Superannuation for the Older General Practitioner

SIR,—The older general practitioners, caught between the low salaries of the early days of the National Health Service and the rapid inflation of the last few years, find that their superannuation rights are quite unrealistic at this moment of time.

Pension rights are at the moment under review and new legislation is most unlikely to be retrospective. An immediate boost to help the prospects of these older practitioners could be obtained by granting a fourth increment to their seniority award of £1,000 to £1,200 to all general practitioners who were in practice ten years or more before 5 July, 1948—this without prejudice to any betterment in a general pension review.

This would give these older general practitioners—whose numbers are gradually decreasing—a chance to up their retiral benefits and perhaps save a little in their last few years in practice. This would not be an expensive exercise for the Exchequer, and it would in some measure help to right the wrongs of the great degradation of the value of the compensation repayments.—I am, etc.,

KENNETH CAMERON

Motherwell

Overpopulation and Subnormality

SIR,—P. J. Horsey (25 March, p. 803) mentions that in the 12 years before the Abortion Act the numbers of mentally handicapped children almost doubled. The reason I write is to make it known that in future years we shall not know the number of mentally handicapped (formerly mentally subnormal and before this mentally deficient) children. The numbers of mentally subnormal children were previously known because local health authority medical officers had a duty to ascertain under Section 57 of the Education Act, 1944 those children who were unsuitable for education at school. When the care of mentally subnormal children was transferred from the Health Departments to Education Departments in April, 1971, this ascertainment ceased, and all children from the lowest grade (idiot level) up to the fringe of average ability, say I.Q. 80%, are now included in one category—the educationally subnormal.

This move will produce no measurable benefits to the children, and is merely an example of buoying up false hopes of the parents of the children when in the long run it would have been better to have faced the issue realistically and accept that children of poor intelligence unfortunately do exist. Although this may appear to be an insignificant point I feel that at least we should know the numbers of children who will throughout their lives remain a burden on society. How otherwise are we to plan successfully future provision for such persons? To turn a blind eye to the situation serves no useful purpose.

The Department of Health and Social Security has recently considered a small number of unfortunate experiences in hospitals for the mentally subnormal and has decided that to an increasing extent the care of the subnormal should rest with the family and on the community services. I have seen at first hand on innumerable occasions the burden that individual families have to bear in trying to cope with the constant needs of a severely subnormal child. The whole family is affected including the other children. This situation is almost certain to get worse and as the number of the metally subnormal increases the number of individual families with severe problems will increase pari passu.

The problem of overpopulation of Britain has many facets, one of which is certainly that the majority of large families are "the socially deprived and over fertile," and this is the most serious difficulty in achieving a zero population growth based only on voluntary limitation of family size. These are the families which, in general, produce a disproportionate number of mentally handicapped children, although I would be the first to admit that there are many exceptions.—I am, etc.,

R. D. HAIGH

City Health Department,
Lincoln

Points from Letters

Gynaecological Illness after Sterilization

DR. R. N. EBBING (Manchester) writes: A grief reaction coupled with frigidity is a not uncommon consequence of hysterectomy. In a well balanced woman with a sympathetic husband this grief reaction passes after several months and she returns to her normal mental state and to her normal sexual life. In an emotionally immature woman, however, the grief reaction may be both severe and prolonged. . . . In my view far too little attention is being paid to the psychological consequences of hysterectomy. This may be partly due to the fact that a woman will have little reason to visit a gynaecologist once her womb has been removed. From a psychological viewpoint hysterectomy is not a good operation, and I strongly advise the patients in my practice not to have a hysterectomy unless it is essential for their physical well-being.

