and districts by 18 January. The reverse process for submitting comments began on 11 February to complete the cycle back to the RHA by 24 February. Three weeks to discuss such matters is utterly absurd and even dangerous. I am informed that other areas and districts have had even less time available than Kent.

A F CRICK
Clerk,
Kent Local Medical Committee
Gravesend, Kent

A subconsultant grade in surgery

SIR,—Mr F S A Doran's article (11 February, p 385) gives evidence that in a typical non-teaching hospital the work normally done by consultants is concentrated on those patients for whom his knowledge and experience are required and that much work of a simpler but equally important nature is done by registrars, presumably with results comparable with those of consultants. Many of those who have spent their surgical lives in provincial hospitals will agree that these findings coincide with their own experience. But I think his article omits something that must be said if the introduction of a subconsultant grade is once again raised. Many of those graded senior hospital medical officer whom he mentions had full control of beds in their hospitals before nationalisation and had higher qualifications, yet they were in general practice. If later they decided to devote themselves entirely to surgery they found it almost impossible to become consultants and became intensely dissatisfied; and the difficulties were such that eventually the grade was abolished.

All surgeons have had young assistants the quality of whose work is excellent but who are quite unable to pass higher examinations. Such men have been lost to surgery and often to the country; and this is a loss that should never have been allowed to happen. Should a subconsultant grade be established such are the men who should fill it. If subsequently any one of them achieves higher qualifications access to consultant level should be made easy for him, but the others, as permanent members of a surgical team, would feel fulfilled and by their personal qualities and by the continuity of their employment add great strength to the team.

HENRY MILNES WALKER
Stratton Audley,
Nr Bicester, Oxon

Entry into occupational medicine

SIR,—We work in a profession within which it has become almost impossible to change direction. The young doctor, once embarked, is congealed in aspic until the day he starts drawing his state pension.

Now, in the field of occupational medicine, it seems that the intention of the committeemen is to impose a rigidly formalised training, heavily hospital-biased, on new entrants and to make mandatory the possession of membership of one of the colleges. While appreciating the need to attract young doctors into occupational health, to raise and maintain standards, and to reduce professional isolation, one suspects the purity of the underlying motives. The next two decades are quite likely to see increasing medical unemployment in Britain. It would not be surprising if, in these circumstances, those dug into or fighting to reach the consultants' trenches would like to gain and hold the occupational health area of the medical battlefield.

At present occupational health is leavened by men and women who enter late, often after wide experience in other disciplines. It would be a pity if these doctors were effectively barred in the future. The company medical adviser is all the better for being able to function as a "proper" doctor. To do this he must have sufficient confidence and experience to enable him, in his patients' interests, to manage the management, and accept—and protect—the confidences of employees when they turn to him with anxieties about themselves, their family, and their employment. The technical problems peculiar to each industry can, if the doctor is willing to be taught by non-medical colleagues, gradually be learnt. What cannot quickly be learnt—or for that matter taught—is wide practical experience of general doctoring.

Why is it that some in our profession, including younger members, are so eager to climb into straitjackets of our own making?

BENJAMIN LEE
London WC2

Points from Letters

Appeasement 1977 style

Mr L BUTLER (Department of Pathology, Good Hope General Hospital, Sutton Coldfield) writes: May I say how pleased I was to read the refreshingly common-sense view put forward by Dr Marguerite King (21 January, p 171)? Your readers may also be interested to learn that consultants and head technicians throughout the West Midlands Regional Health Authority experienced little difficulty in reaching agreement and producing a paper entitled "Management and responsibility in pathology laboratories."

Subclavian artery thrombosis with contralateral hemiplegia

Professor J C DE VILLIERS (Department of Neurosurgery, University of Cape Town) writes: A recent short report (17 December, p 1583) by Drs Ruth English and M Macaulay describes a patient with subclavian artery thrombosis extending into the common carotid artery and consequent embolisation into the right internal carotid circulation. May I draw attention to the fact that an identical case was described in this journal under the title "A brachiocephalic vascular syndrome associated with cervical rib" in 1966?[1] The literature was reviewed up to 1966 and a total of nine reported cases were analysed. . . .

[1] De Villiers, J C, *British Medical Journal*, 1966, **2**, 140.

Why smoke a pipe?

Dr W F HAMILTON (Virginia Water, Surrey) writes: Dr J A McM Turner and others (26 November, p 1387) find that "primary" pipe smokers absorb, when smoking, barely significant amounts of nicotine and say that this raises the question why these people smoke. . . . Cushny, in 1918, suggested that the rhythmic and effortless movements associated with smoking and watching the smoke drifting lazily upwards might be factors in the enjoyment. Perhaps these are contributory factors, but, as a primary pipe smoker who has enjoyed an occasional cigar, I am sure that the essential factor is the aroma arising in the smoke of one's favourite blend or cigar. Since I started smoking I have always been surprised that Cushny did not realise this, and now, 60 years on, Dr Turner and his colleagues have again not recognised it. It was, however, recognised by no less an authority (on smoking) than Stanley Baldwin. "My thoughts grow," he wrote, "in the aroma of this particular tobacco." . . .

Country health

Dr C K ELLIOTT (West Walton, Wisbech, Cambs) writes: The statement in your leading article (24-31 December, p 1621) that "no such service [that is, of separate occupational health] exists for the farm worker" is in fact correct in that no single body exists for the accepted needs of research, teaching, and information into the occupational health of all who work on the land. A new organisation, the Rehabilitation Trust of Great Britain, has as one of its immediate objects the study of the rehabilitation needs of the agriculturist. In the future it aims to found an Institute of Agricultural Medicine in the UK which would undertake research—both academic and clinical—and offer both undergraduate and postgraduate teaching and an advisory service.

Vitamin A and Sir Douglas Mawson

Dr E H BACK (Great Yarmouth) writes: I was extremely interested to read Professor David J C Shearman's article (4 February, p 283). Mawson's expedition of 1911-14 was indeed an epic—in addition to the journey described by Professor Shearman the expedition also reached the south magnetic pole. One of the members of the magnetic pole party, Major E M Webb, is still an active member of the Antarctic Club and last year flew over the south magnetic pole in a jumbo 65 years after he had been there on foot.

Gastrointestinal chickenpox

Dr G F MAYALL (Royal Devon and Exeter Hospital (Wonford), Exeter) writes: With reference to Dr K D Bardhan's letter on chickenpox oesophagitis (11 February, p 370) a case of chickenpox involving the stomach and small bowel with radiological changes was reported and illustrated with radiographs by Marshak and Lindner. . . .[1]

[1] Marshak, R H, and Lindner, A E, *Radiology of the Small Intestine*, pp 487-490. Philadelphia, Saunders, 1976.

Correction

Incontinence

We regret that an error occurred in the letter from Mr S L R Stanton and others (11 February, p 364). The last sentence of their third paragraph should have read: "If present the treatment is medical, using flavoxate hydrochloride or emepronium bromide 200-300 mg four times a day or imipramine hydrochloride 25-50 mg twice a day."