the large bowel and found that they did not give rise to malignancies.[7] At Baragwanath Hospital, colonoscopy studies (over 100 a year) confirm absence of polyps; the colons even of elderly black patients have the same appearance and elasticity as those of young white patients.[8]

Conceivably, any population subsisting on a diet high in foods containing fibre could be similarly protected. In the early 1800s rural Scots ate oat porridge three times a day, seven days a week, with a thick vegetable soup at night.[9] In England, rural farm workers consumed a huge amount of bread, several times our present consumption,[10] but virtually all were active physically. Perhaps their gastrointestinal tracts resembled those of rural Africans in their lesser proneness to disease. Present dietary guidelines, however vehemently urged, will never cause the gastrointestinal tract to revert to its pattern in former times.

A R P WALKER
B F WALKER

Human Biochemistry Research Unit,
Department of Tropical Pathology,
School of Pathology of the University of the Witwatersrand,
Johannesburg,
South Africa

I SEGAL

Gastroenterology Unit,
Baragwanath Hospital and University of the Witwatersrand,
Johannesburg,
South Africa

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Waiting lists out, booking systems in

SIR,—Miss Linda Beecham describes a "revolutionary" new system for booking patients in for operations. I was appointed consultant surgeon in West Berkshire in 1977 with outpatient clinics at Battle Hospital, Reading, and Newbury District Hospital. All patients seen at Battle Hospital have their operations there; most patients seen at Newbury Hospital can have their operations there, but those with more major problems are admitted to Battle Hospital.

From the date of my appointment I ran a diary system at both hospitals, every patient needing surgery being given a date for admission and operation. I still continue this practice at Newbury Hospital. At Battle Hospital, however, in August 1989 a management decision resulted in 18 beds and three operating lists being taken away from the two consultant firms on which I work. I was forced to start a waiting list. During the past 18 months, from having no patients on the waiting list at Battle Hospital I now have 97, 25 of whom have been waiting for more than six months.

Even if the beds and operating sessions that were taken away were returned there are now too many patients on the waiting list for the diary system to be reintroduced. Proposals such as those suggested by South Western Regional Health Authority are excellent in theory but fail to take into account those patients already on the waiting list. There are two prerequisites before waiting lists can be abolished: firstly, an initiative has to be taken to create over a defined period extra beds, operating sessions, and staff to work off the existing waiting list; and, secondly, adequate facilities (beds, operating time, and staff) must be made available to maintain a booking system. I doubt whether the political will and the finance will ever be made available to achieve these two prerequisites.

R G FABER

Battle Hospital,
Reading,
Berkshire RG3 1AG

1 Beecham L. Waiting lists out, booking system in. *BMJ* 1991;**302**:929. (20 April.)

DRAMS scheme

SIR,—We wish to clarify the Health Education Authority's position about the DRAMS (drinking reasonably and moderately with self control) scheme, which was developed in Scotland by the Scottish Health Education Group (now the Health Education Board for Scotland).[1]

The Health Education Authority is the statutory body charged with health education and health promotion in England. It has agreed to introduce the DRAMS pack to general practitioners and others together with a range of materials, such as the COD (cut down on your drinking) pack, which we and others are currently developing for those working in primary health care. These materials address the issue of sensible drinking in a variety of ways.

Our intention is to acquaint general practitioners, trainers, and other staff with this range of materials and the different approaches through a series of introductory workshops. We hope that this will encourage general practitioners and regional advisers to make informed choices about alcohol training and support materials appropriate to their needs and the needs of their patients.

We are confident that the incentives contained in the general practice contract will help achieve the widest practicable dissemination of DRAMS, COD, and other materials beyond these initial workshops. We will be happy to supply further details of our plans to anyone who contacts us.

RAY EARWICKER
TARA WOLFF

Health Education Authority,
London WC1H 9TX

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Gradients of portable ramps

SIR,—We found Dr A F Travers's article on ramps and rails interesting,[1] having recently evaluated commercially available portable ramps for the Department of Health[2] and completed a separate study that aimed to establish gradients that could be negotiated by wheelchair users on two different lengths (1 m and 1·8 m) of otherwise identical portable ramps.[3]

In the light of the findings of the second study, we would query Dr Travers's recommendation that a ramp's gradient should not exceed 1 in 12 and should ideally be 1 in 20. Indeed, both the British Standards Institute and the American National Standards Institute recommend gradients of 1 in 12 or shallower,[4,5] but we found that gradients of 1 in 8 and 1 in 6 could be negotiated on both lengths of ramp by a significant number of subjects in our study. A gradient of 1 in 10 on the 1 m ramp could be negotiated with relative ease by most of the subjects, and we concluded that a short ramp with a gradient of 1 in 10 may be easier to accommodate (in terms of space) and to use than a longer ramp with the traditionally recommended gradients of 1 in 12 to 1 in 20. The short ramp required a short burst of energy, whereas the longer ramp required a slower, sustained energy expenditure. These results confirmed the findings of a study by the Disabled Living Foundation that recommended, for wheelchair users who propel themselves, a gradient of 1 in 10 on a 3 m ramp.[6]

