legislatures is predominantly lawyers. This has led, in the case of New York State, to the legislature's passing an amendment to the no-fault automobile accident insurance law whereby any doctor treating an automobile accident case must accept the same fee schedule as allowed by workmen's compensation (about half the regular private fee).

A number of New York State orthopaedic surgeons founded a society called the Surgical Specialties Association of New York State to fight this unacceptably low fee schedule. They applied for a legal injunction against the application of the new fee schedule, but this was denied by the courts. In order to bring pressure on the New York State legislature, they then organised a strike against caring for patients under the workmen's compensation laws, except in emergency situations. As the Surgical Specialties Association is not a trades union, the attorney general of New York State has instituted a prosecution against eight orthopaedic members, charging them with conspiracy to have physicians withhold services from patients. This has been felt by many doctors to be a purely political move by the politicians in power gradually to wear down the medical profession.

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Money and medicine

SIR,—In his very amusing excursion through the morals of the just price (21 July, p 220), Professor Rudolf Klein omits an element which would certainly not have escaped any of the earlier commissions whose work on medical remuneration he quotes. For simplicity, this may be referred to as the family investment factor.

While student grants and, more particularly, the appropriate means tests remain at their present level, it would cost two consultants some £7000, paid out of taxed income, to start an offspring on the same course. This is very much more than if sonny had decided to be a coal miner, or daughter a university teacher. The consultants themselves, if they qualified before the effect of the 1944 Education Act made itself felt, represent an even greater investment by the same family; it is likely that *her* dowry, rather than the down-payment for a house, was some five-sixths of a medical education, a second-hand fur coat, and some medical textbooks which were already becoming obsolete.

Professor Klein is right to say that the schoolmen would have felt at home in the argument. They were notoriously reluctant to admit that a profit on an investment was justified, but I fancy that they would have been acutely sensitive to those factors which resulted in the reduction of the wealth or circumstances of a family.

KENNETH ULYATT

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Remuneration of armed Forces medical services

SIR,—Figures that I quoted on recruiting to the armed Forces medical services in my report to the Annual Representative Meeting in Liverpool have been challenged by the Ministry of Defence. It maintains that these

differ from those quoted by the Armed Forces Pay Review Body in its supplement to the *Eighth Report on Medical and Dental Services of the Armed Forces*. May I therefore explain the circumstances?

The Review Body Report was published on the last day of the Annual Representative Meeting and I therefore had no opportunity of knowing what figures were to be published; the figures that I used came from earlier estimates, which had been supplied to us officially and which applied to slightly different periods. I must also point out that the Review Body figures included preregistration medical officers, whereas mine referred only to fully qualified practitioners. I regret if this has caused any confusion. However, the differences to which I have referred do not alter the main burden of the argument to be derived from a study of either of these sets of figures. Up to the present time the recruiting figures to the armed Forces medical services and the number of voluntary resignations have given cause not merely for disquiet but also for alarm. *

The fully up-to-date remuneration for doctors and dentists in the armed Forces vigorously pressed for by the British Medical Association and my committee, and now awarded, will we hope do something to alleviate this crisis. This, however, is only a start, for we still feel that there has been misunderstanding in the way that the present analogue with general practitioners is applied. We shall be studying the whole question of the basis of the pay of doctors and dentists in the armed Forces in our discussions with the Review Body during the course of this year.

J C WATTS

Chairman, Armed Forces Committee
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VAT on emergency equipment

SIR,—It seems to me quite irrational that value-added tax should be charged on items of medical equipment which are needed to deal with acute emergencies. I am thinking in particular of defibrillators and monitors. It is essential that departments such as mine should have efficient equipment, and an additional 15% on top of an already expensive machine makes it increasingly unlikely that this will be obtained.

CYNTHIA ILLINGWORTH

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Hospital practitioner grade

SIR,—At the ARM in Liverpool I asked for the following motion, which my division had introduced, to be withdrawn: "That until recalcitrant hospital consultants expedite the appointment of those suitably 'qualified' persons to the hospital practitioner grade, general practitioners should limit referral to the consultants of private patients." Nevertheless, many general practitioners believe that such action would be warranted.

As well as serving on the Surrey LMC and the Surrey AHA I am a member of the hospital practitioner grade vetting and appointing panel. No general practitioner is ever accepted for the grade until he has been vetted fully by the examining panel and there is full agreement about his suitability. A representa-

tive of one of the royal colleges is always present. Why is it that there are such inordinate delays before appointments are made or even substantiated after a candidate has been approved by the panel? My inquiries have shown that it is usually because some consultants—many of them HCMA members—are blocking the way, and I believe this happens because they are jealous of general practitioners' pay yet do not understand how it operates.

