High consumers had faster and less formed although seldom liquid stools. Accordingly, in inter-racial studies of transit time cognizance must be taken of this seasonal dietary aspect as well of course as the type, amount, and coarseness of the staple cereals.

In addition to faster transit time, emphasis again must be laid on the phenomenal capacity of young Bantu to defaecate on request. In some studies 98% responded. Stools thus yielded are not necessarily small; 20-120 g. wet faeces are usual. This propensity permits estimation of pellets voided up to any cut-off interval after ingestion, and thus facilitates learning of the effects of differences or of changes in diet, also of differences in physical activity (for example, in Bantu who walk 5-10 miles to school compared with local dwellers).

We cannot help thinking, like Burkitt,[3] that the aspects of bowel motility mentioned and the associated patterns of bacterial flora (now being studied at this Institute) have a powerful bearing on the rarity of intestinal polyps[4] and of colonic cancer[5] in Bantu and similarly-placed populations.

These studies are supported by a grant from the National Cancer Association of South Africa.

We are, etc.,

ALEXANDER R. P. WALKER.
B. F. WALKER.
B. D. RICHARDSON.

M.R.C. Human Biochemistry Research Unit, South African Institute for Medical Research, Johannesburg, South Africa.

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Doctors and Adultery

SIR,—In your leading article "Doctors and Adultery" (13 June, p. 620) you wrote "last week, however, for the first time the Committee decided not to erase from the *Register* a doctor who had had an adulterous relationship with a former patient."

In fact the decision of the Committee in the case to which you refer does not constitute a precedent. During the last 20 years the Committee has, in like circumstances, found a practitioner guilty of infamous conduct in a professional respect, but has not proceeded to erasure from the *Register* on three occasions (in 1951, 1954, and 1963).—I am, etc.,

M. R. DRAPER.
Registrar, General Medical Council.

London W.1.

Training for the Specialties

SIR,—May I say how much I regret the suggested proposal to reduce the number of junior staff in training in the regional hospitals. Half of these posts, I understand, are utilized by doctors from abroad who go to Britain for the practical training they receive and for the attainment of one of the worthwhile specialists' degrees.

I write as one who enjoyed and appreciated seven instructive and valuable years in the regional hospitals training as a surgeon. It would be a major loss if such facilities were reduced.

British traditions of scholarship and teaching have for a long time attracted doctors from abroad, but if they are denied the final posts of registrar and senior registrar I am sure they will not arrive in any numbers of consequence. I am sure you will also agree that the Commonwealth registrars have been a numerically important, and one would like to think valued, element in the hospital staffing at this level for a long time. One hopes that the Department of Health will see fit to allow these excellent facilities provided for such training in the regional hospitals to continue.—I am, etc.,

ALLAN E. J. MULLINS.

Penrith, N.S.W., Australia.

Primary Medical Care

SIR,—It was refreshing to read the excellent letter of Dr. L. H. Cane (6 June, p. 598). I would like to add some words in support.

I take the duty of a general practitioner to be the diagnosis, treatment, and prevention of significant organic and mental disease. This is what we are trained to do. What is the evidence of our diagnostic and therapeutic failure rate? Is four or five years further postgraduate work going markedly to lower that failure rate?

Surely the present problem is not the medical complexities of our work—for these we have the help of our specialist colleagues—but the multiplicity of medical trivialities on the one hand and the morass of economic, social, family, and matrimonial problems on the other in which the medical content is variable, often negligible, and usually secondary. In using the word "triviality" I refuse to be trapped by the favourite journalistic question "but how does the patient know that his complaint is trivial?" "Trivialities" are of two easily distinguishable kinds. First, there is the patient who comes complaining of a symptom about which he is anxious. We listen, we examine, we find nothing wrong, and we reassure. This is not trivial to the patient and his visit to the doctor is justified. Second, there is the patient with the minor cut, scratch, bruise, abrasion, cold in the head, or digestive upset. This patient is well aware of the nature of his complaint and of the outcome. This is trivial and he should not have come to the doctor. Under the present open access system these patients come to the doctor, and it takes appreciable time to divert them with reasonable sympathy and civility to the care of the appropriate ancillary.

While all but the absurdly rich fear the cost of a long illness or major surgery, it is quite wrong to assume that the generality of people at work would object to payment of a small fee for themselves or their family a few times each year, and in any case could cover themselves by private insurance. Those who could not afford a fee are already identified by possession of pension or supplementary grant books.

