courteous and may, in some circumstances, become quite outrageous. Readers should decide for themselves where on this scale they would place the following example (from one of the correspondents whose cause your leading article champions):

1. A very long, critical letter raising many points is sent to me as president.

2. In my absence in California, the letter is immediately answered on my behalf by the executive director in a way we had both decided would be the most helpful, by an invitation to come and discuss all the points raised.

3. Without a reply to the invitation, a letter is now sent to the press, identical with the original except that it now adds an expression of doubt about the sincerity of the president on the grounds that the letter was "not answered by him," thus allowing the reader to conclude that the letter was unanswered without actually saying so.

4. Without any apparent embarrassment at having attacked in public the good faith of its president an acceptance is now sent to the invitation to come and talk in the society.

Your leading article may truly say that as an incoming president I inherited many difficulties. Some of them, of course, have yielded in direct conversation to that valuable combination common sense and good will. Others, more complex and requiring a more long-term solution, will take time, and the claims of some of these can be seen to conflict. As an example, what can a president do when told that certain changes are urgent and should be made at once and that one of these urgent changes is that important decisions should be implemented only after they have been fully discussed by the councils of all 34 of the individual sections?

It was apparent at the society's AGM that additional means of communication would be appreciated. An immediate first presidential newsletter perforce concentrated on an urgent matter, the restoration of morale following the publication in *World Medicine* of an article which the editor agrees could have been construed as an invitation to believe that the affairs of the society was in the hands of officers who were "either incompetent or acting from personal motives" (it is now accepted that the article was not intended to give such an impression). The first newsletter was intended to reassure and set the pattern for the future rather than to be informative on matters of detail. The very great majority of fellows and members writing to me were in fact reassured by it and it is perhaps a little unfair to criticise it for "lack of substance." But a letter in the January issue of the society's journal will, as succinctly as possible, inform fellows and members of some of the difficulties and the basis of some of the decisions in regard to a number of thorny problems—the library, attendance at sectional meetings, the new journal, public health education, and Chandos House and the rebuilding programme among them. However, it is my belief that the best answer to doubts lies in deeds rather than words, and, though one cannot have both the speedy introduction of reforms and a greater degree of consultation, I believe that what fellows and members wish to have put before them at the next AGM is a blueprint for the future setting out how the major issues facing the society might be handled both with dispatch and also with the certainty of general support (not by any means as easy as it sounds).

It must be said here that it would be quite impossible for the RSM, or any other society of comparable size, to remain in existence other than through electing a responsible body to act on its behalf and then trusting it to make the right decisions. A suggestion made at the last AGM, for instance, that council should not make any decisions of importance without first referring the matter to the fellows and members, would be totally impracticable. However, it is reasonable to examine the means whereby officers and council are elected and how the views of the sections are made available, and these aspects of the constitution of the society will undoubtedly receive the examination they deserve.

It is my belief—indeed, from letters received I have ample evidence—that the very great majority of fellows and members of the RSM are satisfied with the general state of health of their society, have complete confidence in the ability and integrity of their officers and council, are glad that all constructive suggestions made constitutionally within the society, and in particular at the AGM, are under careful scrutiny, and are not sympathetic in any way to a small minority with less patience than they have, who damage the reputation of the society by public attack.

When an attack of this kind casts doubts on the sincerity of the president and contains statements which are demonstrably untrue, the temptation is there to write in terms which might genuinely qualify for the title of your leading article, but I have resisted this. Perhaps the *BMJ* would wish me now to list these statements and deal with each in detail but I have used enough space already. If, however, I am to take literally your last sentence—"Their doubts" (that is, all the doubts listed in two long letters, which I would have been happy to spend an afternoon discussing had they been brought to me personally) "should be answered in full and in public"—this is not impossible, given adequate space. It is not clear to me, however, whether or not I am being offered a couple of pages in the *BMJ* for the next few months.

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Nursing at a crossroads

SIR,—The provision of nursing support in adequate quantity and quality is a vital factor in any health care system and is quite properly the concern of the medical profession, for it is the foundation on which doctors work. There is great concern at area level over the present difficulties in staffing hospitals with nurses in sufficient number of the right calibre. My purpose in writing is to alert those who may not be already aware of the situation because there are signs that it may deteriorate.

The problems in our area are probably mirrored in many other parts of the country and may even be worse in some. At the moment we have not enough nurses to staff all our wards and have recently closed a medical ward; the advent of winter makes one certain that contraction of nursing staff through illness may cause further closures at a time when the demand is heaviest. At the moment, provision of finance is not the problem—nurses simply cannot be recruited. While strenuous efforts have been made locally to try to improve the situation, there is one factor which can only be altered by national agreement. The age for entering into nursing is at present 18 and is shortly to be reduced to 17½. There are very few nurses who do A level courses so it means that those who leave school at 16 may have to wait 18 months before taking up nursing training; this is manifestly not going to happen. I think it a matter of some urgency that entry into nursing be allowed from the age of 17, to be preceded by a year of cadetship so that these girls can enter training straight from school.

