tion in cases of obesity or difficulty with the bowel, since the high fibre content reduces the calorie value but increases the aperient properties.—I am, etc.,

T. L. CLEAVE

Fareham, Hants

- ¹ Morris, J. N., *Lancet*, 1941, 1, 51.
- ² Connell, A. M., Hilton, C., Irvine, G., Lennard-Jones, J. E., and Misiewicz, J. J., *British Medical Journal*, 1965, 2, 1095.
- ³ Lord Horder, Dodds, C., and Moran, T., *Bread*. London, Constable, 1954.
- ⁴ Cleave, T. L., *Journal of the Royal Naval Medical Service*, 1956, 42, 55.
- ⁵ Cleave, T. L., and Campbell, G. D., *Diabetes, coronary thrombosis and the saccharine disease*, Bristol, Wright, 1966.

Varieties of Memory

SIR,—As an amateur pianist, I was very interested in the last paragraph of "Personal View" by Professor L. J. Witts (1 April, p. 43) and can perhaps throw a little light on the subject of how performers memorize music. He draws attention to visual and auditory memory. I believe that there is a third type, which might be described as kinaesthetic, which stems from the muscles, joints, and nerves of the upper limb.

When learning the piano 50 years ago I soon found that after practising a piece of music I could close the book and play it from memory having made no conscious effort to memorize it; visual memory played no part at all in this and auditory memory a minor one, but my fingers seemed to know where to go next. This facility persists, for I still find that I can play a piece of music from memory which I have not played for perhaps 20 years or more.

I am sure that the degree to which these various forms of memorizing are used varies with the individual performer and their relative importance varies, but I also think that without kinaesthetic memory—even well developed visual memory—it would not be possible for a concert pianist, say, to command his large repertoire of memory performances.—I am, etc.,

T. D. CULBERT

Manchester

New Thoughts on Essential Hypertension

SIR,—Your leading article "New Thoughts on Essential Hypertension" (15 April, p. 121) argues against the prolonged use of diuretics in mild hypertension and therefore must interest the obstetrician in his treatment of pre-eclampsia, wherein they have been employed. You have indicated that low levels of sodium thereby brought about could act as a stimulus for renin release and defeat the desired hypotensive effect.

In this connexion the risk of provoking hyponatraemia in pregnancy has long been recognized, while recently Chesley¹ has warned against their use, but for a different reason. He has brought evidence to show that as "toxaemia" mounts hypovolaemia and haemoconcentration also increase and these two states are exacerbated by the resultant plasma depletion.

Leyssac² maintains that changes in glomerular filtration rate are secondary to alterations in the reabsorptive rate of the proximal tubule. Thus the increased loss of fluid by the tubule would effect a corresponding increase in glomerular filtration, in turn producing a reduction in the tone of the glomerular afferent arteriole and implying a reduction in its stimulation by renin.

Therein may lie its hypotensive action.

Though it is difficult to account for the effects of specific changes in glomerular pressure per se on reabsorption, such a mechanism could well underlie the usefulness of diuretics in pre-eclampsia.—I am, etc.,

JOHN SOPHIAN

Worthing, Sussex

- ¹ Chesley, L. C., *American Journal of Obstetrics and Gynecology*, 1972, 112, 440.
- ² Leyssac, P. P., *Acta Physiologica Scandinavica*, 1963, 58, 236.

Sabbatical Year

SIR,—While I agree to a large extent with Dr. R. E. Loder (22 April, p. 226) and many consultants in the National Health Service both deserve and need a real break from routine duties at long intervals, I think that this applies particularly to those working maximum part-time or whole-time clinical appointments outside teaching hospitals. While consultants in teaching hospitals are not immune to pressures or to stress the scale of assistance is usually much higher than for their contemporaries in non-teaching hospitals, upon whom heavy routine work falls far more directly.

If Dr. Loder's suggestion were acted upon I believe that many early retirements would be prevented and that the standard of consultant working in those whose burden has been exceptionally heavy would be preserved to a degree which is at present seldom achieved.—I am, etc.,

T. J. WILMOT

Tyrone County Hospital,
Omagh, Co. Tyrone

Family Doctors and Contraception

SIR,—The vice-president of the Pharmaceutical Society, Mr. J. P. Kerr, speaking in Glasgow on Sunday, 26 March at a conference sponsored by the Socialist Medical Association, pressed the Society's view that oral contraceptives should be available on the National Health Service. Mr. Kerr outlined the Society's proposed scheme, in which family doctors would issue prescriptions on a modified E.C.10 form. This special form would be similar to the E.C. 19 form and would contain a total of three separate prescriptions. At each consultation the doctor would issue prescriptions for three or six months' supply (see the *Pharmaceutical Journal*, 8 April 1972, p. 312).

