NEWS AND NOTES

Views

Lord Flowers seems to be encountering heavy opposition to his proposals (p 691). Perhaps he should have taken more account of the conviction among medical academics that they are scientists—and in the words of Professor Kenneth Boulding (*Science* 1980;**207**:831-6), "It is a fundamental principle of the scientific community that people's minds should be changed by evidence. . . ."

He will, however, be pleased to see that the report of the Joint Cardiology Committee (from the Royal Colleges of Physicians and Surgeons) published in the "British Heart Journal" (1980;43: 211-9) says that at present there are too many cardiac surgery units in London doing too little work. Their numbers should be reduced, says the report, by combining two or more units to form large, more viable, and economic cardiac centres.

Marathon runners and joggers in a recent American study ate significantly less red meat, bacon, and sausage than the inactive men (*New England Journal of Medicine* 1980; **302**:357-61). The differences that were found in high-density lipoprotein cholesterol concentrations, however, appeared to be related to the distance run rather than to diet.

The current debate in Britain about the outcome of neonatal intensive care is being echoed in the United States with one additional factor—cost. A report in the "Journal of Pediatrics" (1980;95:755-61) from Denver analysed 174 cases and found that the highest charges were accrued by infants with the worst outcome. Of 14 infants whose parents were presented with bills exceeding $30 000 four died and 10 had obvious sequelae of anoxia; and in 40% of cases where the hospital bills were from $20 000 to $30 000 the infants had obvious handicaps. Most of these costs are met by insurance but parents may still be left with sizable bills as well as handicapped children.

Despite the high success rate of surgery for coarctation of the aorta, the survivors seem to be at risk of late sudden death (*Acta Medica Scandinavica* 1979;**206**:375-9). About 5% of patients develop aneurysmal weakness of the ascending aorta, probably owing to hypertension during the growth period possibly in combination with a concomitant congenital weakness of the aortic wall.

Are doctors unrealistically optimistic about their patients' drug compliance? After all, says Professor Donald L Dudley in "Chest" (1979;76:744-9), the average American jaywalks, drives over 55 mph, demonstrates against and for causes, drives while intoxicated, and smokes pot and tobacco. He even murders, rapes, starts fires, and robs. Despite all this the medical team thinks he will take his pills.

Set against the estimated 10 000 Japanese thought to have developed subacute myelo-optico neuropathy in association with clioquinol the 220 possible cases reported elsewhere in the world may seem trivial. Further examination (*Journal of Neurology, Neurosurgery, and Psychiatry* 1979;**42**:1073-83) whittled this total down to 42 probable and 69 possible cases—but still enough to show that other races are susceptible. The high concentration of cases in Japan remains, however, completely unexplained.

Quadraplegics have to rely on their diaphragmatic muscles to move air in and out of their chests; not surprisingly, many die from respiratory infections. They should be encouraged by a report in the "American Journal of Medicine" (1980;68:27-35) from the Rehabilitation Institute of Montreal: both the strength and the endurance of the diaphragm can be substantially improved by training based on regular sessions of inspiration against resistance.

Further experience with the perfluorochemical blood substitute, Fluosol, is showing up its limitations. Artificial blood provides oxygen transport, but its effects last for only 72 hours (*Journal of the American Medical Association* 1980;**243**:719-20). Nevertheless this brief duration of action may be lifesaving in, for example, Jehovah's witnesses.

Surgeons still disagree on whether the rectum should be preserved in operations for ulcerative colitis. The age of the patient may be one factor. In a series of 50 children described in the "Scandinavian Journal of Gastroenterology" (1980;15:123-7) rectum-preserving procedures were performed in 31 cases. Follow-up for nine to 23 years showed that only three of these 31 patients had entirely satisfactory results, in contrast with 14 of the 19 treated by panproctocolectomy.

What do women think about during sex? Not England (or not nowadays); in fact nearly one-third of those who formulated erotic fantasies (*British Journal of Social and Clinical Psychology* 1980;**19**:81-3) based these on being overpowered or raped, so confirming the stereotypes currently decried as "sexist."

Among the many predictable difficulties faced by surgeons in rural tropical areas are those of the climate, says "Tropical Doctor" (1980;10:9-14). The combination of high humidity and heat encourages growth of fungus on the walls of operating theatres —so that they have to be painted once a month—and corrodes metal instruments and rubber anaesthetic equipment. Two days' disuse is often long enough for a piece of equipment to stop working.

