permitted left-heart catheterization with a catheter of the same calibre as that introduced at the femoral artery. Perhaps Drs. Ikram and Nixon could give more information on this point, and also as to whether the catheters were of a bore sufficient for adequate angiocardiography.

In our series the catheter used has (almost invariably) been the grey Kifa-Odman (O.D. =2.8 mm.: I.D.=1.8 mm.). A smaller bore catheter is not adequate in our hands for the performance of left angiocardiography in the adult.—I am, etc.,

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REFERENCES

1 Grainger, R. G., *Brit. J. Radiol.*, 1964, in press.
2 Lang, E. K., *Radiology*, 1963, **81**, 257.

Future Management of Infectious Diseases

SIR,—The paper by Dr. A. M. Ramsay and his colleagues (17 October, p. 1004) will, I hope, stimulate some interest in the future of this specialty. The publication too was well timed, since all over the country staffing establishments are now being considered in the light of the Platt and Wright Committee Reports, and at the same time regional boards are planning the building of new hospitals.

With the decline in incidence of the well-known infectious diseases, many of the smaller infectious diseases hospitals have had to close. The larger infectious diseases hospitals have already in many cases been changed to multipurpose hospitals, including units for chronic chest diseases, neurology, gynaecology, etc., but, so far as I know, none has yet been redesignated as a general hospital. In any case they are nearly all very old and laid out on the old idea of separate pavilions. Hospitals with wards in separate buildings must be expensive to run because of the consequent increased demands for nursing and domestic staff, higher cost of heating, and, not least, being uncomfortable for the patients whenever they have to be taken to other departments in the hospital with perhaps exposure to inclement weather. There is no reason why our new hospitals should not include infectious diseases units. If such a unit must be contained in a separate building, as suggested by Ramsay and his colleagues, then I would expect it to be linked to the main building and/or other buildings by a corridor. I should emphasize, however, that we must destroy the misconception that infectious diseases should all be regarded as highly infectious and segregated in separate buildings. Smallpox, being the exception, of course, will continue to enjoy the distinction of having separate accommodation on a regional basis. In the designs for our new hospitals, where a proportion of single-bed cubicles is allocated to each unit, it might be hoped by some that chance infections might be contained in each unit as they occur. Whilst this might suffice for the occasional case of infectious disease or surgical sepsis, there will be occasions when more isolation accommodation will be necessary, and this should be available in the infectious diseases unit of the same general hospital. Reserve accommodation, however, for epidemics should be reserved in the older hospitals to be opened up and expanded when necessary. It is important too that the active infectious diseases units be attached to general hospitals in order that the medical and nursing staffs of such units may maintain contact with their colleagues in other specialties, sharing their knowledge and experience. Not least, all units, including the infectious diseases unit, should have ready access to an intensive care unit, which will naturally be centred in the general hospital.

It is not always fully appreciated that the practice of infectious diseases demands a wide knowledge of medicine, including paediatrics. After all, the age groups of those admitted to infectious diseases units vary from the very young to the very old. In spite of the decline in incidence of the notifiable diseases, many infectious diseases units to-day have a greater average annual turnover than existed in the first half of this century. I have consulted the old annual reports of this hospital and there was a wide variation in total numbers admitted due to the periodicity of epidemics—e.g., one year only 400 patients were dealt with and another year 1,900. To-day the demand for accommodation remains fairly constant. It is true that many cases referred to infectious diseases units are, in fact, suffering from a wide variety of conditions, many of which are not infectious. It must be remembered, however, that only a few of our present-day cases are diagnosed before admission, in contrast to those times when diphtheria, etc., were common infections. Many patients to-day are admitted for the investigation of vague symptoms associated with fever. Diarrhoea is a frequent symptom, which suggests infection, but in a great many cases a non-infective disease is the final diagnosis. Clinical and laboratory investigations are to-day so much wider and more detailed that the infectious diseases physician must necessarily be a competent physician. Infectious diseases to-day if properly practised is not to be regarded as a separate minor specialty but rather as an important branch of general medicine.—I am, etc.,

ROBERT LAMB.
Gateside Hospital,
Greenock, Renfrewshire.

Amalgamation of Hospital Management Committees

SIR,—There is concern among psychiatrists that the increasing practice of regional hospital boards of amalgamating management committees of general hospitals with those of psychiatric hospitals may operate to the disadvantage of the latter. The reason for this concern is the dominant influence on these amalgamated committees of physicians and surgeons who may have little understanding of the special needs of a psychiatric hospital.

Various reasons have been advanced for the present trend, one being that it is regarded as a step in the evolution towards an integrated service under an Area Health Board,[1] and another that it is a natural development related to the increasing number of psychiatric beds in general hospitals. These amalgamations which are meant to further the integration of medicine and psychiatry may, in fact, have the opposite effect. Many psychiatrists think true integration can be better achieved at the clinical rather than the administrative level.

