tainly pointed to the atrophic kidney as the leading suspect. The history of polyuria (nocturia) at the onset of the patient's symptoms, however, would suggest the possible role of increased aldosterone secretion. The values of serum sodium and potassium would therefore be of some interest. The malignant phase of the disease is against primary aldosteronism,[1] but would appear not to be completely inconceivable or incompatible.[2] The finding of a small adrenal adenoma in "slightly heavy" adrenals is therefore of some interest in a hypertensive patient, even in the presence of proved renal artery disease.

I raise this point because primary aldosteronism can easily be missed if a diligent search is not made for evidence of potassium depletion with autonomous adrenal secretion of excessive aldosterone. Difficulties arise only in cases with hypokalaemia, normal serum sodium, and increased aldosterone secretion in association with obvious renal artery disease when definite proof of the participation of the kidney is lacking. Particular attention to the degree of cellularity and granularity of the juxtaglomerular apparatus in the smaller kidney might have been an important clue in this particular case, except that prior diuretic therapy had been given. In primary aldosteronism the juxtaglomerular apparatus might appear inactive because of increased aldosterone production from a tumour.

Of course, the finding of an adrenal adenoma in a hypertensive patient does not justify the diagnosis of primary aldosteronism, but neither should the finding of renal artery stenosis always convict the kidney.—I am, etc.,

Toronto, Canada. E. CARL ABBOTT.

REFERENCES

1 Conn, J. W., Knopf, R. F., and Nesbit, R. M., *Amer. J. Surg.*, 1964, **107**, 159.
2 Kaplan, N. M., *New Engl. J. Med.*, 1963, **269**, 1282.

Attitudes to Nursing Among Intelligent Schoolgirls

SIR,—We do make a great effort to recruit nurses "personally" in some hospitals, and I would like to outline some of the methods we have adopted in a large recruitment campaign just being completed by the three hospitals of which I am matron:

(1) During the autumn 24 career talks were given at local schools. To each we took a staff nurse or student nurse, in uniform, who was a good looker and a good speaker. After the talk had been given the student nurse was frequently left alone with the schoolgirls to answer their questions informally—many more questions were asked in this way.

(2) At two of the hospitals the trained staff invited all the school heads and their deputies to a sherry party. These were a great success and were very good for communications.

(3) At St. Margaret's Hospital, Epping, 450 schoolgirls attended open days and a hospital exhibition, which was held for girls and boys interested in nursing and other hospital careers. Films were shown on student and pupil nurse training and the nursing cadets acted as guides to take parties of schoolgirls round the hospital, the school of nursing, and the nurses' home.

Similar open days are being held at Harlow Hospital in December for schools in this area. A successful "back to nursing" course is also under way—an average of 36 candidates attend classes each Thursday afternoon, and we have a waiting-list already for a similar course in the spring of 1965.—I am, etc.,

MARY W. BOURNE,
Matron,
Harlow Hospital,
St. Margaret's Hospital, Epping,
and Honey Lane Hospital, Waltham Abbey.
Essex.

Typical Medical Students

SIR,—Mr. M. J. R. Healy (31 October, p. 1138) doubts whether the analysis reported by Dr. Walton and his colleagues (19 September, p. 744) has indeed identified "types" of medical graduates, and suggests that the bipolar factors are better regarded as "continuous scales along which the actual individuals can be located." Such a definition would be correct in relation to factors derived by R-technique (i.e., "ordinary" factor analysis). "Delegate analysis," however, is in essence a variant of "Q-technique," in which correlations are carried out not between *tests* but between *persons*. Consequently, in interpreting the data one must—if one can, and it is quite a difficult exercise—adjust one's thinking so as to consider tests in the role of persons, and vice versa. In R-technique a factor may be regarded as a "dimension," as Mr. Healy suggests, but the consensus of opinion is that for Q-technique this is not so. Thus, Guilford[1] writes: "What the Q-technique brings out is personality types or syndromes. . . . Only when a syndrome is dominated by a single common factor would a Q-technique factor coincide with an R-technique factor."

The extent to which individual graduates resemble the types can in fact be determined, and in any case one "recognizes" individuals in the types. But one does not expect any individual to be representative of a "pure" type, any more than one would expect a test to be a "pure" measure of a factor in which it has a loading. The very considerable residuum of what constitutes the individual personality remains, and it is this that corresponds to the specific factors to which Mr. Healy rightly calls attention.—I am, etc.,

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University of Edinburgh,
Edinburgh 8. BORIS SEMEONOFF.

REFERENCE

1 Guilford, J. P., *Psychometric Methods*, 1954, 2nd ed., p. 529.

Family Planning in London Teaching Hospitals

SIR,—Mr. Elliot E. Philipp (31 October, p. 1132) has pointed out in his letter the lack of training in contraceptive techniques in London teaching hospitals. I would like to emphasize the point which he also makes, that nurses and midwives rarely receive any instruction whatever in this subject. It might be argued that this is outside the scope of a general nursing training, but midwives and health visitors at least ought to have some knowledge of contraception, and this subject should be included in the regular curriculum.

