proximal jejunum to absorb glucose. The trapping of available carbohydrate within intact cell walls and alterations of the physical characteristics of the intraluminal contents by unabsorbable carbohydrates may both result in reduced availability of glucose for absorption in the proximal small bowel while increasing its availability in the distal small bowel. The adaptation of the proximal jejunum may then be reversed, resulting in a flatter glucose tolerance curve.

It is possible that some diabetic patients might benefit from treatment with wheat bran or other dietary fibres and unavailable carbohydrates.

ANTHONY LEEDS
M A GASSULL
D J A JENKINS
K G M M ALBERTI

MRC Gastroenterology Unit,
Central Middlesex Hospital,
London NW10

University Chemical Pathology and
Human Metabolism Unit,
Southampton General Hospital,
Southampton

¹ Jeffreys, D B, *Proceedings of the Nutrition Society*, 1974, **33**, 11A.

² Leeds, A R, *et al*, *Lancet*, 1975, **2**, 1213.

³ Van der Westhuizen, J, Mbizuo, M, and Jones, J J, *Lancet*, 1972, **2**, 719.

⁴ Wapnick, S, *et al*, *Lancet*, 1972, **2**, 300.

Student counselling

SIR,—Your leading article (13 March, p 605) is timely. It does not, however, adequately emphasise weaknesses in the present situation in Britain nor point to the future. What is the prevalence of student problems? How should they be managed? How might they be diminished or prevented?

A review of prevalence studies¹ suggests that, over all faculties, 1-5% of students suffer from serious personality problems or psychiatric disability and a further 10-20% from a miscellany of difficulties: minor psychiatric disturbance, problems with living, study difficulties,² psychosocial and psychosexual problems,³ psychosomatic disturbances. This minor morbidity can lead to considerable personal unhappiness, and, more relevant, is eminently treatable. Management involves counselling techniques⁴ as well as other forms of treatment not mentioned in your article, principally psychotherapy, both psychodynamic⁵ and behavioural.⁶ All three forms of treatment should be available and crucially, as you mention, there should be close harmony with the academic tutorial system. From experiences⁷ I have no doubt that liaison between these helping services is far more effective than either academic or psychological guidance alone. These treatment techniques are as yet available only to a small—it is not accurately known how small—percentage of students in higher education, in both the university and non-university sectors. Medical schools in London are conspicuous for their backwardness in introducing any comprehensive helping service relevant to students other than formal psychiatric treatment, including psychotherapy, provided by psychiatrists.

With current emphasis rightly on preventive medicine, other related measures should be considered which might lessen the burden on counsellors and others. With sexual and relationship problems so important in the student age group, sex education⁸ is surely high on the list of priorities, especially for medical

students, who should, as doctors, be in a position to pass on their expertise to their patients. Comprehensive sex education needs the co-operation of persons with special areas of expertise—atomy, physiology, sociology, psychology, psychiatry, gynaecology—but this has been achieved elsewhere as, for example, in Denmark.⁹ As with counselling, so with sex education, London medical schools keep their heads firmly in the sand so that those, like me, with a special interest in this area of medical education may be offered two one-hour periods in a behavioural science course to teach human sexuality. Given these constraints, one is either arguing with the sexually experienced student or frightening the inexperienced.

The time has come to make a positive contribution to the personal fulfilment of students. Counselling, psychotherapy, behavioural modification, co-ordination with academic tutors, and sex education represent a systematic attempt to reduce the incidence of new problems or, where prevention fails, to provide a more effective and co-ordinated programme of management.

SIDNEY CROWN

The London Hospital,
London E1

¹ Lucas, C J, and Crown, S, *British Journal of Psychiatry*, 1974, **125**, 595.

² Crown, S, Lucas, C J, and Supramaniam, S, *British Journal of Psychiatry*, 1973, **123**, 381.

³ Cauthery, P, in *Psychosexual Problems: Psychotherapy, Counselling and Behavioural Modification*, ed S Crown, p 157. London, Academic Press. In press.

