develop ways in which health and safety performance can be improved.

The HMSO's sectional list 18 (Health and Safety Executive forms and publications) lists many publications, parts of which are now applicable to hospitals and associated areas. Sectional list 18 (Department of Health and Social Security) enumerates many codes, etc. Publications listed under "Health Technical Memoranda" relate to antistatic precautions (rubber, plastics flooring in anaesthetic areas), electrical services, piped gases, and other items, while under "Hospital Technical Memoranda" is the safety code for electromedical apparatus. The electrical safety code for hospital laboratory equipment comes under "Hospitals, Building and Equipment." Other codes and handbooks cover ionising radiations, radioactive isotopes, and radiological protection. All are available from HMSO.

A publication which I have found most helpful is the *Safety Manual* of the University of Manchester Institute of Science and Technology.[1] This excellent work was compiled on behalf of the Safety and Environmental Health Committee, and 78 subjects are covered. These include laboratories—pathological, chemical, and animal; chemical hazards and gases; gas cylinders; explosions; electrical safety; glassware; hand tools; lasers; lifts and lifting; fire prevention and first aid; wastes, water supplies, and welfare; autoclaves; car parks; and other areas. There is a wealth of reference material available at the end of each chapter, and codes of practice, British Standards recommendations, DHSS handbooks, Department of Employment circulars, HMSO publications, and statutory instruments and regulations relating to the subject are listed. Such a work is a fine example of how health authorities could compile a similar manual for use in our hospitals.

I would also recommend to health authorities and safety committees the magazine which was first published in September 1978: *Health and Safety at Work*, edited by David Farmer. It has become one of the leading journals in this subject. Also useful are the TUC's handbook[2] and *A Worker's Educational Manual: Accident Prevention*.[3]

Gone are the days when any health authority could "sit comfortably" in the face of the many hazards possible in our hospitals. I hope I have managed to identify much of the literature available. The National Health Service employs one million workers of all grades in all sorts of working areas. Dr Boucher's article has identified in detail many risk areas. I await with interest the reports of the inspections now legally possible by recognised trade union safety representatives.

GWEN M PRENTICE

London SE28 8LB

[1] *Safety Manual*, UMIST (PO Box 88, Manchester M60 1QD).
[2] *Safety and Health at Work*. London, Trades Union Congress (Great Russell Street, London WC1B 3LS), 1976.
[3] *A Worker's Education Manual: Accident Prevention*. Geneva, International Labour Organisation, 1978.

Service commitment and the training of surgeons

SIR,—There has been a misleading and arbitrary separation of parts of the training of young consultants in so far as a major part of their work is described disparagingly as "service commitment."

In the training of surgeons it is absolutely essential that the trainee actually operates, preferably under supervision for most of the time, and carries out not only a large variety of operations—operations in fact that he has to deal with when consultant level is reached—but also such a number as will cover the various permutations and combinations that can arise and the difficult problems involved in operating for the third or fourth time in such conditions as Crohn's disease, etc.

Far and away the most suitable place for such training is in a busy, thinly staffed district general hospital. Regional consultants attending selection committees may make a point of looking for evidence of such experience among the candidates. There is no point whatsoever in appointing a young surgeon who has had no practical experience as it virtually means that one or more of the acting surgical staff are compelled to do his possible share of the difficult surgery. There is no room in a busy district hospital for a young man who has spent most of his time joining in the training of undergraduates and carrying out theoretical research with the exclusion of practical work. It should be clearly laid down as part of the college advice that doctors seeking surgical consultantship should be obliged to carry out under supervision a large comprehensive list of operations and to be employed by a hospital where this work can be carried out. From the pragmatic point of view the sequestration of young doctors in the undergraduate hospitals where they are described as "senior registrars" is a loss of valuable time—unless, of course, the would-be consultant hopes to stay on at a teaching hospital to carry out research work and teaching.

Let us hope that the criticism of "service commitment" is dropped, and let us insist that practical training is regarded as the sine qua non for the maturation of would-be surgeons. It is far better for young doctors to be apprenticed to busy surgeons for a few years than to chase around from specialty to specialty obtaining fragments of information, mostly of a theoretical nature, by watching and not performing. Surely if effective, practical surgeons are needed practical training is mandatory.

JOHN J SHIPMAN
KEITH W GILES
ROGER H ARMOUR

Lister Hospital,
Stevenage, Herts SG1 4AB

College of Anaesthetists?

SIR,—Dr R S Atkinson and others question the need for an independent college of anaesthetists and express their satisfaction with the present arrangement (3 March, p 624). There are, however, many who do not share their complacency.

They state that "the Faculty acts as an independent body in all important respects." We would question this view. Its board has, as ex-officio members, the president and both vice-presidents of the college, who are eligible to vote on all matters including the election of the dean and vice-dean. The board—and hence the Faculty—is represented on the 30-strong college council by three members. There is no financial independence and subscriptions and examination fees are kept in line with those of the surgical and dental fellows. The fellowship examination is held in the examination halls, which are partly owned by the college, and the examination therefore incurs the high costs of supporting that building. Can this be said to be independence? It is abundantly clear that the academic body for anaesthesia can never have true independence until it is separated from the Royal College of Surgeons.