MINERVA

EPIDEMIOLOGY

Outbreak of infection in a urological ward

J A LOWES, J SMITH, S TABAQCHALI, E J SHAW

During two weeks in the late summer of 1979 a multiply antibiotic-resistant strain of *Acinetobacter calcoaceticus* (identification confirmed by the National Collection of Type Cultures, Public Health Laboratory Service) was isolated from urine samples of eight patients in a male urological ward. Two of the patients required treatment for symptomatic infection. The common factors preceding the isolation of the organism were urological surgery, catheterisation, and the use of co-trimoxazole prophylactically to prevent infection.[1]

Operating theatre practice was reviewed but no source of infection was identified. An environmental survey revealed that the organism was widely distributed in pools of water in the ward sluice area and was present on the inside of the bedpan washer-pasteuriser used to disinfect the jugs into which urinary catheter bags were emptied. Subsequent investigation revealed that the water heater and steam generator in the pasteuriser, which were supposed to heat bedpans to a temperature of 80°C for one minute, were not working at all. The organism was also present in the urine jugs just processed by the bedpan washer-pasteuriser. Even the jugs of those patients whose urine was not infected were contaminated. Unfortunately, these jugs were stored upright before reuse and did not dry completely.

Care of urinary catheters by the nursing staff was by closed-system drainage. The procedure incorporated all the recommended methods of preventing infection with the exception of adding disinfectant to the catheter bag. The weak point appeared to be the bedpan washer, which contaminated the urine collecting jugs. Contamination of the gloved hand when the jug was picked up could then have led to further contamination of the valve in the outlet of the catheter bag, and retrograde infection in the urine collection system.

The widespread use of co-trimoxazole prophylactically was probably responsible for selecting an organism in which co-trimoxazole resistance was linked with resistance to other antibiotics, including gentamicin.

Disinfection of the urine-collecting equipment in the bedpan pasteuriser was discontinued. Instead a system was introduced of emptying the urine collecting jugs, rinsing with water, and soaking in 1% hypochlorite solution followed by drainage. Nursing staff were reminded of the importance of eliminating residual pools of water in the sluice. These measures, together with probable improvement in catheter-care technique, brought the outbreak to a close.

Because of the demands of this system on nursing time, a simpler solution is needed for the disinfection of large quantities of urine collecting equipment in the ward. We are currently investigating the possibility of using a domestic dish washer for disinfecting urine equipment.

[1] Hills NH, Bultitude MI, Eykyn S. Co-trimoxazole in prevention of bacteriuria after prostatectomy. *Br Med J* 1976;ii:498-9.

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Gentamicin-resistant Klebsiella strains in a hospital

A M GORDON

Outbreaks of infection due to multiply antibiotic-resistant Gram-negative bacteria have recently become more prominent in hospitals. Though colonisation by these resistant organisms is not necessarily accompanied by clinical evidence of systemic infection, more serious outbreaks of *Klebsiella* infection leading to septicaemia and death have been recorded, especially in relation to urological surgery and in intensive care units.[1 2]

Recent experiences of multiresistant klebsiellae in this health district have highlighted the epidemic potential of these "opportunist" pathogens in elderly debilitated patients. During the five weeks from 30 October 1979 *Klebsiella* infections occurred in 11 patients, most of whom had been admitted to hospital with urological complaints. Six cases were identified in two separate general surgical wards in one hospital, four in another (three in a surgical ward, one in the intensive care unit), and one in the radiotherapy unit of a third. All these patients were debilitated and their ages ranged from 66 to 91 years. Nine of the 11 had been admitted with urinary retention secondary to prostatic obstruction. Six patients had had prostatectomies and all of these had indwelling catheter drainage. Eight of the 11 patients had received prophylactic ampicillin or ampicillin and flucloxacillin after admission to hospital.

All the patients acquired appreciable bacteriuria due to multiresistant klebsiellae. Two patients became septicaemic and one of these, a man of 91 who had undergone a transurethral prostatectomy for benign prostatic hypertrophy, died despite treatment with intravenous gentamicin. Terminal blood cultures were positive for gentamicin-resistant klebsiellae. The other septicaemic patient, a man aged 68 years who had had a partial gastrectomy after perforation of a duodenal ulcer, developed postoperative paralytic ileus, renal failure, and bronchopneumonia, necessitating transfer to the intensive care unit. Multiresistant klebsiellae were repeatedly isolated from the catheter urine, the abdominal wound, and tracheal aspirates, and on one occasion from a blood culture. This man had received a prolonged course of intravenous ampicillin and flucloxacillin. Rapid clinical improvement followed a course of intravenous amikacin with successful eradication of klebsiellae from all colonised sites.

