of certain globulin molecules other than gammaglobulin which bind calcium more effectively than albumin.¹—We are, etc.,

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- 1 Pedersen, K. O., *Scandinavian Journal of Clinical and Laboratory Investigation*, 1972, 30, 321.
- 2 Robertson, W. G., *Clinica Chimica Acta*, 1969, 24, 149.
- 3 Pedersen, K. O., *Scandinavian Journal of Clinical and Laboratory Investigation*, 1970, 25, 223.
- 4 Rose, G. A., *Clinica Chimica Acta*, 1972, 37, 343.
- 5 Danowski, T. S., et al., *American Journal of Diseases of Children*, 1957, 93, 604.
- 6 Jones, J. H., et al., *Quarterly Journal of Medicine*, 1967, 36, 301.

Surgery in Crohn's Disease

SIR,—Your leading article (23 February, p. 295) is slightly misleading. The following comments are pertinent to the subject:

(1) The vast majority of surgeons in the U.S.A. favour resection rather than bypass. A short-circuit procedure is advocated only in cases of Crohn's disease of the duodenum or in the elderly, debilitated patient with a "burnt out" stenosing lesion.

(2) Controversy no longer rages over the optimum extent of excision. Most centres experienced with the disease do not advocate excision of enlarged lymph nodes. Conservative surgery is the rule.

(3) The surgeon should be warned of perianal disease associated with asymptomatic intra-abdominal Crohn's disease. In our experience at the University of Chicago Hospitals adequate treatment of perianal lesions should be accompanied by excision of the intra-abdominal disease.

(4) The recent recognition of occult obstructive uropathy complicating Crohn's disease¹ should now be an essential part of the evaluation of these patients. Adequate treatment includes intestinal resection and ureterolysis to achieve renal decompression.—I am, etc.,

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- 1 Block, G. E., Enker, W. E., and Kirsner, J. B., *Annals of Surgery*, 1973, 178, 322.

Assessing the Safety of Comatose and Postanaesthetic Patients

SIR,—I was interested to read the technique for assessing the safety of postanaesthetic patients described by Drs. A. W. Grogono and A. R. de C. Deacock (20 April, p. 174). I am sure that it will prove to be a valuable and much-needed aid, but one aspect of the procedure deters me from adopting it regularly. However gently one might apply the pressure to the chin and however successfully the patient might resist it, any attempt to throttle a patient soon after he has recovered consciousness must cause some alarm. I think I know a sign that is just as sensitive but causes no discomfort.

The patient is laid in a flat supine position with the head on a low pillow. The toes of one foot are grasped and the foot gently dorsi- and planti-flexed alternately, the heel being kept in firm contact with the mattress. If the patient is unconscious the point of the chin will follow the movements of the

forefoot. As the movement is transmitted by ligaments rather than by muscles, paralysis does not significantly affect it. If the patient is conscious the movement of the chin is greatly reduced or absent. It is possible to rock the head visibly and so move the chin in a fully conscious person by exaggerating the movement of the foot, but such movement of the chin is so much less and requires so much more force to be applied that the sign is an effective way to assess the level of consciousness of a patient recovering from an anaesthetic.

Sometimes a patient may actively move his foot in response to the passive movements. Alternatively he may raise his head in puzzlement as to what is going on. Either reaction confirms the alertness of the patient.—I am, etc.,

E. N. S. FRY

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Diet and Colonic Cancer

SIR,—With reference to your leading article (2 March, p. 339) we agree that it would be of interest to know if the incidence of cancer of the large bowel is appreciably lower in vegetarians than in the rest of the population. At present it is estimated that there are between 100,000 and 500,000 vegetarians in Britain. For some years we have been studying the incidence of disease in vegetarians. The findings so far would indicate that there is no apparent difference in the incidence of cancer in general between vegetarians and the rest of the population.

Estimation of the incidence of cancer of the large bowel among vegetarians is no simple task. The average annual incidence of cancer of the large bowel among the general population is estimated to be in the region of 30-40 per 100,000. Thus the detection of any significant difference in its incidence between vegetarians and the rest of the population would require the study of a very large sample, possibly the total vegetarian population of the country. In practical terms this is very difficult. However, we are currently investigating the incidence of all cancers and other diseases of the alimentary tract in vegetarians and hope that this may throw some light on the matter.—We are, etc.,

FREY R. ELLIS

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Self-administered Clinical Questionnaires for Outpatients

SIR,—Drs. J. M. Gumpel and A. M. S. Mason (27 April, p. 209) have shown that standard items of information are obtained much more consistently by questionnaire than by conventional history taking. The information is also much more accessible since it is found in a standard place on a printed sheet not in a random spot in illegible notes. A longer questionnaire of the type they describe has been filled in conscientiously by more than 90% of new patients attending my clinic for the past 12 years. The practice may be the norm in a few years. A few additional hints may therefore be helpful.

