assessed 48 hours after each exchange fell successively from 7.8 to 5.4 g/l.

Our failure to confirm Dandona's findings is unlikely to be due to any differences in the method used. Havard¹ states that plasmapheresis is effective only in acute and rapidly progressive exophthalmos; and although our patient's signs were progressive at the time of plasmapheresis they had been present for seven months, and one possible explanation is that irreversible fibrotic changes may have taken place.

If a circulating plasma factor such as an immunoglobulin is directly involved in progressive exophthalmos, some improvement in the eye signs should be expected following its removal by plasmapheresis. Individual variation in rate of synthesis and degree of tissue binding of any immunoglobulin is another factor that could affect the response to plasmapheresis. Nevertheless, the lack of response in our patient indicates that plasmapheresis is not a universally successful treatment of progressive exophthalmos.

In view of the variation in response to plasmapheresis in the two cases published to date, the place of this costly and potentially hazardous treatment of exophthalmos and pretibial myxoedema needs to be clearly defined.

R A LEWIS
N SLATER
D N CROFT

St Thomas's Hospital,
London SE1 7EH

¹ Havard, C W H, *British Medical Journal*, 1979, **1**, 1001.

Fenclofenac-induced nephrotic syndrome

SIR,—Further to the review by Professor H A Lee (14 July, p 104) on drug-related disease and the kidney, we wish to report a patient with nephrotic syndrome secondary to fenclofenac therapy.

A 71-year-old woman was admitted for investigation in July 1978. She gave a three-week history of severe leg oedema and shortness of breath. Three years previously she had been diagnosed as suffering from rheumatoid arthritis, predominantly affecting her shoulders, hands, ankles, and feet. The latex test was strongly positive. In October 1977 she was started on fenclofenac, 300 mg three times a day. In November, one month after starting treatment, she was noted to have 7% eosinophilia (absolute count $0.4 \times 10^9/l$), with normal liver function tests. In April 1978 the dose of fenclofenac was increased to 1200 mg/day. Over the first eight months of treatment her urea rose from 5.4 mmol/l (32.5 mg/100 ml) to 15.1 mmol/l (91 mg/100 ml), and creatinine from 63 $\mu\text{mol/l}$ (0.7 mg/100 ml) to 143 $\mu\text{mol/l}$ (1.6 mg/100 ml). In June she developed proteinuria and oedema up to her sacrum. Fenclofenac was discontinued.

On admission she was not anaemic but was oedematous up to her mid-chest. Investigations revealed serum creatinine 136 $\mu\text{mol/l}$ (1.5 mg/100 ml), creatinine clearance 29 ml/min, urinary protein loss 4.70 g/24 hours, serum protein 41 g/l, albumin 19 g/l, and cholesterol 14.1 mmol/l (544 mg/100 ml). Differential protein clearance showed a selective proteinuria. Haemoglobin was 13.4 g/dl and ESR 83 mm in the first hour. A diagnosis of nephrotic syndrome was made. An intravenous urogram showed normal-sized kidneys with no evidence of obstruction. A renal biopsy showed mild focal proliferative glomerulonephritis. There was mild interstitial fibrosis but no arteritis or amyloid was present. The patient was treated with diuretics and, in view of the urinary protein loss rising to 7.9 g/24 hours, she was started on steroids (intravenous

prednisolone 128 mg/day for five days and then orally 80 mg/day). Her oedema settled, creatinine clearance improved, and urinary protein loss fell. Over the next six months her diuretics and steroids were gradually tailed off. In January 1979 her diuretics and steroids were discontinued. She remains well with no oedema, no proteinuria, and a serum creatinine concentration of 63 $\mu\text{mol/l}$ (0.7 mg/100 ml).

