staff and a very different atmosphere from the acute wards. My own experience of geriatric long-stay wards, some with a high proportion of demented patients, is that eventually some trained staff are found who derive much satisfaction from their work. They have to learn to organize them more like homes and not to compete with the acute wards. The geriatrician does not have to spend much time in the long-stay units, but he must set the pattern and have control of admission.

This difference of view is a minor matter, however, compared with our general agreement on the development of medical services for elderly people and on the great need for doctors to interest themselves in this field—I am, etc.,

T. B. DUNN

Chadwell Heath Hospital,
Ilford, Essex

Royal College of Psychiatrists

SIR,—Dr. A. Shapiro (17 July, p. 188) is right to draw the attention to the need for academic units in the field of mental handicap. It should be added that the need is just as great in the case of child psychiatry. Existing academic departments of psychiatry and paediatrics pay little attention to child psychiatry, and there are scarcely any child psychiatrists on their staffs. The result is a paucity of research, little teaching of child psychiatry to medical students, and generally low academic standards in the field. The one shining exception to this is the work of Dr. Michael Rutter and his colleagues at the Institute of Psychiatry.

The statement by Dr. J. P. Crawford (same issue) that "the academic side of psychiatric training is now well taken care of in British universities," is certainly not true of child psychiatry. I would also question Dr. Crawford's reference to "those psychiatrists who accept and deal with the general run of psychiatric problems thrown up by a given population. . . ." Who and where are these people? Or are children not part of the "given populations" he refers to?

In reality, few "general" psychiatrists have had much training or experience of child psychiatry, which tends to be a poor relation (in company with mental handicap) of the general psychiatric service. In most areas it has a secure place in neither the academic centre nor the district hospital service. It is to be hoped that the Royal College of Psychiatrists will urgently apply its energies to remedying this situation. The new college must, I am sure, represent all aspects of psychiatry, academic and otherwise, but it has an urgent duty to interest itself in the under-developed branches of the subject.—I am, etc.,

PHILIP BARKER

The Charles Burns Clinic,
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Hazard of Self-inflating Resuscitation Bag

SIR,—Reporting on the hazard of insufflation of rubber debris prevailing in yet another foreign-made resuscitation bag (Aga revivator), Dr. P. J. C. Baxter and others (5 June, p. 589) advocate the use of a filter to be incorporated in all self-inflating bag systems, fitted between the bag and the patient, to prevent the potentially dangerous occurrence of inhaling rubber debris. This particular requirement has previously been demanded by Drs. R. Loveday and D. G. Hurter (11 October, 1969, p. 111) in respect to the Danish-made Ambu resuscitation bag.

May I point out that a simple mesh-type filter inserted between self-inflating bags and valve, in both the unlined and the foam-filled type of self-inflating resuscitation bags, is only partially effective—that is, in respect to very coarse rubber particles or other debris and certainly cannot retain micro-organisms, as pointed out by Dr. R. Y. Cartwright and Pamela Hargrave (1 November 1969, p. 302). Rubber debris resulting from the deterioration of rubber consists both of very coarse particles but very largely of very fine powder, which, owing to its small particle size, can penetrate into the alveoli. On the other hand, a filter capable of retaining very fine rubber and other debris particles also would have to be of a size of density incompatible with the use of it in conjunction with a resuscitator of this type. Moreover, such a filter would not take care of particles which result from deterioration in valve diaphragms: conversely, the filter could not be directly between valve outlet and patient as it then would impose a very high resistance to expiration, which takes place by the elastic recoil of lungs and thorax.

Generally speaking, self-inflating bags to comply with all practical risk requirements arising in emergency resuscitation must be of rubber, fabricated in one piece (that is, not made in sections glued together), of the highest quality, and completely untreated by glazing or other finishes. The self-inflating bags made of thermoplastics are generally considered unsuitable because of the hardening of such materials at low outside temperatures, and also because of the potential hazard of acute deterioration and/or emission of highly noxious vapours, or even complete destruction in the presence of certain chemicals, vapours, or atmospheres in which such resuscitation devices may be used. The suitability or otherwise of self-inflating bags, and their valves from the viewpoint of hazards of insufflation of rubber debris and sterilizability, can quite readily be assessed if the user of such equipment ascertains from the manufacturer the results reported from ultraviolet exposure of these materials. A standard method of testing available in a number of research laboratories in the oil and rubber industry is carried out by the Xenotest apparatus providing accelerated and very severe tests for materials with a colour temperature of 5500-6500° K emitting light within the visible and the ultraviolet regions of the spectrum—that is, very close to natural sunlight.

