Body? We'll all do better by forgetting about it. We hold far stronger cards.

Surely our strongest claim to better pay, better terms and conditions of service, lies in the rapidly worsening recruitment figures—as it did and has just done so again for Service doctors. Dr. W. E. Dornan, the chairman of the Medical Practices Committee, quite recently told a meeting of the Sheffield Division that during the past year applicants for practice vacancies have fallen almost by half, some practices have had to be dispersed because suitable applicants were not forthcoming, and the total number of principals and assistants is likely to show a fall larger than the small fall in the previous year—all trends difficult to halt before 1970, all imperilling the satisfactory maintenance of general medical services. Yet perhaps not impossible to halt—hence the strength of our present claim. I believe this evidence will be available for the Review Body. At this stage it is pertinent to ask how any absolute rise in pay can be maintained in the context of rising population, inflating lists, and a static or wilting complement of general practitioners paid from a central Pool. Payments for increased work are going to swallow a large slice of any absolute increase, a tendency which would be greatly magnified by the coming birth bulge if we fail to have maternity services taken out of the central Pool.

There is a great deal to be said for submitting separate claims to the Review Body, as worried members of the G.M.S.C. must now be realizing. But there's little to be said for a claim which starts united then becomes sectional because of absolute disagreement.

As already stated, I do not believe the consultant committees can prudently or wisely make further concessions. Meanwhile, tempers at the general-practitioner periphery are beginning to boil, and the "full differential or nothing" school threatens to carry the day in March. Does unity then end and civil war on all fronts begin? Is the differential issue worth it? Shouldn't we all do much better without it—and keep our friends?—I am, etc.,

Dinnington, Nr. Sheffield. J. R. BATTY.

Basis of Unity

SIR,—Your editorial comments on professional unity (1 February, p. 253) were echoed at a recent meeting of general practitioners in North Middlesex. An amendment had been proposed to include the "differential" as part of the general practitioner's case to the Review Body, and representatives of our negotiating bodies argued against this. We were told in effect that the consultants agreed to support our claim only on condition that the differential was not cited, and we were urged to accept this in the cause of unity. We were told that the Review Body had intimated it would prefer to receive a case presented by the whole profession; this was quoted as a further inducement to unity.

The mood of the meeting was of bitter resentment that the nature and presentation of the general practitioners' claim should be dictated by any and every body except the general practitioners. It was felt that professional unity on these terms was utterly spurious and the amendment was accepted by a large majority.

For myself I had been very dubious about using the differential as a basis for our pay claim; but after listening to the arguments against it from the platform I changed my mind and voted for the amendment.

I was left hoping that our representatives would be more successful in presenting the general practitioners' case to the Review Body than they have been in presenting the C.C. and S. Committee's case to the general practitioners.—I am, etc.,

London N.9. D. J. SLOAN.

Parity and Unity

SIR,—The danger in the present situation is that both the Review Body and the Government may get the impression that the majority of general practitioners are satisfied with the disparity between their earnings and that of the consultants. By dangling an £18m. carrot before our tired, anxious eyes the consultants, through the B.M.A. Council, have blinded us to the reality. The memorandum of evidence may be a good expedient at the present juncture, but expediency has an unhappy way of recoiling on itself.

I am sure that the vast majority of general practitioners believe the gap between their remuneration and that of the consultants is too wide. The consultants have tried to cloud the issue by denigrating splinter groups, talking of envy and jealousy, unity of the profession, and so on, but their real opposition to the important resolution of the Representative Body at Oxford last year regarding the differential is based essentially on their sectional interests. Let us take care that we are not again misled, as we were in 1948, by the Royal Colleges.

Further, let us not be taken in by off-the-record talk of B.M.A. Council members that the differential question will somehow creep into the discussions with the Review Body, or that the Body reads the *B.M.J.* and is aware of the violence of opposition to the memorandum of evidence as now printed. All opposition will be blandly explained away as a minority opinion, and the impression will prevail that the mass of general practitioners thinks the differential just and proper. This in my opinion is just one leg of the basis of the opposition from consultant quarters to the inclusion of the differential in the memorandum of evidence.

In your editorial of 1 February (p. 253), leaving aside the charming semantic jugglery regarding the Oxford A.R.M. resolution, you say that the consultants have backed up the present claim "without putting forward any claim of their own." Nobody had been discussing consultants' pay, so presumably what has been omitted is the word "yet." An award to the general practitioners with the differential question seriously considered by the Review Body and accepted by the Government would hamper any such claim. This I venture to think is the second leg of the consultants' case for opposition.

On the key matter at the core of the present dispute the two sides of the profession are clearly divided. General practitioners have long been squeezed from above by consultants and from below by the welfare state. The consultants talk of their long years of training, but make no mention of the long hours of work of their colleagues in general practice. They hardly mention their six weeks' leave with pay, arrangements for sickness, their superior pension benefits, their merit awards, but try to fob us off with talk of Schedule D and Schedule E tax. They certainly have the glory and seem to have the power to sway opinion in the Council of the B.M.A., but now they are trying to ride rough-shod over the considered opinion of our representatives as expressed at the Oxford A.R.M.