⁴ Newsome, A, in *Psychosexual Problems: Psychotherapy, Counselling and Behavioural Modification*, ed S Crown, p 59. London, Academic Press. In press.

⁵ Crown, S, in *Issues and Approaches in the Psychological Therapies*, ed D Bannister, p 187. London, Wiley, 1975.

⁶ Meyer, V, and Liddell, A, in *Issues and Approaches in the Psychological Therapies*, ed D Bannister, p 223. London, Wiley, 1975.

⁷ Crown, S, *University Quarterly*, 1970, **24**, 422.

⁸ Cole, M, in *Psychosexual Problems: Psychotherapy, Counselling and Behavioural Modification*, ed S Crown, p 433. London, Academic Press. In press.

⁹ Bechmann, J, *et al*, *British Journal of Medical Education*, 1975, **9**, 114.

Assessment of preoperative cases

SIR,—Dr P R Fletcher's letter (6 March, p 580) commenting on Dr T W Ogg's article (10 January, p 82) stimulated me to survey 230 outpatient cases I had anaesthetised using a questionnaire similar to that used by Dr Ogg. The series included 133 dental and 97 genitourinary cases. The dental cases were evenly distributed in regard to sex but in the genitourinary series 61.8% were males. The age distribution was as follows.

Age (years)	No of patients		Total
	Dental	Genitourinary	
2-16	67	0	67
17-45	59	43	102
46-65	6	35	41
66-83	1	19	20

Of the 169 patients aged 2-45, 10.1% had medical histories and 31.3% were on concurrent drug therapy. The corresponding proportions of the 61 patients aged 46-83 were 19.6% and 32.6% respectively. Of the patients aged 2-45, 4.7% gave a history of allergy, and of those aged 46-83, 6.5% gave a similar history. No patient under 17 admitted to smoking, but 33.3% of those aged 17-45 and 45.9% of those aged 46-83 did so.

Anaesthesia was postponed in no case in the series, but consideration was given to one girl aged 17 weighing 15.5 kg who presented

for exodontia cyanosed and with marked finger-clubbing. She was not dyspnoeic, however, and perusal of her questionnaire revealed a history of chronic cystic fibrosis and that she was on ampicillin.

The questionnaire appeared to be a useful screen in all age groups, but undoubtedly the institution of preoperative clinics would be the ideal.

W N ROLLASON

University Medical Buildings,
Aberdeen

Spasmolytics for postoperative bowel contractions

SIR,—In the search for a suitable spasmolytic agent to antagonise neostigmine-induced bowel contractions (Drs E N S Fry and S Deshpande, 13 March, p 646) hyoscine butylbromide was likely to prove disappointing. Most workers have found its nicotinic to predominate over its muscarinic actions in keeping with its quaternary ammonium structure so that it is a poor antagonist of the local accumulation of acetylcholine.

Alternatives might include another anticholinergic drug, propantheline bromide, with strong selective muscarinic properties in addition to its nicotinic effects. Herxheimer¹ reported a spasmolytic potency of 3-75 in comparison with atropine, while the antisialogogue potency was 0.76 and the heart acceleration potency was 0.70. As with hyoscine butylbromide, however, duration of action was brief.² Among those spasmolytics acting directly, papaverine may have a place as it is reported to have 50 times the potency of hyoscine butylbromide in inhibiting barium chloride spasms.³ Mebeverine in turn was found to be more potent than papaverine by Lindner,⁴ and Connell⁵ was able to demonstrate a decrease in colonic muscle motility lasting 10-35 minutes in man after 50 mg given intravenously.

While searching for the ideal spasmolytic for use in conjunction with neostigmine one would like to have some more information to what extent ruptured intestinal anastomoses are a problem in association with neostigmine, bearing in mind that all the subjects in Bell's study⁶ had had steroid therapy and that anastomotic leakage was demonstrated radiologically with barium, not clinically.

J W H WATT

Department of Anaesthesia,
Walton Hospital,
Liverpool

¹ Herxheimer, A, *British Journal of Pharmacology*, 1958, **13**, 184.

