

Standardization of Electrical Outlets

SIR,—Dr. J. H. Holland's letter (August 17, p. 445) calls for standardization of electrical outlets, a change which will take time. When a new hospital was built in this city and equipped throughout with the then new 13-amp sockets much irritation was caused to visiting doctors whose apparatus was invariably fitted with round-pin plugs. The difficulty was overcome by providing wards and departments with portable boards, each carrying one two-pin 5-amp, one three-pin 5-amp, and one three-pin 15-amp socket, all connected at the back to one cable carrying the standard hospital type of plug. Any type of apparatus could thus be connected to the hospital outlets without changing plugs. The cost was small and the convenience great.—I am, etc.,

Nairobi, Kenya.

W. G. S. HOPKIRK.

Radiation Hazard to Patients

SIR,—Dr. A. C. Glendinning's letter (September 21, p. 745) draws timely attention to some of the difficulties of implementation of the second report of the Adrian Committee¹ which face the diagnostic radiologist.

Radiologists must carry considerable responsibility in ensuring the proper use of ionizing radiation in the departments they control, in the light of the mingled technical, administrative, and clinical recommendations contained in this report. Under ideal conditions of direct consultation between clinician and radiologist no great problem arises. In practice, as Dr. Glendinning points out, the initiation of x-ray examinations by so many who are not conversant with the report creates serious difficulties and often places the individual radiologist in an invidious position.

Although I do not agree that a *directive*, from any authority, could provide either a proper or an effective solution to this problem, undoubtedly there exists a need for a deeper awareness of the clinical aspects of the Adrian Committee's findings. The task of achieving this has, in the event, been left to the radiologist; I am sure that Dr. Glendinning is not alone in feeling the need for some support in this respect.

The British Institute of Radiology, through its Radiation Protection Committee, has maintained a deep interest in all the implications of the Adrian Report; it is pertinent here to mention that a publication by the Institute is envisaged, with the aim of promoting wider application of the recommendations than has hitherto proved possible.—I am, etc.,

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REFERENCE

- 1 Radiological Hazards to Patients; 2nd Report, H.M. Stationery Office. London, 1960.

Psychiatry and the Medical Curriculum

SIR,—Dr. C. J. Lucas's letter (September 28, p. 807) implies that medical students who have a psychological disturbance during their training are discriminated against in examinations and when they apply for pre-registration posts. It is suggested that there should be "appropriate mental health facilities" to which the distressed student could turn outside the teaching hospital. It is questionable whether these assumptions are true. Many students are distressed when they meet disaster, whether physical, mental, or social, in a patient for the first time. Some may have difficulty in learning not to become personally involved in the patient's problems, but the support and guidance a student receives from his teacher in overcoming emotional problems of that nature should not be underestimated. It is my experience as medical officer to a clinical school that psychological difficulties frequently are dealt with successfully by teaching members of the staff. Where specialist psychiatric help is needed, this is always given unreservedly and discreetly by other members of the staff. I believe it is doubtful whether a body outside the teaching hospital is necessarily better qualified to deal with these problems. The really important thing is that a student knows that he has easy access to help and that he can find somebody with whom he can discuss his problems. I have not found that the suggestion that an episode of psychiatric illness during his medical career is held against the student when he applies for a pre-registration post is true. If anything the staff falls over backwards to help a student who has had emotional difficulties, provided of course that his professional qualities are of the necessary standard. I have found that examiners without exception show great understanding if

they have been forewarned of emotional troubles in a candidate.

If a student persistently fails to adjust in spite of readily available help within the school, the probability is that he is in the wrong profession and that it would be better for him and for his patients if he chose another career.—I am, etc.,

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Protein Intake in Renal Failure

SIR,—In your report on the Symposium on Acute Renal Failure at the Royal Free Hospital (September 21, p. 739) my own contribution has been slightly misquoted, and I shall be grateful for the opportunity of correcting any wrong impression which may have been conveyed.

The work on ¹⁴C-labelled urea was carried out by Dr. Alan Robson of this department; he studied patients with stable chronic renal failure, but the results are probably applicable to acute renal failure in patients without massive trauma or infection.

We were not attempting in these studies to assess the value of anabolic steroids, which has already been extensively studied, but to decide the ideal protein intake in patients who were receiving these drugs. We found that an increase in protein intake above 20 g. per day resulted in an increased urea production rate in all of the five patients studied. It does not necessarily follow that 20 g. of protein is the ideal diet, since the maximum calorie intake we can achieve in our patients with this diet is about 1,350 calories. The advantages of a low rate of protein breakdown must therefore be weighed against an appreciable calorie deficit.

The results of Dr. Robson's experiments will be reported in greater detail in the report on the Second International Congress of Nephrology, Prague, 1963.—I am, etc.,

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POINTS FROM LETTERS

Postgraduate Training in Obstetrics

Mr. G. DALLEY (The West Hill Hospital, Dartford, Kent) writes: For the information of Dr. John Bush (September 28, p. 806) the above more or less local hospital is approved by the Postgraduate Federation for residential courses in obstetrics for general practitioners, a fact of which he is apparently unaware. This arrangement has only been in existence for about a year, but even so we have had surprisingly few inquiries. One wonders whose duty it is to publicize such things.

Hospital Manners

Dr. D. W. R. LYLE (Burgess Hill, Sussex) writes: Let us have one detailed and signed letter on the day of the patient's discharge from hospital, and not one or more interim reports followed weeks later by the information we require.