Dr Atkinson goes on to make a number of points about accommodation and subscriptions which illustrate the comfortable view that anaesthetists are better off firmly tucked under the surgeons' wing, hitching their wagon to a surgical star and basking in the prestigiousness of their splendid building—the Royal College of *Surgeons*. But is such an arrangement really in the interests of the future development of anaesthesia? We submit that it is not.

Anaesthesia is the largest single specialty in the United Kingdom. It is also the only major medical specialty not to be led by its own college. To allow this state of affairs to continue is to accept a subordinate status in both national and international affairs. We believe that an independent college of anaesthetists is an important evolutionary step in the development of the specialty and urge the Association of Anaesthetists and the Board of Faculty of Anaesthetists to unite in working for its establishment.

P J F BASKETT
D F COCHRANE
A W DIAMOND
M B DOBSON
R GREENBAUM
D F JONES
T M O'CARROLL
R M WELLER
D G WILKINS
S M WILLATTS
J S M ZORAB

Department of Anaesthesia,
Frenchay Hospital,
Bristol BS16 1LE

Clinical medical officers in a child health service

SIR,—I crave the hospitality of your columns in order to refute a serious error of fact in Professor Donald Court's letter (3 March, p 611).

In this letter Professor Court refers to "the rapid demise of the Society of Community Medicine." May I please inform him that the Society of Community Medicine is very much alive and kicking. In fact, last week (on 23 March) I chaired a meeting of its council which began at 11 am and did not finish until 5 pm—most of the items discussed relating to the projected future of the society. Furthermore, the society has a large current membership, is financially soundly based, and continues to publish its journal *Public Health*, which has a world-wide distribution.

J H WHITTLES
President, Society of Community Medicine

London W1N 4DE

Pay-beds and the NHS

SIR,—In the face of continuing erosion of private practice in NHS hospitals, we should like to raise some points which we feel have not received sufficient public discussion.

Three of us are in clinical academic work, and the fourth is a full-time NHS consultant. As such, we receive no personal financial reward from work done for private patients in our teaching hospital. Fees charged for investigations on such patients are paid into research funds. In our own department there are technical staff paid or about to be paid from these funds, and some of the diagnostic work for

NHS patients is necessarily done by these members of our staff, partly because of special skills related to their research and partly because of a severe shortage of technical posts on the NHS side; in spite of an ever-increasing NHS work load, one of our technical posts is currently "frozen" for lack of funds. If the funds derived from private patients in our hospital were to disappear, there would be further unemployment and we should be unable to offer the service now available to both NHS and private patients. In short, everyone would suffer.

A second point, which we have been discussing for many years, long before the issue of reduction of pay-beds was raised, is the benefit to all concerned in having consultant staff working in one place—the principle of "geographic full time." The more the private patients can be brought into the NHS hospitals, the better the service to the NHS patients; the legitimate absence of NHS colleagues at other, private hospitals is an excellent way to ensure an inferior service for the NHS. The total loss of our highly esteemed NHS colleagues to the private sector outside our own hospital we should regard at the very least as a serious misfortune. Is it not time that the issue of pay-beds was publicly discussed in practical terms rather than politics, and that the welfare of both private and NHS patients was considered?

ISOBEL P BESWICK
J E MCLAUGHLIN
P J SCHEUER
G B D SCOTT

Department of Histopathology,
Royal Free Hospital School
of Medicine,
London NW3 2QG

Points

Anaesthetic deaths

Dr R W D NICKALLS (Department of Anaesthetics, University Hospital of Wales, Cardiff) writes: Your leading article on anaesthetic deaths (17 March, p 703) indicated that the risk of death associated with anaesthetic mishap during caesarean section was "about 1 in 3000." I would like to suggest that during the period 1970-2, the risk was nearer 1 in 5300. The last published report of the confidential inquiries into maternal deaths[1] found that, of the 111 deaths associated with caesarean section, only 20 were associated with complications of anaesthesia, and the report estimates that 106 391 such operations were performed in this three-year period. . . .

[1] Arthure, H, *et al*, *Report on Confidential Enquiries into Maternal Deaths in England and Wales, 1970-72*. London, HMSO, 1975.

Shortening hospital stay for psychiatric care

Dr ERNEST H BENNIE (Leverndale Hospital, Glasgow) writes: Professor S R Hirsch and others reported (17 February, p 442) that brief hospitalisation for psychiatric illness had certain merits. In this connection it may be worth noting that it has been claimed[1] that long-acting tranquillisers, which were developed for maintenance treatment of psychoses, may have a role in the management of acute illness and that the use of these drugs results in a superior treatment response. The advantages of prescribing a long-acting tranquilliser are that the patient has for certain been given his medication, frequent injections are avoided, rapid onset of therapeutic action is usual, and the transition to maintenance treatment is simplified. . . . Cis-clopenthixol decanoate (Clopixol) recently became available and, as this drug was claimed to have strong calming and sedative properties in addition to its antipsychotic action and to be indicated in the management of the aggressive and disruptive psychotic patient, it was decided to extend the range of acute psychosis to be treated with long-acting tranquillisers. . . . To date it is possible to report that in some instances successful control of symptoms has been quickly achieved with cis-clopenthixol decanoate and a clinical trial is being designed to evaluate this treatment in a proper manner. . . .

