hearing, dentition, and painful feet were common.

By seeing one patient per week per worker we will be able to cover the elderly patients of this group practice systematically in about three years. High risk patients can be identified, and the work load is not greatly increased. The interviews take about 20-30 minutes, and greeting and leaving patients may take more time than the actual screening. Sometimes there is a request for further regular calls which are not medically necessary, and these may be hard to refuse. As the scheme stands, it can be applied immediately, and because of the comparatively small resources that are needed we are prepared to proceed without a planned evaluation of the benefits that acrue.—We are, etc.,

G. C. RIVETT
R. G. BROOKE
S. A. COZENS
D. E. LAWSON
R. KERR

Bletchley,
Bucks

1 Williamson, J., *et. al.*, *Lancet*, 1964, **1**, 1117.
2 Stokoe, I. H., *Update*, 1971, 1, **9**, 677.

Vasodilators in Menière's Syndrome

SIR,—I was most interested to observe a dramatic improvement in auditory function in a 60-year-old woman treated with betahistine hydrochloride for symptoms suggesting Menière's syndrome.

The patient's records, extending over more than ten years, showed a progressive deafness, associated with recurrent otorrhoea. She consulted me for the first time in November 1970, following an isolated fainting attack. Blood pressure was 160/100, and there were no abnormal neurological signs. She complained of tinnitus, worse on lying down. There was no evidence of any middle ear infection or of nystagmus. She was reassured that nothing serious was wrong, and after mild sedation there was no further complaint.

Six months later she had a similar attack, but the symptoms were much more severe showing the typical clinical pattern associated with a Menière's syndrome. Vertigo was severe with associated vomiting, and her tinnitus was exaggerated. She was treated with betahistine hydrochloride (Serc) 8 mg three times daily, and within 24 hours nausea and vomiting had lessened, and it was decided to continue with this treatment.

She had, over the years, been in the habit of switching on her radio for the morning time signal, but although the "time pips" were audible, voices and music were distorted. On the sixth day after her attack, she switched on the radio in the usual way, and to her astonishment she heard voices and music with perfect clarity. Later on, she spoke to me excitedly of hearing the tap dripping and the kettle boiling. The improvement in her hearing was maintained for four weeks, but deteriorated slightly after an upper respiratory infection with middle ear involvement. Betahistine hydrochloride was increased to 8 mg four times daily without any noticeable side effects. Though her hearing is not perfect, distortion of sound and tinnitus no longer worry her, and there have been no further acute attacks of vertigo.

Experimental studies suggest that Menière's syndrome may be associated with vasospasm of microcirculation of capillaries supplying the inner ear. Histamine by injection has been shown to increase this circulation.[1-3] Betahistine hydrochloride has a similar effect to histamine, but is effective orally.[4]—I am, etc.,

N. M. PIERCY

Montrose,
Angus

1 Schayer, R. W., *Progress in Allergy*, 1963, **7**, 187.
2 Williams, H. L., *Lancet*, 1964, **84**, 344.
3 Maggio, F., *Microhemocirculation*, Springfield Illinois, Thomas, 1965.
4 Wolfson, R. J., Myers, D., and Schlosser, W. D., *Eye, Ear, Nose and Throat Monthly*, 1967, **46**, 891.

Destruction of Case Records

SIR,—Dr. E. C. O. Jewesbury's remarks (25 September, p. 769) are of the greatest importance. As storage space for records becomes exhausted the question of what to keep and for how long has to be answered.

This problem was the main reason for carrying out a research programme in Glasgow during the years 1965-8.[1] As a result, a new system of storing medical records was introduced in Glasgow Western Infirmary, which, so far, seems to have conserved storage space without the loss of vital clinical information.[2]

What worries me now is the growing inability of house officers, particularly British graduates, to write good English; spelling and punctuation are deteriorating to an alarming extent. This is, of course, a general trend throughout commerce and industry, and is a measure of the quality of our present State education.—I am, etc.,

J. H. MITCHELL

Raigmore Hospital,
Inverness

1 Mitchell, J. H., *A New Look at Hospital Case Records*. London, H. K. Lewis, 1969.
2 Lennox, B., and White, K. J. C., *Lancet*, 1971, **1**, 489.

Community Medicine

SIR,—Community medicine has been described as being concerned with the study and application of the principles of epidemiology, social and preventive medicine, organization of medical care, and administration of health services. It would appear that medical officers of health and the royal colleges are jockeying for positions, and family doctors cannot ignore the establishment of departments of community medicine based on universities.

It cannot escape your readers that the hospital services are obtaining the cream of doctors qualifying in Britain, thus greatly increasing their numbers, while those in general practice have remained static until recently. As a family doctor, I ask what is the future for general practice if there is fear of a take-over bid of part of our work?