(1) The questionnaire should be individualized to suit the clinician's specialty. My special interests are renal and hepatic diseases, so half my patients sent by general practitioners have urinary infection

or hypertension or both and half the referrals from other consultants are for renal failure. A questionnaire that did not explore these subjects in depth would be of little use to me but the three pages I give to renal disease would be excessive for most other clinicians. A personal version is not administratively difficult to use. The secretary knows which consultant the patient will see and can readily extract the appropriate version from a few files.

(2) There should be clear instructions on how to fill in the form—for example, "Please answer the questions by putting a ring round the appropriate answer." A questionnaire with the answers ringed is much easier to read than one with the alternatives deleted. Some questions are better couched in vernacular. A Tynesider instantly recognizes "backbody" and "forebody" as synonyms for anus and vulva.

(3) Positive (that is, pathological) responses should be arranged down the right hand side of the page, with a wide margin for brief comment, like this:

Can you start to pass water without hesitation?
Yes No.

Do you dribble for a while after stopping?
No Yes.

How often do you rise at night to pass water?
Never Occasionally Regularly Twice Thrice
once once or more

With this arrangement a largely negative questionnaire can be read at a glance.

(4) Family history is difficult to obtain on a questionnaire. I have found it necessary to mention each category of relative individually and ask specifically for age, state of health, or cause of death.

(5) Information about past and present drug therapy is important. Analgesics and oral contraceptives are worthy of specific questions since they are often omitted if not spelt out in detail (including common trade names of analgesics). Drug identification at the clinic can be improved by using a sample display, which must be kept in a locked cupboard when not in use.

(6) A modified questionnaire can be used for the repetitive questioning of follow-up, such as in dialysis and transplant review clinics. One has been used at our dialysis follow-up clinic for five years and has proved invaluable in research as well as patient care. It is readily adaptable to computer storage. We are experimenting with one for conservative management of chronic renal failure.

(7) It is uneconomic to print individualized questionnaires but cyclostyled versions are acceptable and may be revised in the light of experience. Some questions have to be eliminated because they generate too many positive responses—about half the women in this area claim to be uncomfortable in both hot and cold weather. No rephrasing of these questions eliminated the false-positives answers.—I am, etc.,

DAVID KERR

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Nurses in Administration

SIR,—For some considerable time members of the medical profession have been using your correspondence columns to express their disquiet with the consequences of the Salmon recommendations for nursing staff. I would like now to draw the attention of your readers to an even more pernicious development in nursing care than Salmon. This is the proliferation of administrative nurses which is a consequence of the reorganization of the Health Service and the setting up of the area health authorities.

In the Cleveland A.H.A., where I work, we formerly had three general hospital groups, each of which had been Salmonized with appropriate administrative nurses and, in addition to this, we had two local authority nursing services, each of which had

implemented the Mayston recommendations with appropriate administrative nursing hierarchies. These five hierarchies and a further Salmon hierarchy from a large psychiatric hospital were all taken over by the A.H.A. on 1 April and their senior nurses confirmed as district nursing officers and other new high-flown titles. In addition to this, we have acquired an area nursing officer and she is happily acquiring four second-line administrative nurses to help her administer the former chief nursing officers who are now district nursing officers, etc. It seems to my untutored mind that an area nursing officer and four trained nurses as her assistants represent five nurses who could be employed on a ward. If they were employed as ward sisters the saving in salaries could be used to pay seven further ward sisters or, translated into another of our shortages, two consultant anaesthetists or four surgical registrars. We could even re-deploy their salaries as capital and perhaps upgrade 12 wards.

I understand that Drucker¹ suggests that when a professional becomes a manager he should subordinate his professional objectives to those of managerial efficiency within the organization he serves. It seems unfortunate that, at a time when professional nursing skills are in such short supply, more and more highly skilled nurses are being encouraged to give up nursing in order to embark upon highly irrelevant second-line administrative posts which appear to have been created only to give credibility to the status of their superior.—I am, etc.,

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¹ Drucker, P. F., *The Practice of Management*. London, Heinemann, 1969.

G.P.s and Family Planning

SIR,—I was greatly disturbed to read in the General Medical Services Committee's report to the Annual Conference of Representatives of Local Medical Committees, 1974, that "no training requirements will be specified for doctors who apply to go on the contraceptive list." This implies that to provide a family planning service in the context of general practice no qualification or experience is deemed to be necessary other than the rudimentary clinical instruction provided in medical schools and the ability to read the promised "memorandum on good modern contraceptive practice." If this is so we need hardly be surprised if our patients, the larger proportion of whom had previously preferred to consult their family doctor in the belief that he would be knowledgeable and experienced in this area, up sticks and hasten to the nearest Family Planning Association clinic. Furthermore, we shall presumably have small grounds for complaint should we find that the appropriate item-of-service fee currently under negotiation turns out to be derisory. In short, I feel that this declaration has done general practitioners with special training in this field a grave disservice and will deter others who had intended to seek further instruction.

