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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Medical school intake and manpower implications

SIR,—It has been widely suggested that the Conference of Colleges and Faculties together with the universities, the BMA, and the Health Departments should set up a standing forum which would review statistics relating to medical staffing and career structure. This forum could provide the Government and other relevant bodies with continuing informed and up-to-date advice on medical manpower from student intake to retirement. We, as representatives of the collegiate members of the three Royal Colleges of Physicians, support this suggestion and consider that a solution to the problem is a matter of urgency and that, in the light of the information available, medical school intake should be held static until such time as the standing forum has been established.

The current output of graduates from

United Kingdom medical schools appears to exceed currently available career posts by 50%.¹ In the Irish Republic there is a similar situation with output greater than needs. In the short term it may be possible for some of these graduates to take up junior training grade posts at present occupied by overseas graduates, but it should be emphasised that under the existing organisation many of those in SHO and registrar posts have no hospital career prospects. Because of changing policy in the United States, Canada, and Australasia, British and Irish graduates have fewer opportunities to emigrate. On the available information further medical school expansion without a radical restructuring of hospital medical staffing in the UK Health Service will result in medical unemployment. We should like to stress that this is not a problem which might

arise in the future, but one which already exists.

ROGER SMITH
Chairman, Collegiate Members' Committee,
Royal College of Physicians of Edinburgh

N STIRLING
Chairman, Standing Committee of Members,
Royal College of Physicians of London

D A KELLY
Chairman, Collegiate Members' Committee
Royal College of Physicians of Ireland

¹ Department of Health and Social Security. *Medical manpower—the next twenty years*. London. DHSS. 1978.

Medical charities and prevention

SIR,—I have been impressed but somewhat saddened by the defensive and even slightly petulant reactions of foundations to your

important, well-documented, and highly prescient editorial (22-29 December, p 1610). British medical charities are obviously falling behind their international counterparts in the monies which they devote to health education and prevention. The twenty-first century will be the era par excellence in which the practice of medicine must move decisively from cure to prevention and care; the destiny of the profession as a whole will be inextricably linked with its ability to make this metamorphosis. The outlook at present is far from promising and, in spite of relatively massive expenditure, mainly on glamorous feats of technological legerdemain, we remain very far indeed from putting comparable effort into unravelling the complicated web of factors responsible for society's main killers, carcinogenesis and coronary heart disease.

As the decade of the 1980s opens may I offer two suggestions which might assist the foundations in making more effective and rational contributions to disease prevention? The first concerns the type of advice which they seek and particularly their dependence on opinion which, by its very process of moulding over a period of years or decades, tends to be over-specialised and treatment-orientated rather than ecological in character. In an otherwise sombre scene the Spastics Society and the King Edward's Hospital Fund for London stand out as notable exceptions. Here at least the importance of prevention is recognised, as is the idea that in a world pressing ever closer to its resource limits an ecological approach to medicine is mandatory. Both organisations have pioneered imaginative approaches. The Spastics Society conducted a critical but constructive examination of some aspects of antenatal and postnatal care, while the King's Fund was instrumental in establishing the unit for the study of health policy at Guy's Hospital.

The second suggestion which I offer is that it would be very much in the foundations' own interests to be seen to be sponsoring an increasing number of studies in the general field of prevention. To say that the human future is unknowable is, of course, a truism. But we need not be astrologers or soothsayers—merely observers attuned to some degree to the forces of contemporary history—to forecast that for our grandchildren the paramountcy of preventive medicine will be undisputed.

JOHN A LORRAINE

Centre for Human Ecology,
University of Edinburgh,
Edinburgh EH8 9LN

SIR,—In a recent leading article (22-29 December, p 1610) you rightly criticised major British charities such as the British Heart Foundation, the Cancer Research Campaign, and the Imperial Cancer Research Fund for their reluctance to face up to the challenges of prevention. It was perhaps inevitable that the charities should defend themselves (19 January, p 178; 26 January, p 249), although it is regrettable that they should have done so by seeking to cast doubt on the value of preventive activities such as health education. In this depressingly outdated view they are—as your leading article points out—out of step with their highly respected counterparts in several other countries.

The scientific secretary and secretary general of the Cancer Research Campaign, for example, recognise that for lung cancer "action to reduce cigarette smoking is likely to be

more effective in reducing mortality than attempts to find a cure." So far so good; but they continue, "Unfortunately the means of changing people's social habits have yet to be discovered. . . ." It is to be hoped that Dr N H Kemp and Brigadier K D Gribbin will familiarise themselves with the evidence of the past few decades before they next criticise one of your leading articles. The cat seems, however, to have been let out of the fund-raising bag in a further sentence from their letter. They write, "The people who contribute so generously to the Campaign on the basis of an appeal for research into the causes, prevention, and treatment of cancer might reasonably be unhappy were we to allocate large sums to publicity aimed at changing their life habits." This seems almost to suggest that the cancer charities should not campaign on smoking for fear of offending potential donors.