And so I take the unfashionable view that general practitioners are probably overtrained rather than under-trained for the work that they are actually being called upon to do. This in turn leads to frustration. Frustration is a word which has frequently been used in recent years and many are the suggested causes. But the paramount cause is the feeling that one is not being stretched to the limit of one's training and capacity. This being so the "new" general practitioner with long postgraduate training will, *a fortiori*, be even more frustrated.

As Dr. Cane writes, if we could be set free from the trivialities and the non-medical problems we could do more of the work for which we were trained and the burden on the hospitals would be made lighter.—I am, etc.,

W. G. R. M. LAURIE.

Oxford.

The Eternal Triangle

SIR,—I whole-heartedly support Miss Mary Jones (16 May, p. 416). I must, however, disagree with her on one point. I cannot accept her statement that professional nursing has been diluted by the introduction of the Enrolled Nurse.

Dilution means the replacement of skilled men or women by unskilled persons, (O.E.D.) and to include the Enrolled Nurse in this category is outrageous. When, oh when, are my colleagues and others going to realize that the enrolled nurse is a trained nurse?

Here we have a nurse who has undergone a recognized statutory training and who is quite competent to take her place beside her Registered colleague. Unless everyone in the National Health Service recognizes and uses to the full this excellent trained nurse, it will become impossible to nurse our patients.

It is a sad reflection on all of us that after 23 years the Enrolled Nurse is still having to fight for recognition, and the sooner we put this right the better.—I am, etc.,

M. G. TUCKER,
Matron.

St. Helen's Hospital, Ipswich.

Sensitivity of Liver Function Test

SIR,—Bromsulphthalein (B.S.P.) is considered to be the most sensitive test of liver function routinely available today.[1] A standard dose of dye is calculated upon the basis of 5 mg./kg. of body weight. A standard time interval for removing blood after dye injection is 30 or 45 minutes. Castenfors and Hulman[2] showed that the sensitivity of the test was increased by using a high single dose (20 mg./kg. body weight).

We have now observed in rabbits that the sensitivity of this test can be further increased by shortening the time interval to 15 minutes. Earlier we had shown[3 4] that a single dose of intramuscular prednisolone acetate (6·25 mg.) in adult New Zealand white rabbits produced ballooning of hepatocytes and hepatomegaly which reached a peak in 72 hours. Significant regression occurred by the seventh day and complete recovery by the fifteenth.

In order to determine whether prednisolone-induced hepatic changes were a physiological reaction, or whether they constituted injury, B.S.P. test was done on control and treated (single 6·25 mg. intramuscular dose of prednisolone acetate) rabbits. Three dose-time schedules were tried.

In Group I (4 controls and 3 treated), given 5 mg. B.S.P./kg. body weight, no differences were found in the levels of dye retention at 30 minutes between 2 subgroups. In Group II (6 controls and 7 treated), given 25 mg. B.S.P./kg. body weight, again no clear-cut differences were found in the levels of dye retention at 30 minutes between 2 subgroups.

However, in Group III (6 controls, 8 treated), given 25 mg. B.S.P./kg. body weight, there was a striking difference in the levels of dye retention at 15-minute interval between normal and treated animals.

B.S.P. Retention Before and After Prednisolone in Rabbits (Dose-time schedule 25 mg./kg. body weight—15 minutes)

No.	B.S.P. retention % before prednisolone (normal group)	B.S.P. retention % after prednisolone ("treated" group)	Time (in hrs.) after prednisolone
1	10	11	24
2	10	16	24
3	9	17	48
4	11	19	48
5	18	42	72
6	13	31	72
7	—	10	96
8	—	15	96
8A*	—	13	168

*8 and 8A represent two readings on the same animal at different time intervals.
Animals 1 to 6 served as their own controls.

This small experiment seems to show that even when increasing the dose of B.S.P. fails to increase the sensitivity of this test, shortening of time interval could achieve this at the same dose.

No easy explanation of this phenomenon is possible, but if also found true in humans the observation may have some practical interest.—I am, etc.,

ARVIND G. BHAGWAT.

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Charles Hastings Wine Club

SIR,—I shall be grateful if you will allow me through the medium of your columns to inform members of a small but significant change in the name of the Hastings Wine Club. At its recent meeting Council agreed that the name be changed to the Charles Hastings Wine Club.