Bacteriology

All the isolates had the biochemical characteristics of *Klebsiella aerogenes*. Routine controlled disc diffusion sensitivity testing showed that all isolates possessed an identical pattern of multiple resistance, with all strains highly resistant to ampicillin, tetracyclines, cephaloridine, co-trimoxazole, gentamicin, and tobramycin, and sensitive only to cefoxitin and amikacin. Dr M Casewell, St Thomas's Hospital Medical School, London, reported that they all belonged to capsular type K2. This is the second most common serotype encountered in British hospitals.[3]

Control measures

Measures were taken to prevent further epidemic spread of these organisms. Patients found to be colonised or clinically infected by klebsiellae were barrier nursed or discharged if their clinical condition permitted. Since contamination of the hands has been shown to be the most important method of spread of these organisms,[4] all attendant staff were instructed to wear gloves and plastic disposable aprons when handling secretions and excretions from affected patients; chlorhexidine gluconate 4% hand cleanser and hand rub were used routinely between all contacts with patients. Patients with indwelling catheters and with significant *Klebsiella* bacteriuria (in the absence of associated systemic infection) were treated with bladder irrigations containing noxytiolin 2·5 g.

No further instances of multiresistant *Klebsiella* colonisation or clinical infections ensued. More recently, however, four further patients have developed chronic bacteriuria due to gentamicin-resistant strains of *Klebsiella aerogenes* (capsular type K2, as in the previous cases). All four were elderly; three had recently undergone urological surgery—two for benign prostatic hypertrophy and one for carcinoma of the bladder—and the remaining

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patient had suffered a cerebrovascular accident; all had indwelling catheters and had received prophylactic ampicillin. In three cases there appeared to be no epidemiological link with the original cluster of patients, but one patient underwent prostatectomy in the same surgical unit as four of the original cases. Treatment with pivmecillinam, to which the organism was sensitive, at a dosage of 400 mg twice daily for 10 days, eradicated the organism from this patient's urine.

These episodes illustrate the increased risk of Gram-negative infection in elderly debilitated patients who have been subjected to major surgery, particularly urological procedures. Patients with indwelling urethral catheters are especially susceptible, while broad-spectrum prophylaxis with ampicillins further increases the risk by conferring a selective advantage on the resistant gut organisms.[5]

[1] Casewell MW, Dalton MT, Webster M, Phillips I. Gentamicin-resistant *Klebsiella aerogenes* in a urological ward. *Lancet* 1977;ii:444-6.
[2] Curie K, Speller DCE, Simpson RA, Stephens M, Cooke DI. A hospital epidemic caused by a gentamicin-resistant *Klebsiella aerogenes*. *J Hyg* 1978;**80**:115-23.
[3] Casewell M, Talsania HG. Predominance of certain Klebsiella capsular types in hospitals in the United Kingdom. *J Infection* 1979;**1**:77-9.
[4] Casewell M, Phillips I. Hands as a route of transmission for Klebsiella species. *Br Med J* 1977; ii:1315-7.
[5] Anonymous. Gut as a reservoir for resistant bacteria. *Lancet* 1979;ii:945-6.

MEDICOLEGAL

A Minister misled

BY OUR LEGAL CORRESPONDENT

The Secretary of State for Social Services has a potent armoury at his disposal when he wishes to bend health authorities to his will. The weapons are to be found in the 1977 National Health Service Act, and particularly in sections 17, 85, and 86. Briefly, section 17 enables him to give directions to area health authorities on the exercise of their functions. If an authority disobeys, the Secretary of State may unleash the nemesis of section 85—declare the authority in default, remove the current members from office, and replace them. In emergency, he can fall back on the mighty howitzer that is section 86: for a specified period he can summarily unman a recalcitrant authority by transferring its functions to another body altogether.

It was that last course which Mr Patrick Jenkin took on 1 August 1979. Some health authorities had grossly overspent their authorised cash limits in the previous financial year and had been warned by Mr Jenkin's Labour predecessor to bring their expenditure under control; one of these was the Lambeth, Southwark, and Lewisham Area Health Authority (Teaching). The Lambeth AHA obeyed the Labour Secretary of State's instructions and managed to ensure by June 1979 that its 1979-80 expenditure would in real terms be held to the level of 1977-8. The budget proposals put up by the new Government in June 1979 threatened tighter limits still, and on 30 July the AHA passed a resolution refusing to countenance any reduction in what were inelegantly termed "patient activity levels" below the levels of 1977-8 without the AHA's express authorisation; furthermore, the resolution similarly declined to reduce services or staff to accommodate shortfalls in the 1979-80 inflation allowance.