² Barowsky, H, *et al*, *American Journal of Digestive Diseases*, 1965, **10**, 506.

³ Wick, H, *Archiv für experimentelle Pathologie und Pharmakologie*, 1951, **213**, 485.

⁴ Lindner, A, *et al*, *Archives Internationales de Pharmacodynamie et de Thérapie*, 1963, **145**, 378.

⁵ Connell, A M, *British Medical Journal*, 1965, **2**, 848.

⁶ Bell, C M A, and Lewis, C B, *British Medical Journal*, 1968, **3**, 587.

High intestinal lactase in Pakistanis

SIR,—Though I have no means of questioning the technical validity of the paper by Drs S M Rab and A Baseer (21 February, p 436), I would like to make the following comments on their ethnic conclusions.

(1) Punjabis, though depicted as a Mediterranean race, are actually a product of the

original Indian inhabitants and the various invading Mongolian armies. (2) Both Pashtun and Baluch are Aryan or have Aryan roots and thus have more common links with Iranian stock.¹ (3) The Pashtun in the Jinnah sample are not representative, as obviously they were taken from the million or so people working in the factories of Karachi. If one has to validate the argument a survey at Peshawar or Jalalabad would be more realistic.

G Y ZAKARIA

London SE9

¹ Caroe, O, *The Pathans (550 BC-AD 1957)*. London, Macmillan, 1964.

Cervical diameter after suction termination of pregnancy

SIR,—In their study of cervical diameters following suction termination of pregnancy Mr F D Johnstone and his colleagues (10 January, p 68) observed that dilatation of the cervix beyond 10 mm at the time of suction termination of pregnancy results in a greater frequency of abnormally high cervical diameters when measured subsequently. As pointed out by the authors, measurement of cervical dilatation has limitations, particularly as cervical incompetence is likely to be a disorder of function rather than anatomy. However, their results support previously reported¹ findings that "something happens" when cervixes are dilated beyond 9-11 mm in the pregnant and non-pregnant state.

In a series of in-vivo and in-vitro studies of 38 cervixes dilatation was achieved with a cone-shaped dilator under standard conditions and the applied forces recorded. Sudden loss of resistance occurred on over 50% of occasions when dilatation exceeded 11 mm diameter. A similar loss of resistance during the course of clinical cervical dilatation is frequently experienced by many gynaecologists and may represent the yielding or rupture of tissue. By the use of mechanical longitudinal vibration it was possible to achieve greater cervical dilatation at lower values of applied force.

More work will be necessary to determine the clinical importance of these findings, but the frequency with which damage to cervical tissue seems to occur at dilatations over 11 mm is disturbing. In order to reduce the morbidity of dilatation and curettage it is likely that more efficient methods of dilating the cervix will need to be developed. The use of vibration may prove to be one such method. Meanwhile we would advocate the wider use of Vabra curettage for endometrial biopsy and support the recommendation of Mr Johnstone and his colleagues that dilatation of the cervix should whenever possible not exceed 10 mm.

MARTIN M BLACK

Department of Medical Physics,
University of Sheffield

BRIAN ALDERMAN

Department of Obstetrics and Gynaecology,
University of Liverpool

¹ Black, M M, *et al*, in *Clinics in Obstetrics and Gynaecology*, ed J M Beazley, vol 2, no 1. London, Saunders, 1975.

GMC election

SIR,—Along with my fully registered medically qualified colleagues I have recently received a ballot paper from the General Medical

Council for the purpose of electing eight members to the Council. The ballot paper gives virtually no useful information to voters. For readers of the *BMJ*, some information on the eight BMA-sponsored candidates is available. This leaves a considerable number of candidates who remain just short of anonymous, although standing for election to one of the profession's most powerful controlling bodies.

As I feel sure that many electors must find this unsatisfactory, I propose that in future years the GMC invite all candidates to make a statement about themselves indicating not only their medical achievements but also the sort of policies they would advocate if they were elected to the GMC. In addition, they should have to declare their membership of any political party or organisation (Conservative, Labour, Liberal, Communist, Fascist, etc) or similar body now that medicine is no longer free from much political interference; failure to make such a declaration or the making of an incorrect one should result in their candidature being invalid.

