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.

MICHAEL G DAVIES

Department of Dermatology,
University Hospital of Wales,
Cardiff

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.

H M S NOBLE

Sheerness, Kent

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.

MICHAEL WEINTRAUB

Department of Pharmacology and Toxicology,
University of Rochester School of
Medicine and Dentistry,
Rochester, New York

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.

PATRICK KINSELLA

MARY CORBETT

A C BOYLE

M RICHTER

Middlesex Hospital,
London W1

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.

FRED N ESHELMAN

Beecham Laboratories,
Bristol, Tennessee

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

the United Kingdom, where the percentage is 5½%, but there are constant complaints of underfunding, the use of outmoded hospital buildings, and the lack of new construction.

M G JACOBY

Patchogue,
Long Island, New York

Kava: a postscript

SIR,—The effect of Kava on a retired gynaecologist septuagenarian parent visiting the New Hebrides (Personal View, 4 February, p 294) was interesting to the drinker and to his wife who observed it.

Fortunately I had always been an experimenter and had started my enjoyment of alcohol in all its forms at a tender age, and, apart from a 3½-year interval during the war when only a drop of saki touched my lips, I have continued my interest in drink up to the present day. It was as well, as watching the preparation of kava is far more traumatic than the description given by my son.

I downed a large half-coconut-shell, approximately a pint, in one, standing facing the correct way, spat on the ground as protocol required, then returned to my seat on a tree trunk and ate the portion of fish and rice presented to me on a leaf.

All was quiet. I thought of nothing. I was at peace and still, perhaps the first time except when asleep for 70 years. When it was time to depart I rose, still in a roseate glow, but alas, as they say in this part of the world, my legs had been "cawed away." Supported by my son on one side and a villager on the other who had been previously detailed for this work by the headman, I staggered back to the hospital compound. I was happy, and a couple of mouth-cleansing gins increased the effect and gave me a bad hangover. Kava itself does not provoke headache.

One interesting observation I made during my five weeks' visit was that in the villages most of the children are conceived in the afternoon.

RICHARD DE SOLDENHOFF

Minishant, Ayrshire

Distinction awards

SIR,—As the only surviving past chairman of the Distinction Awards Committee I feel that I should reply to the article by Drs S Bourne and P Bruggen (18 February, p 456).

The first thing to point out is that it is a distinction awards system and not a system for giving all consultants equal chances of higher pay. It should therefore have the effect of keeping our most distinguished consultants here and lessening the temptation for them to emigrate to the USA or elsewhere. It is therefore to be expected that some rapidly advancing specialties which are at present attracting the best of our graduates will have a much higher percentage of awards than other specialties which are not so attractive. Nevertheless it is of course the duty of the chairman of the Distinction Awards Committee to watch these figures closely and see whether there are any flagrant discrepancies.

The Distinction Awards Committee has always recognised that it is more difficult for consultants in non-teaching hospitals to turn out research work for publication and therefore we always took into account the work a man

had done for his subject and for the hospitals in the area in which he was working.

The real question to ask when one specialty seems to be doing badly is, "Why is it not attracting the best graduates?" and Drs Bourne and Bruggen would be better advised to remove the chips from their shoulders and devote their energies to the advancement of their subject.

The fault, dear Brutus, lies not in our stars* but in ourselves that we are underlings. . . .

Finally, the question of secrecy has always been a difficult one. When Dick Crossman took over the newly formed Department of Health and Social Security he questioned me very closely on this subject and I put to him the jealousies and endless letters of complaint which would arise if lists of distinction awards were widely published or even if they were available only to members of our profession. You can imagine the difficulties which would arise if a practitioner referred a patient to a consultant at the local hospital; perhaps he might be a young man highly skilled in a new technique but as yet not sufficiently established to hold an award and the patient would ask, "Who is this chap, doctor, what kind of an award has he, A, B, or C?" The doctor would reply that he has no award at all. Would that suit Drs Bourne and Bruggen? I saw Dick Crossman twice more on the subject and he became convinced that if there were to be an awards system at all it must be secret.

PLATT

House of Lords

*It is generally thought that by "stars" Cassius was referring to the Distinction Awards Committee.

SIR,—It is easy to criticise the distinction award system, as your correspondents Dr H Jacobs and Mr J F Gould (17 December, p 1607, and 14 January, p 112) have done, and we agree that there are many aspects that we don't like. However, to change to identical NHS salaries for all consultants would bring its own inequalities, as your latter correspondent seems to imply by his last sentence. If it be accepted as equitable that consultants who spend their evenings and weekends doing private practice or domiciliary visits or vasectomies should be paid for this work, surely those who devote their own time to research or founding a new service also should be given some extra remuneration. In fact, even with a higher distinction award the tax system is such that private practice would pay much better.

By all means make awards public and try to improve the method of their distribution, but to scrap the system altogether would lead to even greater injustices than exist at the moment.

D B SHAW
G H HALL

Royal Devon and Exeter
Hospital (Wonford),
Exeter

New consultant contract and the CCHMS

SIR,—In his commentary (18 February, p 453), Scrutator does less than justice to the debate in the Central Committee for Hospital Medical Services on 9 February. As I suspect that his column is read by many of those in high places who are responsible for our future, it is, I think, important that some of his conclusions are not allowed to pass without comment.

Of course changes have taken place in society over the last decade and the CCHMS recognises this fact and that it needs to come to terms with it. This, however, is quite different from the spineless acceptance of conditions imposed on our negotiators by Government over the new consultant contract, as implied by Scrutator. Nothing could be further from the truth—the CCHMS has conceded nothing and is continuing to negotiate towards the new contract. With negotiations entering their most delicate and final stages any form of industrial action or sanctions at this time would be a most unwise course of action to advise and one that would not be likely to be widely supported by consultants. The CCHMS recognised this in its debate, but this should not be taken as any sign of weakness or lack of resolve over our demand for an equitable and properly priced new contract for consultants.

Finally, sir, I hope that those involved in Government and the Department of Health will realise that this present debate almost certainly represents the last chance for this (or any) Government to negotiate rationally with leaders such as we have at present, who are men with a moderate and realistic approach to the problems involved. If present negotiations over the contract fail, and particularly if they are seen to be wrecked by Government for reasons of political expediency, it is inevitable that consultants and future specialists in training will turn in desperation to more militant leaders. Surely none of us want the major medicopolitical confrontation to which this would lead. It is my fervent hope that the Government will allow the present negotiations to proceed to an honourable conclusion and will also allow the Review Body to price the new contract without constraint once it has been agreed. If it does not, then I suspect that Scrutator will have to make a very different assessment of the mood of the CCHMS debate that will follow.

J R HARPER
CCHMS Representative for
Oxford Region

General Hospital,
Northampton

*.*Scrutator is delighted, in this instance, to be contradicted.—ED, BMJ

Stifling professional opinion

SIR,—Two recent documents have been issued by the SE Thames Regional Health Authority, "Strategies and Guidelines on the Development of Obstetric Services" (46 pages) and "Strategies and Guidelines for the Care of Elderly People" (67 pages). These documents, part of the 10-year plan, were prepared by a working party, and the RHA asked that these documents be circulated as widely as possible. The Kent Area Medical Committee received only a sheet of recommendations a week before their meeting; other areas have not even had time for this. The local medical committees were completely ignored. The area administrator's introductory letter regrets the short time available for discussion, but in the interests of planning no guarantee can be given to comments arriving late.

It is not only totally unreasonable to ignore professional opinion, but it is even more of an insult to stifle informed and well-balanced professional opinion purely to meet administrative planning manoeuvres. The Documents were issued on 9 January and reached areas