This was a direct challenge to the authority of the minister and to the clearly stated policy of the Government, and it prompted an immediate response. On 1 August the section 86 direction was issued. It declared that the Minister considered that the AHA had failed to adjust its expenditure for the current financial year to enable it to continue providing its statutory services on the funds available; there was therefore an emergency that made it necessary to replace the AHA by a body able and willing to take the necessary steps, and accordingly, the functions of the AHA would be taken over by the South-east Thames Regional Health Authority. On 6 August, the direction was varied to substitute for the RHA the names of five commissioners.

Court challenge

Lambeth, Lewisham, and Southwark Borough Councils decided to challenge the legality of the minister's direction in the High Court. The questions for the Judge were these: whether there was material on which the minister could reasonably have come to the conclusion that he should exercise his powers under section 86 in the way he did and, if so, whether he exercised his discretion properly—did he take the wrong factors into account, or fail to consider something of importance?—and whether he was entitled in law to make the direction.

The minister set out his reasoning in a detailed affidavit. He had had a meeting on 31 July 1979 with departmental officials, the chairman and administrator of the SE Thames RHA, and the Minister of State (Health). At that meeting, the minister had been advised that the AHA's resolution of the day ruled out the possibility of its making the necessary economies; that his power to give directions under section 17 of the Act could not bring about the results required; and that the emergency, which the minister was satisfied had been a real one, might continue into the next financial year. It was impossible to be sure at the time how long the direction was to be required, and he would have to monitor the progress made towards financial stability, revoking the direction when there was no longer a substantial risk that control of the AHA's affairs by its own members would lead to a breakdown in the provision of statutory services.

At the hearing of the borough councils' application[1] Mr Justice Woolf accepted that the minister could reasonably have concluded that the 30 July resolution was an absolute prohibition on reductions in "patient activity", but he regretted that he had not sought clarification from the AHA. The advice given to the minister about the potential offered by section 17 offered objectors a more vulnerable flank, and the Judge found it to be seriously inadequate. It was clear that the minister accepted the advice that section 17 directions would not be practical. The Judge, however, pointed out that section 17 directions did have the great advantage, even if they were in general terms, of placing on the AHA the duty to obey them. Of course, it was understandable for the minister to be concerned that a general direction would allow more time to elapse before anything was done. But the minister's advice had failed to point out that he could make a specific direction requiring the AHA within a very short time to approve the proposals that it had already rejected. If the AHA had failed to respond, the members could then have been at once declared in default and removed from office under the powers granted by section 85. That, the Judge thought, would have been a much more satisfactory solution than using section 86, and it would not deprive the area of management by those who represented its interests.

No time limit

The Judge found another flaw in the minister's direction. His advisers had told him that the emergency might last into the next financial year; nobody could be sure exactly how long the direction would be required. Consequently, no time limit had been specified in the direction. The wording of section 86 should be examined so that the full deficiency of the advice that the Minister received may be taken in: "If the Secretary of State—(*a*) considers that by reason of an emergency it is necessary, in order to ensure that a service failing to be provided in pursuance of this Act is provided, to direct that during the period specified by the directions a function conferred on any body or person by virtue of this Act shall to the exclusion of . . . that body or person be performed by another body or person, then (*b*) he may give directions accordingly and it shall be the duty of the bodies or persons in question to comply with the directions." A cursory reading of the section shows that the period must be specified. The Minister's advisers knew this: the Minister's affidavit stated as much. None the less, the direction was made. Not many lawyers can have been surprised by the finding of Mr Justice Woolf that the direction was invalid because there was no power in law to make it. Section 86 was intended, the Judge found, to provide an additional reserve power to take steps over a limited period to deal with a particular crisis. It was not intended to enable an authority's functions to be taken over for an unlimited period to control an area's financial affairs.

Mr Justice Woolf concluded that the minister had not acted unreasonably. The advice on which he had acted had, however, been seriously misleading, in that it had ruled out directions under section 17 that would have made resort to section 86 unnecessary and had advocated a direction of unspecified duration, to be revoked when the minister thought it right. Hence he had failed to give proper consideration to the possibilities of section 17 and had misdirected himself on the true effect of section 86; consequently, in addition to making a direction which he had no power to make, he had failed to exercise his discretion properly, and the discretion was vitiated by that failure.