It should further be realized that in many countries only second- or third-rate qualities of rubbers are available. Resuscitation bags successfully having passed such stringent material tests and complying with all requirements and criteria applicable to such devices are in fact made and readily available in this country.—I am, etc.,

D. R. GARBE
Technical Director (Biophysics),
Vitalograph Ltd.

Buckingham

Alcohol and Glibenclamide

SIR,—We would like to point out that the statement "it is claimed that flushing after alcohol does not occur with glibenclamide," Today's Drugs (12 June, p. 644), is not in fact correct. Our studies have shown that after a test dose of alcohol five out of eleven patients taking glibenclamide developed a flush compared with five out of eight patients on chlorpropamide and only one out of fifteen normal controls.

It is our impression that those diabetics who flush are those who already have red cheeks (possibly dependent upon the vasomotor changes of diabetes) and those with higher diastolic blood pressures.—We are, etc.,

E. N. WARDLE
G. O. RICHARDSON

Newcastle General Hospital,
Newcastle upon Tyne

Visits Outside Practice Area

SIR,—Having encountered once again the problem of the patient who moves out of the area in which his general practitioner has contracted to provide general medical services and then requests a home visit at his new address, I sought to obtain an official ruling on the responsibility of the general practitioner in such circumstances.

Executive council clerks were very cautious about expressing an opinion, though an inquiry to the Medical Defence Union elicited a reference to a very useful article by their Senior Assistant Secretary.[1] This article expressed the opinion that, provided the practitioner had accurately defined his practice area in his agreement with the executive council, he was not to be held responsible for patients who moved beyond its boundaries. However, this was still not an official opinion and it seemed desirable to try to obtain something from the Department of Health and Social Security itself.

This has now been done, and as I have never seen anything approaching an official ruling on this matter before, I felt that it deserved some publicity. The relevant paragraph of the letter (a full copy of which I have sent to the secretary of the General Medical Services Committee) reads as follows: "We entirely understand and sympathize with the position of a doctor who is requested to visit a patient who, without his knowledge, has removed from his practice area. Under paragraph 5 (1) of the National Health Service (General Medical and Pharmaceutical Services) Regulations 1966, Statutory Instrument 1966/1210, a doctor must apply to join the medical list or to succeed to a vacancy by completing an application in the form set-out in Part 2, Schedule 1 of those Regulations. The form appears on page 30 of SI 1966/1210. In it the doctor declares specifically the area in which he intends to practise and the circumstances in which he will visit patients who reside outside the said areas. *If a patient has removed outside this area, the distance he has removed is not material, and in our view, a doctor is not obliged to visit such a patient*" (my italics). The letter goes on to mention that a doctor may feel a moral obligation to attend in a real emergency but this, of course, lies outside N.H.S. Regulations.

It would seem, therefore, that in spite of uncertainty displayed by local executive councils and in spite of decisions in service cases on this issue which I have heard to have gone against the doctor, the D.H.S.S. is unequivocally of the opinion that we are not to be held responsible for patients once they have moved outside our defined practice areas.

I am grateful to you for giving this matter publicity, and would urge all general practitioners to look again at their contracts and to read the admirable advice contained in the article cited above.—I am, etc.,

