

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 departments 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