It would be interesting to hear the opinion of those psychiatrists who have had the experience of working in mixed groups.—I am, etc.,

B. M. C. GILSENAN,
Honorary Secretary,
Society of Clinical Psychiatrists.
Shenley Hospital,
St. Albans, Herts.

REFERENCE

1 *A Review of the Medical Services in Great Britain*, p. 22, 1962. Social Assay, London.

Postgraduate Medical Education

SIR,—Your leader (31 October, p. 1087) indicates that non-teaching hospitals have a responsibility to provide postgraduate education.

University education is the end of basic training and the start of voluntary postgraduate education. A desire to learn and how to assess new ideas should be fostered in postgraduates by those consultants who have the ability and inclination to teach. It is certainly important that adequate accommodation with lecture-room, library, etc., should be available in the provincial hospital so that the hospital can function as a focal point for the greater medical profession in the area.

How the objectives of postgraduate education are to be achieved are not easily resolved. As your article states, "the future pattern . . . has still to be worked out." More important than the physical facilities is the ethos of those consultants who attempt to teach. The postgraduate teacher should be able to transmit to his hearers a thoughtful indication of future trends in his specialty and at the same time something that can be put into practice. It is for this reason that those who teach postgraduates should actively participate in clinical research, which fosters a lively spirit of inquiry into clinical work and prevents the participant from becoming a slave of routine.

Regional boards and hospital management committees should, therefore, make available without delay adequate facilities, encouragement, and personnel to those consultants who have the interest to participate in some facet of clinical research. This is, I feel, even more important than providing accommodation for postgraduate education. Participation in postgraduate education without interest and experience in clinical research is like production of *Hamlet* without the Prince of Denmark.—I am, etc.,

R. J. KERNOHAN.
Ballymena,
Co. Antrim,
N. Ireland.

SIR,—In your leader (31 October, p. 1087) on postgraduate medical education you mention that the picture was not perhaps as gloomy as was originally suggested by Sir George Pickering. While this statement is correct to some extent I feel there is scope for much improvement. It is true that postgraduate medical activities are being carried on in a number of peripheral hospitals, but there needs to be much more co-ordination. The position and scope for postgraduate medical activities in hospitals outside the university towns (medical faculty) is far from satisfactory in most places. Quite a number of peripheral hospitals have no well-equipped medical libraries with facilities of a study

room ; leaving aside any academic discussion in form of clinical meetings and clinico-pathological conferences. As you have pointed out, Sir, this needs much more attention and encouragement from the group and the regional boards, not only for the junior staff, as also for the local general practitioners.

Improvements may also be achieved by exchanging the junior staff between peripheral and teaching hospitals. Some teaching hospitals have adopted a system of rotation of their middle-grade and senior registrars with peripheral hospitals. Although the movement from a teaching hospital to a peripheral one is not very difficult, the reverse is rarely true, specially in cases of registrars. It will be of much more help if anybody serving a particular regional board as a registrar for one year is given an opportunity to work in the teaching hospital of the same region for six months, as is the practice in one particular regional board. This is specially more helpful to overseas graduates, who fill up most of the peripheral jobs, although they come mainly for postgraduate education and a number of them will be teaching when they return home.—I am, etc.,

Clare Hall Hospital, Barnet, Herts. P. GHOSH.

SIR,—In your article (31 October, p. 1087) you said that the Nuffield Provincial Hospitals Trust and King Edward's Hospital Fund for London each had allocated £250,000 for the promotion of postgraduate medical education. In fact the Nuffield Trust, which covers the whole of England outside London, has well exceeded this sum, but the King's Fund, for London only, provided £90,000. This sum has now been completely allocated. Prior to this, the Fund had set up the Kingston Medical Centre.—I am, etc.,

R. E. PEERS,
Secretary,
King Edward's Hospital Fund for London.
London E.C.2.

Research in Peripheral Hospitals

SIR,—I would like to congratulate Dr. C. L. Greenbury and his associates (5 September, p. 626) for their ambitious approach to research in a peripheral hospital. This subject has interested me greatly during the past five years, and a recent survey has been supported by the Nuffield Provincial Hospitals Trust into the medical and social needs of the elderly in this area. It is encouraging to see that in Stoke Mandeville there have been eight projects started in a very short time given the stimulus of a centre and facilities for the work, showing the potential for research activities. I have found it possible in a peripheral hospital to investigate changes in the tongue and oesophagus in iron-deficiency anaemia,[1] urinary corticosteroids in obesity,[2] in addition to the problems of the elderly.

