team work and led eventually to the premature termination of the experiment.

These factors were: problems with communication, faulty expectations of roles, problems with status, and a failure to achieve a cohesive team structure.

Paramount in the team's failure in communication was the absence of an integrated patient's record. Other communication difficulties were the failure to establish formal methods of referral between team members and the difficulty of obtaining feedback after referral. Many of these difficulties could have been avoided had detailed consideration been given to formal methods of communication and record-keeping at the outset of the experiment. This failure was due mainly to ignorance as a large amount of time was spent on discussing research methodology in great detail, but the more important aspects of team management were not touched on.

Reilly and his colleagues also mention the expectations and perceptions of the various workers. We found out too late that a proportion of the blame for the failure of the Liverpool project rested on faulty expectations of the roles of the various team members by colleagues and failure to understand adequately the various skills of the individual team members.

Finally, unspoken and unresolved problems of status and status hierarchy led to difficulties which were never anticipated and which contributed to the breakdown of the experiment.

The multidisciplinary primary care team has been compared to a football team in which the player with possession of the ball determines the play at that moment but, at the same time, all the players are collectively responsible for the result of the match. It follows that a good team must train together for a considerable time. It seems that where primary care teams have been unable to overcome the difficulties and stresses of the novel situation they have not spent sufficient time together in practice and training before getting down to the business of caring for patients.

LEN RATOFF

363 Park Road
Liverpool L8 9RD.

JOURNAL STYLE

Sir,

I note with horror that the word 'analyse' has been spelt 'analyze' in the *Journal* since January 1977. I dislike this repellent word because it is an example of unnecessary literary bastardy. As a product of this I know it has no pedigree and can only hope that it has no posterity.

The word 'analysis' is derived from two Greek words *ana* (up), and *lyein* (loosen), (Greek *analysis*). The Greeks spelt this with an 's' and not with a 'z'. Thus the verb 'analyse' has an unimpeachable pedigree, and retains both its meaning and its roots—a splendid example of felicitous adoption.

How did the 'z' appear? I suspect that some pernickety scholar, insisting on the classical way of making a verb out of a noun by adding the Greek (and Latin) suffix 'ize', produced 'analysize' which pedantically correct horror later became falsely contracted to 'analyze'.

I fear that in changing from a house style which used all -ise endings to all -ize, you are jumping out of the frying-pan into the fire. Please do not argue with your colleagues; just ask a straightforward question and demand a straightforward answer. "Why do you think analyze is correct?" Ask them also how they would spell haemolyse and electrolyse.

Authorities are legion and include *Chambers' Twentieth Century Dictionary,* the *Oxford Dictionary of English Etymology,* Fowler (indirectly) and *The Times.*

My kindest regards to your sub-editors and proof readers. I await their counter-barrage with confidence and a complete lack of trepidation. I hope these few observations may help to 'catalyze' the situation.

J. R. MILES

11 Royal Crescent
Cheltenham
Glos.

EMPLOYMENT OF MENTALLY HANDICAPPED PEOPLE

Sir,

In reply to Dr Raphael's criticism (June *Journal,* p. 380), my report (January *Journal,* p. 53) was based on the findings of a two-day workshop held at the King's Fund Centre in December 1974, which was reported by the Centre in a paper entitled *Employment of Mentally Handicapped People.*

Whether Remploy's intake of mentally handicapped is applied to the analysis of primary disablement categories served or to the number of mentally handicapped suitable for sheltered workshops throughout the land it still appears to remain "a tiny percentage".

Page 15 of the above report reads: "The number entering sheltered employment, widely thought to be more appropriate for mentally handicapped individuals than is open employment, reveals a surprisingly lower figure. This can best be explained in terms of low availability of places, for only about 12 per cent of area training centres reported that sheltered work places were available for their trainees. This may not be surprising in view of the small percentage of mentally handicapped people reported to be employed in Remploy, for example. Figures for the years 1963 to 1973 show only a five per cent increase (from four per cent to nine per cent) during the period (Department of Employment, 1973).

"This figure is desperately low, and appears to reflect the Department of Employment's policy of allocating no more than a small percentage of places to 'mentally disordered' people. Wide-ranging enquiries reveal that there is a low expectation of the ability of mentally handicapped people to attain entry requirements for sheltered employment. Indeed, the figures show that it is approximately ten times more difficult for a trainee to obtain a place in a sheltered workshop than it is for him to obtain a place in open employment."

In the same paper Dr Edward Whelan, Director of the Habilitation Research Project, Hester Adrian Research Centre, Manchester, and Joint Director of the Workshop, shows that it seems easier to get a job in open employment than in a sheltered workshop (p. 14). Referring to this the paper goes on to state: "Remploy, as it operates at present, seems to be inappropriate to, and not particularly interested in, the needs of mentally handicapped people" (p. 52), and further on: "Remploy seems to be an industrial organization which employs handicapped people on a selective basis, but which seems to consider itself inappropriate for mental handicap. Perhaps we are wrong. It would be helpful if Remploy would lay down a clear and unambiguous policy on this issue" (p. 55).

