extensively interconverted, and that oestrone is more extensively concentrated by endometrium than oestradiol. Oestrogen sulphates are converted to free oestrogens and it is noteworthy that oestrone sulphate has a four-fold higher concentration in the plasma of the premenopausal patient than does free oestradiol.[10] No studies are available in postmenopausal tissues, but clearly oestrone is a very important hormone for the normal premenopausal human endometrium and it will be important to define precisely any circumstances in which a physiological premenopausal steroid is alleged to become a carcinogenic postmenopausal steroid.

To describe oestriol as an impeded oestrogen is no longer valid, as it is as effective as oestradiol in inducing mammary carcinoma in mice[11] and the receptor-oestrogen complexes induced by oestriol and oestradiol equally stimulate early uterotrophic events in rats.[12] Oestradiol, on the other hand, cannot yet be said to be the ideal replacement therapy either, as micronised oestradiol given orally to postmenopausal patients results in plasma oestrone levels greater than those of oestradiol[13]; thus even the "principal" premenopausal female hormone is metabolised differently in the postmenopausal state. Much more data are obviously required on the metabolism of and responses to exogenous steroids before the field of hormone replacement therapy can be rationalised. As Siiteri and MacDonald themselves urge, their hypothesis should be tested by careful steroid analyses. Much better-quality epidemiological data, particularly of the prospective kind, are also needed. It does not help the clinical situation or the pursuit of knowledge to have specific compounds or preparations interdicted before their aetiological role is unequivocally established.

IAN D COOKE

University Department of Obstetrics and Gynaecology,
Jessop Hospital for Women,
Sheffield

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The community physician of the future

SIR,—Your leading article on this subject (24 April, p 976) is incomplete and misleading. It omits reference to Scotland and it refers to the subjects of the examination for the first part of the diploma of membership of the Faculty of Community Medicine—namely, epidemiology, statistics, social policy, the social sciences, and the principles of administration and management in relation to health and social services—as if they constituted community medicine. They are merely the tools by which a community physician knows and practises his subject. Should a student enter directly for the examination or opt for a set of modules rather than an academic course he may learn an unconnected group of techniques without knowing the community medicine with which to practise them.

Aspiring community physicians should be selected from medical men and women widely experienced in clinical medicine. They should then expose themselves to a period of full-time education in community medicine and follow that up with an apprenticeship under experienced masters. The period of apprenticeship is the place for modules; then maturing specialists need advanced courses in individual techniques to satisfy their particular interests.

You refer to community physicians; the title in Scotland is community medicine specialist. The job is the same. We in Edinburgh have a long experience of teaching community medicine, extending over a century. Glasgow has a similar experience. Our resurgent national feeling in Scotland does not induce us to exclude English students. We welcome them, and we hope that many of them will continue to be pleased with our country and our teaching.

DONALD CAMERON

University Department of Community Medicine,
Usher Institute,
Edinburgh

SIR,—Your leading article (24 April, p 976) sets out with clarity the nature and spacing of the hurdles to be cleared for the membership of the Faculty of Community Medicine. For the newly registered doctor you suggest that a period in general practice before entering specialist training may be valuable. May I add that a period in community child and school health work might also be valuable as a means of acquiring experience in the epidemiology, statistics, and social policy and sciences of the whole population preventive health service? Six months in this work would afford opportunity for the potential community physician to contribute ideas and criticisms but would not be sufficiently long to taint her or him from an association with a service staffed in the main by contractless, transferred local government clinical medical officers who are waiting for Court. This could also afford insight into how the principles of administration and management are applied in the reorganised NHS.

C R HAINES

Cambridgeshire Area Health Authority (Teaching),
School Health Service,
Peterborough Health District,
Peterborough

Driving and medical fitness

SIR,—As medical officer to the local motor taxation department for many years I am concerned about the implications of circular WHSC(IS)94 issued by the Department of Health and Social Security in October 1975. This circular informed authorities that as from 1 January 1976 driving licences would be valid until the driver reached the age of 70, with renewal thereafter every three years. It states that there is a responsibility on the licence holder to inform the licensing authority as soon as he becomes aware that he is suffering from a disability which is, or which may become, likely to affect his ability to drive. Although the responsibility to notify disabilities relevant to driving rests with the holder of the licence, doctors will be expected to warn patients if they find them to be suffering from a disability likely to interfere with safe driving.

I am very unhappy about the whole procedure; in theory it appears satisfactory, but I doubt if it will work in practice. My experience is that drivers in the past have been reluctant to disclose obvious and marked disabilities when renewing their driving licences. In the past it has been possible for general practitioners and others to bring the question of driving up for discussion when patients with handicaps seek treatment, and in this way patients are often advised to register a disability and may or may not have to undergo an independent medical examination. Some cases of disability are referred for independent medical examination by the staff of the local taxation department or by an insurance company. These methods of bringing forward disabilities among drivers will not operate in future and I am concerned that a number of persons with varying degrees of disability making them unfit to drive will be on the roads, adding to the toll of accidents to themselves and other road users.

I would very strongly recommend that the application form which is completed when applying for a road fund licence for a motor vehicle should be reprinted to contain a declaration of health relating to the applicant and to members of his family liable to drive the vehicle. In this way the applicant for a road fund licence would have the question of disability brought to his attention at least annually and be more likely to declare a disability and have any necessary examination and advice and, if need be, an independent driving test. The alternative of leaving the matter to the discretion of the drivers seems a very unsatisfactory way of checking on disabilities which can affect fitness to drive and in this way also, of course, increase the number of fatal and serious road accidents.

G W ROBERTS

Clwyd Health Authority,
Mold

Non-accidental poisoning and child abuse

SIR,—We should like to record briefly two further cases of non-accidental poisoning in childhood (Dr D Rogers and others, 3 April, p 793).

This patient was previously described in 1968, when she was admitted at 19 days old with hypoglycaemic fits and haematemesis caused by aspirin administered by her mother.[1 2] She was readmitted in March 1976 when her mother had hit her with a leather belt, causing extensive bruising of the thighs, and "pushed her against a wall," causing injuries to both cheeks and a large occipital haematoma. During the admission the child said she had previously attended a London hospital with a black eye. Both social services and local magistrates did not think the drug poisoning was relevant, and so the child was returned home despite strong paediatric and psychiatric advice.

A previously healthy 10-month-old girl was admitted from a peripheral hospital with a history of a mild cold for a few days followed by recurrent episodes of unconsciousness. These continued after admission to hospital but abated after subsequent admission to the intensive care unit. Because of a poor social history a specimen of the patient's urine