A few of the training schools do include one lecture on family planning, and an opportunity is given to attend a clinic, but many of these otherwise highly trained nurses know nothing about contraception, and they have told me that they have had to learn from their patients. This subject is often included in refresher courses if the programme allows, but provision for this is inadequate and years of work precede attendance at a refresher course.

If doctors were willing to use their influence on those who decide the curriculum of training then this vital subject might be included in the education of all health visitors and midwives.—I am, etc.,

London S.W.7. ALISON GILES.

SIR,—May I be allowed to congratulate Mr. Elliot Philipp on his timely and excellent letter (31 October, p. 1132)? There is no doubt that the teaching of contraceptive techniques to medical students and even to the newly qualified doctor is grossly inadequate at present. The basic reason for this is that the provision of contraceptive advice and help is not a part of the National Health Service, excepting in cases where there is a "medical" indication.

In order to give contraceptive advice one must have a regular clinic so that patients may return for checking of appliances and for careful follow-up. The establishment of such a clinic is not at present possible in a National Health Service hospital. Those of us who are keen to teach medical students the rudiments of contraceptive techniques find it necessary to demonstrate on a small and highly selected group of patients for whom one can establish adequate physical medical reasons, and even here one encounters considerable difficulties in obtaining and dispensing supplies of contraceptive equipment.

At the present time the oral contraceptive in its many forms is being used on a very large scale in this country, and, virtually speaking, all clinical experience is in the hands of the Family Planning Association. There are very few gynaecological consultants who can claim to have large experience in the use of these potent drugs, since, broadly speaking, they will be using the drug only on private patients. Since the progesterone/oestrogen mixtures are an exceedingly important part of the modern armamentarium of hormones it is a particular pity that their main usage should not be under the supervision and control of the appropriate specialist concerned.

The failure of teaching is not solely confined to imparting the skill to fit and test contraceptive appliances but also in the wider and more important aspect of psycho-sexual medicine, and no doctor or midwife is qualified for very long before the lack is apparent. Dr. Sylvia Dawkins (14 November, p. 1267) makes this point most clearly, and I am sure that the popularity of her clinic is due in no small degree to the fact that patients find it possible to discuss sexual problems there—a thing all too frequently impossible with the family doctor.—I am, etc.,

London W.1. PETER DIGGORY.

Cephaloridine

SIR,—We would like to voice a strong protest at the manner in which the new drug Ceporin (cephaloridine) was brought to the

notice of the general public with a blare of publicity through the mass media. This has given rise to false hopes in several of our patients who had been led to believe that here at last was a miracle cure which would instantly cure their chronic bronchitis. We have had the unpleasant task of disillusioning these patients, and have found it a time-consuming process involving several patients daily. We resent the difficulties that irresponsible accounts have given, and are angry at the painful disappointments that have resulted.

Pharmaceutical firms which encourage publicity directed at the lay public for drugs which are intended for administration under medical supervision are hardly likely to gain or maintain esteem and respect in the eyes of doctors.—We are, etc.,

MONTAGUE SOLOMON.
S. SOLOMON.
E. J. M. HOPKINS.

Liverpool 4.

Doctors' Pay

SIR,—A column in one of the leading national newspapers commented upon the pay rise for M.P.s, under a heading "Rate for the Job," and posed a question—namely, "Who else, for such pay, would work without an office, do his own research, pay £400 from salary to share a secretary, and often recruit his wife's help?"

Who else? Why, of course, the general practitioner working in the National Health Service. The general-practitioner service is unique in its demands—in work, hours, and personal sacrifice. When the time comes will M.P.s feel any similarity in service exists?—I am, etc.,

R. J. S. DOHERTY.

Newport, Monmouthshire.

Area Health Boards

SIR,—It seems a pity that the General Medical Services Committee adopted such a faint-hearted attitude to the proposal to use Wales for the experiment in the operation of area health boards (*Supplement*, 3 October, p. 140). One would expect the experimental approach to extend beyond the field of the practice of medicine and apply to its administration as well.

There is no need to go into detailed arguments in favour of the proposal, as I am sure that Dr. Murray Jones will marshal them well in his memorandum. I would like to emphasize, however, that both the Welsh Committee of the B.M.A. and the Welsh Association of Local Medical Committees are firmly in support of this proposal.—I am, etc.,

D. F. M. ROBERTS.

Llandrindod Wells, Radnor.