It will certainly perpetuate the belief that G.P.s can be expected to provide only a

second-rate service and will be rewarded accordingly.—I am, etc.,

M. J. V. BULL

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Jamaica Meeting

SIR,—After reading the report (11 May, p. 313) of the Association's Clinical Meeting held in Jamaica in conjunction with its local equivalent I still do not know, aside from some trivia, what was available *medically* in Jamaica that could not have been much more readily made available in the U.K. In other words, were the journeys of some 600 doctors really necessary? Jet plane journeys are not, after all, inexpensive. And who would blame a Minister of the Government or a member of the electorate who thought that if even 600 British doctors can afford to fly to Jamaica for something they could have obtained as easily at home, then the doctors' current complaints about pay need not be taken too seriously?

There are two further and graver points to be made. According to the report of the Jamaican meeting a good deal of time was devoted to coronary heart disease, for which lack of exercise and obesity are sometimes considered risk factors. Are the general public going to take much notice of us in this regard when we travel around so readily by jet plane; and when, of the only two "en masse" Jamaican photographs, one (p. 323) shows doctors helping themselves to food at what look to be groaning tables and the other (*Supplement*, p. 70) shows a group of doctors, many of whom appear to be of more than their ideal weight? It hardly helps that another topic of discussion at the congress was "Malnutrition in Children," and in particular malnutrition in Jamaican children. Your report indicates that the Chinese claim to have eliminated malnutrition, and yet I do not hear of the Chinese having to cross oceans to spend a week brushing up their medicine.

Secondly, your leading article (p. 291) states that in Jamaica "the amount of money available for health care is severely limited. . . . Qualified doctors themselves are too few . . . and there is a substantial medical brain drain to the developed countries." There was certainly one session at the meeting devoted to primary health care teams; but will the meeting as a whole, with its discussions of intensive care units (two sessions), coronary bypass surgery, radio-isotopes, etc., have helped to stem that brain drain or to increase it? To put the whole matter more succinctly, who exactly profited from the meeting medically and in what ways?—I am, etc.,

S. BRADSHAW

How Caple

Private Beds in N.H.S. Hospitals

SIR,—Mr. R. J. H. Smith (4 May, p. 280) suggests that queue-jumping by private patients could be avoided by having waiting lists, available for inspection, containing the names of both private and public patients. Admission would take place when the patient's name reaches the top of the list. Alas, this is too simple a solution to succeed. The present waiting list system rightly allows for priorities, for we cannot allow a

patient with carcinoma of the colon to wait patiently behind the normal varicose vein patient. Sudden deterioration rightly warrants urgent admission on occasions. In areas where queue-jumping exists there would be a continuous spate of private patients who deteriorated or who were admitted directly from domiciliary consultations as urgent. When one thinks of the notorious tonsillectomy queue-jumping, it is obvious that an independent medical audit would be necessary to make such a system work.

There are dozens of dodges for private patients (or rather their consultants), though one hopes they are not widespread. This leaves me all in favour of private practice, but outside N.H.S. hospitals, please.—I am, etc.,

R. W. HOWELL

Reading, Berks

Payment for Teaching

SIR,—I could not agree more with Dr. R. S. Morton's brief but pointed remarks (27 April, p. 228) about clinical consultants with teaching commitments. I was most interested, also, in your special correspondent's visit to St. Justin's (11 May, p. 326), especially to learn that Dr. Itchen received only £240 for teaching. As a whole-time officer I do not have private practice to take me away from my hospitals. I do, however, have 11 sessions of clinical work and into this I have to squeeze two hours each week to take final-year students on a teaching round in thoracic surgery. For this I receive the munificent sum of £19.50 for 36 teaching rounds. Before Broadgreen became a teaching hospital two years ago my efforts were worth £50 per annum. The reason offered for this reduction is that the money available is static in amount and has to be divided among the increased number of teachers needed for the greater influx of students. I could do just as well financially were I to give four lectures at £5 each, but to my mind we can arouse much more interest and teach better by taking the students to the bedside. As Dr. Morton says, payment for teaching is indeed niggardly.—I am, etc.,

J. K. B. WADDINGTON

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Practice Expenses

SIR,—We are appalled at the ludicrous estimate for increase in practice expenses for 1973/74 made by the General Medical Services Committee in their report to the Annual Conference of Representatives of Local Medical Committees. The estimate of 13% for repairs, fuel, light, telephone, etc., is patently ridiculous in view of the increase in price of electricity, plus V.A.T., and telephone bills, etc. The figure of 15% quoted in regard to car expenses, which includes petrol, would be laughable if it were not so tragic. Car expenses for 1971/72, based on income tax returns, were calculated at £430. A new car is now depreciating by £400 per annum, the price of petrol has almost doubled and that of tyres has increased by 75%, and V.A.T. appears on repair bills.

We wonder how our representatives can