ing. A family history of depressive illness should increase awareness of the possibility that a particular child's behaviour, which is causing concern, may be based on a primary disturbance of mood. Suicidal threats, gestures, and, occasionally, successful attempts are not unknown in the young, and suicidal threats and gestures should always be taken seriously as being distress signals.

The fact that emotionally disturbed children may be referred to paediatricians, physicians, surgeons, child-guidance clinics, and school medical officers, initially makes diagnosis difficult. It is customary in many child-guidance clinics outside the hospital service for a psychiatric social worker to become involved in case work with one or both parents and for a psychiatrist to be responsible for the therapy of the child.

Parents bringing a child to a psychiatric clinic, especially within the hospital service, should always be seen and interviewed by the psychiatrist in charge of the case. This is a medical matter and the training, skill, and experience of the psychiatrist are needed in order to elicit accurate details concerning the medical aspects of the child's problems. Application of diagnostic criteria used for adult patients suffering from depressive illness, to children and adolescents, increases the difficulties.—I am, etc.,

Child Psychiatric Unit, St. James's Hospital, Leeds 9. MARSHALL FRIEZE.

Work Load in Group Practices

SIR,—Your article by a special correspondent on "Impressions of Group Practices" (27 November, p. 1300) must be of special interest to many general practitioners throughout the country, and for this reason I am wondering whether this report is intended to apply to practices other than near Edinburgh. It appears that seven doctors look after 20,000 patients: and each partner has five weeks' annual holiday; so it would seem that for 35 weeks of the year the six remaining doctors are responsible for 3,300 patients each. As it also reports that "the number of items of service per patient is high, roughly double that in the south of England," I feel I should be capable of looking after more than 6,000 patients and still have time to do haemoglobins, erythrocyte sedimentation rates, and stool cultures, and take an active interest in practice research and possibly also be a regional or industrial M.O.

Can someone please tell me why I think I should find this work load impossible while my friends in Edinburgh take it in their stride?—I am, etc.,

Bognor Regis, Sussex. DAVID HAY.

Independent Medical Services Ltd.

SIR,—Whatever may be the result of the continuing negotiations on the doctors' charter and the decisions reached by the Review Body, and whether or not there is a mass resignation by family doctors, I sincerely hope that all medical men, including consultants who believe in freedom of choice and the upholding of private practice, will support the Independent Medical Services Limited by subscribing £10 to the capital fund needed to launch this all-important service effectively on a nation-wide basis. It will be of value to the patient and to the doctor because it will increase and widen freedom of choice for all. If there is not mass resignation it will run in competition with the N.H.S.—it will be excellent for the N.H.S.—and if there is mass resignation it will give patients an immediate and effective service.

I do not believe such a chance will occur again for a generation, so I hope there will be overwhelming support, and £10 is not too much to pay for such an opportunity now to enhance medical services. The Private Practice Committee, under the inspiring leadership of Dr. I. M. Jones, has sponsored several excellent schemes that have been of great benefit and assistance to all doctors. This is another one—which has the support of Council and of the Representative Body.

Let us have the courage to believe in ourselves and make Independent Medical Services the success it deserves to be. I hope consultants will join in support as well—we are one profession and should demonstrate the fact.—I am, etc.,

Reading, Berks. S. F. LOGAN DAHNE.

Proposals for Salaried Service

SIR,—The publication of the Sheffield Medical Committee's proposals for salaried service (*Supplement*, 20 November, p. 212) should not be allowed to pass without examination of some of its assumptions and consideration of related factors to which it makes no reference. The first assumption which I challenge is the statement that the system of remunerating consultants is one which has aroused no complaint from the doctors concerned. On the contrary, there has been complaint from the doctors ever since its inception. The sessional system of payment includes no relationship between work load and remuneration. The conscientious can work themselves into the ground without recompense. The difference in work load as between different specialties and different posts is not recognized; part-time contract-holders are expected to provide the same service as whole-timers, and essentially the consultant's responsibility for his patients is the same as that of a general practitioner—namely, 24 hours a day seven days a week.

We come now to factors not mentioned. First, it must be realized that in 1948 the consultants were compelled to accept a salaried service because, by reason of the N.H.S. taking over ownership of the hospitals, they had no option but to accept the terms offered by the new owners of the only premises in which they could work. Hospital staff could not then, and cannot now, withhold their services from the N.H.S. without also withholding those services from all but a tiny fraction of the population. In other words, the consultant, being salaried, and having nowhere to work but State-owned hospitals, cannot bring pressure to bear on the Ministry by offering an alternative service to the public, as can the general practitioner who owns his own premises. The salaried officer's only recourse is to strike, thereby withholding his services from the public, a course of action many consider, and I think rightly, to be unethical.