Holding that the applicant boroughs were entitled to judicial review of the minister's direction, the Judge awarded them costs against the DHSS. Pending any appeal (see page 724) the Judge said that he would not indicate that the commissioners appointed under the direction should cease to function, for that would not be in the public interest.

[1] *The Times*, 26 February 1980.

PARLIAMENT

Abortion (Amendment) Bill

When the report stage of the Abortion (Amendment) Bill resumed on 29 February, an amendment removing power from the Secretary of State for Social Services to lower the upper time limit for abortion was carried. The Bill as drafted requires the doctor to consider whether the risk to the woman's life or of serious injury to her physical or mental health would be substantially greater than if the pregnancy was terminated. An amendment to leave out the word "serious" was carried; one to leave out the word "substantially" was rejected by 180 votes to 177.

The sponsor of the Bill, Mr John Corrie, said that the House should come to a conclusion on the Bill so that MPs knew where they stood—to which Mr David Steel replied that the House had come to a conclusion in 1967. Topics like abortion, he said, were not issues on which people were likely to change their minds. Successive abortion reform Bills had been launched under the guise of improving the 1967 Act, whereas they were designed to undermine the very basis of that Act. The Chief Opposition spokesman on social services, Mr Stanley Orme, reported that the BMA had said that the last-minute suggestion by Mr Corrie, which would result in the deletion of large sections of the Bill, had made matters worse. The 1967 Act should be left as it was. Mr Douglas Hogg pointed out that a major change in the statutory criteria would make it more difficult for poorer and less sophisticated women to achieve an abortion.

The report stage was adjourned.

Lambeth, Southwark, and Lewisham AHA(T)

The Secretary of State made the following statement on the judgment on the appointment of commissioners in Lambeth, Southwark, and Lewisham on 26 February:

"In August 1979 I gave directions under section 86 of the National Health Service Act 1977 in effect appointing commissioners to manage the affairs of the Lambeth, Southwark and Lewisham Area Health Authority (Teaching). My action was intended to ensure that the AHA(T) should keep its spending for the year 1979-80 within the cash limits laid down by my predecessors.

"Although the court expressly held that I acted reasonably and in good faith in giving those directions and moreover accepted that the situation that faced me required immediate action, the learned judge found that in giving directions without specifying the duration I acted outside the power conferred by section 86. He also suggested that there was an alternative course that I might have taken. I shall study the judgment in detail when I receive a copy and any question of an appeal must wait until then.

"However, my first concern is that proper respect for the courts and the rule of law means that I must give urgent consideration to the early restoration of their powers to the members of the authority. I shall therefore this afternoon be considering with the chairman of the regional health authority and the chairman of the commissioners the steps that might now be taken. All this must be done in a way that ensures that the progress made by the commissioners in establishing financial control will be maintained.

"The learned judge said that it was in the public interest that the commissioners should continue to act in the interim and I know that the House will applaud what they have done to bring the financial affairs of the area under control."

AHA to resume control

In the House of Commons on 3 March Mr Patrick Jenkin announced that the commissioners he had appointed in August 1979 would remain in post until 31 March and that members of the AHA would resume control on 1 April. The members had accepted that the authority's expenditure should stay within cash limits. He had decided not to appeal against the judgment of Mr Justice Wolff that the appointment of the commissioners was invalid (1 March, p 665). Legislation would, therefore, be necessary to regularise the position over the past seven months and to give backing to the status of the commissioners until the end of the month.

A medicolegal report on Mr Justice Wolff's judgment appears at p 723.

Questions in the Commons

Medical laboratory scientists. The Minister of State, DHSS, made the following statement about the pay and terms and conditions of service of laboratory scientific officers in the NHS:

"The rates of payment to medical laboratory scientific officers in the National Health Service for undertaking emergency duties fall to be negotiated nationally in the professional and technical staffs "B" Whitley council. Health authorities are required under regulations to observe the terms approved by Health Ministers following such negotiations. While negotiations were proceeding the union mainly concerned, ASTMS, pressed authorities to enter into local agreements at high rates which could be met only by reducing other services to patients. After protracted negotiations, the two sides of the council failed to agree on revised rates, and at the specific request of the management side and following the staff side's withdrawal from negotiations, my right hon Friend authorised authorities to pay the rates offered by the management side. Authorities were also told that they should not enter into and, if necessary, should withdraw from, any local agreements which conflicted with the authorised terms. The new rates involve increases of over 24% in expenditure and supplement agreed increases in basic pay averaging about 25% and a reduction in conditioned hours worth about 2½%: they are patently reasonable within the cash limit. The present arrangements for emergency duties are by no means satisfactory and I regret that the management side's requests to review the agreement have so far been rejected by the staff side."

