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SUPPLEMENT

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BRITISH MEDICAL ASSOCIATION, TAVISTOCK SQUARE, LONDON W.C.1 TEL : 01-387 4499

Correspondence

Correspondents are asked to be brief.

Occupational Health

SIR,—With the publication of the new Green Paper[1] it is appropriate to stress again the inadequacy of the Government's proposals for occupational health. Admittedly the proposed Employment Medical Advisory Service will go a short way towards extending occupational health in Britain, but it is a meagre advance and will leave us well behind the recommendations of the International Labour Organization which have been accepted generally and implemented in many industrial countries.

To leave occupational health out of the main stream of medicine and to ally it with the inspectorate services will necessarily limit its application and growth. The Bristol Advisory Council on Occupational Health has prepared a pilot study for the provision of an occupational health advisory service for Bristol and District. It is notable, and perhaps unique, that this report has been prepared jointly by representatives of the chamber of commerce, trades unions, and the medical profession.

This report shows how the Government's proposals are inadequate, and describes how an effective service could be introduced at a modest cost, in both medical manpower and finance. Copies of the report may be obtained from the Bristol Advisory Council on Occupational Health, British Medical Association, 4 Berkeley Square, Bristol 8.—We are, etc.,

K. LEE,
R. TANNER,

Joint Honorary Secretaries,
Bristol Advisory Council
on Occupational Health.

Bristol 8.

REFERENCE

1 *The Future Structure of the National Health Service.* Department of Health and Social Security, 1969. London, H.M.S.O.

Functions of the District General Hospital

SIR,—The Bonham Carter report[1] makes three mistakes. First, it places too much emphasis on functional efficiency as a criterion for the size of the hospital and not enough on the human aspects of medical care. In an age of rising costs and shortage of medical manpower we do not underrate the need to make best use of resources, but there are other considerations. There is, for example, the need for every general practitioner to practise within easy reach of a hospital; how else can integration of the two services be achieved?

The second mistake is that the committee has overdramatized the work undertaken in hospital. The care of many medical admissions should be well within the competence of their general practitioner and few need continuous consultant supervision or intensive therapy; a sense of proportion has been lost here.

The third and most serious error is the attitude of mind the committee discloses when discussing the role of the general practitioner. Section 36 is offensive in tone and disastrous in import. It concedes grudgingly that general practitioners working in remote areas might be "allowed" to admit patients within the framework of an admissions policy; for the rest of us the prospect is bleak. This section deprives the general practitioner of freedom of clinical judgment and of the opportunity to take responsibility for the inpatient care of his own patients. We are not prepared to work in the manner advocated under guardians, and we affirm our determination to achieve integration of the two services in this area in a manner which maintains our clinical freedom.—We are, etc.,

D. BRYANT, Chairman. IAN WALLACE, Secretary.

MICHAEL E. CARPENTER, G. E. SINGER,

C. O. LISTER, BRIAN WINCHURCH,

ALAN PORTER,

Farnham Group General Practitioner Integration Committee.

Camberley, Surrey.

REFERENCE

1 Central Health Services Council. *Functions of the District General Hospital,* London, H.M.S.O., 1969.

Hidden Perforating Veins

SIR,—The leading article (24 January, p. 186) on the hidden perforating veins states that the junctions of the long saphenous vein and the femoral vein, and the short saphenous vein with the popliteal vein, are physiologically perforating veins, and incompetence of these sites can have *just the same effect* (my italics) as incompetence of valves of the small connecting veins in the lower thigh and leg. While agreeing that the two junctions mentioned are perforating veins, I do not agree that their incompetence has the same effect as incompetence of perforators lower down. In the dynamic limb the pump pressure that may be transmitted through an incompetent perforator low in the limb is much higher than the pressure transmitted through incompetent terminations of the saphenous veins. Patients with solely sapheno-femoral or sapheno-popliteal