The ultimate result of failure to implement that now famous resolution will be a further loss in status for the general practitioner, a dwindling in recruitment to our ranks, and a real threat to the general efficiency of the general medical service to the nation.—I am, etc.,

Carshalton, Surrey. J. SIMON.

SIR,—I have been in practice for over 30 years and I have reached the time of life when my views are likely to be those of the more staid members of the profession.

Nevertheless I and presumably many like me, to say nothing of our young and less settled colleagues, are very, very angry, resentful, and distrustful. We feel that our expressed wishes have been disregarded and that our claims, which are admitted to be just, have been deliberately watered down. We hope that this may be because our views are still not fully realized by the executive, but we are beginning to believe that it is because the policy of the Association is controlled by men who are willing to see the general practitioner become utterly subservient to his consultant colleague.

It is surely beyond all argument that the case to be presented to the Review Body has been seriously weakened, if not virtually destroyed, by the cuts which have been forced by the Central Consultants and Specialists Committee. The Chairman of Council has justified these cuts (*Supplement*, 25 January, p. 25) on the ground that the unity of the profession is paramount (though some of us hold that justice is as important), and the Chairman of the C.C. and S. Committee, whilst insisting on the cuts, quoted, "General practice is the basis on which the medical services are built and must continue to rest." (Memorandum of Evidence, para 6, *Supplement*, 25 January, p. 18.) Nevertheless, by the very act of forcing these cuts on the general practitioner they have utterly destroyed the unity of the profession, and have made an infinitely more dangerous split between the consultants and the general practitioners than would have occurred if the consultants had merely decided to take no part in the negotiations. In that case any ill-feeling would have been transient and soon dissipated.

Unless the executive realize the strength of the feelings that they have aroused, and unless the cuts are restored, the general practitioners will have no faith that their representatives are willing and able to see that they are not pushed aside by other interests.

If this is the case then surely there would be mass resignations from the B.M.A. by general practitioners and a transference of allegiance to the new association pledged to look after their interests, thus leaving the B.M.A. as the negotiating body for the consultants alone. This final split would indeed be tragic both for the B.M.A. and the profession. What would make it even more tragic is that I do not believe that

the ordinary consultant at the periphery would wish uncompromisingly and ruthlessly to safeguard his own very comfortable terms of service at the cost of deliberately weakening if not wrecking his colleagues' case. I suspect that this is a further example of the executive failing to appreciate the views of the periphery.

If we general practitioners allow ourselves to be so humiliated and browbeaten we shall deserve to lose our position as partners to the consultants (albeit senior and junior partners), and we shall strike general practice a blow from which it will take years to recover, if ever.

Time, Sir, is running short. Let us hope that our representatives at the Conference of Local Medical Committees, and at the Special Representative Meeting will have no part of this sorry business.—I am, etc.,

Salcombe, S. Devon. R. A. E. HAMMOND.

SIR,—The final paragraph of your leader "The Basis of Unity" (1 February, p. 253) is a classic example of bunkum. You have quite conveniently ignored the position of public health medical officers, who have been excluded from the negotiating unity of the profession by agreement between the B.M.A. and the Government.

General practitioners are at present being slowly manœuvred into the equivalent of a salaried service. One day a Minister of Health may slyly ask why they cannot emulate their dedicated colleagues in the public health service and accept the latter's princely salary scales, which have been approved by the B.M.A. and acquiesced in for so long by the rest of the profession.

The B.M.A. is right to chide a splinter group for sacrificing the principle of professional unity to gain themselves a temporary financial advantage. It is just a pity it did the same thing itself in the notorious "package deal."—I am, etc.,

Glasgow S.2. M. SILVER.

The Working Party

SIR,—It fills me with utter horror to read in to-day's *Journal* (22 February, *Supplement*, p. 52) that once again the general practice section of the National Health Service is to be submitted to a hurried whitewashing operation.

The proposed Working Party must not meet until all family doctors have been given ample time and opportunity to state their views both on the subjects for discussion and also on the selection of the profession's spokesmen, as many members have no faith in some of the people whose names have already been mentioned.—I am, etc.,

Doncaster, Yorks. W. E. MCPHILLIMY.

SIR,—You state in your leader (22 February, p. 447) that "hardly one of the writers has a good word to say about existing terms and conditions of service."

May I endeavour to correct this by suggesting that there are in fact among general practitioners many who are tolerably satisfied with things as they are and who find conditions of work both stimulating and satisfactory compared with pre-Health Service conditions; though not necessarily either financially rewarding or incapable of improvement.

But such people do not write you letters. They would like ancillary help, and they would like smaller lists; but these can be obtained by negotiation in the Joint Working Party, rather than joining in the welter of discontent which is at present gaining almost Gadarene momentum.—I am, etc.,

London S.W.14. J. H. S. HOPKINS.