G M SWEENEY
A K CLARKE

Royal National Hospital for Rheumatic Diseases,
Bath BA1 1RL

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Brain, mind, insanity, and the law

SIR,—In his editorial on sane and insane automatism Dr P B C Fenwick repeats the canard that when a defendant is found to be suffering from insane automatism the judge must inevitably send him to a secure hospital.[1] This is not so. These defendants may be, and indeed are, sent to ordinary psychiatric hospitals, and the Home Secretary is by no means inflexible about their management. Thus in his research on the insanity defence and its consequences Mackay describes three cases in which the defendants were found to be insane, were sent to local hospitals, and were discharged within six weeks.[2] One of these was a person with epileptic automatism. This does not mean that the 1964 act is altogether satisfactory, only that it can be operated humanely, and the Criminal Procedure (Insanity and Unfitness to Plead) Bill now before parliament will definitely be an improvement as it will make the proper disposal in these cases much easier.

As an addendum, I should like to hear from Dr Fenwick when and where defendants suffering from anxiety are found to be insane. Mackay did not come across this diagnosis in any of those found insane in the years 1975-88.

D TIDMARSH

Broadmoor Hospital,
Crowthorne,
Berkshire RG11 7EG

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Been to Africa

SIR,—Recently a wealth of material has been published testifying to the benefits of an elective period spent practising clinical medicine in the developing world.[1-5] I agree with these sentiments, having recently returned from working as a lecturer in surgery in Nigeria. Clinical skills, operative experience, and management skills are all enhanced in a way that is not possible in the United Kingdom. Ms Alison Fiander, however, identifies a very real problem when she states that "unsupervised tropical experience is largely overlooked."[6]

Given the benefits attested to by so many, is it not time that formal links between clinical and

academic departments in the United Kingdom and the developing world were made? This would allow trainees to spend one or two years of a teaching hospital rotation in the developing world. The hospital to which they were going would be known, as would the degree of supervision there; an operative or case log book could be kept, and a suitable research project could be undertaken to be presented and published on return. Returning to the United Kingdom to complete a career registrar rotation would remove much of the uncertainty and insecurity that currently attend such a move and would allow further training, which would build on and enhance the experience gained abroad.

Such links would lead to greater appreciation of the benefits of clinical practice in the developing world and, perhaps, to an elective in the developing world being seen by trainer and trainee as a positive factor enhancing both clinical skills and career prospects. Such links could and should be made.

CHRIS HOLCOMBE

Department of Surgery,
Charing Cross Hospital,
London W6

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Adequacy of general practitioners' premises for minor surgery

SIR,—I was concerned to read of the low standards that Leeds Family Health Services Authority and the district health authority have adopted as minimum criteria with regard to resuscitation equipment, back up staff, and asepsis when assessing facilities for minor surgery in general practitioners' premises.[1]

The minimum requirements of an adequate airway device (such as a Guedel or the now outmoded Brook airway) and adrenaline with no specification for the provision of oxygen are in stark contrast to the recent recommendations of an expert working party to the Standing Dental Advisory Committee,[2] in which essential items for maintaining an airway, giving oxygen and artificial ventilation, and maintaining the circulation are listed together with first line and second line drugs for resuscitation. In addition, every member of the dental team should be trained in resuscitation and the procedures should be regularly practised in the surgery under simulated conditions.

Although Messrs N Zoltie and G Hoult state that a suitable, working, and adequate method of sterilisation is the only criterion regarding asepsis, in the current climate of concern about cross infection can it be that sterilisation by boiling or chemical immersion is acceptable and that gloves are not mandatory to protect both the patient and the practitioner?

If an increasing volume of minor surgery is to be done in general practice surely patients, many of whom probably have significant underlying disease and are taking potent medication (and in whom anaphylaxis from the local anaesthetic is unlikely to be the most dangerous potential complication) will assume that their medical practitioner is providing the safe environment that is required in every general dental practice.

I appreciate that most are providing facilities far superior to the minimum requirements, but with the progressive emphasis on resuscitation skills being gained by the general public, patients will expect rather more from their doctor.

JOHN LOWRY

Department of Maxillofacial Surgery,
Bolton General Hospital,
Bolton BL4 0JR

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Freeman Hospital

SIR,—I have much sympathy with Drs Ian D Griffiths and Peter D Wright[1] but regret that I do not agree with their history of events.