There has been one previous report of nephrotic syndrome in a patient taking fenclofenac.¹ No renal biopsy was performed. A complete recovery occurred on withdrawal of the drug. A hypersensitivity to alclofenac has been reported in three patients,² resulting in cutaneous vasculitis, mild proteinuria, and elevated serum urea. A renal biopsy in one patient showed focal proliferative glomerulonephritis with partial sclerosis of several glomeruli. It seems likely that our patient suffered a hypersensitivity reaction to fenclofenac resulting in eosinophilia and nephrotic syndrome, probably immune-complex mediated.

D V HAMILTON
J S PRYOR
NEIL CARDOE

Norfolk and Norwich Hospital,
Norwich, Norfolk NR1 3SR

¹ Smith, R B, *Proceedings of Royal Society of Medicine*, 1977, **70**, suppl 6, p 46.

² Billings, R A, et al, *British Medical Journal*, 1974, **4**, 263.

Gutter treatment for ingrowing toenails

SIR,—Mr W A Wallace and others in their recent article (21 July, p 168) state that the gutter technique may be the primary surgical treatment of choice for ingrowing toenails. They have reported a good symptomatic response with nail preservation, but a poor cure rate when compared with standard ablation techniques employed for recurrent ingrowing toenails. The gutter treatment must therefore be directly compared with simple avulsion of the toenail, at present the primary surgical treatment of choice for ingrowing toenail employed by numerous centres throughout the world. Mr Wallace's study, in which only 15 cases of simple avulsion are reported, fails to demonstrate that the gutter treatment has any significant advantage over simple avulsion, both methods of management having a reoperation rate of 33%.

Simple avulsion can be performed under local analgesia in over 90% of cases¹ with rapid symptomatic relief. The technique is no more complicated for the operator or distressful for the patient than gutter treatment and does not require the purchase of specially manufactured equipment. One hundred and thirty-eight out of 200 Glaswegian patients (69%) with an ingrowing toenail had both nail folds involved at presentation to hospital² and therefore would have required a gutter to be placed on both edges of the nail. This would prolong and possibly complicate the procedure, adding to the risk of failure due to the slipping of the gutter.

There is no theoretical reason why gutter treatment of ingrowing toenails should result in better long-term results than simple avulsion of the toenail, followed by conservative management of the new nail as described by Lloyd-Davis and Brill.³ A large randomised study is required to compare these two techniques and define their role in the primary surgical management of ingrowing toenails. Until the results of such a study are available

simple avulsion of the toenail should be retained as a useful technique in any toenail management protocol.

W R MURRAY
J E ROBB

University Department of Surgery,
Western Infirmary,
Glasgow G11 6NT

¹ Murray, W R, *Clinical Orthopaedics and Related Research*, in press.

² Murray, W R, and Bedi, B S, *British Journal of Surgery*, 1975, **62**, 409.

³ Lloyd-Davis, R W, and Brill, G C, *British Journal of Surgery*, 1963, **50**, 592.

Hepatitis a cure for hay fever?

SIR,—I have read with great interest Dr John Morrison Smith's contribution on asthma under the heading "In My Own Time" (14 July, p 118) because my own experience has been very similar.

My first attack of hay fever was in the summer of 1916 when I was 10 years old. We had recently moved to London from Newcastle upon Tyne and during a game of cricket at my prep school I was afflicted with intense irritation of both eyes. Since this persisted and my eyes were obviously inflamed, the local GP was called in. He diagnosed my condition as "granular conjunctivitis." I was given some dark brown eye drops and the condition subsided after a few weeks. The following summer the same condition recurred and, in time, responded similarly to "treatment." The following winter I underwent appendicectomy, tonsillectomy, and adenoidectomy at the same time and had no more eye irritation until 1934, when this recurred during the summer while driving to Wales in an open car on my honeymoon. On this occasion I also had marked nasal congestion. A knowledgeable sister-in-law told me that I had hay fever, which would subside in the autumn. She was right. Since then I have been a regular sufferer from this complaint, complicated in moments of stress by symptoms of asthma—with characteristic sputum. For many years I have had desensitisation treatment without noticeable benefit.