On government involvement, the paper has this to say: "There seems to be a lack of co-ordination, for example, between the Department of Health and Social Security (responsible for area training centres) and the Department of Employment (responsible for sheltered workshops)" (p. 54).

It seems that a major concern of the two-day workshop was that better education and training for the subnormal and severely subnormal should not, and cannot, be an end in itself. There is great need of much more sheltered employment. Can there really be the slightest doubt that central and local government have failed lamentably in this? To train young subnormals, and then have so little suitable employment for them to move on to, makes neither socio-economic or moral sense.

To quote further from the King's

Fund paper: "Government departments seem to be afflicted by the same low expectancies which affect other agencies and individuals . . ." (p. 6).

"Trainees need a broad and progressive range of new placements: for example, work preparation courses, pre-vocational and vocational training, work experience groups, sheltered workshops, enclaves, seasonal and permanent open employment. The criteria for sheltered employment should be critically re-examined . . ."

Of course, I am not criticizing Remploy staff, but policies of successive governments. For instance, the paper states: "The contribution of Disablement Resettlement Officers is patchy: we would like to see them orientated towards meeting the needs of the mentally handicapped" (p. 55). But, like local authority social workers, they need the back-up facilities. More often than not, these are just not there.

H. D. ORRISS

11 The Row
Hartest
Bury St Edmunds
Suffolk.

References

Department of Employment (1973). *Sheltered Employment for Disabled People.* London: HMSO.

King's Fund Centre (1975). *Employment of Mentally Handicapped People.* Mental Handicap Paper 8. London: King's Fund Centre.

BOOK REVIEWS

A HANDBOOK OF TREATMENT

Eds H. W. Proctor & P. S. Byrne

Medical and Technical Publishers Lancaster (1976)

434 pages. Price £9.95

I was dubious about the value of another book on treatment, but the more I looked at this book, the more valuable I found it. An impressive array of clinicians from an anaesthetist to a venereologist with one academic and one active general practitioner and one non-clinical medical director of population services make up the authors of the various chapters.

The first 14 chapters are a guide to modern treatment with sections on the therapy of modern diseases and the drugs in current use, with four supplements on areas of special interest. The second section contains ten chapters on selected aspects of therapy.

Naturally a book of this kind, written largely by hospital doctors, assumes facilities not usually available to the majority of general practitioners. For example, in the chapter on cardiorespiratory emergencies it states: "the degree of metabolic acidosis should be determined and corrected by appropriate investigations", but this is not likely to happen in the majority of cases in general practice. There is also only a small paragraph on carcinoma of the bronchus, which is commoner in general practice than pulmonary embolus, which is allotted seven paragraphs.

The book ends with a chapter on prospects in medical treatment which concentrates on metabolic bone disease. This is certainly very interesting but is, again, less common than, for instance, cancer, heart disease, and mental disorder, where new advances are forthcoming.

This is the sort of book I certainly felt I would like to have on my shelf to dip into and use as a basis for discussion. It combines clarity with up to dateness and could well be read by non-medical personnel in the health care team. In view of the price, I hope the book will be brought out in paperback so that more people can appreciate its benefits.

JOHN COHEN

CONTRACEPTION AND FAMILY DESIGN

John Peel & Griselda Carr

Churchill Livingstone Edinburgh and London (1975)

176 pages. Price £3.50

A questionnaire given to a sample of British women who married in the winter of 1970/71 forms the basis of this book. The report is intended as the first of a series studying these women at five-yearly intervals throughout their reproductive lives.

Few doctors would wish to read the whole book. The presentation, though scholarly, is rather dry and about a third of the book is devoted to survey procedure. However, it is well worth dipping into and this approach is helped by the convenient summaries at the end of most chapters.

Some of the effects of occupational, educational and religious differences in family building are discussed. In general, I am impressed by the smallness of these effects.

By far the most popular methods of contraception were the Pill, the condom and withdrawal, in that order. Used separately or in combination, they were the first forms of contraception to be used after marriage by over 95 per cent of the sample. A higher proportion of wives relying on the condom or on withdrawal said they were prepared to take risks with family planning than those who relied on the Pill, diaphragm or intrauterine device.

This is a carefully and ethically conducted enquiry and is presented as a model of good survey technique. There are weaknesses, however. Some of the data collected in the questionnaire were omitted without explanation. The definition of "postponers" was unfortunately geared to the timing of the interview rather than to a set interval after the marriage. There is no discussion of how far results were affected by different interviewers or the presence of any additional people at the interview, or to what extent the national findings might be applicable to small communities of the size dealt with in general practice.

ARTHUR JOHN