Ancillary Help

SIR,—It is more than a little puzzling to find our negotiators recommending the proposed scheme for direct payment of the cost of ancillary help as "a generous offer" (Dr. I. M. Jones, *Supplement*, 31 October, p. 169). Surely they must know that this scheme *per se* would not cost the Government a penny, being as it is a redistribution of the Pool. Wherein then lies the generosity? And is it not misleading, to say the least, to present the additional money which would come into the Pool if more doctors employed ancillary help as a benefit of the proposed scheme, which it is not. It is, of course, a benefit of the Pool system as already constituted, and would accrue whether the proposed scheme were instituted or not.

If then we are to see clearly the benefits of this scheme, we must exclude from our calculations any benefits already in the Pool system. What then are we left with? Firstly, that no one will find his income increased by up to three-fifths of the amount he spends on ancillary help. The net gain which any doctor can expect from this scheme will be up to three-fifths of the difference between what he pays and the average paid for ancillary help by all doctors in the general-practitioner service. At present this average is about £130 per annum per doctor.

Secondly, we are left with the fact that as more doctors employ ancillary help that average will rise and each doctor's gain will fall. Indeed general practitioners should be warned that if, encouraged by the promises of this scheme, they all employ ancillary help from its commencement at an equal rate then no one will be a penny richer, and we shall be back paying the full cost ourselves. (For the record it should be stated that, due to the fall in capitation fees, the larger lists would lose a little and the smaller list gain a little.) Herein then lies the absurdity of this scheme as an incentive: that as long as no one takes advantage of it the incentive will remain, but as more and more reach for it it will, like a mirage, disappear. We shall then be left with the incentive we already have, that any increase in practice expenses finds its way eventually into the Pool—albeit two years later.

It is this two-year lag, together with the fact that the extra money is distributed to all and sundry, that constitutes the great deterrent to the expansion of facilities and ancillary help in general practice. If the Ministry of Health is really anxious to give some inducement to the employment of ancillary help it can do two things:

(1) Make the whole cost of ancillary help, not just three-fifths of it, directly payable. The fact that this has been refused though it would cost the Government nothing more seems to indicate that the Ministry is anxious to retain the deterrent.

(2) Put the equivalent of any *new* expenditure on ancillary help into the Pool in the quarter in which it is incurred without waiting until it turns up in the final settlement two years later after going through the ponderous machinery of Inland Revenue assessments. Needless to say this would still not involve the Government in paying more than 100% of practice expenses.—I am, etc.,

Gateshead 11. L. FAIRBAIRN.

Medical Secretaries

SIR,—Secretary-receptionists in general practice represent a new career-grade emerging in the National Health Service. If the grade is to develop satisfactorily not only must the pay but also the superannuation and terms of employment be equal to those of equivalent Health Service workers. Too many bodies, both medical and educational, are now concerned with this work and none of them is currently able to play a decisive role in moulding the future pattern of events. If the Association of Medical Secretaries had been formed some years ago things would have been very different.

The work of secretary-receptionists and other ancillary helpers is of national importance, since it involves everyone who attends a doctor's surgery where ancillary help is employed. There are a number of legal and ethical problems involved in employing ancillary help. I suggest that they should be discussed in the Fraser Working Party, taking what legal advice is necessary, and some general guidance issued. No educational course can be satisfactorily devised until these questions are settled. The Ministry of Education should be asked to co-operate in the standardization and co-ordination of training courses which might otherwise develop along lines differing widely in substance and standard.

Ancillary workers should be encouraged to establish their independent negotiating machinery as rapidly as possible. This is essential, since the interests of the medical profession, the ancillary workers, and the patients may before long come into conflict, and it is on the successful settlement of these problems that the status of the ancillary workers will depend. Our negotiators with the Ministry must point out in the financial discussions the importance of an early administrative as well as financial independence of ancillary workers, with the ultimate goal of a status recognized by the Council of Professions Ancillary to Medicine.—I am, etc.,

Newcastle upon Tyne 5. N. D. MACKICHAN.

Out-patient Prescriptions

SIR,—In my letter on the subject of out-patient prescribing which you very kindly published (31 October, p. 1139), I confined myself strictly to the question of prescribing when out-patient dispensaries are closed owing to lack of staff. I have just received the reply to a copy of my letter which I sent to the Secretary of the General Medical Services Committee, which states: "The correct procedure in such circumstances as those you describe and one which is usually adopted, is for the hospital to issue a prescription on Form E.C.10 (HP). Patients are thus able to obtain their drugs from the local chemist. We have drawn the attention of the Chief Medical Officer to the need to keep hospitals informed of the correct procedure"—thus confirming my own views of the correct procedure to be adopted.

Your correspondents Drs. J. B. Glass and G. E. R. Bibbings (14 November, p. 1268) broaden the issue by raising the general question of prescribing for hospital out-patients. The retention of patients for out-patient supervision, often without even the knowledge, and usually without the consent and co-operation of the patient's own doctor, is perhaps the most potent source of frustration and humiliation in general practice under the National Health Service to-day. I maintain that patients taken over from us in this way should be prescribed for by the doctor undertaking the self-imposed task of