Social Services, 27 February.

London teaching hospitals. The following table shows the endowed capital each London teaching hospital holds at its own disposal as distinct from resources from the NHS:

Teaching hospital (see note)	Balance sheet value of endowed capital held by special trustees for that hospital at 31 March 1979 £
St Bartholomew's	13 892 148
The London (Whitechapel)	4 675 083
The Royal Free	2 031 561
University College	1 929 345
The Middlesex	5 032 676
Charing Cross	1 034 093
St. George's	2 273 283
Westminster	2 234 214
St Mary's	4 461 462
Guy's	8 751 685
King's College	1 745 172
St Thomas's	17 886 810
Hammersmith	822 902

Note
There are a large number of hospitals involved in undergraduate teaching; each hospital listed above is the main hospital linked to a particular medical school.

The number of beds in London teaching hospitals are:

General teaching hospitals

	Beds
St Bartholomew's	780
The London (Whitechapel)	675
Royal Free	798
University College	598
The Middlesex	663
Charing Cross	751
St George's (Hyde Park Corner and Tooting)	551
Westminster	358
St Mary's, W2	414
Guy's	795
King's College	604
St Thomas's	961
Hammersmith	570
Total	8518

Area health authorities (Teaching)

Total number of beds in the hospitals managed by the Area Health Authorities (Teaching) in Greater London 32 253

Specialist postgraduate teaching hospitals

	Beds
Hospitals for Sick Children	546
National Hospital for Nervous Diseases	348
Royal National Throat, Nose and Ear Hospital	128
Moorfields Eye Hospitals	129
The Bethlem Royal and the Maudsley	481
St John's Hospital for Diseases of the Skin	54
The National Heart and Chest Hospitals	616
The Royal National Orthopaedic Hospitals	326
St Peter's Hospitals	124
The Royal Marsden Hospital	358
Queen Charlotte's Hospital	284
The Eastman Dental Hospital	Nil
Total	3394

Social Services, 19 February.

MEDICAL NEWS

Health and personal social services statistics

The changing pattern of hospital psychiatric services is illustrated by figures published in the 1978 edition of the DHSS's *Health and Personal Social Services Statistics for England (with summary tables for Great Britain)* (HMSO, £8·50). The daily average number of occupied psychiatric beds in Britain fell from 138 900 in 1968 to 99 700 in 1977 for mental illness and from 64 700 to 56 600 for mental handicap. Discharges and deaths, by contrast, increased from 207 300 to 212 900 for mental illness and from 13 600 to 21 900 for mental handicap. Outpatient attendances for mental illness rose from 1 667 500 to 1 904 300 and for mental handicap from 11 900 to 21 000; there was, however, a substantial fall in the number of new outpatients suffering from mental illness, though

mentally handicapped outpatients increased. The number of new day patients attending regularly showed a large increase—from 19 700 to 46 100 (mental illness and handicap combined), the total number of attendances by these patients rising from 1 486 100 to 3 603 700.

Other sections of the report contain tables on population and vital statistics, finance, manpower, hospital administration statistics, family practitioner committee services, community health and personal social services, maternity and child health and social services, preventive medicine, morbidity, abortion, and miscellaneous health statistics.

Personal chair in clinical anaesthetics, Queen's University of Belfast

Dr R S J Clarke has been appointed to a personal chair in clinical anaesthetics in the department of anaesthetics, Queen's University of Belfast. Dr Clarke, who is 50, graduated in medicine from Belfast in 1954, and after house appointments at the Belfast City Hospital did postgraduate research in the Medical Research Council's Climate and Working Efficiency Research Unit at Oxford from 1955 to 1958. He was then appointed registrar anaesthetist at the Royal Victoria Hospital in Belfast and St Bartholomew's Hospital in London, becoming lecturer in anaesthetics in the Queen's University of Belfast and consultant in anaesthetics in 1965. In 1968 Dr Clarke was promoted to senior lecturer, and reader in 1972.

Twins Clubs Association

The emotional as well as the practical and financial difficulties of parents of twins have led to the creation of mutual support groups of such parents, and in October 1978 a national Twins Clubs Association was formed. Since then the number of local groups has increased from 12 to 95, and over 2500 people have sought help directly from the association. Inquiries from parents of twins or anyone else interested will be welcomed by the association; they should be addressed to Dr Elizabeth Bryan, Twins Clubs Association, Woodstock, Heathdown Road, Pyrford, Surrey (a stamped addressed envelope should be enclosed).