Surrey and Berkshire have several such "recalcitrants." When I tackle them the answer has always been, "General practitioners are paid too much as hospital practitioners." General practitioners do not go around asking for consultants' salaries to be reduced; in fact, if they are also competent private practitioners we augment their incomes by sending them private patients. Yet these same consultants are saying that hospital practitioners cannot be appointed because the general practitioners will get as much as a consultant. Why not?

In using such a dog in the manger argument they forget two facts: firstly, a 40% or more expense factor has to be built into all general practitioners' remuneration from all sources to cover expenses which whole-time consultants never have to bear; secondly, the Review Body judges what consultants should be paid, and for many this can include substantial merit awards. Indeed, the NHS gives a living to many consultants—and perhaps quite a few general practitioners—who in my view could never earn one in private practice.

The hospital practitioner grade should be implemented forthwith. Mr David Bolt has asked general practitioners for their help. We give our support willingly. Now it is time for all consultants to support general practitioners.

E B ALLEN

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Training posts and disillusioned registrars

SIR,—I read with some concern the letter of Dr Colin Taylor (30 June, p 1798), in which he lays the blame for his predicament and that of other disillusioned registrars on the regional postgraduate advice network. From my experience as a regional postgraduate dean I would like to suggest that in many instances junior doctors must accept some responsibility for their own career frustrations—for example, in selecting oversubscribed specialties unless they are of outstanding calibre. At the same time I would like to say that in discussing career prospects with junior doctors I am continually surprised that it very often appears that career advice from their consultants has been neither sought nor given and also that many doctors do not appreciate the scope and extent of the postgraduate network available to them.

In order to ensure that junior doctors take advantage of the postgraduate facilities available, the regional postgraduate committee of the South-west Thames Region has recommended that it should be written into job descriptions that junior doctors should discuss with their consultant their career aims and aspirations and their proposed training, study leave, etc, when they take up a new post, and should acquaint themselves with the clinical tutor and the postgraduate facilities available. The regional adviser in psychiatry has also recommended writing into the

consultant job description that the consultant appointed will be expected to take an active interest in teaching and will have a special responsibility for the general and higher professional training of junior medical staff working with him or her.

Because of the interest which the South-west Thames regional postgraduate committee has in the training of junior doctors (and consultants) the regional postgraduate dean, accompanied by the regional specialist in community medicine (medical staffing and postgraduate medical education), the regional adviser in general practice, the regional librarian, and the regional records co-ordinator, visits the medical centres at each of the district general hospitals and psychiatric and mental handicap hospitals about once a year. The programme of these visits includes an opportunity for any junior doctor or consultant who wishes to meet the regional postgraduate dean and his colleagues to discuss his or her career, training, and aspirations; the visits also include meetings with the local postgraduate committee, the district management team, and other administrators.

I sympathise with Dr Taylor, but wish to assure him that the regional postgraduate network is both sympathetic and concerned that early career advice was apparently not sought or was not available to him; but the problem of the career prospects of registrars will never be solved until we have resolved the service requirements of the NHS and have stopped holding some "trainees" in SHO or registrar posts exclusively for service purposes. It may interest your readers that, in order to facilitate the training of registrars and prevent the situation referred to by Dr Taylor, the South-west Thames regional postgraduate committee is setting up a system whereby registrars will receive an annual questionnaire which will encourage them to consider their career prospects and seek appropriate advice from their consultants and tutors.

GEORGE DICK
Regional Postgraduate Dean,
South-west Thames Region

RON VINER
Regional Records Co-ordinator,
South-west Thames Region

London NW1

A glut of doctors?

SIR,—York is a nice city. It has good facilities—a university and a medical school within easy reach for postgraduate courses. When I took a registrar job here in 1961 there were five British graduates as applicants short listed.

In 1979 we have had a consultant post standing empty for three months. We have four SHO vacancies—for which there were three overseas applicants, none of whom turned up for interview and none of whom bothered to let us know. The local mental handicap hospital has two consultants retiring and maybe will finish up with no consultants at all. No appointments were made in 42% of consultant posts in mental handicap for which interviews were held in 1974-7 (a saving for the DHSS of £200 000-£300 000 per annum). Other specialties are in the same boat. People do not want to train in hospital posts and they do not want to take these consultant posts—or there are no trained people to fill them.

We read in the *BMJ* of a glut of doctors on the way. I only wish we could get a sight of

one. Places are going to close. When is the DHSS—or one of our committees—actually going to do something about it?

