dialysate,[1] is recommended routinely for all chronically dialysed patients. It is suggested that the patient under this treatment can not only substitute iron, folate, and amino-acid losses from the remaining blood into the dialyser, blood sampling for analysis, and to the dialysate, but also effectively utilize these elements incorporated in the diet, according to his real needs.—We are, etc.,

H. YATZIDIS
D. TRIANTAFILLIDIS
C. KOUTSOYANNIS
S. VOUDICLARIS
P. DIGENIS

General Clinic of Athens,
Athens, Greece

1 Yatzidis, H., Triantafillidis, D., Voudiclaris, S., and Koutsoyannis, C., *British Medical Journal*, 1970, **4**, 52.

Social Services and Community Health

SIR,—The recent Department of Health and Social Security circular[1] is very opportune as it does officially confirm that the medical officer of health is still medical adviser to his council on all subjects and problems appertaining to community health (and this includes social welfare).

Many medical officers of health have suspected that with the advent of the new departments of social services their advice and expertise were no longer welcome. Close reading of the circular makes one wonder why there was ever any real need for such an upheaval and reorganization of health departments as followed the Social Services Act, 1970. Has not the change been wrongly made for the sake of expediency? Has the immediate aim not been to relieve the intensive pressure brought to bear by social workers for unified social welfare departments and was not this pressure directed so influentially that they gained their objective?

Now the Department of Health and Social Security appears to have sensed the obvious danger, to the detriment of the patient, for whose benefit the services exist, in splitting the health and welfare services down the middle. Many medical officers of health will have a wry smile as they read between the lines of this circular. I consider it naive to expect that all will be as before in this field of community welfare. There is no guarantee that the advice given by the medical officer of health will be implemented. There is also no provision for the cost in money, manpower, and resources of providing within health departments the machinery for this liaison. Many health departments may even be in the process of running down their establishments or finding it difficult to maintain their staff in what appears to be an increasing atmosphere of indifference and uncertainty as to the future. This is a particularly pertinent point when it is remembered that the creation of the new social services departments was itself a costly manoeuvre.—I am, etc.,

WILFRID H. PARRY

City of Nottingham

1 Department of Health and Social Security. *Co-operation between Social Services Departments and Health Departments*. L.A.S.S.L. 33/71.

Uses of Bureaucracy

SIR,—The finding of the missing baby Denise Weller is a direct result of the initiative of Mr. Harris, the superintendent registrar of births for Brighton, in seeking the collaboration of the chief nursing officer and her staff in the Brighton Health Department. The discrepancy between the peculiar request for registration to Mr. Harris, and the absence of any official legal notification of a birth to the medical officer of health, showed that something was amiss and needed investigation.

This success demonstrates the value of the proper application of the routine information we require. It is easy to label local authority staff as bureaucrats and to abuse us when we require forms to be filled in. There is constant outcry from the profession about certificates and the like but family doctors cannot have it both ways. The choice is theirs. If they do not want to collaborate, they deny us the opportunity of this sort of rescue operation. The whole country now sees what we do with the information we seek.—I am, etc.,

W. S. PARKER

Health Department,
County Borough of Brighton,
Brighton, Sussex

Stilboestrol and Cancer

SIR,—I read with great interest your leading article on "Stilboestrol and Cancer" (11 September, p. 593), but I would like to point out that stilboestrol is not a hormone but a hormone analogue.

Diethylstilboestrol was produced in the Courtauld Institute of Biochemistry in the Middlesex Hospital Medical School, by my colleagues and myself after many years of intensive investigation. Its synthesis was published in *Nature*,[1] and is, as far as I know, the only substance that bears no structural relationship to a natural hormone, but has the same action.—I am, etc.,

E. C. DODDS

London W.2

1 Dodds, E. C., Goldberg, L., Lawson, W., and Robinson, R., *Nature*, 1938, **141**, 247.

Points from Letters

Anxiety and the G.P.

DR. C. W. D. PHILLIPS (Huddersfield, Yorks) writes: The accessibility of the general practitioner is a topic that needs to be discussed openly now that many doctors have (quite rightly) introduced appointments systems. The problem arises when enough time is not allocated for appointments. One of our main tasks is to alleviate anxiety, and we may fail to do this if the patient has to wait too long to get an appointment to see us. The question of what is urgent in general practice is a vexed one. How long should a middle-aged man with a vague pain in his chest have to wait before he can see his doctor? Dr. C. A. H. Watts (14 August, p. 419) says that all patients in general practice, apart from those clearly not urgent, should be seen within 24 hours. Disquiet is being expressed at the vast quantities of medication, especially hypnotics and tranquillizers, consumed by the British populace. Most of this medication is presumably prescribed by us general practitioners. Do we sometimes take the easy way out, and continue to sign prescriptions for these drugs without seeing the patients, rather than spend a few minutes with the patients to see if the prescription is really necessary?

General Practitioner Obstetrics

DR. M. B. CLYNE (Southall, Middx) writes: Mr. R. M. Burton (28 August, p. 532) is one of our local consultants with whom we general practitioners in the area of Hillingdon Hospital and Perivale Maternity Hospital work so well together in shared antenatal care. The benefits of this shared care are immeasurable, both for patients and for general practitioners. The patients benefit not only by saving waiting time and long journeys, but also because they are always aware that their general practitioner is taking ultimate care of them during pregnancy. General practitioners benefit because the shared system of care is bound to raise their level of antenatal care and because they are never ignorant of their patient's condition during pregnancy, as is apt to happen when the patient is taken over by an antenatal department. . . .

Scotland's Anaesthetists

DR. C. S. JONES (Worcester, C.P., South Africa) writes: Dr. S. D. Parbrook's interesting report on anaesthetic staffing and training requirements in Scotland (31 July, p. 293) is apparently based upon the premise that all anaesthetics in Scotland should be given either by consultants or by anaesthetists in the specialist training programme. . . . I wish to disagree most emphatically and to call attention to a large and most useful group of doctors who should be incorporated in the anaesthetic services—that is, the general practitioners . . . . An analysis of the anaesthetics administered in Scotland will reveal that a very large number are for such operations as dilatation and curettage, cystoscopy, open bone operations on the extremities, operations for varicose veins and hernia, breast biopsies, and mastectomies, and many others performed on patients who are usually healthy and who can be anaesthetized by simple techniques. All these anaesthetics can very well be administered very adequately by general practitioners who have a special interest in, and have been given some training in, anaesthetics, and who have consultant anaesthetist supervision and assistance readily available. Consultant anaesthetists should surely be reserved for anaesthesia for "poor risk" patients; for anaesthesia for major surgery; and for those special techniques which exotic surgery demands. They should also be freely available for advice and assistance to, as well as for the teaching of, non-consultants also practising anaesthetics. This surely is what is implied in naming them "consultants"? . . .

Onycholysis and Enzyme Detergents

DR. H. R. VICKERS (Department of Dermatology, Radcliffe Infirmary, Oxford) writes: I have been trying to find the incidence of skin damage caused by enzyme detergents, and from replies received to a questionnaire sent to all British dermatologists the incidence is extremely small. One interesting feature about the case described by Drs. G. Hodgson and R. T. Mayon-White (7 August, p. 352) is the fact that the patient was in contact with the washing agent for such a long time each day and this degree of exposure must be unusual in Britain. It is also of interest that if the keratin of the nail was so severely damaged the keratin of the skin was only mildly affected. Loss of nails as described is very uncommon and no other similar cases were reported to me in my inquiry.