It is hoped that in the discussions that will ensue in the coming months concerning the reorganization of the Health Service that a new type of medical officer of health will emerge who will act as a community physician and work rather with the family doctor service rather than with the hospital services.—I am, etc.,

M. MACLEOD

Wallasey, Ches

SIR,—While the announcement of a new faculty of community medicine of the Royal Colleges of Physicians is much to be welcomed (9 October, p. 117) it highlights a current problem that deserves consideration: what is the most appropriate training for a practitioner who wishes to enter the field?

The traditional method was that of apprenticeship in a unit under an acknowledged research worker. But others have gained experience in depth or breadth in various aspects of medicine, public health, and administration, before extending their expertise into a different field. Recently, established is the London School of Hygiene M.Sc. course, but the limited numbers cannot at present provide workers for the considerable range of research and practice envisaged.

Advice on this subject may be expected to be forthcoming from the new faculty. But while there is an opportunity, would it not be valuable to engage in open discussion beforehand with those who hope to be trained: to establish the value of other higher diplomas and degrees or work in other fields: and carefully to consider the desirability of a (?competitive) examination, in the light of current cogent criticism of the new M.R.C. Psych. proposals?[1]—I am, etc.,

M. J. MCCARTHY

Tooting Bec Hospital,
London S.W.17

1 *World Medicine*, 28 July, 1971, p. 5.

Medical Illustrators

SIR,—I was pleased to read reference to our report *Medical Illustration in the National Health Service* (25 September, p. 779).

However, I was surprised that you mentioned only medical artists when, in fact, the report deals also with the careers of medical photographers.

I have for some time now been concerned that the title "medical illustration" is usually regarded as meaning medical art and graphics, and is not being used as we intend as the generic term to cover photography, art, and all the more modern techniques of audiovisual communication.

This report has been prepared by our institute as the first attempt to provide a proper career structure for all these personnel and it would be unfortunate if its failure to do so was, in fact, due to the very two first words on the cover.—I am, etc.,

LESLIE BOWCOCK

Past Chairman,
Institute of Medical and Biological Illustration
Newcastle, Staffs

Staffing Accident and Emergency Departments

SIR,—Incidents recently reported in the press and other media have drawn widespread attention to the difficulties experienced by hospitals in the provision of accident and emergency services. Unfortunately, individual doctors and hospitals have been subjected to criticism which should be directed elsewhere.

Salford Hospital Management Committee, in common with many others, is extremely concerned with the problems of staffing

levels in accident and emergency departments. In our own group—though at present the junior medical staffing is relatively satisfactory for the two major departments which provide a continuous casualty service—there have been occasions over the past nine months when the service has been maintained only by the employment of locum tenens, clinical assistants, or by the payment of extra duty allowances to junior medical staff.

Work in emergency medical departments requires a high degree of competence and is not appropriate for the inexperienced junior doctor without continuous support of senior medical staff. Casualty duties have been regarded traditionally as a disagreeable chore to be performed or avoided as expeditiously as possible in the hope of escaping the lurking litigation that preys on inexperience. Such duties, therefore, are only acceptable when the junior doctor knows that senior opinion is available in support until a higher level of competence is reached through a defined system of promotion.

Winter is again approaching, and with the complex of motorway intersections in this area, we are seriously concerned at the prospect of coping with multiple road accidents, etc., with a medical staff which relies initially on a medical assistant who is the only member of the medical team in the accident and emergency department providing any continuity, plus (if we have been fortunate in recruitment) a senior house officer.

Our committee feels that staff of at least medical assistant seniority should be available 24 hours a day. The recent M6 disaster occurred at approximately 7.00 a.m. Had a similar accident taken place in the Salford area, in which is situated the Worsley braided interchange, Britain's most sophisticated motorway multilevel interchange, known locally as "Spaghetti Junction," senior medical staff would not have been available on duty at either of the two major accident centres in this group, which provide a 24-hour casualty service. This implies no criticism of assistance which is readily available at all times in cases of emergency; it is rather that so important a unit as an accident and emergency department should not have to be dependent on assistance from other departments. There are always "back up" services within the hospital; it is the initial facilities in the way of medical staff which are inadequate. Undoubtedly, it may be necessary to rationalize the number of accident and emergency departments which are available, but a prerequisite of this rationalization must be adequate accommodation, adequate theatre space, and, above all, an adequate medical staff with a specialist consultant in charge.

The Regional Hospital Board has been extremely generous over the years in providing finance to improve facilities for the reception and treatment of accident and emergency cases and to improve the junior medical staffing of these departments, but there is little doubt that attendances will continue to increase. Within the present level of medical staffing it is difficult to see how these patients can be adequately dealt with, particularly if they attend outside what is commonly known as the normal working day—that is, between 5.30 p.m. and 9.00 a.m. We can no longer depend upon general practitioners, who are also hard pressed, to assist with locum tenens sessions.