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Points

Postinjection reactions to gold

Dr R WYBURN-MASON (Richmond, Surrey) writes: I would like to draw the attention of Dr B D Williams and others, who describe severe exacerbation of rheumatoid arthritis soon after injection of gold thiomalate (28 July, p 235), to the fact that gold injections were used extensively in the treatment of tuberculosis before the discovery of specific drugs against the causative organism. They were sometimes effective in killing the tubercle bacillus and were shown to be active in vitro against a whole series of organisms, including *Treponema pallidum*. Have the authors never heard of a Herxheimer reaction? This consists of an exacerbation of the symptoms of a disease when a drug which kills the causative organism is administered. . . . The reaction that they describe when gold is given in cases of rheumatoid disease is a typical Herxheimer reaction and points to the organismal or infective causation of rheumatoid disease, so often postulated in the last century or so. . . . I was able to recover¹ from all the tissues of all patients with this disease a free-living amoeba of the *Naegleria* genus, by using the property of thermotaxis possessed by many parasites of warm-blooded animals, including the free-living amoebae. . . . It was found that it could be killed by metallic copper and copper salts in minute traces, by organic gold compounds, dilute solutions of bile acids, pentamidine, emetine and dehydroemetine, clotrimazole and levamisole (both of which contain antiprotozoal imidazole groups), and in particular by 5-nitroimidazole compounds, such as metronidazole, tinidazole, ornidazole, and nimorazole, all of which have a spectrum of activity against protozoa (including free-living amoebae). When any of these substances were used in the treatment of active rheumatoid disease, they caused either a fairly rapid disappearance of disease activity or a typical Herxheimer reaction—that is, an exaggeration of the symptoms of rheumatoid arthritis exactly like that described by Dr Williams and his colleagues, usually followed by improvement and finally disappearance of symptoms and signs of inflammatory activity, sometimes after multiple doses. . . . The use of gold with its very toxic reactions can be dispensed with by simply using one of the 5-nitroimidazole antiamoebic compounds, such as metronidazole, which are innocuous.

¹ Wyburn-Mason, R, *The Causation of Rheumatoid Disease and Many Human Cancers: A New Concept in Medicine*. Tokyo, IJI Publishing Co, 1978.

Pulmonary oedema in falciparum malaria

Dr S M MARKS (Warwick Hospital, Warwick CV34 5BW) writes: With reference to the short report by Dr R W Martell and others (30 June, p 1763), I wish to point out that in our report of the first recorded case of malarial lung in Africa we considered the early use of

positive-pressure ventilation to be the treatment of choice. In addition I would like to comment that the almost complete resolution of pulmonary opacification within 24 hours occurred rather quickly.

Upper airways obstruction after Dettol ingestion

Dr N C VAREY (Reckitt and Colman, Kingston-upon-Hull HU8 7DS) writes: . . . In his report (7 July, p 19) Dr L N J Archer states that Dettol is "described on the label as non-poisonous." This wording was removed from Dettol labels some 15 years ago. Very large quantities of the product continue to be used the world over and, as Dr Archer states, serious poisoning is rare; but at that time we realised that the wording was not strictly correct and under the present product licensing system such a claim would not be permitted.

A case of ileus?

Dr W D BRINTON (Arisaig, Inverness-shire PH39 4NT) writes: . . . Here is another epitaph in a case of ileus (Words, 14 July, p 120) or perhaps acute dilatation of the stomach—composed, I suspect, rather than found by my late brother-in-law L A G Strong:

Here be the bones of Jesse Welch
Who died of keeping back a belch
Which same did in his pipes expand
And waft him to the heavenly band.

When is a cube . . . ?

Dr R EBAN (Ealing Hospital, Southall, Middx) writes: Could Dr P G Wheeler and his colleagues instruct us in their method of preparing a cube of 2×2×4 mm (28 July, p 243)? Or would it be more appropriate to ask you to be as wary of your English (and your geometry) as you assure Dr F J Wright (p 276) that you will be with your Greek?

Other people's lives

Dr R G H BETHEL (Englefield Green, Surrey TW20 0NX) writes: Dr P J Toghill (7 July, p 35) is not only 20 miles short on his location for Kipling's house, Batemans. He is also one volume short on Mr Harold Macmillan's autobiography (six not five), which may imply that he has yet more pleasurable reading of the elder statesman to anticipate.

"To fart"

Dr D E EVANS (University Department of Physiology, Manchester M13 9PT) writes: . . . "Flatus," like "inflate" and "deflate," arises from *flare*, "to blow." As Dr Eric J Trimmer (28 July, p 277) points out; the prefix "de-" signifies a deprivation or taking away—that is, an act done to the subject. The prefix "ex-", signifying a sending forth, seems more apt for an act by the subject. As usual (compare "effluent"), the x drops out and the f repeats, thus: "efflate," "efflator," "efflation." The e is short, abrupt, and emphatic, contrasting with the longer, less stressful e of "deflation."