The only certain method of obtaining both immediate help and temporary oblivion would seem to be for the over-burdened to take a non-lethal overdose of drugs and thus gain admission while unconscious to the casualty ward of a general hospital. A psychiatrist must then give him the once-over within 24 hours. Should he suspect psychotic illness, his patient will be transferred to a mental hospital for observation and specialized treatment; otherwise he will be discharged home—thrown straight back into the deep end but given, maybe, an outpatient appointment for a week or two's time. Nobody loves him, for his reckless act will have thrown a lot of work on a casualty department probably already strained to its limits. If he has misjudged the drug and its dosage, he dies—which is a pitiful waste.

I wonder if Sir Keith Joseph and his advisers have taken into account that, according to Professor Ivor Mills's lecture at the annual meeting of the Samaritans in Leeds on 3 September, 90,000 unhappy individuals make suicidal attempts or gestures each year—about one every six minutes. That a fatal outcome is just under 4,000 a year is surely significant?

If psychiatric treatment in the future is to be administered in general hospitals, could not the present mental hospitals be usefully transformed into asylums (yes, asylums) for the despairing and world-weary before they reached breaking point? Running costs would be insignificant compared with those of a general hospital. Moreover, the stigma still attached to mental distress would soon disappear. No religious person who can afford the time and money is ashamed of "going into retreat" periodically.—I am, etc.,

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Career Structure and Casualty Departments

SIR,—May I comment on the topic of accident and emergency departments as featured in the National Conference of Hospital Medical Staffs (*Supplement*, 18 December, p. 81)?

The reason why there is a crisis in casualty departments is purely and simply that the National Health Service is hide-bound by a "career structure" from senior house officer to consultant. Apart from the fact that the imposition of a careers structure is obviously going to penalize the best workers anyone with a backbone will make his own career, rather than accept the kind of academic spoonfeeding which is now considered mandatory it should be remembered that all medical practitioners are legally entitled to practise in any specialty of their choice. Many general practitioners are those who have completed their house jobs and are practising medicine, which is their legal right.

For the last year I have been a completely single handed casualty officer in a small hospital. I may safely claim to have put a great deal of effort into this job, and would like to continue it. Although I am neither consultant nor general practitioner I certainly have a similar degree of responsibility as I am finally responsible for all the patients who set foot in my department. It is, however, a disgusting fact that I cannot stay in this job, even though I would like to stay in it and even though my seniors and the hospital management committee would like to appoint someone who could keep the department going. The grade of senior house officer is regarded as a "training grade," yet in a casualty department very little training is provided. It should also be remarked that the senior house officer, a very junior employee within the hospital, is quite at liberty to walk out of his hospital and set up in general practice where he would have the same professional status as a consultant.

It is high time those who are in charge of medical education took into account the aspirations of those for whom the education is intended. Although there is a shortage of casualty officers, no inducement is made to encourage anyone to work in casualty departments. The emphasis on "career structure" is an added deterrent to working for the Health Service at all.—I am, etc.,

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Prognosis of Gastric Cancer

SIR,—Your leading article (9 October, p. 67) on the prognosis of gastric cancer ignores the major contributions of the Japanese over the past decade. They have shown that cancer confined to the mucosa or submucosa has a 90% five-year survival rate. At the National Cancer Centre Hospital, Tokyo "early cancer" forms 30% of the gastric cancers coming to surgery. Such accuracy is possible by the skilled use of gas contrast radiography (H. Ichikawa, personal communication), and gastric photography techniques,[1] which permit demonstration of mucosal detail, greater than in the gross specimen.

Unless these are mastered in the Western world, we cannot expect any improvement in the survival rate, which has remained stagnant in recent decades.—I am, etc.,

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[1] Sakita, T., in *Proceedings of the Third World Congress of Gastroenterology*, Vol. 1, p. 275. Tokyo, 1967.

Transport to the Surgery

SIR,—Your discussion of transport of patients to doctors' surgeries (18 December, p. 697) is particularly opportune so soon after the publication of *The Organisation of Group Practice*.[1] This report considers much larger group practices than those which are now usual.

If very large groups of doctors are to practise from central premises it follows that they will attend patients from large catchment areas. But in these circumstances some patients will be unable to get to the central premises because of the distance involved, and will need a home visit which would not have been necessary if their doctor were nearer.

At present most urban practitioners already have to contend with time-consuming traffic delays and difficulty in parking when visiting patients (and this is liable to worsen as the number of vehicles on the road increases). Whatever the advantages to patient or doctor of very large group practices they can hardly justify wastage of doctors' time in doing more visits. Or could the provision of transport of patients ever become a reality with general application and include transport for emergencies?—I am, etc.,

GEORGE MOSES

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[1] Department of Health and Social Security, Welsh Office, *The Organisation of Group Practice*, H.M.S.O., London, 1971.

Ampicillin and Mononucleosis

SIR,—As the instigator of an investigation into the duration of sensitivity to ampicillin following reaction from its use in mononucleosis, I must take issue with Dr. J. O'Grady (11 December, p. 685). First let me agree wholeheartedly with his opening paragraph. Antibiotics should not be used in uncomplicated viral respiratory illness, which of course includes mononucleosis, or blindly in pyrexial illnesses. Regrettably, however, we find that the great majority of patients admitted to hospital with mononucleosis have been given ampicillin and have a reaction to it. As this is a valuable antibiotic it seemed reasonable in the patients' interests to determine whether there was any lasting hypersensitivity. The results, which largely confirm that the sensitivity is indeed short lived should be published shortly.—I am, etc.,

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Hospital Waiting Lists

SIR,—The suggestion made by Mr. N. H. Harris (27 November, p. 554) may be an administrator's dream of efficiency, but it cannot but earn the disapproval of any clinician who is devoted to the welfare of his patients because it contains one great flaw—the discharges depend upon the admissions. To permit the bed state to depend upon booked admissions is to limit the efficiency of treatment. No account is taken of emergencies, whose number will vary from week to week, and on the day of admission when x number of new arrivals is expected a similar number must be discharged irrespective of whether they are fit to be discharged or not.

When working in hospital I used a system which permitted maximum use of beds and uncurtailed treatment, while subjecting neither admissions nor discharges to any inconvenience. The majority of patients were sent for a week or two in advance, due note having been taken in the first instance of dates that were convenient or inconvenient. In addition to this every patient for admission who had a telephone was asked if he were willing to be admitted at short notice. Whenever beds became available which were not filled by the routine admissions the short-notice list was used. It is essential that short-notice patients are contacted by telephone and not by telegram, otherwise the hospital has no means of knowing till too late if the patient is unable to take advantage of the offer. Using this method it is possible to maintain a very high occupancy rate while keeping down the use of extra beds for emergencies to a minimum; indeed, they were seldom used.—I am, etc.,

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