levels in accident and emergency departments. In our own group—though at present the junior medical staffing is relatively satisfactory for the two major departments which provide a continuous casualty service—there have been occasions over the past nine months when the service has been maintained only by the employment of locum tenens, clinical assistants, or by the payment of extra duty allowances to junior medical staff.

Work in emergency medical departments requires a high degree of competence and is not appropriate for the inexperienced junior doctor without continuous support of senior medical staff. Casualty duties have been regarded traditionally as a disagreeable chore to be performed or avoided as expeditiously as possible in the hope of escaping the lurking litigation that preys on inexperience. Such duties, therefore, are only acceptable when the junior doctor knows that senior opinion is available in support until a higher level of competence is reached through a defined system of promotion.

Winter is again approaching, and with the complex of motorway intersections in this area, we are seriously concerned at the prospect of coping with multiple road accidents, etc., with a medical staff which relies initially on a medical assistant who is the only member of the medical team in the accident and emergency department providing any continuity, plus (if we have been fortunate in recruitment) a senior house officer.

Our committee feels that staff of at least medical assistant seniority should be available 24 hours a day. The recent M6 disaster occurred at approximately 7.00 a.m. Had a similar accident taken place in the Salford area, in which is situated the Worsley braided interchange, Britain's most sophisticated motorway multilevel interchange, known locally as "Spaghetti Junction," senior medical staff would not have been available on duty at either of the two major accident centres in this group, which provide a 24-hour casualty service. This implies no criticism of assistance which is readily available at all times in cases of emergency; it is rather that so important a unit as an accident and emergency department should not have to be dependent on assistance from other departments. There are always "back up" services within the hospital; it is the initial facilities in the way of medical staff which are inadequate. Undoubtedly, it may be necessary to rationalize the number of accident and emergency departments which are available, but a prerequisite of this rationalization must be adequate accommodation, adequate theatre space, and, above all, an adequate medical staff with a specialist consultant in charge.

The Regional Hospital Board has been extremely generous over the years in providing finance to improve facilities for the reception and treatment of accident and emergency cases and to improve the junior medical staffing of these departments, but there is little doubt that attendances will continue to increase. Within the present level of medical staffing it is difficult to see how these patients can be adequately dealt with, particularly if they attend outside what is commonly known as the normal working day—that is, between 5.30 p.m. and 9.00 a.m. We can no longer depend upon general practitioners, who are also hard pressed, to assist with locum tenens sessions.

The lack of a decision on policy in this field is increasing the risk to patients and the unfair burden on young doctors who are obliged to accept an excessive responsibility. Urgent consideration must now be given by the Department of Health and Social Security to providing a similar way of medical staffing structure within accident and emergency dpeartments to that which is already enjoyed in other specialized fields in the Hospital Service.—We are, etc.,

R. I. MACKAY
Chairman,
Medical Executive Committee

J. B. DUCKWORTH
Group Administrator and Secretary

Salford Hospital Management Committee,
Salford

Shortage of Physiotherapists

SIR,—I fully agree with Dr. R. S. Savidge (16 October, p. 169), but may I make two points?

It is difficult in a busy department to make use of the valuable services of a part-time married physiotherapist or occupational therapist with children at school, because she will not be available during school holidays, which often coincide with annual leave of full time staff.

Anyone seeking such employment would be well advised to discover whether she will be taxed on her husband's income. If she is, she may find herself actually out of pocket at the end of the year.—I am, etc.,

CLIVE SHIELDS

London S.W.3

Evidence to the Coroner

SIR,—Dr. J. Shackleton Bailey, Coroner of the District of Norfolk (25 September, p. 766), shows a regrettable lack of understanding of the relationship between doctors and health visitors. There are several points in his letter which suggest that he is unaware of the good working relationships which are being developed between them through the attachment of health visitors to group practice, or by general practitioners working in health centres. Even where this close partnership does not exist, relationships between these two branches of the Health Service are generally good, and circumstances such as he describes would not arise as there would be adequate consultation between all those involved.

The circular Dr. Shackleton Bailey refers to was sent to all medical officers of health with a copy to chief nursing officers, and I quote below the two relevant paragraphs.

"We know you will appreciate the vital importance for the success of a health visitor's work of winning and retaining the confidence and trust of the families she visits and consequently the damaging effect of publicized court appearances.

"Consequently, after very careful consideration of all issues involved, my committee has requested me to ask that health visitors, in their capacity as such, should be protected from giving evidence in court proceedings except under subpoena when evidence which only they can give is essential in the interests of justice. Experienced health visitors report that provided they have been subpoenaed they can explain to other families who might otherwise lose confidence in them that they had been legally compelled to give evidence on the occasion in question."—I am, etc.,

G. M. FRANCIS

Health Visitors' Association,
London S.W.1

Hallucinations of Widowhood

SIR,—No doubt there are many well-authenticated historical examples of the phenomena described by Dr. D. Dewi Rees (2 October, p. 37).

