residual toxicity is currently in an advanced state of planning.—We are, etc.,

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¹ Fisher, B., et al., *New England Journal of Medicine*, 1975, 292, 117.

Fibre Content of Bread

SIR,—Many of your readers may have watched the recent B.B.C. T.V. Horizon programme "A Spoonful of Roughage" with considerable interest because of the possible implications for the nation's health of the high fibre hypothesis. Relatively few of them, however, may have been aware of two significant inaccuracies which occurred.

Firstly, the background narrative referred at least twice to the wholemeal bread of 100 years ago in relation to the incidence of certain diseases, implying that this was the bread in general consumption. This is completely contrary to fact. White bread was as common 100 years ago as it is today, and the change from stone grinding to roller mills made very slight difference to the amount of fibre in white flour. Bread flour was sifted to produce a finer (whiter) product long before roller milling was introduced, and white bread was eaten in very much greater quantity than today. Whatever the reasons for the lower incidence of gastrointestinal disorders 100 years ago general consumption of wholemeal bread was not one of them.

Secondly, reference was made in the background narrative to improved national health and to lower incidence of intestinal disorders during the war years due to the higher content of fibre in the war-time national loaf. Official records show that the higher fibre content of flour was not introduced until April 1942, the extraction rate of flour being increased to 85%—at which level, incidentally, the fibre content of the flour was much closer to that of white flour than of wholemeal flour. Whatever the reasons for the lower incidence of diseases from 1939 certainly to well into 1942 a difference in the fibre content of bread was not responsible. Other foods were subject to changed conditions. Less fat, less meat, and less sugar were consumed. Bread was deliberately left unrationed to permit optimum consumption.

These two facts are quite easy to validate.

We in the flour-milling and baking industries share in the desire of Mr. Denis Burkitt and his colleagues that the whole field be investigated thoroughly and that the true facts should emerge in due course, whatever they may be. It is important in

the meantime that the background presented by the media should not become distorted, even inadvertently, through inaccuracy, since sound judgement may be impaired.—I am, etc.,

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Dangers of Humidification of Inspired Air

SIR,—It is necessary to write a word of warning about the use of commercial humidifiers, whether they be small and domestic or large and industrial. The water in the reservoir is apt to act as a culture medium for bacteria and algae which are then sprayed over the unsuspecting people beneath, causing an acute alveolitis. Understandably, this is often called "influenza."¹ This culture is more likely when the reservoir is inaccessible (such as when attached to the ceiling) and when the atmosphere is very warm. Hospitals or large crowded overheated offices form good culture conditions.²

This bacterial or algal dissemination can be avoided by designing humidifiers without reservoirs which use instead water straight from the main. Introducing an antiseptic into the reservoir water is not safe as it merely sprays people with a potentially dangerous chemical aerosol instead of with bacteria or algae.—I am, etc.,

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¹ H.M. Chief Inspector of Factories, *Annual Report*, 1969, p. 72.

² Browne, R. C., *Proceedings of the Royal Society of Medicine*, 1973, 66, 1165.

Prevention of Overdoses

SIR,—In order to prevent overdoses why cannot the commonly used hypnotics have incorporated in them a very small dose of an emetic? This could be gauged so that in correct dosage the emetic had no effect but with overdoses it caused vomiting.—I am, etc.,

P. M. VICARY

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Basic Science and Specialist Registration

SIR,—Your leading article "Perinatal Research" (3 May, p. 236) raises the question just how much experience in "basic science" a clinician can obtain before the requirements for specialist registration are jeopardized. Specialist registers of the royal colleges are now in operation and require hospital doctors to have spent a specified period in each of the training grades in an approved post. As most basic science positions offered to interested clinicians are not approved posts those who wish to gain insight into scientific and clinical research may find themselves ineligible for specialist registration when they wish to return to their chosen field. The anomalous position may therefore arise that someone wishing to increase his knowledge and therefore provide a better service to his patients may find himself unable to re-enter his specialty.

Until recently this problem has not arisen as many of those availing themselves of

opportunities for basic study returned to university clinical departments. Training in such departments was not formalized and could be tailored to the individual's needs while advantage could be taken of the special knowledge or skills of the individual and ongoing education continued. However, it now seems that academic positions are to be assessed for specialist registration by the royal colleges. If this is so then it would seem that all university clinical posts have to be equated with N.H.S. positions and occupied by those who have followed, to the letter, the experience laid down for specialist registration.

This policy would make it more difficult for those who had either qualified abroad, studied abroad, or spent time at establishments such as the Nuffield Institute to enter university medicine in this country. The result of such a process would be a loss of diversity in academic medicine and consequently a loss of assets.

If the present character of university departments is to be retained the system has to be flexible enough to allow movement from basic science to clinical medicine and vice versa. In my opinion flexibility is being lost and the present trend should be halted before rigidity sets in.

If these problems are not considered now, then a rigid, sterile, and therefore inefficient system may be grafted on to the body of academic medicine for little reason other than conformity to the Treaty of Rome.—I am, etc.,

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Women Doctors

SIR,—Clearly shortage of space precludes full reporting of parliamentary proceedings in the *B.M.J.*, even when these are of interest and relevant to the profession. However, it is nothing short of censorship when you choose to report the beginning and end of a question-time exchange between the Secretary of State for Social Services and Mr. Bruce Douglas-Mann but neatly leave out a derogatory reference to the B.M.A. which occurs in the middle.

In a Medical News paragraph entitled "Conference on Women Doctors" (10 May, p. 347) you quote almost verbatim the member's question about "the steps taken to recruit, encourage, and ensure the effective deployment of women doctors" and Mrs. Castle's answer "that at present she was not satisfied that enough was being done." Mr. Douglas-Mann went on to ask, "Is my right hon. Friend aware that her attitude is extremely encouraging? Is she satisfied that the British Medical Association is doing all it can in this matter? Does she agree that it has a vital role to play in the efficient operation of the National Health Service? Is she aware that many people feel it is getting a little out of touch? Does she realize that it has recently made redundant the only woman doctor it employed?" Mrs. Castle replied, "I am aware of that. Naturally, as co-chairman of the Women's National Campaign in International Women's Year, I deeply deplore the reduction in the employment of any women in posts of responsibility."¹

These few lines did not appear in your pages, and I wonder if it is because the