The lack of a decision on policy in this field is increasing the risk to patients and the unfair burden on young doctors who are obliged to accept an excessive responsibility. Urgent consideration must now be given by the Department of Health and Social Security to providing a similar way of medical staffing structure within accident and emergency dpeartments to that which is already enjoyed in other specialized fields in the Hospital Service.—We are, etc.,

R. I. MACKAY
Chairman,
Medical Executive Committee

J. B. DUCKWORTH
Group Administrator and Secretary

Salford Hospital Management Committee,
Salford

Shortage of Physiotherapists

SIR,—I fully agree with Dr. R. S. Savidge (16 October, p. 169), but may I make two points?

It is difficult in a busy department to make use of the valuable services of a part-time married physiotherapist or occupational therapist with children at school, because she will not be available during school holidays, which often coincide with annual leave of full time staff.

Anyone seeking such employment would be well advised to discover whether she will be taxed on her husband's income. If she is, she may find herself actually out of pocket at the end of the year.—I am, etc.,

CLIVE SHIELDS

London S.W.3

Evidence to the Coroner

SIR,—Dr. J. Shackleton Bailey, Coroner of the District of Norfolk (25 September, p. 766), shows a regrettable lack of understanding of the relationship between doctors and health visitors. There are several points in his letter which suggest that he is unaware of the good working relationships which are being developed between them through the attachment of health visitors to group practice, or by general practitioners working in health centres. Even where this close partnership does not exist, relationships between these two branches of the Health Service are generally good, and circumstances such as he describes would not arise as there would be adequate consultation between all those involved.

The circular Dr. Shackleton Bailey refers to was sent to all medical officers of health with a copy to chief nursing officers, and I quote below the two relevant paragraphs.

"We know you will appreciate the vital importance for the success of a health visitor's work of winning and retaining the confidence and trust of the families she visits and consequently the damaging effect of publicized court appearances.

"Consequently, after very careful consideration of all issues involved, my committee has requested me to ask that health visitors, in their capacity as such, should be protected from giving evidence in court proceedings except under subpoena when evidence which only they can give is essential in the interests of justice. Experienced health visitors report that provided they have been subpoenaed they can explain to other families who might otherwise lose confidence in them that they had been legally compelled to give evidence on the occasion in question."—I am, etc.,

G. M. FRANCIS

Health Visitors' Association,
London S.W.1

Hallucinations of Widowhood

SIR,—No doubt there are many well-authenticated historical examples of the phenomena described by Dr. D. Dewi Rees (2 October, p. 37).

A good one is recorded by Antonia Fraser in her recent biography of Mary Queen of Scots.[1] Shortly after the death in December 1598 of her teenage husband Francis II, King of France, Mary wrote stanzas on the grief she felt after her tragic bereavement. One stanza was as follows:

"As I sink into my sleep
The absent one is near
Alone on my couch
I feel his beloved touch
In work or in repose
We are forever close."

—I am, etc.,

W. B. ROANTREE

Deal, Kent

[1] Fraser, A., *Mary Queen of Scots*, London, Weidenfeld and Nicholson, 1969, p. 108.

Hypoglycaemia in Infancy and Childhood

SIR,—I was somewhat concerned to read some of Dr. A. D. Griffiths's 21 August, p. 475) comments on your leading article "Hypoglycaemia in Infancy and Childhood" (17 July, p. 130). He suggests that hypoglycaemic newborn infants without symptoms should not be treated with intravenous glucose because the treatment itself has an element of risk and because of lack of evidence that asymptomatic hypoglycaemia results in brain damage. While I would agree that the prognosis in symptomatic and asymptomatic hypoglycaemia is very different, it seems to me that it would be unwarranted at the moment to say that asymptomatic hypoglycaemia is harmless. Of 71 infants with hypoglycaemia seen at this centre during the past 10 years, 48 have been followed up so far. Neurological sequelae were subsequently found in 14 of 23 infants who had had symptoms and in 4 of 25 infants who had had no symptoms.[1] However, it is often a matter of opinion whether a baby should be classified as "symptomatic" or "asymptomatic." Symptoms may be minimal and none are pathognomonic of hypoglycaemia. A hypoglycaemic baby with apnoea or convulsions, disappearing within a few minutes of giving intravenous glucose, is clearly "symptomatic," but I have seen tense, irritable, but otherwise asymptomatic infants who relax and go to sleep after receiving glucose. Should these not also be called "symptomatic?"

Also, I cannot agree with Dr. Griffiths that, in the infant of the non-diabetic mother at least, symptomatic hypoglycaemia usually occurs after the first day of life, whereas asymptomatic hypoglycaemia is transient and confined to the first 24 hours. Of 34 infants with symptomatic hypoglycaemia seen in Winnipeg (infants of diabetic mothers excluded), 14 first developed symptoms when less than 24 hours of age whereas in six of seven asymptomatic infants, in whom blood