A good one is recorded by Antonia Fraser in her recent biography of Mary Queen of Scots.[1] Shortly after the death in December 1598 of her teenage husband Francis II, King of France, Mary wrote stanzas on the grief she felt after her tragic bereavement. One stanza was as follows:

"As I sink into my sleep
The absent one is near
Alone on my couch
I feel his beloved touch
In work or in repose
We are forever close."

—I am, etc.,

W. B. ROANTREE

Deal, Kent

[1] Fraser, A., *Mary Queen of Scots*, London, Weidenfeld and Nicholson, 1969, p. 108.

Hypoglycaemia in Infancy and Childhood

SIR,—I was somewhat concerned to read some of Dr. A. D. Griffiths's 21 August, p. 475) comments on your leading article "Hypoglycaemia in Infancy and Childhood" (17 July, p. 130). He suggests that hypoglycaemic newborn infants without symptoms should not be treated with intravenous glucose because the treatment itself has an element of risk and because of lack of evidence that asymptomatic hypoglycaemia results in brain damage. While I would agree that the prognosis in symptomatic and asymptomatic hypoglycaemia is very different, it seems to me that it would be unwarranted at the moment to say that asymptomatic hypoglycaemia is harmless. Of 71 infants with hypoglycaemia seen at this centre during the past 10 years, 48 have been followed up so far. Neurological sequelae were subsequently found in 14 of 23 infants who had had symptoms and in 4 of 25 infants who had had no symptoms.[1] However, it is often a matter of opinion whether a baby should be classified as "symptomatic" or "asymptomatic." Symptoms may be minimal and none are pathognomonic of hypoglycaemia. A hypoglycaemic baby with apnoea or convulsions, disappearing within a few minutes of giving intravenous glucose, is clearly "symptomatic," but I have seen tense, irritable, but otherwise asymptomatic infants who relax and go to sleep after receiving glucose. Should these not also be called "symptomatic?"

Also, I cannot agree with Dr. Griffiths that, in the infant of the non-diabetic mother at least, symptomatic hypoglycaemia usually occurs after the first day of life, whereas asymptomatic hypoglycaemia is transient and confined to the first 24 hours. Of 34 infants with symptomatic hypoglycaemia seen in Winnipeg (infants of diabetic mothers excluded), 14 first developed symptoms when less than 24 hours of age whereas in six of seven asymptomatic infants, in whom blood

glucose was measured sequentially, blood glucose remained below 20 mg/100 ml for longer than 24 hours. Furthermore, a hypoglycaemic baby may develop symptoms after many hours of being asymptomatic. This occurred in an infant, seen some years ago, who had a blood glucose level of 15 mg/100 ml at 10 hours of age. He was asymptomatic and was not treated. The glucose level remained low until, at 75 hours of age, he had a convulsion which responded to intravenous glucose. Following our experience with this baby we have advocated intravenous glucose treatment for hypoglycaemia whether or not the baby is symptomatic. To wait until a baby has convulsions or other major symptoms before starting treatment is surely not right. In infants of diabetic mothers the hypoglycaemia is usually, but not always, transient, and opinions still differ about the need for treatment.[2]

Finally, I would share Dr. Griffiths's apprehension about giving hypertonic glucose into the umbilical vein. In my opinion it should always be given through a peripheral vein.—I am, etc.,

J. C. HAWORTH

Department of Paediatrics,
University of Manitoba,
Winnipeg, Canada

1 Haworth, J. C., and Vidyasagar, D., *Clinical Obstetrics and Gynecology*, in press.
2 Beard, A., *et al.*, *Journal of Pediatrics*, 1971, **79**, 314.

Cameron Fund

SIR,—It is now six months since the Cameron Fund went into operation in the field of medical charities (20 March, p. 672), and already it is establishing itself as a valuable source of assistance available to general practitioners and to their dependants in times of financial difficulty.

Grants totalling over £9,000 have been awarded to date, with a further £3,000 allocated in principle by the cases committee and awaiting ratification by the full council at its next meeting. The grants have been given to assist with both general and educational expenses, and it is anticipated that more than half of those being assisted at the present time will require help on a long-term basis.

Through the courtesy of your columns I should like to take this opportunity of asking your readers to bring to our attention the needs of any general practitioner or his or her dependants who might benefit from the resources of the Cameron Fund. Publicity within the profession is the most effective way of ensuring that the full capacity of the Fund is engaged in assisting our colleagues with the minimum of delay.—I am, etc.,

B. HOLDEN
Chairman,
Council of Management

Tavistock House North,
Tavistock Square,
London W.C.1

National Hospital Staffs Conference

SIR,—The National Hospital Staffs Conference is to be held on 27 November at B.M.A. House. It has been agreed that three junior representatives should be sent to this conference by each of the regional junior staff groups, and it is of course most important that the regional groups ensure that their representatives attend the conference.