J. P. LESTER

Walsall, Staffs

1 Robb, D. F., *Practitioner*, 1968, **200**, 874.

Points from Letters

Pre-hospital Coronary Care Service

DR. F. M. RIFKIN (Salford) writes: . . . In Salford we actually train all family doctors in the diagnosis and management of acute coronary disease as a first priority. We teach monitoring of the pulse and the use of atropine and lignocaine in suitable cases. We also provide each doctor with an Ambu bag and Brook airway which can readily be worked as one because of a simple device we have invented in Hope Hospital. It is a pity that as many as 144 patients in the Dublin series (3 July, p. 33) were dead before admission to hospital. We find it very encouraging to be able to say that in one practice alone in the last six months our coronary ambulance team, consisting of a doctor and two nurses from our coronary care unit, has been called to four patients in whom there was no spontaneous cardiac contraction or respiration for periods of up to 10 minutes. During this time, an adequate circulation was being maintained by the use of cardiac massage by the general practitioner and the ventilation effectively carried out under his supervision by some other person present. By these efforts, the patients were enabled after an hour or two, to be admitted to hospital and to be subsequently discharged as able to carry on with many of their normal activities. . . . There is no doubt that it is difficult to provide cardiac massage and ventilation in the case of cardiac arrest in a moving ambulance. In Salford, the ambulance is always stopped for this procedure. All ambulance drivers who serve this hospital are carefully and regularly trained in cardiac massage and ventilation, and arrangements are now in hand to train the first aid staff of 50 of the largest factories in the region in the diagnosis of coronary thrombosis; since we are now sure, through our enthusiastic general practitioners, that by means of cardiac massage and forced ventilation a patient with cardiac arrest can survive and be kept in perfect condition for up to 10 to 15 minutes or more, which is the time it takes our expert coronary care team to arrive. I must say that I look forward to the time when all these personnel will be able to monitor the pulse as well as know when to decide whether atropine or lignocaine should be given. . . .

Resuscitation of Drowned Children

Dr. T. C. PANG (Police Headquarters, Hong Kong) writes: Mr. J. R. Gibbs's letter on this subject (22 May, p. 470) is very interesting as it reminds me of a commonly used method adopted by the fisher folks of Hong Kong and China. Instead of having the child held in front, the "drowned" subject, even an adult, is carried with his legs dangling down in front grasped by the rescuer, and with the body back to back the rescuer runs or trots around the sea-shore for some time until respiration recommences. The advantage is that a single person can do all this without assistance to hold the legs of the child. The method is quite successful.

Locum Relief for Mission Hospitals

Dr. A. HANTON (*Medical Missionary News*, 26 Penn House, Main Avenue, Northwood, Middx) writes: I was delighted to read Dr. H. M. Woodman's letter (17 July, p. 189) about the rewarding experience of relieving overstrained mission hospital staff as "an excellent and worthwhile answer to retirement occupation." As honorary home director of a global medical missionary work, I would like to stress this need . . . Capable, efficient dedicated nursing staff would give loyal support to any such helpers, including assistance with language problems where these arise. . . . As mentioned, Dr. D. Johnson, Christian Medical Fellowship, 66 Kingsway, London W.C.2, would willingly supply information, as would the present writer.

Unmarried Fathers

Dr. H. J. RICHARDSON (Peterborough District Hospital, Peterborough) writes: Pregnant unmarried girls suffer much emotional and psychological upset. . . . Meanwhile, the boy friend has gone and invariably wants nothing more to do with the girl or her baby and often seeks fresh pastures. Surely the time has come to make him become much more involved in the consequences of his voluntary actions. Is it beyond the power of our legislators and all others who are deeply concerned with the Abortion Law to find a way to make the man pay for the entire cost of the abortion, and the money be paid by him to the State? This would act as a deterrent at least. Legally such measures may be difficult to enforce, but we have a law which attempts to enforce maintenance orders. . . . As a member of the operating team which takes part in many abortions I feel more and more concerned and saddened at the plight of some of these girls and less and less for the fathers, who at the moment suffer not one bit for their indiscretions.

Migraine Research

DR. ERIC GAMBRILL (Crawley, Sussex) writes: Further to your articles on migraine (26 June, pp. 751, 754, and 756) we would like to draw attention to experience over the last six years in our urban practice of 9,000-10,000 patients. During this period, we have had at least six patients with a classical migraine who have subsequently suffered a subarachnoid haemorrhage following rupture of a berry aneurysm. None of these patients had a late onset presentation, and most have had migraine for years. While it is obviously not feasible to investigate all causes of migraine intensively, in view of the widespread prevalence of this disease and the costs and risks involved, it would be helpful if any clinical pointers to arterial risks could be delineated. . . .

