lymphoma, increased levels of serum IgE (often very high) compared with controls have been reported by at least two groups of workers.^{1,2} In the four patients with mycosis fungoides seen in this department during the past two years the serum IgE levels have all been raised (range 979—>5000 U/ml). As with Hodgkin's disease, the pathogenesis of these high serum IgE levels (in the presence of normal levels of IgG, IgA, and IgM) is at the moment unclear.

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¹ Tan, R S H, *et al*, *British Journal of Dermatology*, 1974, **91**, 607.

² Mackie, R, *et al*, *British Journal of Dermatology*, 1976, **94**, 173.

Consultant physician to outpatients

SIR,—How refreshing to read Dr John Todd's paper on the role of the consultant physician (18 February, p 417).

Most general practitioners would agree with him that patients have "problems" rather than a diagnosis. But he should not be too modest in assessing the importance of the general physician. It is true that the general practitioner can nowadays fairly fully investigate the great majority of his patients. However, I can think of many cases—the young unstable diabetic; the patient with rheumatoid arthritis or epilepsy which is not controlled by one's treatment; the anxious patient who will not accept one's reassurance; the case when one fears that perhaps an essential clinical finding has been missed; and one could go on—when the second opinion of the skilled general physician is of inestimable help to the family doctor. Here surely is the true *métier propre* of the consultant physician.

One might perhaps add a plea that the patient is then returned to the care of his own doctor with the opinion of the physician and not kept attending at hospital follow-up clinics. This second opinion reassures greatly both patient and general practitioner.

The only sad point in Dr Todd's enlightened article is the comment that he has retired.

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Recording events in clinical trials

SIR,—Dr D C G Skegg and Sir Richard Doll (10 December, p 1523) use the example of gastrointestinal bleeding developing during intravenous ethacrynic acid treatment reported by the Boston Collaborative Drug Surveillance Program (BCDSP)¹ in support of their thesis that all events, attributable to medications or not, be reported during clinical trials. I do not believe that the report cited illustrates the value of blind data-gathering or adverse event-reporting. Even putting aside the demonstrated fact that some of the patients began bleeding before administration of ethacrynic acid and the resulting partial retraction of the relationship by the authors of the report² there have been no further new cases discovered by the BCDSP according to a recent review of their data³ and no corroboration from the Israeli⁴ or Canadian⁵ event-gathering associates of the BCDSP. Furthermore, there has been no independent confirmation of the "relationship" in the English

literature. An article in French⁶ discusses five cases of gastrointestinal haemorrhage in seriously ill patients with renal failure who received intravenous ethacrynic acid; the authors believed that a causal relationship would be difficult to prove.

Dr Skegg and Sir Richard Doll may be correct that uncritical reporting of undesirable events during clinical trials will uncover important adverse effects early. The example that they chose is a poor one, however. Their proposed system makes clinical trials more complex and later interpretation of event-reporting difficult and may uncover many false leads, as the BCDSP has done. Unexpected benefits and unexpected undesirable effects have both been discovered during clinical trials. Careful, inquisitive, imaginative investigators and monitors will continue to make such observations. Adding uncensored event-collecting to current procedures, if based on the example cited, seems of questionable value, however.

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¹ Stone, D, *et al*, *Journal of the American Medical Association*, 1969, **209**, 1668.

² Stone, D, *et al*, *Journal of the American Medical Association*, 1969, **210**, 347.

³ *Drug Effects in Hospitalized Patients*, ed R R Miller and D J Greenblatt, New York, Wiley, 1976.

⁴ Levy, M, *et al*, *Israel Journal of Medical Services*, 1973, **9**, 617.

⁵ Borda, I T, *Canadian Medical Association Journal*, 1976, **114**, 517.

⁶ Talbot, P, and Lemieux, G, *Union Médicale de Canada*, 1971, **100**, 792.

Arthritis associated with psoriasis

SIR,—We were interested to read your recent leading article on the treatment of psoriatic arthritis (4 February, p 262). Your contentious statement dismissing gold in the treatment is at variance with our experience. We are currently looking at the records of some of our patients with psoriatic arthritis—that is, patients with psoriasis who are seronegative and anodular—and are impressed with the efficacy of chrysotherapy. Our custom is to start patients on gold when it has become apparent that non-steroidal anti-inflammatory drugs are not controlling disease activity. Out of over 50 patients so far studied, 14 have been given long-term gold therapy. In three of these it was stopped (a) because it was ineffective, (b) because of possible worsening of the psoriasis, and (c) because the patient became scared of gold.

We hope to publish full details of our study in due course.

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Drug compliance in diabetics

SIR,—Dr A Melander and his colleagues presented very interesting data on serum levels of tolbutamide and chlorpropamide in diabetics (21 January, p 142). However, a very important factor was not mentioned—namely, patient medication compliance.

In a study of outpatients at an urban hospital compliance was measured by pill counts and urine assay.¹ Since we found urine assay to be a sensitive but non-specific

compliance indicator, scores were derived based on pill counts obtained in the home. Two of the drugs analysed were tolbutamide and chlorpropamide. For tolbutamide 23% of patients took less than 20% of prescribed dose, 8% took 20–49%, 38% took 50–79%, and 31% fell into the "compliant" range of 80–109%. The corresponding figures for chlorpropamide were 14%, 22%, 14%, and 29%; 21% of these patients took more than 140% of the prescribed dose. Unfortunately, blood glucose determinations did not always correspond to the exact date of compliance measure. Nevertheless, no correlation was found between compliance and fasting blood sugar.

Dr Melander's blood level results thus appear to confirm the erratic compliance which we found among diabetics treated with oral hypoglycaemic drugs. The authors' suggestion of "suboptimal dosage" may be in fact suboptimal compliance.

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¹ Eshelman, F, Fitzloff, J, and Troyer, W, *Clinical Trials Journal*. In press.

Treatment costs in the USA

SIR,—The discussion in your correspondence columns about the cost of medical care in the United States (10 December, p 1542) is largely on a hearsay basis. To acquaint your readers with the actual facts of the situation I am giving my own fee schedule.

I have a high-class family practice in a prosperous suburban area on the south shore of Long Island, 60 miles from New York City. I see about 30 patients in an eight-hour day in the office—slightly less than four patients an hour.

My initial office visit charge for a new patient is \$40. This is for taking a complete history and doing a comprehensive physical examination—eyegrounds, ears, mouth, throat, blood pressure, heart, chest, breasts, abdomen, pelvic examination and taking a cervical smear, rectal examination, testing the stool for occult blood, and dipstick urine analysis. Blood is taken for complete blood count and chemistry, but the fee does not include the laboratory charges. Repeat visits are \$18 and at that time ears, throat, blood pressure, heart, chest, breasts, and abdomen are examined routinely each time, as well as a dip stick test of the urine at each visit. Routine procedures such as syringing the ears would be included in the fee. The charge for a home visit is \$25.

When considering these charges one must also consider incomes in the area. My senior office aide is paid \$5.25 an hour plus 25% for a private pension plan—a total of \$6.56 an hour. This is the equivalent of \$7000 a year at the current rate of exchange for a 40-hour week.

At a postgraduate course for family doctors six months ago on talking around I found that the charge for an office visit for a family physician varied from a high of \$20 to a low of \$8 in different parts of the US, the lowest fees being in the rural areas. A better picture of medical costs is the fact that the total percentage of the gross national product spent on medical care in the US is about 7½%. The percentage of the national product spent on medical care in the countries of Western Europe is about 7½–8½%. The exception is