There is clearly a large and vocal body of consultant opinion which is trying to resurrect the permanent subconsultant career grade. During the last session junior representatives, along with the remainder of the profession, have agreed to a 4½% per annum expansion of the consultant grade, and this will create the best career prospects for hospital junior doctors since the inception of the Health Service. But their prospects will be seriously prejudiced if a permanent subconsultant career grade is allowed to become an integral part of future hospital staffing. Furthermore, it could well lead to a repeat of the tragic circumstances in which many S.H.M.O.s and medical assistants now find themselves.

I hope that junior hospital doctors throughout the country will recognize this grave threat to their future career prospects and that they will attend the conference and vote against the proposal.—I am, etc.,

F. J. BRAMBLE
Chairman,
Hospital Junior Staffs Group Council

London W.C.1

Consultants' Contracts

SIR,—Under discussion at the moment is a complete revision of the obligations contained in all consultants' contracts. If a consultant accepts a "maximum part-time" instead of a "whole-time" contract, since 1955 the following terms were accepted: that the consultant would be "prepared to devote substantially the whole of their time to hospital work and give it priority on all occasions." H.M.(66)14. This commitment is unacceptable.

Terms for the consultant may be drawn along these lines: "The medical officer signing this contract will in agreement with other members of the medical staff accept a reasonable amount of 'on-call' and emergency duty provided that (1) the board ensures that the hospital staffing is adequate for the patient care in the opinion of the hospital medical advisory committee, and (2) that such commitment does not by its excessive work load endanger the routine care of the patients entrusted to the consultant."

With major staff reductions recently ordered and implemented by the Department of Health with many posts remaining unfilled, this phrase binding the consultants to a 168-hour week of full responsibility is ludicrous and must be laughed out of court.—I am, etc.,

J. J. SHIPMAN

Letchworth, Herts

Pensions and the Abatement Rule

SIR,—Medical members of the N.O.T.B. Association have often found themselves affected by the pensions abatement rule, and several have complained of loss of part of their pension to which they have contributed a proportion of their past earnings. Your correspondent (2 October, p. 52) drew attention to the impropriety of this rule when it caused the closure of a casualty department in his district. May I draw attention to the fact that it is iniquitous in any context, and if it were to be carried out in ordinary business the pensioner would rightly consider himself to be a victim of fraud. I can think of no argument that could be used by honourable men, whether politicians or not, that could decently defend a rule that deprived a man of his own earnings. Had we realized the implications of this rule when we were persuaded to enter the N.H.S. in 1948, I feel certain that most of us would have opted out of the government pension scheme and some of us would not have become government servants at all.

Each increase of salary makes matters worse for the abatement is not adjusted but is still pegged down to the original earnings figures. Parliament must be persuaded of the necessity to kill this rule; or, at any rate, abate it so that calculations are based on figures that are adjusted to take this last point into consideration.—I am, etc.,

VICTOR PURVIS
Chairman,
N.O.T.B. Association

London W.C.1

Points from Letters

Hospital Staff Appointments

MR. J. W. OGILVIE (Aintree Hospital, Liverpool) writes: The present method of applying for medical staff appointments in the N.H.S. is time-consuming and unnecessarily difficult. Why not devise a standard application form? This form could be obtained locally instead of writing for it. The form, filled in by typewriter, could be duplicated by machine and the duplicate copies used for each appointment applied for. Should further information be required for a particular appointment an extra form could be sent to each applicant with a stamped addressed envelope enclosed.

Scotland's Anaesthetists

DR. G. D. PARBROOK (Department of Anaesthetics, Royal Infirmary, Glasgow) writes: I cannot agree with Dr. C. S. Jones's suggestion (18 September, p. 708) that Scotland's anaesthetist problem could be solved by the widespread use of general practitioners. Dr. Jones writes from South Africa where general practitioners play a large part in the anaesthetic services and a recent study from Pretoria by Kok and Mullen[1] confirms that, as Dr. Jones recommends, the general practitioner there anaesthetizes the fitter patients. Despite this, these authors found that "when a death occurred associated with anaesthesia, the anaesthetic played a major role three times as often in the general practitioners' case compared to that of the specialist." In Scotland only occasional general practitioners with appropriate additional training undertake anaesthesia and several of these have "limited specialist" grading in recognition of their special position and experience. In this way patient safety is protected.

1 Kok, O. V. S., and Mullan, B. S., *Medical Proceedings*, 1969, **15**, 31, 55, 76, 91.

False Positive Tests for Abnormal Haemoglobins

DR. J. S. LILLEYMAN (Department of Haematology, Royal Infirmary, Sheffield) writes: An error has been brought to my attention in the letter (21 August, p. 480) on the above subject. The letter stated that 0·4 ml of peripheral blood should be added to the Sickledex test solution in patients with a haemoglobin of 7·0 g/100 ml blood or less. This should have read 0·04 ml of peripheral blood to be added to the test solution.