International Society for Internal Medicine

The International Society for Internal Medicine is holding its 15th international congress at the Congress Centrum, Hamburg, from 18 to 22 August 1980. The symposia will be on recent advances in interstitial lung disease; new methods of treating viral infections; management of urinary tract infections; new aspects of tropical disease; new non-invasive diagnostic tools; significance of prostaglandins in medicine; chronic liver disease; and postgraduate medical education. There will also be free communications together with a varied social programme. Registration fees will be reduced if paid before 30 April. Details from VIP International Conference Services, 42 North Audley Street, London W1A 4PY (01-499 4221). The British national representatives of the Society are Dr John Batten (St George's and Brompton Hospitals, London) and Professor A W Asscher (Cardiff Royal Infirmary).

George Peter Baker prize

Dr G P Baker has established a prize in medicine at Cambridge, called the George Peter Baker prize, to be awarded to the best candidate in Part II of the final MB examination. The first recipient is Dr R A Chalmers.

COMING EVENTS

National Health and Safety Conference—Sponsored by the Health and Safety Executive, British Safety Council, Royal Society for the Prevention of Accidents, and Institution of Industrial Safety Officers, 22-24 April, London. Details from Victor Green Publications Ltd, 106 Hampstead Road, London NW1 2LS. (Tel 01-388 7661.)

Clinical Genetics Society—Spring meeting, 24-25 April, Southampton. Details from Professor K M Laurence, Department of Child Health, Welsh National School of Medicine, Heath Park, Cardiff CF4 4XN.

National Association for Mental Health—Conference "What direction for psychiatric day services?" 21-22 May, London. Details from the conference secretary of MIND, 22 Harley Street, London W1N 2ED. (Tel 01-637 0741.)

Indian Medical Service Reunion—27 June, London. Details from Colonel C W A Searle, 17 Lower Common South, Putney, London SW15 1BP.

British Nuclear Medicine Society—8th Annual meeting, 30 June-2 July, London. Details from Mrs Angela Taylor, 22 Leinster Avenue, East Sheen, London SW14 7JP.

First International Congress on Innovation of Care Delivery for Health—14-18 October, Noordwijkerhout, the Netherlands. Details from the secretariat, Catharijnesingel 123, 3511 GX Utrecht, Netherlands.

Manchester Medical Society—Details and copies of the March programme are now available from the society, Coupland Building, The University, Manchester M13 9PL. (Tel 061-273 6058.)

SOCIETIES AND LECTURES

*For attending lectures marked * a fee is charged or a ticket is required. Applications should be made first to the institutions concerned.*

Monday, 10 March

ROYAL SOCIETY OF MEDICINE—6 pm, Nuffield lecture by Dr J R Vane: Prostacyclin in health and disease.
UNIVERSITY COLLEGE LONDON—5.30 pm, Freud memorial lecture in psychoanalysis by Dr A Green: Identity and difference.

Tuesday, 11 March

UNIVERSITY COLLEGE LONDON—1.20 pm, Dr R L Souhami: New developments in cancer treatment.

Wednesday, 12 March

INSTITUTE OF ORTHOPAEDICS—6 pm, Professor L Kessel, Mr J I L Bayley, and Dr D J Stoker: Clinical examination and evaluation of the shoulder.
INSTITUTE OF PSYCHIATRY—5.30 pm, Dr A M Adelstein: Psychiatric epidemiology at the Office of Population Censuses and Surveys.
ROYAL COLLEGE OF PATHOLOGISTS—At Welsh National School of Medicine, Cardiff, 5 pm, 31st Kettle memorial lecture by Professor J O'D McGee: Alcoholic liver disease.
UNIVERSITY OF CAMBRIDGE—At Fenner's, 3.30 pm, Dr N D L Olsen: Reducing smoking-related disease: a challenge for community physicians.
ROYAL COLLEGE OF SURGEONS OF ENGLAND—5 pm, Hunterian lecture by Professor B N Brooke: Progress and frustration in inflammatory bowel disease.
ROYAL FREE HOSPITAL—5 pm, Dr David Saunders (Seattle): The effects of laxatives.

Thursday, 13 March

KING'S COLLEGE LONDON—1.15 pm, Dr J Leahy Taylor: Strikes in health care.
ROYAL COLLEGE OF SURGEONS OF ENGLAND—3 pm, Hunterian lecture by Professor J Barton-Booth: Menière's disease—the selection and assessment of patients for surgery using electrocochleography.
WEST WALES GENERAL HOSPITAL—1 pm, Dr Madeline Mayne: Case demonstration. (Preceded by light lunch.)

