more specifically low in sugar, is associated with the healing of any ulceration that may accompany the dyspepsia, as well as relieving the symptoms.

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¹ Doll R. *Scott Med J* 1964;9:183-96.

² Yudkin J. *Med Press* 1961;246:64-8.

³ Yudkin J, Evans E, Smith MGM. *Proc Nutr Soc* 1971;31:12A.

⁴ Szanto S, Yudkin J. *Postgrad Med J* 1969;45:602-7.

⁵ Hunt JN. *J Physiol* 1951;113:169-84.

SIR,—In your leading article "Eating and ulcers" (26 January, p 205) the advice offered appears to be that there is nothing to be done except keep on taking the tablets. While agreeing that conventional dietary regimens have little significance in the management of European peptic ulcers, we would like to draw attention to the increasing evidence of a relationship between diet and the incidence of duodenal ulceration in India.¹

Animal experiments in peptic ulcer cannot be dismissed quite so easily as you suggest. Their relevance to man in establishing the regulatory mechanisms of gastric secretion is surely acceptable. The fact that there is no difference in the acid output between patients on different diets from high- and low-incidence areas should not be used to dismiss diet as irrelevant, but rather to indicate that its effects are on some aspect of the aetiology other than acid.

Animal experiments based on dietary manipulation to resemble that of subjects from high- and low-incidence areas also show a correlation which may explain the geographical distribution in peptic ulcer.² Our experiments with the pylorus ligation technique in the rat clearly show that prefeeding the animals with diets similar to those eaten in low-incidence areas confers considerable protection against experimental ulceration.³ There is increasing evidence that foodstuffs from low-incidence areas contain a protective factor which is a lipid or liposoluble substance. If this is the case, no doubt a suitable therapeutic agent can be developed. However, a more logical approach would be appropriate modification of the diet. No diet exists with an inherent H₂ antagonistic activity, but diets probably already exist in India which protect against ulceration. We are not yet at the death of dietary regimens.

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¹ Tovey Frank I. *Gut* 1979;20:329-47.

² Tovey FI, Jayaraj AP, Clark CG. *Postgrad Med J* 1975;51:366-72.

³ Jayaraj AP, Tovey FI, Clark CG. *Postgrad Med J* 1976;52:640-4.

Compliance or unnecessary prescribing?

SIR,—The two themes of your editorial (10 November, p 1168) are well illustrated by the drug treatment of epilepsy.

There is no doubt that poor compliance with anticonvulsant therapy, even the omission of one or two doses, does matter. The patient is thus exposing himself to the possibility of withdrawal seizures, the perpetuation of his problem, and occasionally to such disasters as the burning described by Drs W F Durward

and M G Harrington in the same issue (p 1218). This applies throughout the many years of such therapy and imposes particular difficulties on patients who are often asked to take complicated regimens of polytherapy several times a day. However, it is especially important in the early years of therapy as poor compliance is the major cause of recurrence of seizures, the apparent failure of the first drug, and the subsequent escalation to polytherapy.^{1,2}

On the other hand, there is no satisfactory evidence that polytherapy is more effective in the control of seizures than a single drug used to its maximum potential with the assistance of blood level monitoring.^{2,3} The aim of treatment should be to use one or at the most two drugs per seizure type, with the maximum of compliance and ensuring if necessary optimum blood levels. If the patient fails to comply with unnecessary polytherapy he may be at no disadvantage, provided he does not indulge in intermittent therapy.

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¹ Shorvon SD, Chadwick D, Galbraith AW, Reynolds EH. *Br Med J* 1978;ii:474-6.

² Reynolds EH. *Lancet* 1978;ii:721-5.

³ Shorvon SD, Reynolds EH. *Br Med J* 1979;iii:1023-5.

Legal aspects of child injury or neglect

SIR,—We would like to correct a technical point in our paper "Legal aspects of child injury or neglect" (13 October, p 910).

In the final paragraph under the heading "Care order" (p 911) it is stated that a local authority or voluntary body can appeal to the Crown Court if they are concerned about the failure to obtain a care order, or are concerned by the termination of a care order by a juvenile court on the application of a parent. This statement is inaccurate in that, under the Children and Young Persons Act 1969 (Section 2 (12)), only the child in question can appeal to the Crown Court.

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Prolonged intravenous use of chlormethiazole (Heminevrin)

SIR,—We were interested to read the article by Dr S Lingham and others (19 January, p 155). Since 1974 we have found intravenous chlormethiazole (Heminevrin) to be effective in the treatment of status epilepticus in children who did not respond to conventional anticonvulsant therapy, including infusions of diazepam and lignocaine. Although rarely required, prolonged chlormethiazole infusion is sometimes both necessary and possible, as illustrated by the following case.