Shortage of numbers potentiates the already dangerous situation; when work is laborious and effort not properly recognised, nurses become discouraged. They may leave for other fields or for other areas or even countries in the hope of improving the situation. As numbers get shorter, those willing souls remaining get more and more discouraged, the sickness rate goes up, and a vicious downward spiral ensues. This will no doubt be exacerbated by the intended introduction of the 37½-hour week for nurses. There has been a criminal miscalculation here in that this change will undoubtedly result in a greater relative shortage of nurses; but, as has been pointed out recently, so many of the national and international regulations we accept have financial implications for the Health Service which are not funded.[1] I would therefore like to suggest that one possible way to relieve this problem would be once more to restructure nursing shifts. The old split shifts were deservedly unpopular; the present system, however, whereby the morning and evening shifts overlap between 1.00 and 5.00 pm is wasteful and inefficient. I would like to suggest that shifts be reduced but better spaced—for example, 7.00 am to 2.30 pm, 2.30 to 10.00 pm, and 10.00 pm to 7.00 am. This would give five 7½-hour days for those on day duty and four 9-hour nights for those on night duty, so that no increased numbers of staff would be needed.

Nursing is at a crossroads and there must be a radical rethinking of its role. Until this occurs, we have to ensure that the hospital provides a service which is still based on traditional nursing. I would earnestly beg, through your columns, that doctors become actively involved in this problem and I hope that my two suggestions will be taken up at a higher level.

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[1] *Hospital and Health Services Review*, 1978, **74**, 421.

Severe hyponatraemia in hospital inpatients

SIR,—Dr P G E Kennedy and his colleagues from the Whittington Hospital (4 November, p 1251) draw conclusions from their study on severe hyponatraemia in hospital inpatients which have already been challenged in your columns (9 December, p 1640). The data on which these conclusions are based deserve closer scrutiny.

In their prospective study over a 10-month period only 44 patients had plasma sodium concentrations below 125 mmol/l. We have 34 such patients drawn retrospectively from the single month of November this year (median sodium concentration 120, range 105-124 mmol/l). These hyponatraemic patients represent 4·1% of all medical and surgical admissions during this month. Furthermore, the incidence in surgical admissions is 5·4%, which is no less than 13·5 times greater than

that reported in such patients at the Whittington Hospital. Possibly this higher incidence results from our retrospective study in which "simultaneous blood and urine samples" were not collected. I doubt, however, that this can be the explanation as Dr Kennedy and his colleagues have not excluded the 59% of their patients in whom urine analysis is not reported.

Drs S J Iqbal and P J Ojwang (9 December, p 1640) express concern about the conclusion that biochemical analysis of the urine is of little value in such patients. I would go further and ask what conclusion one is entitled to make on data from 18 isolated estimations in 44 patients. Surely the value of this estimation lies in daily evaluation of electrolyte homoeostasis.

To describe hyponatraemia as "dilutional" on the basis that postoperative patients have been infused with undisclosed volumes of 5% dextrose is dangerously misleading. Most of our patients received more than 100 mmol sodium/24 h; 5% dextrose was only occasionally used. Is surgical practice at the Whittington Hospital so very different? Surely the widely recognised views subsequently expressed by Dr C T G Flear and his colleagues (9 December, p 1640) are in no way challenged by the information presented.

Finally, the observation that hyponatraemia cleared rapidly after intravenous dextrose infusion had been stopped and that "water restriction or hypertonic saline was not needed" leaves the surgical houseman confused. Should he then infuse saline to his fasting patients or merely deprive water by omission? Saline, and particularly hyperosmolar saline, should be used with caution as many such patients easily become overloaded with sodium. Fortunately, hyponatraemia tends to recover with improvement in general condition, but two of our postoperative and jaundiced patients required prolonged treatment with dextrose, potassium, and insulin. These patients survived, whereas the mortality in our hyponatraemic group was worse than the 27% in the Whittington patients. It is hard to imagine what evidence can justify a statement that "although 12 deaths occurred among the 44 patients hyponatraemia did not play a part in any."

Dr Kennedy and his colleagues planned to comment on inappropriate antidiuretic hormone secretion. They conclude that it is not a common cause of hyponatraemia. It had not occurred to us that it was. I hope house officers and students will be advised to treat hyponatraemia by established methods. They should not be discouraged from the selective postoperative infusion of 5% dextrose as a valuable source of the water upon which life depends.

C N McCollum

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Sir,—We entirely agree with Dr C T G Flear and his colleagues (9 December, p 1640) that internal shifts in sodium and water contribute to the hyponatraemia found in a number of conditions which cannot be explained solely by changes in external balances. However, we do not agree that the "sick cell" concept need be invoked to explain the hyponatraemia of the large number of our patients on diuretics and intravenous dextrose.

