the evidence suggests that what we are achieving is not enough. The reservoir of wild rubella in children and men must be eliminated by a national programme of vaccination in early childhood.

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Should general practitioners be informed of patients' convictions for drug offences?

SIR,—Your three commentators replying to Dr R G Neville's letter (14 June, p 1579) have avoided the important points regarding notification to GPs of alcohol and drug convictions. Most of the discussion focused on the pros and cons of onward passage of this information to other bodies—another and more difficult ethical question. It ignored the use the GP himself might make of it.

With the growing drug problem and severely limited resources, specialist drug units clearly cannot provide adequate services for abusers requiring treatment. The GP and primary health care team are ideally placed to take over this role; they are local and constantly available, probably already have a relationship with the patient, and have knowledge of the social and family structure. They may be already attending the patient for the physical and emotional sequelae of drug abuse. All they usually lack is the knowledge that the abuse is occurring.

It is true that drug addicts are shy of seeking their GP's help, perhaps because they fear Home Office notification, but more probably because of the mutual fear and distrust generated by the old and hopefully discredited policy of supply and maintenance.

Drug abusers need to know that their GP will neither "shop" them nor ever supply them but will give sympathy, counselling, care, and support. If they should then make a resolution to go through withdrawal he will help them through it at home, using simple measures only. Detoxification in a specialist unit could then be reserved for severe barbiturate or mixed drug addiction. Notification by the courts to GPs of their patients' convictions for drug or alcohol offences would greatly help in bringing this about.

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SIR,—I found Dr R G Neville's suggestion that general practitioners should be told of patients' convictions for drug offences (14 June, p 1986) both flawed and disturbing. His aims of increasing the notification rate of addicts to the Home Office and "recognising patients with controlled drug addiction" are unlikely to be achieved. At present, the great majority of offenders are dealt with for offences involving cannabis[1] while several others will have been using amphetamines or barbiturates. Addiction to these drugs does not require notification to the Home Office. The notification procedure itself requires that a doctor be satisfied "a person shall be regarded as addicted to a drug if, and only if, he has as a result of repeated administration become so dependent on the drug that he has an overpowering desire for the administration of it to be continued." This may not be equivalent to a conviction for possession of a small amount of a controlled drug.

Like our other patients, drug misusers are a mixed bag who deserve care and professional help in the prevention, diagnosis, and treatment of disease. To achieve this they must be encouraged to attend for help and not subjected to possible humiliation. Can Dr Neville guarantee that all GPs informed by the courts, as suggested, will react favourably or might some seize the opportunity to react, as he himself appears to be doing, by confusing policing with doctoring?

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1 Home Office. *Tackling drug misuse: a summary of the government's strategy*. 2nd ed. London: Home Office, 1986.

Happiness is: iron

SIR,—Mr Geoffrey Cannon raised an interesting point in relation to the bioavailability of iron added to manufactured bread products in the UK diet (14 June, p 1599). As he is no doubt aware, the availability of iron from cereals and vegetables is generally poor, and it is therefore important to ensure that iron which is added back to low extraction flours is readily absorbed and used. In fact the present state of knowledge is more complex than his remarks imply.

The iron currently added to bread is a purified elemental powder, prepared by electrolysis or by chemical reduction to a specification controlled by law.[1] This type of iron has been shown to be well absorbed and utilised by experimental animals and man, but its bioavailability falls sharply as the particle size rises above about 40 μm.[2] The bread and flour regulations currently require that 95% of the particles in fortification iron should be less than about 50 μm.

The members of the DHSS panel who considered the nutritional aspects of bread and flour[3] had no information on the bioavailability of the iron currently added to bread in the UK, and their conclusion that it was unlikely to be well absorbed was based on data obtained with iron which did not conform to modern specifications.[4] The iron currently added to breads is probably significantly more available than the early studies would imply, and this question is currently under investigation.