Three years ago at the beginning of June, on my 70th birthday, I developed a febrile illness, which completely abolished my hay fever symptoms and which turned out to be infectious hepatitis. In spite of the high pollen counts during that very hot summer, and with all windows open to get some fresh air into the bedroom, I had no symptoms of hay fever that year; but these have since returned. It is interesting to record that two male relations (by marriage) used to suffer from hay fever but both were "cured" by an attack of "jaundice," and neither has had any recurrence since. Neither of them associated the cessation of hay fever with the previous attack of hepatitis. It might be illuminating to learn if such an occurrence is common.

W W WALTHER

Bishop's Stortford, Herts CM22 7UE

An ethical dilemma

SIR,—The BMA has recently issued a draft of a new edition of its handbook of medical ethics, which has been received with general approval. But one important matter involving an ethical dilemma is not even mentioned. I refer to pre-employment medical examination.

When a prospective employee is applying for a job, such as air pilot or engine driver, in which his sudden incapacity can hazard the lives of others, there is of course no ethical objection to the doctor's recommending his rejection if he is found to have a condition making him liable to such incapacity. But many people applying for jobs where this risk to others does not arise are nevertheless compelled to have a medical examination. And although they have all the right qualifications and are accepted "subject to medical examination" they may later be informed that because they have "failed" the medical they cannot after all have the job. I have come across many such rejects during my medical career. In the *Guardian* of 23 August 1978 appeared a news item under the heading "Healthy man who failed medical loses job." The man concerned had obtained a job as a porter and bench hand but the company doctor found he had hypertension and commented, "I am sure he is fit for work, but we are not so much concerned about his present health as his future health." If this kind of medical rejection can be justified by one doctor working for one corporation, it can equally be justified by other doctors working for other corporations. In consequence, unfortunates with, say, hypertension, diabetes, heart murmurs, and albuminuria may be unable to get any employment.

I have suggested¹ that those doctors who advise rejection on medical grounds need the following modified version of the Hippocratic Oath: "The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong, unless I am examining them on behalf of an employer, when the welfare of the patient shall count for nothing, and the interests of the employer shall be my sole concern." Such doctors would do well to consider how they would feel if they were at the receiving end. Suppose that a senior registrar, after years of fruitless application for consultant appointments, is finally made a consultant "subject to medical examination." He is later informed that because his blood pressure is too high he cannot become a consultant after all. Would his rage and despair be lessened by the kindly assurance of the chairman of the appointments committee that he will be able to stay on as a supernumerary senior registrar?

JOHN W TODD

Farnham, Surrey GU9 8DR

¹ Todd, J W, *Lancet*, 1965, 1, 797.

A patient's charter

SIR,—I wish to comment on the stimulating paper by the late Dr B B Zeitlyn (14 July, p 103).

Despite the merits of many staff, and allowing for the unattractive presentation of some of the people with whom they deal, it seems clear that some patients sadly are downgraded in their contact with the NHS. This hazard extends across all strata of staff, being related to temperamental and social factors rather than to status. An example of the former might be a personal need to seek relationships with the dependent and a liability to react angrily if superiority is challenged, while in the latter group is the erroneous "them and us" ethos to which Dr Zeitlyn referred.

My own experiences as a patient or patient's relative have generally been very favourable but I am uneasily aware that this may not be typical. Sensitivity training and opportunities effectively to ventilate various stresses should help toward better awareness of psychodynamics, and indeed most of us may benefit from recognising the more destructive as well as the more constructive aspects of our personalities.

Patients and relatives could perhaps often become more complete partners in the therapeutic efforts (rather than appearing as objects to be manipulated), and this does not deny them the security of professional decisiveness when this is justified. An increase in the already almost intolerable pressures on some NHS staff is not implied, and with an easing of relationships actual improvement in this respect could follow.

