already have a strong impression that cortical evoked potentials are much more susceptible to ischaemic change than the E.E.G. We are of the opinion that, with proper safeguards against the changes in evoked potential amplitude and form due to changes in conscious level, the evoked potential may be a valuable tool in differentiating between ischaemic and expanding lesions. Though not identical, the criteria for abnormality used by Dr. Bergström and his colleagues are generally similar to ours. In particular it is essential not to give significance to amplitude asymmetries in which the lesser potential is not less than 50% of the greater, as asymmetries of less than this are relatively common even in the control group.

An interesting observation was made in only three cases in our series (subdural haematoma, convexity meningioma, and intracerebral secondary deposit) in which the return of the somatosensory evoked potential to a greatly increased and abnormally high amplitude followed surgical removal of the lesion. The homologous potential remained unaltered and in two of the cases the abnormally large potentials gradually returned to a more normal amplitude over a period of about six weeks.

Details of these cases and the results of the study will be published in full when our analysis is complete.—We are, etc.,

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Advertising of Preregistration Posts

SIR,—May I, as a final year student to whom the matter is of some interest, make some comments about the advertising of preregistration house officer posts?

There is a great variety of information given; of the 15 advertisements for preregistration house surgeons (excluding locums) in a recent issue of the *B.M.J.*, only four stated whether married accommodation was available or not, two mentioned the number of beds concerned, two spoke of the activities of postgraduate centres, and only one stated the number of fellow house

surgeons, thus giving an indication of the duty rota. I believe points like these are of great importance to the would-be applicant. I would also suggest that an informative advertisement recommends both the hospital and the job to the potential candidate, just as a well-presented applicant will recommend him to his prospective employers.—I am, etc.,

CHARLES CAMPTAN-SMITH
Edinburgh

Displacement of a Pacemaker

SIR,—In January 1973 a man aged 64 came to see me complaining of jerking movements of the right leg which had started the day before. The jerking was rhythmical and consisted of clonic spasm of the adductor muscles of the right thigh. These contractions came at the rate of 70 per minute and were synchronous with the pulse and heart beat. Change of position affected the condition; when he lay down the contractions stopped; they started again when he sat up; leaning back stopped them; leaning forwards started them again. It was obvious that there was some abnormal stimulus of the obturator nerve (L2, 3, and 4) so an x-ray of the lumbar spine was done and this revealed the cause.

The patient had been to me a year before with a history of Stokes-Adams attacks, and an E.C.G. showed atrioventricular block with Wenckebach periods. He had gone to London, where a demand pacemaker had been fitted in December 1972 and this had functioned well till 29 January. The spasms started on the next day. The x-ray showed a long wire lying to the right side of the spine down as far as the body of L4. This was the pacemaker, which had become dislodged and was stimulating the obturator nerve roots at the rate of 70 per minute. The patient had to return to London to have the pacemaker, which had slipped down into the inferior vena cava, repositioned in the right ventricle.

I have never heard of a similar case, but it is possible that mishaps of this sort have occurred before.—I am, etc.,

S. C. BETTENCOURT-GOMES

St. Joseph's Mercy Hospital,
Georgetown, Guyana

Consultant Representation

SIR,—Mr. P. R. J. Vickers (1 February, p. 276) touches on a subject which is causing increasing anxiety in the profession. He is quite right to suspect that Council's third report on the constitution of the Association (28 December, p. 777) will do nothing to improve matters.

I wonder if he recalls that at the 1974 Annual Representative Meeting, contrary to the recommendation of the Chairman of the Central Committee for Hospital Medical Services, the Representative Body resolved: "that this Meeting would welcome the speedy introduction of local representation of consultants along similar lines to those existing in general practice" (20 July 1974, p. 207). The strength of general practitioner representation lies essentially in local medical committees which are elected

by and from all G.P.s in each N.H.S. area. These committees maintain G.P. representation on the district and area medical committees of the N.H.S. and directly elect their own representatives to the Annual Conference of Local Medical Committees, which defines broad outlines of policy for the General Medical Services Committee. The bulk of the G.M.S.C. is elected by local medical committees grouped on a regional basis for the purpose. Each local medical committee member has a vote.

Thus G.P.s enjoy a particularly democratic arrangement for their representation involving both distillation upwards and accountability downwards. If consultants endorsed similar arrangements they could more easily determine their local N.H.S. representation, their policy at and repre-

sentatives to an annual conference and their choice of the most suitable from among themselves to represent them on the C.C.H.M.S. The chief reason for the existence and relative success of the Hospital Consultants and Specialists Association would then disappear.—I am, etc.,

P. F. KIELTY
Representative, West Herts Division, B.M.A.
Harpenden, Herts

Time to See Patients

SIR,—In early March it will be the tenth anniversary of the "Charter for the Family Doctor Service." It is interesting to have another look at this document to see some of the things which our leaders at that time considered so necessary for the revival and continued prosperity of family medicine.

The first essential laid down was that there should be adequate time for a doctor to deal with each patient. This was to be achieved by the gradual reduction of average list size to between 1500 and 2000 patients without financial loss to the doctors. It was considered also, those 10 years ago, that in order to make general practice financially attractive a capitation fee of £1.80 was necessary. Ten years later we have barely achieved this figure, which at today's value would be about £4, and made no progress whatsoever towards reduction in list size. In fact, as all of us in general practice well know, as the years have gone by the pressure of public demand has increased. It is, indeed, a sad reflection on the success of our leadership that so little has been achieved in 10 years on these two vital matters.

It is therefore most interesting that probably the most important effect of the consultants' work-to-contract has been to restore to many of those worthy people a sense of professional dignity. For the first time for many years (and probably, for some of them, for the first time ever) they have been able to carry out the job for which they have trained in a proper way with adequate time to deal with their patients and free from the pressure of numbers. They have discovered the reality of leisure time and relaxation. Some of them have told me personally that whatever happens they will not allow themselves to return to the pressures to which they were previously subjected.

I earnestly hope that this dramatic lesson will not be lost upon family doctors and their leaders. There is no earthly reason why we also should not insist that we should be able to carry out our professional work in a peaceful and dignified manner. If the tide of public demand cannot be stemmed, and no Government appears willing to try to stem it, then the profession must stand united and make it crystal clear to the Government that consultants and family doctors cannot and will not continue to work under these pressures and that the only solution is the provision of far more finance, so that many more doctors can be persuaded not to emigrate, hospitals be fully staffed, and list sizes drastically reduced.—I am, etc.,

J. M. LONDON
Redditch