Out of this arises my second point. The two great steps forward in remuneration which have rescued the N.H.S. from imminent collapse in the past were the Danckwerts Award and the Royal Commission. In both instances the impelling force which activated the Governments of those times to seek arbitration in one case, and to form a commission in the other, was the threat of mass withdrawal by general practitioners. At the present time we are in the midst of negotiations to recast remuneration for the general-practitioner side of the N.H.S., and no one can refute the argument that once again the threat of withdrawal by general practitioners is the lever by which the profession has again forced the Government to take action.

Because hospital staff are salaried and have no lever which they can ethically use, they cannot make their own terms with their employer. The concluding lines of these proposals, "The Minister cannot afford to forfeit the good will and trust of the profession," etc., make no sense in the light of recent history, and suggests a disregard of facts by the authors.

The only strength the profession has in its relationship with the Minister is the ability of the general practitioner to withhold his services from the N.H.S. while at the same time offering those services outside the N.H.S. Once he becomes salaried, or does not own his place of work, then all the doctors in the N.H.S. are rendered helpless and completely in the power of their monopoly employer—unless they emigrate.—I am, etc.,

H. LESLIE LEAMING.
Middlesbrough, Yorks.

SIR,—As a proponent of a salaried service I write to support Dr. J. C. MacLarnon (27 November, p. 1312), and I am much impressed by Dr. J. W. Wigg (20 November, p. 1248) and by the Sheffield paper (*Supplement*, 20 November, p. 212). It is surely time for us to consider and to be seen to consider the quality of the service as an end in itself and not just a chance by-product of better conditions and higher pay for doctors.

Dr. MacLarnon's medico-social crisis must be resolved, for it is unthinkable that in a civilized country with a social conscience anyone in need of them should want medical advice and care. There is little chance of increasing the doctor/patient ratio in the near or even the foreseeable future, so we must increase our productivity by redeployment of personnel and by integration and rationalization of the whole N.H.S. A salaried service would make this possible and indeed would be a *sine qua non*. We should take the initiative, and by campaigning for it demonstrate that we think of more than our own pay and conditions, and make certain of having a big say in the planning and control of it.

Of course it would take a ten-year plan to assemble such a service and perhaps another five years to have it running at full steam, but by taking the initiative we could have all that is good in the hospital service without what is bad, and at the same time have a family doctor service which was the envy of the civilized world.

Let us now, before we go any further in considering the fatuous and ultra-complex Second Report, have a plebiscite for the family doctors under 50 years of age. "Assuming that the terms and conditions of service would be similar to those now enjoyed

by medical officers in the Ministry of Health and the like, do you want a salaried service? Yes or No?"

As the old and bold will not be in it we can leave them out.—I am, etc.,

Perth. A. J. MUTCH.

Action Group's Action

SIR,—I would be grateful if you would allow me the opportunity of correcting some of the misconceptions of the Action Group which were expressed in your columns (27 November, p. 1311).

The Action Group has always felt that the Hospital Junior Staffs Group of the B.M.A. have done their utmost in trying to obtain the best deal for junior staff. However, we have been alarmed to see many of their excellent recommendations in the past rejected or obstructed. We do not believe that this situation will improve unless they are represented at higher level—that is, such as on the Whitley Council.

I should like to assure your readers that the evidence of the Action Group, far from being hastily drawn up, was the result of some three months' intensive and careful work.

I cannot understand how Dr. Gunn reaches the conclusion that we are telling the Review Body how to do its job. The Review Body considers the evidence of the profession, and we have provided it with evidence on behalf of the junior staff who have supported our work.

Our objective has been to see, first, that the Review Body receives the views of junior staff directly. Secondly, that junior staff are represented at all levels. We have clearly expressed our belief that this should be within the B.M.A., but if the B.M.A. are unwilling to accede to junior staff having reasonable representation, then we shall ask all junior staff whether an independent body representing them should be set up. After further investigations into the possibilities of setting up such an organization we find to our surprise that the financial and administrative problems would be in no way insuperable.—I am, etc.,

MAURICE H. ROSEN,
Acting Secretary,
Hospital Junior Medical Staff Action Group.
London S.E.19.

*** The Central Consultants and Specialists Committee recommended at its meeting on 9 December to extend the representation of the Hospital Junior Staffs Group (see *Supplement*, p. 246).—ED., *B.M.J.*

The Basic Factor

SIR,—A new charter has materialized for the family doctor, and the position of the junior hospital medical staff is being reviewed. There is an ever-growing trend to group practice and a new enthusiasm for the concept of health centres. All of these facts are to be wholeheartedly applauded, but they do nothing to solve the basic factor of a shortage of doctors.

A move to sweep away outmoded restrictive covenants and the icy barrier at "management" level would unfetter doctors engaged in local-authority preventive and social medicine and mark a step forward. This would permit the more enterprising to assist part-time in general medical practice, where they could help in surgeries and domiciliary visits or in hospital work, just as family doctors are rightly encouraged to work in local-authority clinics. Why cannot this interchange of functions be allowed, and family doctor and community physician work ever more closely together? It would further the integration and harmonizing of the three branches of the profession, as well as breathing new life into an underprivileged and unglamorous one.