While Dr Flear and his colleagues are in agreement with us that urine analysis is of little value in the diagnosis of the cause of severe hyponatraemia, Drs S J Iqbal and P Ojwang (p 1640) take another view. However, they provide precious little evidence that the management of such patients is improved by urine analysis, and in one of the references they give it may possibly have been a disadvantage.[1] If Drs Iqbal and Ojwang reread our paper carefully they will see that we did, in fact, compare plasma urine ratios. We can confirm that plasma:urine osmolality ratios proved no more helpful in diagnosis than other direct and derived biochemical measurements. In addition, we ourselves stressed that diuretic-induced hyponatraemia is more often dilutional than depletional.

Finally, so far as "emergency" is concerned, we were referring to acutely ill patients who are found to be severely hyponatraemic.

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[1] Ruby, R J, and Burton, J R, *Lancet*, 1977, **1**, 1212.

Seat belts and the safe car

Sir,—I read with great interest the article of your special correspondent on road accidents about seat belts and the safe car (16 December, p 1695). I am delighted that your journal is being used to disseminate so clear an account of the issues at stake, and so careful a weighing of the evidence.

However, it is not enough for doctors to convince doctors. Doctors must now convince the public. It was because the surgeons of the Royal Australasian College of Surgeons convinced the Australian public that the politicians in that country followed public opinion and legislated. In Northern Ireland, the involvement of virtually all the surgeons in an education campaign has completely changed public attitudes here. Unfortunately, for other reasons, our legislation has never been brought forward.

What about compulsory wearing of seat belts in England, Scotland, and Wales? The British Medical Association is in favour—so are the London and Edinburgh Royal Colleges of Surgeons and many other medical and surgical associations. But as yet the public is totally unaware of this. The Government has announced its intention of bringing in legislation. Will this move go by default through sheer inertia? There is the inertia of MPs who do not know or care about the facts; the inertia of the public, who are confused and have other things on their minds; and the inertia of the medical profession, who are in possession of the facts and support the measure but cannot or will not communicate their concern to the public.

It is the Sunday papers, the weeklies, the national and provincial papers, the radio, and the television that we need to communicate through. The *British Medical Journal* is not enough.

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Sir,—Your special correspondent writing on this subject (16 December, p 1695) makes no mention of laminated glass in cars. This is unfortunately not compulsory in this country and without it no car is safe for its occupants. The latest figures (for 1977, quoted in the *Daily Telegraph*, 29 December) show that, of the 6614 people killed on the roads, the majority were not occupants of cars. There were 2313 pedestrians, 301 cyclists, and 1031 motorcyclists killed, a total of 3645 non-occupants. The number of car occupants killed was 2441 and one suspects some of these to have been suicides. Of course, seat belts properly used would reduce deaths and injuries to occupants but it is not just occupants one should consider. A car out of control or in irresponsible hands was presumably the cause of most of the pedestrian deaths and no seat belts would have saved them.

As to injuries to the occupants, many of the serious ones we have to deal with are serious just because of fragmentation of glass. It is not just the unrestrained occupant who breaks the windscreen. I have recently had a patient with perforation of the eyeball from a fragment of broken windscreen even though he was properly belted in. I have also had a case of ruptured eyeball from mugging when the car stopped at traffic lights as the victim was belted in and could not evade his attacker. There are some terrible people loose on the roads these days.

It seems to me that more good would accrue from the non-controversial and easily enforcible measure of making laminated windscreens compulsory on all new cars, as in most countries, than in trying to enforce the controversial body restrainers of one type or another. Not all doctors are in favour of legal enforcement of seat belts or other penalties after the damage is done and I am one of them. After all, it is usually the innocent passenger who bears the brunt of the injuries rather than the supposedly responsible driver and one does not wish to add to his or her distress.

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Dialysis and transplantation and the quality of life

Sir,—I welcome your timely leading article (25 November, p 1449) on dialysis and transplantation and would particularly support your call for medical and nursing staff increases to match the increased funds for kidney machines. It is right, too, that the deplorable level of renal replacement therapy in Great Britain should be publicised to the medical profession.

Having said this, however, I am disturbed by the implications, particularly in the last paragraph, that dialysis and transplantation might not result in the restoration of a reasonable quality of life. I think it is important to stress that these treatments, in fact, result in a remarkable rehabilitation rate. Two-thirds of patients on home dialysis are in full-time employment and a further 7% work part time. Four out of five successfully transplanted recipients achieve the life style that they hope for, and the overall three-year survival figure for renal replacement therapy is 70%[1] (these statistics are from all Europe and, therefore, include older patients and those with multisystem disease, whose treatment the leader writer appears to question). There can be very few treatments for potentially fatal conditions which achieve the figures quoted