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1 Ministry of Agriculture Fisheries and Food/Department of Health and Social Security. *The bread and flour (amendment) regulations*. London: HMSO, 1972. (SI 1391.)
2 Pennell MD, Wiens W, Raspar J, Motzok I. Factors affecting the relative biological value of food grade elemental iron powders for rats and humans. *J Food Sci* 1975;**40**:879-83.
3 Department of Health and Social Security. *Nutritional aspects of bread and flour*. London: HMSO, 1981.
4 Elwood PC. A clinical trial of iron fortified bread. *Br Med J* 1963;i:24.

A place for a permanent subconsultant grade?

SIR,—The speakers at the senior hospital staffs conference (21 June, p 1682), while having noted the existence of the subconsultant, seem to have omitted from their list of those already in tenure of such posts the "Short"-handed consultant. Mr Tom McFarlane spoke of a multiplicity of grades in the future, as though the present consultant grade were not as stratified as an American layer cake. At the top, crowned with icing and marzipan, is the consultant in the university teaching hospital with an "A" merit award, large junior staff, good private practice, wide powers of patronage, and little or no night work. The bottom layer is the "Short" consultant with no junior staff, a heavy service commitment, no prospects of a merit award, no time for private practice, no political clout, and every prospect of doing night work until retirement.

Mr C J Cutting touched the nub of the matter when he spoke about workloads and of some work being "not necessarily of consultant status." Consultants tend to have strong but confused ideas about what is and what is not work of consultant status. For example, the repair of an inguinal hernia may be registrar surgeon's work in the district general hospital but consultant's work in the local Nuffield hospital. Until it attracted a fee sterilisation was considered mainly too trivial for a consultant gynaecologist. Similarly, the profession makes arbitrary but absurd distinctions about emergencies, most of which fall to the lot of the juniors. It is absurd but common for the junior anaesthetist to deal with the emergency caesarean sections, while the consultant deals with the easier elective sections. On grounds of safety alone priorities should be reversed.

If consultants were to accept that the greater part of the emergency workload, and hence more of the night work, merited their accumulated experience and skill then they would have to accept that there should be a considerable increase in their number, as Mr A H Grabham advocates. This government has been swift to seize on that part of the Short report that recommended reduced numbers of registrars but slow to expand the senior grade. Dr M M Vosey came within an ace of the simple sum that explains why. The registrar is contracted to a working week of 80 hours, the consultant to one of 40 hours or 10 sessions of 3¾ hours. Therefore in terms of service commitment one registrar equals two consultants, and when we are discussing the Short type department we are talking about sharing out the workload among consultants and within the terms of their sort of contract. Status nowhere enters into the calculation, only commitment.

If the profession is to make more room at the top it will entail a revolution in habits of mind and in the way in which we regard our commitment to the service workload. Nobody should pretend or be led to believe that this will be a cheap solution. It may well result in a magnificent service to our patients, but it will be costly.

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Standard of manuscripts submitted to medical journals

SIR,—I read Dr Sidney Crown's personal view with interest (21 June, p 1665), but in criticising the standards set by "some famous teaching hospitals" he misses some important points. I am a registrar in a "centre of excellence" and have submitted a number of manuscripts. Because I am not employed by the university I cannot use its facilities. Medical secretaries in the NHS are underpaid and overworked and the typing of manuscripts does not form part of their contractual obligations. Despite this they are often willing to undertake such extra work (and indeed a letter to the *BMJ*) as a favour, but this is not invariable. The alternative is a typing agency. These are expensive and the secretaries are not used to medical terminology, often resulting in numerous errors. It is not unusual to have the manuscript retyped three times to satisfy the understandably high standards of the quality medical journals, twice to satisfy the assessors and once for the copy editor. An average length manuscript can therefore cost about £80 to produce in its final form. This is the reality for junior staff and is the explanation for some of the criticisms, put forward by Dr Crown, which will not have occurred to him because, as he says himself, "I am so protected as an editor that I will probably never know."

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