[1] Chien, C P, and Cole, J O, *American Journal of Psychiatry*, 1973, **130**, 13.

Epilepsy and learning

Dr RUTH HARRIS (Maudsley Hospital, London SE5) writes: . . . In your leading article "Epilepsy and learning" (3 March, p 576) an association is suggested between certain common behavioural problems and their distribution between the sexes with a very particular EEG finding (a persistent left temporal spike discharge). The reference to Nuffield's work[1] is also a little unfortunate as an attempt to replicate his study 15 years later in the same hospital proved to be impossible.[2] Refinement of EEG technology and practice over the years meant that the EEGs of 946 children (not 46 as printed) containing spike discharges could not be classified in the simple way described by Nuffield. . . .

[1] Nuffield, E A J, *Journal of Mental Science*, 1961, **107**, 438.
[2] Kaufman, K R, Harris, R, and Shaffer, D, *Electroencephalography and Clinical Neurophysiology*, 1977, **43**, 288.

Brain failure in private and public life

Dr P J M DAVIS (Warwick Hospital, Warwick) writes: . . . Dr William Gooddy's warnings on brain failure (3 March, p 591) are clear. I report here a simple piece of work that may be relevant.[1] Our brains do not begin to lose substance until the age of 55-60 years. Thereafter some decrease in volume appears inevitable. This has been shown by measuring accurately the ratio between brain volume and the cranial cavity volume. In apparently mentally normal young adults who died of diseases not directly involving the nervous system $92{\cdot}2\% \pm 1{\cdot}6\%$ of their skulls were filled with brain. After the age of 55-60 the proportion begins to fall, reaching an average of 85% by the age of 80. . . . Perhaps we should concentrate on using our supply of cerebral tissue to the maximum before our 60th year so that we may have a greater reserve before decay sets in. . . .

[1] Davis, P J M, and Wright, E A, *Neuropathology and Applied Neurobiology*, 1977, **3**, 341.

Immersion injury and frostbite

Dr PETER MCDONALD (Basingstoke, Hants) writes: I was interested to read Paul Marcus's letter on "immersion" injury (3 March, p 622) and am in agreement with everything he states. I would, however, like to point out that frostbite and immersion injury, being at different points along the same pathological continuum, often occur together. If a man gets frostbite of his toes in response to cold stress it is more than likely that the syndrome of "immersion" injury will be present more proximally, where the greater blood supply modifies the injury—as was made apparent to me when I was in the Himalayas on a climbing expedition. . . . It is therefore reasonable to warn a frostbitten individual that he may experience symptoms in his limbs long after the initial injury has healed. . . .

Osteoarthritis

Mr RODNEY SWEETNAM (Middlesex Hospital, London W1N 8AA) writes: I was disappointed to see the leading article "Crystals and arthritis" (10 March, p 642) refer to a joint as osteoarthrotic. . . . The words osteoarthritis and osteoarthritic are generally understood and established by common usage over very many years. Why change now? To argue that the suffix "itis" is unjustified because there is no inflammatory component is surely nonsense; indeed you refer to inflammatory episodes in osteoarthrotic joints. . . .

Euthanasia

Dr M J PLEYDELL (Oxford) writes: . . . Though I do not wish to detract in any way from Canon Eric James's review (3 March, p 606), the fact remains that Arthur Clough's famous words "Thou shalt not kill; but needst not strive/Officiously to keep alive" are quoted and requoted completely out of context—especially by doctors of medicine. The poem was written as a mocking parody and satire of the Ten Commandments. How Clough would have laughed if he had been present to read its solemn interpretation in the present century.

Some new titles

Professor I FRIEDMAN (Northwick Park Hospital, Harrow) writes: I was amused to read on your page "Some new titles" (17 March, p 744) a book on speech pathology listed under "Pathology."

ABC of Ophthalmology

Dr EDWARD GLUCKSMAN (London SW4) writes: I find Dr P A Gardiner's series on ophthalmology very useful. In his article on "Evaluating common signs and symptoms" (10 February, p 389) he discusses the problem of grittiness. Since he includes systemic disorders in his discussion of the significance of various eye complaints, I would have liked to have seen hypercalcaemia listed as a cause of grittiness. . . . He reports that this symptom is more common in women than in men (as is hyperparathyroidism) and also that it is a complaint commonly of middle age, when other systemic and often more sinister causes of hypercalcaemia, such as metastatic malignancy, should be considered. Although I do not know the proportion of patients who complain of grittiness and who have raised calcium concentrations, the possible association should be kept in mind.