It is fatuous to bemoan the shortage of medical manpower until all potential sources of medical skill which we do possess have been utilized fully to the benefit of the individual and the nation alike.—I am, etc.,

Stamford, S. Lincs. H. ELLIS SMITH.

The Gastro-camera

SIR,—With reference to my article of 20 November (p. 1209) on the gastro-camera, it should now be noted that Smiths Medical Equipment Company Limited, Towerfield Road, Shoeburyness, Southend-on-Sea, Essex, are now the agents for the Olympus Gastro-camera in this country, and I understand that a number of their personnel have been trained by Olympus technicians to carry out servicing and minor repairs. It should also be noted that Olympus Optical Company have now established an agency and a repair shop in Hamburg.—I am, etc.,

London W.1. G. D. HADLEY.

Merit Awards

SIR,—Mr. W. B. S. Crawford's slur on the Socialist Medical Association is hugely amusing (27 November, p. 1312). Though our ideas are taken, we do not sit at any negotiating table, so the charge of self-interest hardly arises. For the other groups he implicates his letter is either libellous or meaningless. The negotiators are there to act in a political situation which they may not understand (the failure of successive Governments to finance and organize general practice to meet modern needs), but surely perform in good faith.

As it happens, the declared policy of the S.M.A. is against merit awards, especially in secret, for consultants. We are against secret awards for general practitioners, or merit awards under a capitation system, where they can have no value in raising the general standard of medical care. We are for an incremental salary for family doctors based on experience, higher qualifications, research, and so on. There would in fact be a fairly comparable scale for all doctors—an important step in restoring unity to the profession.—I am, etc.,

GEOFFREY RICHMAN,
Hon. Assistant Secretary.
London W.8. Socialist Medical Association.

B.M.A. Bridge Club

SIR,—The B.M.A. Bridge Club has now completed its third successful year, and I should like to take this opportunity of drawing the attention of members, especially those in the Greater London area, to the amenities it offers.

There must be many bridge players who would welcome the chance to play duplicate and competition bridge in a congenial and friendly environment, but who ordinarily have little opportunity of doing so. Rubber bridge is also played.

We meet at 7.45 p.m. on the second and fourth Tuesdays of each month at B.M.A. House. There is a bar, and coffee is also available.

Membership is open to all members of the Association. Non-medical guests are welcome at all ordinary meetings. I hope that any colleague who would like to come and see for himself will regard himself as my guest on the first occasion. It would be as well if he were to ring up the club secretary, Mr. L. E. Drake (Euston 5601) beforehand to confirm date and time. Members receive notices of all meetings individually.—I am, etc.,

L. S. POTTER,
President,
Bushey, Herts. B.M.A. Bridge Club.

Points from Letters

Physiology of Lactation

Dr. MARY N. M. PAULIN (Belfast) writes: In your leader (13 November, p. 1137) on the physiology of lactation no mention was made, in the advantages of breast-feeding, of the recommendation of breast-feeding contained in the recently published report *Enquiry into Sudden Death in Infancy*.[1] This stated that breast-feeding for the first two weeks after birth might reduce these unexplained deaths, which form a not inconsiderable proportion of the infant-mortality rate. Now that breast-feeding is not insisted on in many maternity hospitals, the attention of all who work in such hospitals should be drawn to the recommendations of this report.

REFERENCE

1 *Enquiry into Sudden Death in Infancy*, 1965. H.M.S.O., London.

Chronic Salicylate Poisoning and Renal Tubular Damage

Dr. L. F. PRESCOTT (Aberdeen) writes: In the Registrar-General's Statistical Review of England and Wales for the year 1962, 10 deaths were attributed to intake of salicylates and aspirin, and of these one was recorded as being due to "tubercular degeneration of the kidneys." As this seemed rather unlikely I wrote to the General Register Office requesting further details of this case. There had been an error in transcription, since the cause of death in this patient was recorded in the original documents as follows: left ventricular failure; myocardial fibrosis; tubular degeneration of the kidneys due to chronic salicylate poisoning. Recently there has been renewed interest in the nephrotoxic effects of salicylates and the possible role of these drugs in the aetiology of analgesic nephritis.[1,2] In view of the reluctance of some authors[3–5] to accept that the chronic administration of salicylates may result in renal damage it seems worth while to put this additional case on record.

REFERENCES

1 Prescott, L. F., *Lancet*, 1965, **2**, 91.
2 Ramsay, A. G., and White, D. F., *Canad. med. Ass. J.*, 1965, **92**, 55.
3 Scott, J. T., *Lancet*, 1965, **2**, 243.
4 Clausen, E., and Harvald, B., ibid., 1965, **2**, 386.
5 Douthwaite, A. H., ibid., 1965, **2**, 299.