We would suggest that they are wrong on two main counts. Firstly, charities such as the American Cancer Society and—closer to home—the Ulster Cancer Foundation have found that forceful anti-smoking campaigns can coexist with highly successful fund-raising programmes. Secondly, and crucially, cancer and heart charities should make every effort to reduce the mortality and morbidity caused by these diseases even if this means a recognition that time-hallowed policies for allocating funds must be reconsidered, and even if fund raising itself becomes a little more difficult.

We believe that charities such as the Imperial Cancer Research Fund, the Cancer Research Campaign, and the British Heart Foundation should recognise that changed circumstances and knowledge justify the allocation of far more of their resources to prevention. Window dressing—such as the few projects they cite in their responses to your editorial—is not enough. Trusting and generous donors expect those responsible for the running of charities to make decisions in the best interests of the public rather than on the basis of outdated tradition. We ask that the charities involved think again.

DAVID A PLAYER

Scottish Health Education Unit,
Edinburgh EH12 5EH

MIKE DAUBE

University Department of
Community Medicine,
Edinburgh

Follow-up of patients with colorectal cancer after surgery

SIR,—We were very interested to read the paper by Mr J P S Cochrane and others (1 March, p 593) on the follow-up of colorectal cancer patients after surgery.

As the authors state, there are few data to suggest that more detailed follow-up increases the detection rate of curable recurrent carcinoma of the colon. Follow-up must be capable of detecting any new asymptomatic lesions, either polyps or carcinoma, and should include occult blood testing and, as most lesions occur on the left side of the colon,¹ flexible sigmoidoscopy. The association of an adenoma with a rectal or colonic carcinoma when the operative specimen is examined makes such patients a particularly high-risk group.² The detection and treatment of further polyps may even prevent a proportion of these patients developing a second malignancy, and even if this is only in a very small number of patients it is surely a policy worth pursuing.

Improvements in surgical techniques and management have made little impact on the mortality from colorectal cancer in the last 25 years. The hope for the future must rest in the earlier detection of primary colorectal cancer and the better prediction, detection, and management of recurrent carcinoma.

K D VELLACOTT
J D HARDCASTLE
T W BALFOUR

Department of Surgery,
Queen's Medical Centre,
Nottingham NG7 2UH

¹ Gillespie PE, Chambers TJ, Chan KW, *et al.* *Gut* 1979;20:240-5.

² Heald RJ, Lockhart-Murray HE. *Br J Surg* 1972;59:16-9.

Chlormethiazole and temazepam

SIR,—We must criticise the claim of Dr R S Briggs and others (1 March, p 601) to have shown that chlormethiazole and temazepam do not cause detectable hangover effects in young or old, and that these drugs allow sleep to be safely interrupted.

The authors reported negative results. It is difficult to prove a negative. One must always ask first if the tests are sensitive, for if the measuring devices do not work the results are bound to be negative. The results from the sway test underpin the claim about safe interruption of sleep. We are not offered any evidence that this one-minute test is established as sensitive to other hypnotic drugs. One sees that in the sample of old volunteers on placebo the range of scores was 7-59. One would consequently like to know if intra-subject test-retest variability is also very large, for if the variability inherent in measures is large the likelihood of getting a statistically significant difference with only 10 subjects is small.

The psychomotor performance test required the crossing out of the letter e from prose for a mere two minutes. Complex decisions were not required, nor were the subjects required to sustain attention (as, for example, motorway drivers must). The authors have, in our view, used too limited a battery of tests to merit a claim that they have shown that hangover effects may be avoided if these particular drugs are used. One hopes that their statement will not be used to justify intake of these drugs a few hours before skill is required of pilots, drivers, or anyone else.

They state that the order of presentation of placebo, temazepam, and chlormethiazole was balanced. We are unable to see how, when they had three conditions and 10 subjects of each age group. Their subjects slept with catheters in their arms and had blood withdrawn frequently for the first four hours of the night. During the 30-minute electroencephalogram the next morning, any tendency to fall asleep that might have been caused by lingering drug or drug metabolites was therefore presumably confounded by an element of sleep deprivation, so drug effects would be rendered less discriminable. We suggest too that the authors should have first examined their data by analysis of variance, and, where they made so many comparisons and repeatedly used the Wilcoxon test, they should have reminded us to expect a few "statistically significant" differences by chance.

The authors are certainly to be congratulated on combining plasma levels with behavioural tests and for emphasising the