A girl presented at age of 27 months with progressive right hemiparesis and right hemiconic seizures. Six months after onset the seizures became exceedingly frequent and were then generalised as well as partial. Various antiepileptic therapies, including all available standard drugs, adrenocorticotrophic hormone, levo-dopa, and ketogenic diet were ineffective. Two computed

tomography scans and a carotid angiogram did not reveal a focal lesion, but on electroencephalography the seizures consistently arose from the left anterior head region. A left frontal brain biopsy showed "focal subacute pan-encephalitis" but no virus was visible on electron microscopy or detectable serologically.

Intravenous infusion of a 0.8% solution of chlormethiazole through a paediatric giving set (Travenol Laboratories Ltd, Norfolk) at a rate of 10-18 mg/kg/h was started when all conventional anticonvulsant therapy had failed to control the seizures. Treatment with this drug was continued for 43 days before the effect of partial section of the corpus callosum allowed us to tail off the infusion. Throughout most of the treatment period, the patient remained conscious and responsive. Thrombophlebitis was a problem on only two occasions and was simply dealt with by changing the infusion site. No haematological, renal, or hepatic toxicity was observed.

Although we agree with Dr Lingham and his colleagues that care is essential, patients should not be denied prolonged chlormethiazole infusion when no other therapy is possible, and particularly when later epileptic surgery is contemplated.

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Whooping-cough immunisation

SIR,—I was not surprised at the reasons that Professor R S Illingworth (19 January, p 179) quotes for parents' refusing immunisation. I think, however, that there is in fact a different explanation for the sources of the myths he mentions.

In our practice more than three-quarters of the mothers of 7-month-old children express misgivings about the safety of immunisation and in particular the pertussis component of the triple vaccine. When asked why they are worried they quote friends, the lady down the road, parents, a man at work, and often a doctor on television. What is so interesting is that the reasons are the same as Professor Illingworth gives as coming from doctors and health visitors in his sample. Dare I suggest that he has yet to learn not to believe all he is told by parents?

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Training for hospital practitioners

SIR,—As a contribution to the solution of the problems of staffing structure, the employment in specialist departments of general practitioners in the hospital practitioner grade has considerable merit and helps to bridge the division between the two major branches of the profession. However, general practitioners are now largely recruited from among those doctors who have primary care as their aim from the time of graduation, rather than from those who have spent a considerable period in specialist hospital work. The new arrangements for vocational training emphasise short but wide-ranging experience in hospital medicine. Thus there will be few principals in general practice with sufficient qualifications to undertake a hospital role in specialist clinics without further instruction.

Some encouragement must therefore be given to general practitioners with an interest in a specialist subject and anxious to forge a

link with their hospital to obtain experience which consultants will accept as qualifying them for appointments in the hospital practitioner grade. Greater use could be made of "clinical attachments," which can be funded under Section 63 money but which are not perhaps fully exploited at present. Greater acceptability could, however, be obtained if general practitioners could be taken on as trainee or probationer hospital practitioners. Consultants would be much more willing to utilise this type of assistance if during the first two years the sessions were to be regarded as for training as well as for patient care, and if complete security of tenure were granted only after satisfactory completion of the training period.

The creation of this new category would allow a trial period before irrevocable commitment and would, I believe, promote a much more rapid expansion of this important development in the NHS.

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Identifying tablets

SIR,—Every medical practitioner must have been frustrated over the identification of patients' current medication ("Little white water tablets, doctor"). Marked gratitude is felt for the easily recognisable tablets ("Black and red capsules, for my infection").

I would like to suggest that pharmaceutical companies adopt an agreed colour coding for all tablets: three rings, or dots, denoting: the type of drug (for example, major tranquilliser, antibiotic); the specific drug; the strength. A black dot could be placed at one end to denote the starting point (similar to electrical resistors). Problems would arise because of the limited number of easily discriminable colours, and because of difficulty in deciding in which group of drugs certain medications should be included (for example, diazepam—sedative or muscle relaxant?). But perhaps the division could be on the basis of chemical structure instead. None the less, with a little application a workable system could be achieved. The patient might be no better at remembering the colours, but at least if he brings several different tablets in one unlabelled bottle, a quick reference to MIMS would specify them. Furthermore, the chemists' bottles labelled with product but not strength need no longer be unhelpful.

Naturally, the tablets could still be produced in different shapes, colours, and sizes so that the pharmaceutical companies could maintain their distinction. But is there not a strong case for some such simple unification of drug identification as this?