Friday, 14 March

INSTITUTE OF LARYNGOLOGY AND OTOLOGY—5.30 pm, Mr J C M Currie: Fractures at the base of the skull.
UNIVERSITY OF LIVERPOOL—At Royal Liverpool Hospital, 5 pm, Dr T M D Gimlette: Radioisotopes and musculoskeletal disorders.

Saturday, 15 March

UNIVERSITY OF LIVERPOOL—At Royal Liverpool Hospital, 9 am, Mr R F Calver: Diagnostic advances in irritable hip syndrome.

BMA NOTICES

Central Meetings

MARCH

10 Mon	Medical Academic Staff Committee, 10 am.
12 Wed	Negotiating Subcommittee (CCHMS), 10 am.
13 Thurs	General Purposes Subcommittee (CCHMS), 10 am.
14 Fri	Scottish Committee for Community Medicine (7 Drumsheugh Gardens, Edinburgh EH3 7QP), 10.30 am.
19 Wed	**Council**, 10 am.
20 Thurs	General Medical Services Committee, 10 am.
25 Tues	Hospital Junior Staff Committee, 10 am.
26 Wed	Consulting Pathologists Group, 2 pm.
29 Sat and 30 Sun	Junior Members Forum, College of Education, Milton Keynes, Bucks.

APRIL

3 Thurs	General Purposes Subcommittee (GMSC), 10.30 am.
9 Wed	Diseases of the Chest Group (during the meeting of the British Thoracic Association, Swansea), 5.30 pm.

Division Meetings

*Members proposing to attend meetings marked * are asked to notify in advance the honorary secretary concerned.*

Aberystwyth—At Conrah Country Hotel, Saturday, 15 March, 7.30 for 8 pm, dinner/lecture, speaker Dr J N M Parry: "The leopard cannot change his spots but the bear won't change his habits."* (Guests welcome.)
Aldershot and Farnham—At Cambridge Military Hospital, Thursday, 13 March, 6.30 pm, spring clinical meeting.*
Clwyd North—At Postgraduate Medical Centre, Rhyl, Thursday, 13 March, 7.30 pm, joint meeting with the clergy, light buffet followed by paper by Dr M Tannahill: "Attempted suicide."
Dundee—At Ninewells Hospital, Friday, 14 March, 8 pm, joint meeting with chemists, speaker Dr Bill Ferrier: "Relatively speaking."*
East Yorkshire—At Hull Royal Infirmary, Wednesday, 12 March, 8 pm, joint meeting with the Royal College of General Practitioners, speaker Mr K Sabbagh: "Teaching the consultation in vocational training."
Edgware and Hendon—At Hendon Hall Hotel, Tuesday, 11 March, 8.30 pm, Dr W Bynum: "Art and science of Victorian medicine."* (Guests welcome.)
Glasgow Regional Office—Thursday, 13 March, 7.30 pm, Dr J D J Havard visiting.*
Halifax—At Marmaville Club, Mirfield, Friday, 14 March, 7.30 pm, annual dinner dance.* (Guests are invited.)
Leicestershire and Rutland—At Leicester Royal Infirmary, Monday, 10 March, 8 pm, general meeting.
Northallerton—At Friarage Hospital, Wednesday, 12 March, agm.
Nottingham—At City Hospital, Wednesday, 12 March, 7.30 pm, general meeting.
Renfrewshire—At Department of Child Health, Sunday, 9 March, 10.30 am, clinical symposium on "Common rarities."*
Scottish Borders—At Peel Hospital, Galashiels, Wednesday, 12 March, 7.30 pm, agm.

Regional Meetings

West Midlands Regional Council—At Medical Institute Library, Birmingham, Tuesday, 11 March, 7.15 pm.
Yorkshire Regional Council—At Pinderfields General Hospital, Wednesday, 12 March, 7.30 pm, special meeting to discuss "Patients first."

UNIVERSITIES AND COLLEGES

LONDON

MD—J P Osborne, R K A M Skinner.
MS—K G Burnand, W E G Thomas.

CONSULTANT APPOINTMENTS

BIRMINGHAM AHA(T)—Dr S M Abraham (histopathologist); Dr P H Weller (paediatrician with a special interest in respiratory disorders).

SALFORD AHA(T)—Dr Christine M Earlam (anaesthetist with an interest in anaesthesia for neurosurgery).

WESSEX RHA—Dr R I Vanhegan (histopathologist).

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