Certification

DR. D. A. LEAHY (Gateshead, Co. Durham) writes: The purpose of certification as we have known and practised it for decades seems to have lost its direction. Certification for incapacity to work in the majority of cases is meaningless, a waste of time, and fraudulent. The so-called incapacity and duration of incapacity are very often dictated by the patient or his employer. The general practitioner has to acquiesce. . . . During our "mini strike" last year, when we refused to issue certificates, our work load was much reduced and we were able to practise real medicine. Neither the Department of Health nor industry seemed to have suffered much inconvenience, and one suspects that the Department and industry could, if a similar occasion should arise, do without our participation. . . .

E.E.G. and Anticonvulsants

Dr. C. D. BINNIE, Mrs. C. DARBY, and Dr. D. FUNG (Department of Neurophysiology, Runwell Hospital, Wickford, Essex) write: Dr. W. I. M. Dow's suggestion (24 April, p. 207) that folate deficiency produces E.E.G. changes remains unsubstantiated notwithstanding his letter (26 June, p. 773). . . . In a recent survey of the chronic epileptic patients in Runwell Hospital, low serum folate (range 0·2-1·8 μg/ml) was found in 31 out of 47 patients (66%) who were taking anticonvulsants and in 8 out of a further 16 (50%) who were taking psychotropic drugs but not anticonvulsants. E.E.G. abnormality as described by Dr. Dow was found in only one patient, who was having three or more major fits per week and was taking excessive doses of anticonvulsants. In another patient with folate deficiency (maintained on phenytoin 100 mg t.d.s.) serial E.E.G.s with low frequency analysis were recorded at twice weekly intervals during a three-weeks course of folate supplement. The E.E.G. showed no change while the serum folate increased from below 1·7 μg/ml to over 20 μg/ml. . . .

Accident and Emergency Services

Mr. N. LAURENCE (Hove, Sussex) writes: There has been a great deal of correspondence as to whether accident centres should be run by casualty surgeons or not. . . . In my view there should be no such person as the casualty officer. We have used this term to designate this kind of post through common usage, whereas in actual fact it behoves us to teach accident and emergency practices in medicine, surgery, trauma, and general practice in relation to completing a young doctor's posteraduate curriculum. It would be therefore much better to teach the young doctor that in his own particular specialty he is not just concerned with the emergency when it is admitted to the ward, or the cold case that is operated on a list in the theatre, but that the training of a particular emergency starts when that patient first comes into hospital down in the emergency department, and to deal with it there prior to its admission. It would therefore be better for accident departments to contain house physicians, house surgeons, orthopaedic house surgeons, and one or more general practitioners who can then, under the co-ordination of a medical administrator, run the department. At present the whole responsibility has devolved around the orthopaedic surgeons and in some hospitals this responsibility has been neglected, and in fact the casualty department has been a dirty word in a lot of consultants' vocabularies for a very long time. It is because of the foregoing that the casualty surgeon has been born. . . .

Recruitment to General Practice

Dr. J. F. YOUNG (Thorpe St. Andrew, Norfolk) writes: Recent figures from various sources suggest that a truly desperate shortage of manpower is going to hit general practice in the next few years, unless something is done to improve recruitment. A remedy suggested is that teaching hospitals should try to improve the "image" of general practice. Yet how can they? Their students, in scientific blinkers from the age of 12 or earlier, and carefully segregated from any liberalizing contact with philosophy, literature, or the arts, are ideal cannon fodder for the curriculum of specialization run by specialists for specialists. The outcome? Fresh generations of illiterate, uncivilized technologists. . . . The only solution, it seems to me, is to forcibly oblige medical schools to take up to say 50% of their preclinical students from young men and women who have studied non-scientific subjects at school or university. The liberalizing influence of this leavening mass of unprejudiced minds could do nothing but good to medicine as a whole, and general practice would undoubtedly benefit from an expanding generation of general practitioners, healthily sceptical of the advantages of technology and concerned more with a philosophy of care for the whole man. . . .