both manufacturers, who were unaware of the therapeutic applications of their products.

Our patient thus took 30 mEq of sodium bicarbonate in the form of "Refreshers" and 9.2 mEq of sodium bicarbonate in the form of a "sherbet fountain" each day and thereby achieved a therapeutic dose.

The extension of homeostatic mechanisms towards the auto-regulation of dietary intake to remedy deficiencies was described by Richter[2] in relation to adrenalectomized rats, which were found to prefer weak saline solution to plain water. He referred to patients with Addison's disease who may be conscious of a need for additional salt well before the diagnosis of the condition. There is no previous evidence of the auto-selection of alkali in a patient with hyperchloraemic acidosis, though patients already on alkali therapy may recognize a deterioration in their condition and increase the dose spontaneously.

The choice by this patient has drawn attention to a cheap alternative and attractive source of alkali which will be of value in treating other patients who find conventional forms of sodium bicarbonate unacceptable. Furthermore, this therapy has obvious attractions for the treatment of children suffering from renal tubular acidosis.—I am, etc.,

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## Exercise and Fibrinolysis

SIR,—I am grateful to Dr. I. S. Menon for his comments (1 October, p. 829) about my article on exercise and fibrinolysis (27 August, p. 502). There appears, however, to be some confusion in terminology which I feel ought to be corrected. Dr. Menon has consistently used the term fibrinolytic *reactivity* when comparing my results with those of Macfarlane and Biggs,[1] Beller *et al.*,[2] Rao,[3] and Brakman *et al.*[4] One of the purposes of this paper was to emphasize the difference between the concept of baseline fibrinolytic activity, which was the subject of the above-mentioned authors' work, and that of fibrinolytic reactivity—which was regarded as the capacity of the individual to generate plasminogen to exercise. It is true, however, that the young females appeared to have a higher level of baseline fibrinolytic activity than the males, and that this is contrary to the findings of Brakman *et al.*[4] and Menon.[5] The reasons for this discrepancy are not yet clear, but investigations are now under way in order to clarify this problem.—I am, etc.,

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## Real Reasons for Emigrating

SIR,—I quite appreciate the remark of Dr. P. D. G. de Buisseret—"My only opportunity for reading and postgraduate study was either in the bath or in bed"—made under the heading "Real Reasons for Emigrating" (1 October, p. 832). I came to this country from India mainly for the purpose of obtaining a higher qualification. But, unfortunately, I have to work an average of 100 hours a week in my present job. And these working hours may be even longer—for example, when one of my colleagues becomes ill or takes a holiday, as there is no arrangement for appointing a locum house-officer in this hospital. I look after about 80 in-patients in addition to working in the operating theatre and in the outpatients clinics. I rely a great deal on nurses to keep myself informed about the condition of the patients in the ward, and I feel guilty that I am unable to observe all the patients as closely as I should like to do.

My post is recognized for pre-registration training and it is also recognized as a training post for the M.R.C.O.G. examination. So, although it is not attached to any medical school, one may rightly expect some sort of regular teaching programme. Because of the circumstances described above and the lack of teaching programme I am now thinking of emigrating to some other country, and other doctors in my position may think likewise.—I am, etc.,

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## Charter for Hospital Doctors

SIR,—We of the Manchester Regional Junior Hospital Staffs Group do not accept that the decisions made at the Hospital Junior Staffs Group Council of the B.M.A. on 27 September were representative of the opinions held by the majority of junior hospital doctors in this country, with particular regard to the main issues to be included in the new Charter. Implementation of such policies will precipitate the acceptance of the British Junior Hospital Doctors Association by junior staff. Decisions were made by people who had, in the majority of cases, not sought opinion beyond their own hospital or its immediate neighbour. In Manchester in the last 12 months we have had a very hard battle to encourage the junior doctor to voice his views through the B.M.A. We have been successful in taking over the Action Group which was developing in our region and substituting a B.M.A. Group which has been the most active in the country gathering opinion from non-B.M.A. and B.M.A. members alike, and publicizing their case through press, radio, television, and even the House of Commons.

In preparing a new Charter from our area our executive visited 20 hospitals to seek opinion on what should be included in the Charter, and this was obtained from hospital staff as far apart as Preston and Macclesfield. We then presented our suggestions for a new Charter to our Regional Consultants and Specialists Committee for their consideration, since the new Charter will be for hospital staff of all grades, prior to taking our comments down to the meeting on 27 September. At this meeting (8 October, *Supplement*, p. 148) I did not withdraw the proposals made by the Manchester region for extra payments for evening and week-end work, as you incorrectly reported, since I did not believe the meeting was truly representative. We suggest a national referendum be made to seek the opinion of all junior hospital doctors in this country on the following matters to know whether they should be included in the new Charter.

(1) There should be a sessional working week of 10 sessions paid at the present basic salary rate agreed by the Review Body (possibly excluding housemen). A morning and an afternoon will count as one session each. Over and above these basic 10 sessions, those directly "on call" will be paid at the fixed rate for each extra session. Those who are available for more senior opinion will be paid an availability fee plus a further fee if required to visit the hospital.

(2) To safeguard the well-being of patients and medical staff maximum sessions on duty must be stated. They could be as follows:

A basic working week of 10 day-time sessions (that is, 45 hours) and a further six evening and night sessions (41 hours)—that is, a maximum of 16 sessions per week (86 hours). Evening and overnight duty to be counted as two sessions. The sessional system can be so defined as to avoid "clocking on and off."

(3) For all grades of hospital medical staff one paid session per week must be set aside for study. If pressure of work results in the loss of this study session it must be held over. The total number of study sessions must, however, be taken by some predetermined date in the year.

(4) Holiday. Registrars should be entitled to five weeks' leave.

(5) In areas where the work load cannot be contained within the scheme suggested above, non-urgent cases should be sent to more fortunate areas. Initially there may have to be a 20 to 30% reduction in seeing non-urgent cases to lessen the present work load in many of our hospitals, and this reduction should be reviewed after a reasonable period of time.

(6) There should be abolition of residency charges.

These are but a few of the things to be considered for the new Charter. It must be borne in mind by the B.M.A. this will be its last opportunity to prove it is representative of all hospital staff, including consultant grades, and B.M.A. spokesmen should see exactly how far they are representative of those they claim to represent. Let the B.M.A. itself take warning: for the sake of its own future it should not bungle this like it did in accepting with alacrity the Government's pay-freeze without asking those in the periphery whether we wished the B.M.A. to sue the Government for breach of contract. Truly, justice must not only be done—it must be seen to be done.—I am, etc.,

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Chairman,
Manchester Regional Hospitals
Manchester. Junior Staffs Group of the B.M.A.

SIR,—The two recent letters on medical assistants (1 October, p. 832) are indeed a sad commentary on the current malaise of our profession and on the short-sightedness of the Platt report.

The much-vaunted new Charter (*sic*) for hospital medical staff must include as a