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A new look at examination marking

SIR,—Congratulations to Drs R B Longmore and D A McRae (22-29 December, p 1640) for attempting to lighten a dreary subject. Unfortunately, the variables they use in their comparison of RAPES and CONVENT methods of marking are not independent. The null hypothesis that the algebraic sum of differences in marks obtained by one or the

other method for each of the 50 pairs of papers (in this case a value of -19), averaged out at -0.38 for each pair, does not differ significantly from zero when tested by the relevant *t* test, yields for *t* a value of 3.15 (table), which is significant at $P=0.01$.¹ 'T is

Differences between RAPES (R) and CONVENT (C) assessment of 50 papers (after Longmore and Macrae)

Value of R-C (x)	No of observations (n)	$n_i \times i$	$n_i \times i^2$
-2	6	-12	24
-1	16	-16	16
0	19	0	0
1	9	9	9
Total	50	-19	49

Average = $-19/50 = -0.38$

$s^2 = (49 - 19^2/50)/49 = 0.85$

$t = -0.38 / (0.85)^{1/2} (50)^{1/2} = 3.15$ for 49 df

true, 't is pity...² Still, since the author's data show that RAPES produced a lower mark than CONVENT in 29 out of 50 papers and a higher mark in only two, perhaps dons of limited athletic achievements should wait for further docimological studies before facing a 0.58 probability of a bloody nose.

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¹ Armitage P. *Statistical methods in medical research*. Oxford: Blackwell, 1971:116-8.

² Shakespeare W. *Hamlet, Prince of Denmark*. London: 1604:11,2,97-8.

Cutting down unnecessary x-ray examinations

SIR,—As radiologists we wish to draw the attention of our clinical colleagues to the recent doubling in price of x-ray film owing to the unprecedented rise in the price of silver over the past year. Now more than ever it behoves those in both hospital and general practice before requesting any x-ray examination to ask themselves the vital question: "Will the result of this investigation affect my management of this patient?"

Cutting down on the number of unnecessary examinations will not only preserve scarce resources but also have the even more desirable effect of reducing the overall radiation dosage to the population as a whole.

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Medically qualified preclinical academics

SIR,—I write in the strongest possible support of Dr R R Sturrock's comments (2 February, p 335) on medically qualified preclinical academics. Two points, I think, need to be made—the first to Dr Sturrock and the second to the general medical public.

Firstly, some preclinical academics would undoubtedly find benefit both to their teaching and to their research by clinical involvement; with a research interest in sensory processes

and a teaching commitment to basic neurology, I am one such. But obviously a great deal depends on what kind of clinical involvement—it should not be anything that's going, or someone's unwanted general sessions. However, medical anatomy in particular is (for most doctors) about living people—and therefore any professional commitment by its teachers to examination of the quick by palpation, percussion, and auscultation would add immeasurably to dissection of the dead.

Secondly, and perhaps more importantly, I fail to understand why the question of proper (that is, NHS-equivalent) payment to medically qualified preclinical academics is such an emotive issue. It is often the same people who demand on the one hand that preclinical teachers (or at least a substantial proportion of them) should be medically qualified, and on the other that they should not receive the same salaries as teachers in "clinical" departments (for example, epidemiology?) without clinical justification—that is, participation. Yet no one animadvert against the payment of clinical (or above) salaries to area and regional and other administrative medical officers, or to the medically qualified secretariat of the BMA, the Medical Research Council, and the DHSS; and they are right. The fact remains, Sir, that medically qualified preclinical academics and full-time research workers are the only group of doctors in the country who are not paid in accordance with their professional qualifications. To repeat the unanswered question which you allowed me to put through your columns last year, what do the great and muscular majority of the profession intend to do about us 300?

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MDs or PhDs in medical research?

SIR,—With regard to the leading article (2 February, p 274) on MDs or PhDs in medical research, this article indicated that there was a vast difference necessarily between people with PhDs and people with MDs. I think the point should be made that it is not necessarily the degree which is obtained that matters but the subject matter for which the degree was given.

I did some medical research leading to a doctoral thesis in 1977. As I did this under the wing of the University of East Anglia, I was awarded a PhD for this work. If I had done it under the auspices perhaps of London University, and this had passed it, I would have received an MD, not a PhD. The difference therefore is how the degree is awarded, not necessarily the subject matter or even whether the man is a clinician or not. This is not made clear in your article and perhaps the difference between the MD and PhD could be demonstrated only by studying the work for which the degrees are granted.

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Revised consultant contract

SIR,—As a longstanding member of the BMA, it seems to me that the letter from Mr David Bolt (19 January, p 202) does not clear up the confusion to which he alludes about the nature of the changes to the consultant contract. In the paragraph headed "Consultants with