Is there any support for my proposal?

GERALD WISEMAN

Department of Physiology,
University of Sheffield

Cover out of hours

SIR,—With reference to the last paragraph of your excellent leading article on this subject (27 March, p 732), I have long maintained that the educational value of the extensive and concentrated experience to be gained by working for a deputising or emergency service should, not would, be enhanced by involving all those involved in training for the general practice of today in the day-to-day operation of these services.

All concerned, be they trainers, trainees, course organisers, lecturers, service operators, or—not least—patients would benefit in both the short and the long term.

M DALES

Leeds

Improving the hospital service?

SIR,—Few would dispute Dr J F Murray's thesis (28 February, p 507) that there is room for improvement in hospital management structure. It is regrettable, therefore, that his arguments are vague and that he gives insufficient evidence to justify his conclusions.

It is asserted that a Dutch hospital "managed its own affairs with 19 people" compared with a British hospital which "employed 49." There is no attempt to define what staff are included in this comparison.

Secondly, Dr Murray writes that "all Dutch nurses are trained to the level of a British SRN." Is it implied that this is desirable? If so, how is the use of highly skilled professional staff to carry out semi-skilled tasks justified?

The accompanying organisation charts are so misleading as to cast doubt on the author's objectivity. The Dutch chart includes seven boxes compared with 11 in the British model. However, the latter includes both the district management team and a "district team of officers," "public health," "general practitioners," and "joint consultative committee." Without these four invalid items the number is seven, as in Holland.

In view of such nebulous argument it is difficult to learn anything of value from the article. This is especially regrettable at this moment, when constructive criticism of the management of hospitals would be welcomed by the majority of administrators.

PETER A HILL

Southampton

Distinction awards

SIR,—Dr L C Hurst (13 March, p 652), commenting on our recent paper (28 February, p 536), mentions important issues which were examined in our previous paper (18 January 1975, p 162). Briefly, the impossibility of arranging 12 000 consultants in an agreed ranking order forces committee members into the dubious compromises of a quota system, prejudged for different sectors, officially disclaimed but amply confirmed by information from several sources. We think that it is impossible to have a discretionary system of awards that is fair, but that the present system is worse than necessary.

Policy statements do not appear to tally with the facts; official figures are scanty, fragmented, and buried. Committees are overloaded with certain specialties and the dependence on award-holders for this work must lead to bias and error from many factors. (It must be a matter of interest to all 12 000 consultants to ask how many minutes of the top committee's time was available for each of the 794 awards they allocated in 1974.) Of course talent is unequally distributed, but the distribution of new awards seems not so much the result of recognising new talent but rather the conservation of prejudged quotas. The Awards Committee invited three times as many nominations for C awards from London teaching hospitals in 1973 as for non-teaching hospital consultants (per head).

It is officially claimed that serious errors are rare and will be corrected when ascertained. As a test case the situation at the Tavistock Clinic seems incompatible with that contention. Dr Hurst writes, "the Tavistock Clinic does not appear to have its fair share of distinction awards and on the face of it this would appear to be unreasonable." Over two years we gave the Awards Committee a great deal of information. As a measure of the clinic's standing, 11 London consultants (two of them at teaching hospitals) applied for a recent vacancy here. Nevertheless the awards allocated, twice revised, rest well below the national average, under half the average for teaching hospitals, and close to that for all psychiatrists.

Our indictment has raised no word in defence or reply, although publicised in *The Times*, the *Sunday Times*, and the local press. The secrecy over the system contrasts with the ready display of peerages and prestigious appointments. Secrecy is supported mainly by those consultants who benefit from the system but opposed by those without awards (CCHMS figures). This suggests what most consultants think about the way awards are distributed. We think the system should be scrapped; it degrades the profession.

S BOURNE
P BRUGGEN

Tavistock Clinic,
London NW3