Staffing our Asylums

DR. D. A. SPENCER (Meanwood Park Hospital, Leeds, Yorks) writes: . . . Long-stay hospitals contain large numbers of patients who are captive populations for clinical study and research. Many of the patients in long-stay hospitals for the mentally ill and mentally handicapped have disorders undiagnosed. . . . Doctors and nurses in training at both undergraduate and postgraduate levels could benefit from spending a period in the long-stay hospitals and these hospitals themselves would gain from their presence. . . . The presence of enthusiastic, questioning young people is a valuable catalyst to promote more activity and change. In the reorganization of hospital groups which has been taking place it is unfortunate that the opportunity is not taken wherever possible of uniting long-stay hospitals for geriatrics, mental illness, and mental handicap with teaching hospitals, medical schools, and university centres. This step would open these hospitals to more of the expertise and interest that is available and be a move towards a more comprehensive and integrated hospital service.

Haemophilus Epiglottitis

DR. D. G. LARARD (Department of Anaesthetics, Warwick Hospital, Warwick), writes: . . . Acute epiglottitis may be suspected by the unusual degree of toxicity and by the presence of stridor greatest during inspiration and often absent during expiration. It is confirmed or excluded only by direct laryngoscopy a rapid and not unduly distressing manoeuvre by the average anaesthetist. While the battle of tracheostomy versus endotracheal intubation will no doubt continue to rage it may be of interest to note that in a small series of 13 cases of acute epiglottitis[1] those children treated by tracheostomy were discharged home between the tenth and the thirteenth day whereas of those treated by nasotracheal intubation five were discharged home within three days and the remainder by the eighth day. In most centres endotracheal intubation is an essential pre-requisite of tracheostomy. It would thus seem to be unnecessary once an endotracheal tube is in place to then undertake the difficult, dangerous, and disfiguring procedure of tracheostomy.

1 Raj, P. P., Larard, D. G., and Diba, Y. T., *British Journal of Anaesthesia*, 1969, 41, 619.

Donors for Organ Grafting

Dr. A. C. E. BREACH (Kingsbridge, Devon) writes: . . . The appalling toll of road casualties has added greatly to the number of deaths by violence, especially in the young and healthy. Necropsy and inquest are accepted sequelae of these tragedies, and it is common practice to cremate the remains. Would not very many of these victims, and their next of kin, be glad to think that their deaths had not been wholly in vain and that they had been able to restore health to others? But it is difficult to get consent when the disaster has occurred, and it seems brutal to ask for it at a moment of such distress. It is submitted that the problem could be largely solved if a form of consent were made available to every applicant for a driving licence, the period of consent to run concurrently with the licence. In the case of minors, parental consent should be required. Where consent was given, the licence would be appropriately stamped, so that, in the event of a fatal accident, the information would be immediately available to the receiving hospital and to the police.

Serum Hepatitis Hazard in Biochemical Control Sera

Dr. G. S. ANDREWS (Department of Pathology, Royal Gwent Hospital, Newport, Mon) writes: Drs. A. D. Evans and K. W. Davies (11 March, p. 691) are right to draw attention to the possible hazard of serum hepatitis from handling biochemical control sera. . . . I would like to point out, however, that the tests referred to were initiated by the biochemistry department of the Royal Gwent Hospital, and that the samples were first submitted for testing by this department. I feel that the initiative and foresight of the members of the biochemistry department of the Royal Gwent Hospital should not go unacknowledged. . . .

Fees for Sight Testing

MR. F. J. CURTIS (Redhill Eye Unit, East Surrey Hospital, Redhill), writes: Mr. R. T. Pine (26 February, p. 572) seeks to justify the entirely anomalous situation in which an optician receives a higher fee than an ophthalmic specialist for doing the same work by claiming that the part of an optician's income received from sight testing is less than the salary of an ophthalmic specialist. He is careful not to bring into his argument the income which the optician is also able to claim from dispensing fees and by the sale of spectacles. . . . Let it not be forgotten by the public, the politicians, or the professions that the majority of O.M.P.'s are, in fact, ophthalmic consultants, whose training has taken probably eight years at least and whose opinion is what is sought by the patient in addition to the actual writing of a spectacle prescription.