Sterilizing Mechanical Ventilators

SIR,—It is now generally accepted that mechanical ventilators are a potential source of cross-infection. Since January 1960 all ventilators in this hospital have been sterilized with formaldehyde. Sterilization with ethylene oxide has been considered, but rejected on the grounds of expense, toxicity, and complexity. Two methods of sterilization have been used. In the first 100 ml. of formaldehyde *B.P.* is added to the water in the humidifier. A 2-litre reservoir bag is connected to the patient's Y-piece, and the circle is completed by connecting the expiratory port to the air inlet. (In the case of the Cape ventilator it is essential to include a large reservoir bag with air-inlet valve in this connecting circuit to prevent collapse of the positive- and negative-pressure bellows during the expiratory phase.) The humidifier and ventilator are then switched on for a period of four to eight hours. After sterilization, the tubing, humidifier, and water traps are washed out with tap water and air is pumped through the circuit for 8–24 hours or until there is no smell of formaldehyde.

The second method is used when bacterial contamination from the patient has been widespread. Formaldehyde is added to the humidifier as above, but the ventilator is then enclosed in a plastic bag. When the machine is switched on formaldehyde vapour is pumped into the bag and recirculated around and through the ventilator. After sterilization the bag is removed, all exposed surfaces are wiped with a cloth damped with dilute ammonia, and air is pumped through the machine until all traces of formaldehyde disappear.

This technique has now been used on over 130 occasions. Bacterial swabs have been consistently negative after sterilization, even when heavy contamination has been artificially induced. Apart from the long period required no disadvantages had been noted until recently. On this one occasion a ventilator was sterilized by the first method described above and checked after air had been pumped through for 24 hours. There was no smell of formaldehyde and the ventilator was returned to the theatre. On the next day the machine was used for the administration of an anaesthetic. Before use the gases issuing from the inspiratory tube were checked, but no formaldehyde was detected. The anaesthetic was concluded uneventfully. Two days later the machine was used on another patient, who was a known asthmatic. Severe bronchospasm occurred 25 minutes after institution of mechanical ventilation and only cleared after the injection of 0.5 g. of aminophylline. When the ventilator was removed at the conclusion of surgery a strong smell of formaldehyde was noted and traced to the gases still being pumped from the ventilator. This appeared to have been the cause of the bronchospasm. The patient was observed carefully but showed no after-effects.

The only explanation of the delayed release of formaldehyde was that a new bellows had been fitted some days before the event. This bellows was not obtained from the usual sources and subsequent testing has revealed that it is extremely difficult to get rid of the formaldehyde vapour after sterilization. In view of this happening it is recommended that care should be taken to smell the inspired mixture before connecting the ventilator to the patient. If the formaldehyde cannot be cleared in 24 hours, or the ventilator is required for use immediately after sterilization, the formaldehyde vapour can be neutralized by pumping ammonia vapour through the machine for a few minutes. This can then be rapidly cleared by flushing with air.—I am, etc.,

Department of Anaesthesia, Postgraduate Medical School, London W.12. M. K. SYKES.

Mental Retardation

SIR,—I suggest that the term submentia or submentality be substituted for amentia, which, as your correspondent (25 January, p. 243) states, is inaccurate. Major, medium, and minor or minimal submentia might then be applied to the various grades of mental defect, thus avoiding the unpleasant association which large usage has given to the words "idiot" and "imbecile," and the cumbersome and ungainly terminology of mental subnormality.—I am, etc.,

Area Laboratory, West Park Hospital, Epsom, Surrey. MYRA K. BEATTIE.

SIR,—May I add to the correspondence springing from Dr. John Gibson's letter (9 November, p. 1201)? He describes the terms "subnormality" and "severe subnormality" as "inaccurate, hideous, and revolting" . . . "descriptions of human beings." This sort of terminological witch-hunting is very common in psychiatry, but surely we have better outlets for our energies.

There is at present no field more full of promise than the treatment of mental deficiency, retardation, subnormality, or whatever you may call it. We cannot sweeten a concept by changing the word for it.[1] The true operational meaning of a term always shines through the verbal patina. A change in terminology is only briefly effective unless it is supported by changes in attitudes and practice. There is no need to worry about the mentally *subnormal* so long as they obtain the best treatments available for the mentally *retarded*. However I do agree that a classification incorporating three degrees of severity of mental *deficiency* is advisable.

Incidentally the terms A, B, and C suggested by Dr. G. Dutton (9 November, p. 1405) would soon acquire the socially non-acceptable implications of the older "feeble-minded," "imbecile," and "idiot."

We should define our terms carefully and publicize these definitions; the terms themselves are, I must insist, unimportant.—I am, etc.,

Ararat, Victoria, Australia. GERALD MILNER.

REFERENCE

1 Davidson, H. A., *Amer. J. Psychiat.*, 1953, **110**, 310.