Before seeking Council's agreement the Club's committee was at pains to ascertain the views of all known descendants of Sir Charles Hastings regarding the proposed alteration. Replies were received from all but three who were abroad and could not be reached. Not only did they all express their appreciation that such an inquiry was made of them, but they all seemed to be delighted that their distinguished ancestor's name was to be used more explicitly in this way.—I am, etc.,

GRAHAM DOWLER,
Chairman.
The Charles Hastings Wine Club.

Gloucester.

B.M.A. and the Junior Doctors

SIR,—I have been a member of the Junior Hospital Doctors' Association since its origin, though recently I have not been in agreement with the leadership of the J.H.D.A. in splitting from the B.M.A., over the "standing committee" issue. Initially I supported the concept of a separate "standing committee" for hospital junior doctors, within the B.M.A., but I think it was a pity that the leadership of the J.H.D.A. put themselves into the intractable position which culminated in the *sine die* adjournment and later resignation. They were thus unable to negotiate a compromise which is now being very well worked out by the excellent new chairman of the Hospital Junior staffs Group Council and his executive. However, I have retained my J.H.D.A. membership, partly because I have supported the other principles for which the J.H.D.A. stands, and partly out of lovalty to the organization which has obtained great improvement in junior doctors' conditions in the past four years.

During the last two weeks I have been extremely distressed and angered by the attitudes taken by the J.H.D.A. leadership over the crisis between the B.M.A. and the Government. The B.M.A. has acted superbly and quickly, firstly in forcing the Government to publish the Review Body report, and secondly in reacting to the breach of faith and principle by the Government. It is essential to the future of junior doctors and to medicine itself for the Review Body to be restored and prevent a return to the anarchy of 1948-60. In this struggle with the Government the profession must be seen to be united behind the B.M.A., and I am very sad that the J.H.D.A. has split this unity.

Recent pronouncements from the J.H.D.A. leaders and their *News Letter No. 6* are a mixture of half-truth and paradox. They have stated that the B.M.A. has not consulted the profession in its actions, which is remarkable in view of the extremely vocal support for the Association emanating from meetings throughout the country. However, while both in the newspapers and on radio the impression is given that the J.H.D.A. represents all hospital junior doctors, it is this organization which is not representative. Out of 12,000 junior hospital doctors in the country J.H.D.A. only claims a membership of 4,000, and it does not even truly represent its own membership. To my knowledge not a single J.H.D.A. member in the Oxford region received notice of the meeting on 7 June, nor were our views canvassed for that meeting. This is quite contrary to the action of my fellow Oxford representative and myself of speaking to all the mess presidents in the region and hearing the views of their doctors before attending the Hospital Juniors Staffs Group Council meeting on 9 June. This council, which had never been so well attended nor briefed before, truly does represent hospital junior doctors, despite the fact that certain J.H.D.A. members have opted out but been very adequately replaced.

I have written to the chairman of the J.H.D.A. stating that unless I hear of very good reasons I will resign my membership of that organization.—I am, etc.,

RICHARD G. FABER.
Chairman,
Oxford Region Junior Staffs Group.

Amersham General Hospital,
Amersham, Bucks.

The Government and the Review Body

SIR,—The *status quo* of the medical profession is being restored, and we are now back to square one. The Review Body is to be re-convened and its position once more defined. However, the acceptance of a principle is of little use unless its meaning is upheld in practice.

A substantial amount of the Review Body's award is again at issue. This time the amount in question will be openly considered by the Government itself, instead of the P.I.B. The Government has given the medical profession advance warning that it might be obliged to plead the political equivalent of the Gaming Act, and cut the award for "compelling reasons" concerned with the national economic situation.

It is to be hoped that the new Government will not descend to the political manoeuvre whereby an incoming administration exaggerates the gravity of the economic situation left by its predecessors, and if there are genuinely reasons so compelling that a reduction in the award to the medical and dental professions is essential, such a policy of income restraint will also be applied to other groups.—I am, etc.,

G. TROSSER.

London N.W.3.

SIR,—At the Brent Division of the B.M.A. meeting there was strong criticism of the letter to *The Times* (18 June) which we had signed in common with a number of other London doctors. May we explain why we signed this letter, which, incidentally, had been delayed in publication by the newspaper strike.

The B.M.A. clearly has a first-class case on which to negotiate, but we were utterly dismayed at the tactics adopted by it. We are a profession taught to practise with reason and equanimity, and, having registered a strong protest, the issue should have been kept completely away from the election platforms, where misrepresentation and misunderstanding were bound to occur, and did occur. Furthermore, the public had the inconvenience of not having certificates