Dr. Lorna Naismith, speaking on behalf of the Family Planning Association, agreed that contraceptive services should be completely free. However, she felt that contraceptives should be supplied only by those who had received special training. Asked to comment on the Pharmaceutical Society's plan, Dr. Maurice Miller (who takes a weekly birth control session at a London Family Planning Association clinic) replied that he also had reservations that the training of many general practitioners in this specialized field was not deep enough. Early detection of untoward side effects, for which the family doctor had neither the time nor the experience, was best carried out at family planning clinics, he added.—We are, etc.,

B. L. FURMAN

A. L. HARVEY

R. M. WADSWORTH

Department of Pharmacology,
University of Strathclyde,
Glasgow

Fair Wage for Auxiliaries

SIR,—Dr. B. E. Brocks (18 March, p. 753) is to be congratulated on the firm stand he has taken on behalf of the remedial professions, particularly in respect of their system of grading and appallingly low salaries. His words come as a timely warning in a situation which is rapidly worsening.

He does them a disservice, however, by referring to them as medical auxiliaries, when in fact they are recognized by Act of Parliament, with other groups, as the "professions supplementary to medicine." Without wishing to be accused of pedantry, I am sure Dr. Brock will appreciate the subtlety of the difference between the dictionary definitions of "auxiliary" and "supplementary." It adds a measure of gloss to the skills and enthusiasm of the supplementary professions.—I am, etc.,

R. BROOKS

Public Health Laboratory,
Swansea

Future of Mental Health Services

SIR,—We read with interest the well-intentioned letter by Drs. F. A. Bleaden and J. H. Price (4 March, p. 624). As they are so critical of psychiatric units in general hospitals and the policy of the Manchester region, some clarification is necessary. We are not qualified to express any comments on the future of services for mentally sub-normal patients, but we have sufficient experience of general hospital psychiatry to make the following comments.¹

For most of us who studied carefully the findings of the Whittingham Hospital Inquiry,² it must be fairly obvious that the sorry state of affairs at that hospital was more due to other failings than to lack of funds. Finance, however, inadequate as it has been for most of us in the N.H.S., should not be the decisive factor in formulating future policy. One of us has already criticized the mistaken policy of a premature run-down on mental hospital beds until adequate facilities are developed in the community and better care provided for the increasing number of elderly confused patients.³

We agree that a greater flexibility in planning is needed than that displayed in the White Paper recently published by the Department.⁴ Local conditions and existing facilities must be taken into account. We disagree entirely with Drs. Bleaden and Price that acutely disturbed psychotic patients cannot be treated as adequately (not "housed") in an active therapeutic community of a general hospital, with its modern clinical facilities, as in a sometimes remote mental hospital. Similarly, personality disorders are better managed in a day hospital nearer home or in the outpatient clinic. Many of those with them should not be hospitalized at all. Many fail to respond, wherever they are.

We think that in the foreseeable future there will still be a real need for active, progressive, mental hospitals with their own areas of clinical responsibility and greater involvement with community services. Some may develop regional special units for forensic psychiatry, drug addiction, and rehabilitation for long-stay patients. They will become smaller and easier to manage when

district units and community services develop.

Finally, as to training and recruitment, the experience in our region should reassure Drs. Bleaden and Price. Several general hospital units train most successfully their psychiatric nurses in conjunction with neighbouring mental hospitals. Many psychiatric nurses proceed with their training in the general hospital to ultimately reach the top of the Salmon ladder. It is somewhat disconcerting that most severe criticism of our regional policy comes from people who have never worked here.—We are, etc.,

JAN T. LEYBERG
MARION E. MACKAY

Department of Psychiatry,
John Mackay Clinic,
Bolton District General Hospital,
Bolton, Lancs

¹ Leyberg, J. T., *Lancet*, 1959, 2, 282.

² National Health Service, *The Report of the Committee of Inquiry into Whittingham Hospital*, London, H.M.S.O., 1972.

³ Leyberg, J. T., *British Hospital Journal and Social Services Review*, 1969, 79, 2189.

⁴ Department of Health and Social Security, *Hospital Services for the Mentally Ill*, London, H.M.S.O., 1971.

Revised Regulations for G.P.s

SIR,—With reference the report of the General Medical Services Committee of 13 April (*Supplement*, 29 April, p. 40) other comments on the revised regulations and terms of service for N.H.S. general practitioners were made but not reported.

For the G.M.S. Committee to ask the Conference of Representatives of L.M.C.S. to accept revised or recast regulations this year is, to my mind, an error of judgement. Such amendments can hardly be described as minor—for instance, the removal of patient responsibility from the independent contractor general practitioner if he is in hospital suffering from a cardiovascular accident. In fact the proposed recasting so alters the original contract (E.C.16) signed by general practitioners as to warrant a fresh signature from each principal.

We have waited six years for these revisions, so why not wait till 1973 when we will know the new deal before we accept and sign again? Some will say that the signed contracts will be transferred by statute to the new area health authority, but why agree to the rules before we see what the new game is going to be? As one who has worked for years to further the concept of a new unified and rationalized National Health Service, and one who has always questioned the so-called "independence" of the independent contractor, I now marvel at the advice of my colleagues on the G.M.S. Committee to local medical committees.