During these studies the quantity of the clinical material available in the peripheral hospital for both laboratory and community research has become apparent. However, the major difficulties are time available for this type of work, and difficulties in setting up laboratory procedures apart from routine work. Such research, I think, will probably require additional medical or technical assistance for results, bearing in mind the pressure of routine work and staff shortages in peripheral hospitals.

In addition to the more difficult laboratory research I feel that invaluable information on subjects of vital interest to hospital administrators and general practitioners on common diseases has yet to be gathered, and centres such as Stoke Mandeville are admirably suited for this purpose.—I am, etc.,

St. Helen Hospital, Barnsley, Yorks. I. MCLEAN BAIRD.

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[2] —— *Lancet*, 1963, **2**, 1022.

Family Planning in London Teaching Hospitals

SIR,—Mr. Elliot E. Philipp (31 October, p. 1132) is to be congratulated on the restraint with which he comments on the state of affairs in the London teaching hospitals as regards the teaching of contraception.

Had the Family Planning Association inquired of the teaching centres out of London, I think they would have found the same state of affairs. In my own faculty there are two paid tutors who are active members of the F.P.A., and students attending for gynaecology are invited to attend in pairs for instruction. Not more than 20% of students avail themselves of this teaching, and only a few attend the contraceptive clinic for instructional purposes which is run by one of my colleagues at the Birmingham Maternity Hospital. We have not yet made attendance at contraceptive clinics obligatory, and, of course, several of our students have religious objections to attending such clinics. So far there has been no question concerning contraception in the final examination, although a few years ago a question was set on the indications for sterilization. Over the past 15 years *postgraduates* have attended for instruction in obstetrics, and as part of this course we have been in the habit of setting aside one hour for lecture-demonstration in the field of contraception given by an expert.

We are by no means satisfied with these efforts, and it is true that most of our students graduate without any detailed knowledge of contraception. Nevertheless, all of them have seen patients on "the pill." These patients come to the gynaecological outpatients for various reasons, and at a recent follow-up clinic I was able to show the students the impact of "the pill" in Birmingham—50% of the patients were on the contraceptive pill under the guidance of their family doctor.

For the future Mr. Philipp makes the point, and we must accept it, that teaching hospitals have a duty in this field which up to the present they have shirked. I hope it will bring him a little cheer when I tell him that we have a small committee working out a new kind of clinic for our teaching hospital in which the various forms of family planning will be taught.

All teachers should be grateful to the F.P.A. for their inquiry and to Mr. Elliot Philipp for his fair comment on the present situation.—I am, etc.,

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SIR,—Mr. Elliot E. Philipp has drawn attention in his letter (31 October, p. 1132) to the lack of provision for practical teaching on contraceptive techniques to students in the London teaching hospitals with one exception. I am writing this letter because I feel since in this hospital the work is done it should also be seen to be done. Professor Nixon of University College Hospital fully realized the need of patients for advice on contraceptive methods and the need of students for instruction. Under his guidance a clinic for this purpose was started at the hospital more than 12 years ago by the late Dr. Joan Malleson, one of the great pioneers in giving help to married couples in their problems, including that of controlling conception. The pressure of work and the time needed by the patients to discuss many aspects of the marital relationship soon necessitated a second weekly session, and now there are three women doctors working in this clinic. The patients' need for such a service is emphasized by the regrettably long waiting-list. The majority of patients are referred from the post-natal clinic and gynaecological department, but also from other departments of the hospital. Help for patients is often sought by other hospitals and by general practitioners ; these requests are difficult to meet because of the already crowded waiting-list—now about three months.

Appreciation of the instruction available in this clinic is indicated by the attendance of students, despite the fact that this subject is not included in the final examination. Not only does the student learn how to give advice to the patient on contraceptive methods but also that it is possible to discuss the sexual relationship without embarrassment or uneasiness on either side, and he finds how grateful the patient is to be given the opportunity of doing this. It is after qualification, however, that the need for some instruction of this kind is realized more fully. Although the examiners do not ask questions on this subject the patients do, and the general practitioner usually finds that the solitary formal lecture leaves him "magnificently unprepared" with the answers.

In 1948 a Joint Committee of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee recommended that "post-natal clinics should widen the scope of their work to include birth-control advice."[1] In 1949 the Royal Commission on Population stated that "The giving of advice on contraception to married persons who want it should be accepted as a duty of the National Health Service, and the existing restrictions on the giving of such advice by public-authority clinics should be removed. The initial duty to give advice should rest with the family doctor. Any clinics needed for this purpose should, wherever possible, be associated with the facilities we recommend for advice on infecundity. This branch of the National Health Service should be so designed as to allow for experimental development, as the needs emerge, for other activities—for example, premarital examinations—of direct relevance to family