K S JONES

Cowbridge, South Glam CF7 7QR

Royal Commission report

SIR,—In attacking the independent contractor status of general practitioners, the Royal Commission has done a very great disservice to the NHS. In health as in any other form of personal service, the true interests of the individual can never be protected and fostered by professional workers employed directly by the State.

While there is some hope (but no guarantee) that the present government will refuse to implement these disastrous proposals, in the long term there is considerable danger that some power-hungry future administration will seek to implement them. This prospect must weigh heavily in the minds of young doctors coming into general practice, and will influence their motivation in many subtle ways, none of which will be to the advantage of their patients.

It is important that the BMA declares its total opposition to the general introduction of a salaried service for GPs, and pursues this policy with skill, persistence, and determination.

CYRIL HART

Peterborough, Cambs PE7 3JL

SIR,—The report of the Royal Commission¹ has, I believe, neglected to clarify the role of community physicians, and because of this discussion is complicated by whether the community physician is regarded as a specialist doctor or an administrator. This highlights the dichotomy between the roles of specialist adviser in epidemiology and that of medical administrator.

Medical administrators work as officers to health authorities and this role is neither that of an independent adviser nor that of a representative of medical staff.² However, the function of the specialist adviser in epidemiology is more that of an independent consultant and it is in this capacity that the community physician may, in the interests of the health of the population, need to put forward proposals which are not necessarily those of the health authority.

The recent report by the Unit for the Study of Health-Policy,³ addressing itself to the low morale and lack of recruitment within the specialty, recognises this problem when it

proposes the creation of local health promotion teams. The report realistically accepts that in order to function effectively the members of these teams should have independence and political support.

The report of the Royal Commission explicitly states that the specialty must be supported in the next few years if it is to survive. However, its recommendations for the provision of adequate supporting staff, guidance on consensus management, and the formation of a central Institute of Health Services Research will probably help only to a limited extent. If, as the report states, the specialty has a future and "the present decline should not be allowed to continue," then something more radical is needed.

The Duncan report⁴ confirmed the need for two types of career appointment within community medicine. However, it is probably only by a much firmer commitment to the independent specialist consultant role that the potential of community medicine may be realised.

A A WARD

Crowborough, E Sussex

¹ Royal Commission on the National Health Service, *Report*, Cmnd 7615. London, HMSO, 1979.

² Cang, S, et al, *Doctors and the NHS*. Brunel Institute of Organisation and Social Studies, 1978.

³ Unit for the Study of Health Policy, *Rethinking Community Medicine: Towards a Renaissance in Public Health?* London, Unit for the Study of Health Policy, 1979.

⁴ Joint Working Party, *The State of Community Medicine*. London, British Medical Association and Faculty of Community Medicine, 1979.

SIR,—I am dismayed at the Royal Commission report that care by some doctors is mediocre in general practice. The commission blames inadequate training and a set of national standards, yet no one mentions work load.

We often see patients at five-minute intervals. Why? Because we need so many on our lists to make practice financially viable. I calculate that if I gave every patient the 20 minutes or so they require I would be working 24 hours continuously per day.

No, neither this report nor the audit suggested is valid considering the condition of general practice today. You cannot criticise or audit a system whose structure is basically unsound. Until GPs' lists are cut by giving them fair remuneration per patient this report is not valid. Audit work, by all means, but at least give us time to think.

B CAPLAN

Timperley, Cheshire WA15 6QQ

A medical union in the United States

SIR,—I read with interest Dr J D J Havard's article "A medical union in the United States" (2 June, p 1500).

The problems of malpractice insurance, which have stayed at crisis levels for several years, are the result of the legal system prevailing in the United States. Lawyers take most civil liability cases on a contingency basis, getting nothing if they lose but up to 50% plus expenses if they win. This has resulted in intense antagonism between the medical and legal professions, although only a relatively few lawyers engage in malpractice work. (However, it is ethical for a trial lawyer to pay part of his fee to the referring attorney, although fee splitting by the medical profession is both unethical and illegal.)

Unfortunately the membership of most state