The morning surgery is of course quite redundant, and is very often a succession of certificates and repeat prescriptions which sap endeavour before the day has really commenced, and it is patently obvious that anyone who is ill will not be out at such times. In many instances it is necessary to start at 8.30 in the morning in order to be ready for 10 a.m. visiting, and this for a surgery scheduled to run 9–9.30. None of the patients attending at this time would suffer any adverse effects if they were to be seen in the evening, and I feel confident that this situation is not peculiar to one area. The results of these early-morning surgeries is to reduce seriously the efficiency of the G.P. when he should be at his peak—that is, for visiting the more serious cases who are not ambulant. The G.P. is very often harassed as a result and far from receptive, particularly if this early scramble has been performed to the tune of the telephone.

The evening surgery then follows on this maladjusted situation, with the G.P. very often below maximum performance, and having to work perhaps a further three hours under stress at top speed to satisfy the truly sick. Is it little wonder that general practice has sunk to such a sickly state? No efficiency experts would subscribe to such conditions, and these archaic working conditions do little for patients and G.P.s alike.

I feel certain that better efficiency would result from abolition of the morning surgery, the G.P. being fresh and alert for his rounds, to return for one surgery in the afternoon, finishing by no later than 6 p.m. It is a false premise to assume that by curtailing evening surgeries it would be difficult for working patients to attend, for in the vast majority of cases such people if under medical treatment are not at work at all. It is an absolute must to throw out these pre-war concepts of general practice. G.P.s must also "get with it"; and, while on this topic, the medical record card has not altered in size or shape for over thirty years; what a sad reflection—it was never born to cope with the present-day spate of investigations.

These considerations I feel are as urgent as pay and the Pool, but all are bound up in some hopelessly out-of-date thinking.—I am, etc.,

Shipley, Yorks. J. A. FRAIS.

SIR,—Whilst it is heartening that there may now be a possibility of the G.P. being paid as he should have been for the past 16 years, it is important not to lose sight of the real problem before us now.

An immediate increase and an altered method of payment cannot and will not produce enough doctors overnight. Nor will they be likely quickly to coax back those who have elected to practise in Canada and elsewhere. Nor will they produce more time. The population is not only increasing but also more demanding. The service is stretched pretty thin.

Therefore if quality of work is to count for what it should it also behoves the Government and the Ministry to make the necessary moves now, however unpopular they may be, to lighten the G.P.'s limitless load by propaganda, by providing for the considerable ancillary help needed, and if necessary by making the appropriate charges.

Thus only will he be able again to work with the dignity and calm required.—I am, etc.,

Bridport, Dorset. N. S. TAYLOR.

SIR,—We keep hearing that general practice is a cottage industry and inefficient and so on. A patient is entitled to have his own doctor, and, while I do not disagree with this, on the question of efficiency it cannot be efficient or making the best use of medical manpower (which we are told is decreasing) if 10 doctors are going down the same street and perhaps two to the same house. In addition, doctors are in small and competing groups so that the service cannot be really either national or good for health, and as long as this is so we must, in my view, remain a cottage industry.

I also read of many doctors asking for a national locum service, six weeks' holiday, and so on. No Government would grant these things without a salaried service, and I presume a large number of doctors would now accept such a service if the Government was foolish enough to grant it and give up what it is now getting so cheaply.—I am, etc.,

Worsbro' Dale,
Near Barnsley, Yorks. D. W. MAYMAN.

Nicotinic Acid and Serum Lipids

SIR,—In their article on the "Effect of Nicotinic Acid on Abnormal Serum Lipids" (18 January, p. 157) Dr. O. Fitzgerald and his co-workers mention two patients who developed gout. One of these "failed to respond to standard uricosuric agents," whilst the other "responded to sulphinpyrazone" ("anturan"). Presumably the gout to which they refer was acute gouty arthritis. The standard treatment for this is not uricosuric agents but either colchicine or phenylbutazone. Sulphinpyrazone is indeed a very potent uricosuric agent, but usually of little use in an acute attack. Uricosuric drugs may actually precipitate an acute attack, or if initiated during an acute episode may prolong it. Aspirin, to which one case is said to have responded, increases urate excretion at a dosage of at least 4 g. a day, but smaller doses lead to renal retention of urates. It opposes the action of uricosuric agents and should not be given with them. For these reasons its place in the treatment of gout is very limited.—I am, etc.,

Regional Rheumatism Centre,
Chase Farm Hospital,
Enfield, Middx. E. N. GLICK.

"Battered Baby" Syndrome

SIR,—I was relieved to see the article on multiple injuries in babies by Mr. D. Ll. Griffiths and Mr. F. J. Moynihan (21 December, p. 1558). Many of us must have felt that but for indolence and apathy we should have said something about this problem long ago. If I may add my experience of the battered baby in so far as head injury is concerned, the fracture is usually extensive, and often consists of more than one fissured fracture extending right across the head. There is no history of injury, or a frivolous history such as "he must have banged his head on the side of the cot." Bruising is often less than might be expected, though swelling is visible when the head is shaved and orbital swelling may be present. The skin is unbroken. (Is the infant swung by the legs against a padded surface, or is the skull so relatively thin that the skin is not lacerated even by a hard surface?) The fundi may show papilloedema, haemorrhages, and large pale areas of oedema, the combination forming a picture that is very impressive to the observer.

Acute or subacute subdural haemorrhage may be present, but merges into brain contusion and laceration. Multiple fractures may be present in ribs or femora. The emotions aroused by these cases vary from a quixotic desire for retribution through cataleptic cynicism to a fervour to protect possibly innocent relatives. What has actually happened to the infant is conjectural. The absence of a convincing lie suggests absence of collusion and the possibility that at least one of the parents is not only innocent but ignorant of the affair; though in the few cases where the truth has finally emerged the innocent spouse has not in fact been ignorant—perhaps a reason in those cases why secrecy was not preserved.

It is not the job of the doctor to act as lawyer or judge, but prevention of disease is part of his role. We are dealing here with the occasional criminal—does not this include all of us? This means that publicity is the more effective. Although this journal will not be read by the next potential baby-killer. an atmosphere in the community can be created which is not conducive to overlooking violence. What is really needed is a *cause célèbre* with front-page treatment in the press. The alternative is to make conviction virtually certain, and then give an exemplary sentence of many years in prison. This has a more powerful effect on the class of occasional criminal than on the professional; witness the effect of long gaol sentences in the Notting Hill Gate assaults. I repeat that as doctors we are concerned with prevention of injury, not primarily with justice. We can start by moving the great palpitating British conscience; or if the phrase be preferred we can make this aspect of our community life acceptable to a generation that must eschew violence or perish.—I am, etc.,

Birmingham 13. ERIC TURNER.

Serotonin as a Teratogen

SIR,—I was interested to read your annotation of 21 December (p. 1546) on serotonin as a teratogen. Several months ago I attempted to produce cardiac malformations in D+K− mice by injecting substances which acted on the cardiovascular system. Among these was 5-hydroxytryptamine (5H.T.), which I administered as a single subcutaneous injection of 40 mg./kg. on any one of the first 12 days of pregnancy. Out of 95 foetuses from 16 litters, one which had been treated with 5H.T. on the eighth day of gestation was found to have bilateral microphthalmia, and another injected on the ninth day had unilateral microphthalmia. Serial sections through the thorax revealed no abnormalities in the heart or great vessels. One hundred and four foetuses from 17 control dams were examined and all were found to be normal except for one instance of transposition of the great vessels.

In your annotation the work of Reddy and his co-workers[2] is quoted in which 5H.T. is

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