The policy to centralise dermatology is more than 20 years old and the 1988 plan was just one of many administrative failures to operate it.

Detailed plans for the transfer of patients and resources from the Freeman Hospital were never agreed, despite all our efforts.

The district general manager did not tell all parties last April that the dermatology department in the Freeman Hospital would be closed after March 1991; on the contrary, he wrote on 25 July 1990, "I agree that the deal made at the start of April was that dermatology beds would remain at the Freeman until suitable alternative provision could be made and I confirm that I stand by that deal." He later wrote confirming that this was health authority policy.

It is beyond dispute that what finally dislodged dermatology before proper provision was available was the Freeman Hospital's adoption of trust status.

This instance raises matters that go beyond the parochialisms of dermatology in Newcastle to the very core of the new, deformed NHS. These defenceless parts of the NHS are at risk of disappearing quietly, like Kurds on a mountain. And that is why I am writing: what is bringing the Kurds off the mountain and back to life is public awareness. The NHS won't fade away if we all know what is happening and are determined to do something about it.

SAM SHUSTER

University Department of Dermatology,
Newcastle upon Tyne NE1 4LP

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Danish junior doctors' hours

SIR,—Last year Mr Jack Hoffman and Dr Anders Fischer urged junior doctors in other countries to heed the experience in Denmark and temper their struggle for shorter hours with a little more concern for their clinical training.[1] Their conclusion, however, was based on several misinterpretations, and most of their assertions lack documentation. Unfortunately, in her more recent editorial[2] Dr Alison Walker took their letter at face value. We would like to correct a few of the assertions of Mr Hoffman and Dr Fischer.

Firstly, the authors seem to equate quality with quantity. Although we share their concern about the clinical training of junior doctors, we do not accept that hours spent at work guarantee better clinical training. There is no evidence that Danish junior doctors trained in the period before 1981, when an industrial conflict gave juniors the right to the same hours as the rest of the population, received a better clinical training than their colleagues educated after 1981.

Secondly, the allegation that the number of doctors and the extra payments for overtime hours are responsible for severe cutbacks in hospital services—for example, the closure of hospital departments and even entire hospitals—lacks any documentation, and for good reasons. In 1990 the number of junior doctors in relation to, for example, nurses was 28%, about the same (25%) as in 1980.[3] Junior doctors' salaries as a proportion of the total expenses in the Danish hospital system in 1980 was under 10%. Unfortunately, more precise assessment of the amount is not possible. Even if the overtime payments, etc, were increased by, say, 20% the junior doctors' share of the total expenses in the Danish hospital system would still be only a maximum of 12%. The actual share in 1990 was 7·5% (these figures are from surveys conducted by the Danish Association of Junior Hospital doctors in 1980 and 1990).

Thirdly, mention was made of junior doctors being off duty for two out of five weeks; this is rare, though admittedly possible. The reason for this, however, seems to be insufficient planning by hospital administration rather than the regulations concerning juniors' working hours.

Finally, Danish junior doctors, the national health authorities, and the county councils responsible for the hospital system in Denmark are currently jointly trying to make clinical training better and more efficient. Among other things, this entails setting explicit goals and objectives, educational programmes, and systematic evaluation. Despite initial difficulties and shortcomings in this reform we find an effort of this sort a more adequate way of addressing the demand for better clinical training than merely increasing the numbers of hours spent at work.

SVEND M CHRISTENSEN

Danish Association of Junior Hospital Doctors,
2100 Copenhagen 0,
Denmark

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Junior staff

SIR,—To describe those hospital doctors who are not yet consultants as junior staff is inappropriate and pejorative. It is high time that some other collective term was employed.

Having done well academically at school, trainee specialists undertake a gruelling five years at university followed by one year as a house officer. At this stage, aged 23 or 24, trainees might conceivably be thought of as being junior even though a person of the same age who is the more junior of two pilots with British Airways is called a first officer or somebody working as a civil servant may be an executive officer.

The next stage for hospital grade staff is as a senior house officer, and this, together with registrar and senior registrar, is not a bad term. It is the collective phrase that is at fault because a registrar has achieved much academically and usually possesses other diplomas or degrees and is anything but junior. It is obviously nonsense to collate senior registrars under the title junior staff.

The point at issue is how the outside world sees this important group of professional men and women. Time and again we see the newspapers talking about junior staff, thereby creating entirely the wrong impression. I suspect that there is even a danger that the use of the phrase will come to influence how they and we think about them. I suggest that in the NHS the collective term should be "medical staff" and that in the context of hospitals medical staff comprise house staff, senior medical staff, and consultants.

C WASTELL

Surgical Unit,
Charing Cross and Westminster Medical School,
London SW1P 2AP