Many younger principles while accepting the status quo until 1974 may have in mind a choice of contracts thereafter, such as a part-time (say, 9/11ths) contract of service on a sessional basis, like our consultant colleagues. Furthermore, it may well be that many general practitioners interested in medicopolitics, realizing the need for their active participation on some of the many committees that will be needed in the management of the new Service, will not be prepared to enter into a contractual obligation for service for 365 days in every year.—I am, etc.,

G. MURRAY JONES

Caerphilly, Glam

G.M.C. Annual Retention Fee

SIR,—I have just received a charming letter from Lord Cohen of Birkenhead in which he blithely tells me that the annual retention fee has been increased from £2 to £5 from 1 May 1972, and that the British Medical Association offered no objection to the proposed increase. This is an increase of 150%, an enormous increase even in these inflationary days. Who can foretell the time when it will be increased to £7.50, to £10, to £12.50, with no foreseeable limit? The escalation is inevitable.

I am totally opposed to the principle that members of the profession should be forced—yes, forced—to pay the ever-increasing expenses of the General Medical Council. Nevertheless, last year you very kindly published a letter from me (8 May 1971, p. 342) in which I suggested a compromise. I suggested that those functions of the G.M.C. which are specifically designed to protect the public should be paid for by the public through public funds. This would at least lighten the financial burden on registered members of the profession. My suggestion did not appear to arouse a flicker of interest anywhere. Certainly there were no follow-up letters published in your columns, nor did the Durham Division of the B.M.A. seem to be interested. I put the suggestion forward again, in the hope that it will be accepted before it is too late.—I am, etc.,

PETER WADDINGTON

Durham

Hospital Staffing

SIR,—Correspondence on this subject, which was opened by Dr. Mary M. Anderson and others (19 February, p. 511) has highlighted some of the adverse effects of the recent staffing recommendations on the obstetrical and other services. In view of the current precarious position of many of our accident and emergency departments all over the country with regard to junior staffing I would like to draw attention to the effect that can be expected if the recommendations are implemented as they stand.

Ten years ago the subcommittee on accident and emergency services in its report¹ laid down certain minimum staffing norms for each major accident unit, and it also recommended concentrating the service to a smaller number of major centres which were to be strategically placed. Many subsequent papers and reports have only helped to reiterate these recommendations. For convenience I shall outline these staffing recommendations: consultants 3, intermediate grade (medical assistant, senior registrar, and registrar) 3; junior (S.H.O.) a requisite number (four or more).

Although these recommendations were endorsed by the Department of Health and Social Security of the day the implementation has been rather patchy, and 10 years later we find that a considerable number of our departments are still understaffed, though admittedly the service has now been more concentrated by reducing the number of functioning and viable departments from 800 to about 350. If we are to accept J. L. Kilgour's premise² that in 10 years' time we can expect a staffing ratio of three consultants to one specialist and two general professional trainees this would mean that in 10 years our already understaffed accident

and emergency departments will have precisely 50% of the present junior staff recommended by the Platt report. To any consultant who has been in active charge of such a department, such a staffing ratio must surely appear not only ludicrous but disastrous. It is difficult to understand the apparent complacency that exists regarding the prospects of our rendering an essential service to some 30% of the population of this land with these recommendations. The increased output of our medical schools even to the recommended proportions could almost entirely be absorbed by the existing 350 accident and emergency (casualty) departments all over the country. We will therefore continue to rely, as at present in our regional hospitals, on overseas graduates, who constitute 80-100% of the junior staff of many a provincial department.

It will probably be suggested that general practitioners will flock to the assistance on any such occasion, but some simple calculations will make it obvious what exactly this will mean. A normal general practitioner session is 3½ hours, and therefore at least six such sessions would be required to provide a 24-hour cover in each department at a cost of £42 per day. Translated in terms of a week and applied to all the 350 departments, we would require 4,700 sessions per week at a cost of £102,900. Admittedly, this figure could be halved if the burden were to be equally shared by the junior doctors and general practitioners, but the problem would still be difficult.

The ultimate burden of the problem will no doubt, as usual, be placed fairly and squarely on the shoulders of the consultants, regardless of whether they are orthopaedic surgeons, traumatologists, or casualty surgeons and we will be expected to produce an indefinite number of rabbits out of a limited number of hats.—I am, etc.,

G. I. B. DA COSTA

Shotley Bridge General Hospital,
Co. Durham

¹ Ministry of Health and Department of Health for Scotland, *Medical Staffing Structure in the Hospital Service*, London, H.M.S.O., 1961.

² Kilgour, J. L., *British Journal of Hospital Medicine*, July 1971, 18.

G.P.s in District Hospitals

SIR,—Within the constraints of brevity I would offer the following proposals for comment. General practitioners are fast approaching a state of training so far in advance of the 1948 pattern that they may well be expected to form a hierarchy. Community physicians may well expect to expand their role into health education and will necessarily overlap with postgraduate general practice training.

If, in addition, overseas groups withdraw their support the time would be ripe for senior practitioners to take charge of general multidisciplinary district general hospital firms, provided that the beds were allocated according to the local authority electoral rolls. Put another way, the hospital is necessarily part of the community and a senior practitioner might well expect to retain general clinical care of the patients in his practice area in their homes or in hospital.—I am, etc.,

PATRICK A. LAWRENCE

Oxford