significant increase in HLA-B8 in patients with polymyalgia rheumatica, particularly women, than in an age- and sex-matched control group.

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Accuracy of data based on hospital discharge diagnoses

SIR,—I was most interested in the comments of Professor B Lennox and others (18 March, p 687), with whose reservations on the accuracy of hospital activity analysis (HAA) data I am entirely in agreement. However, a series of assessments of clinical accuracy in random samples of HAA output has convinced me that the blame lies more with management than with clinical staff.

Problems with diagnoses in HAA are often due not to their absence but to the absence of instructions for finding them; because no formal system is defined the HAA clerk may obtain the diagnosis from discharge letters, house officers' summary letters, operation notes, pathology reports, or general case-notes, the latter sometimes including provisional diagnoses made at the time of admission.

A primary reason for the medical staff apathy which results in the frequent need for clerks to complete HAA forms is the lack of feedback from management. If every doctor regularly received a booklet attractively presenting examples of recent HAA data and clearly demonstrating their applications in improving clinical practice and in medical research the enthusiasm for completing HAA forms would be very much greater.

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Overdose of Lomotil

SIR,—In recent issues of the *BMJ* (26 November, p 1401; 21 January, p 176) there have been discussions of the treatment of Lomotil (atropine sulphate and diphenoxylate hydrochloride) ingestion. We would like to comment, adding our recommendations and cautions concerning therapy.

Induction of emesis is important in the initial treatment of Lomotil ingestion. Several points need to be stressed. Forceful emesis has been shown to be more efficient than lavage in removing tablets from the stomach. Emesis removes only 45% and 30% of an ingested product at one-half and one hour after ingestion respectively. Lavage, however, removes only 30% and 8% at comparable times.^{1,2} Thus delay in accomplishing emesis or lavage will lead to less complete removal of the

ingested product. The delay may be less significant in Lomotil ingestion because narcotic effects (from the diphenoxylate) result in decreased bowel motility and less rapid gastric emptying. Thus emesis may be relatively more successful following Lomotil ingestion.

Naloxone is a pure narcotic antagonist and, as such, has no intrinsic central nervous system (CNS) depressant effects in contrast to the narcotic antagonists used in the past (nalorphine or levallorphan). In any case of suspected narcotic ingestion naloxone should be used as a diagnostic trial and, if successful, then continued as therapy. A patient with Lomotil ingestion will respond with reversal of narcotic signs (CNS depression, pinpoint pupils, depressed respiration, hypotension) to an adequate initial dose of naloxone given intravenously (child, 0.03 mg/kg; adult, 1.2 mg). Once reversal of narcotic effects occurs, then naloxone should be given intravenously in amount and frequency necessary to maintain the patient free of narcotic signs. When naloxone has been given before or during transfer of the patient to hospital care must be taken because the duration of action of naloxone is as short as 15-20 min and symptoms of narcotic poisoning may recur before the patient arrives at the hospital.

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¹ Arnold, F J, *et al*, *Pediatrics*, 1959, **23**, 286.

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Drug compliance in diabetics

SIR,—Dr F N Eshelman recently commented (4 March, p 581) on our study concerning serum levels of tolbutamide and chlorpropamide in diabetics (21 January, p 142), suggesting that part of the huge interindividual variation we recorded may have been due to erratic compliance.

We do fully agree with this possibility. Indeed, we mentioned this in the second paragraph of the discussion of our paper. Our aim was to emphasise that the use of sulphonylurea drugs is far from optimal and that treatment failure should not always be blamed on the drug per se. It may just as well be due to erratic compliance and/or erratic dosage.

We are very grateful to Dr Eshelman for presenting the frequencies of non-compliance with sulphonylureas; too many doctors are still unaware of this highly relevant problem.

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Foreign intervention in the private sector

SIR,—As more pay-beds are to be phased out of the NHS a private firm, American Medical International, is to step into the gap by building another private hospital in Britain. We know that their standards are high and already eclipse those in many of the hospitals in our underfunded, overbureaucratised, and increasingly union-dominated Health Service. But this is no consolation when it is apparent that North America has already benefited greatly from the emigration of graduates from

our great medical schools. If this consortium sees a place for private medicine why is our Government blindly encouraging the export of good doctors rather than good medicine?

A booming private sector is, I believe, inevitable and may well be the salvation of British medical standards. We do, however, have a choice of deciding whether this private sector emerges from the corpse of the NHS or is used now urgently to support it. The revenue gained by the Service by an expansion of the number of pay-beds would be enormous and it is beyond dispute that money spent in private medicine is money saved to the Health Service. Such revenue should be put back into the hospital concerned to support patient care, equipment, and clinical research rather than disappear down the vortex of central administration.

My personal involvement is one as a consultant at a teaching hospital where the surgical work has been brought to a standstill by the vandalism of inter-union conflict for the past four weeks. The waiting list grows, patients are put at risk, and some may die while we have empty surgical wards and doctors and nurses eager for work. I now despair for the Health Service. It seems that all of the major decisions of the last 10 years have been the wrong ones. Reorganisation with its proliferation of administrators; the Salmon career structure whereby the only avenue of promotion for senior nurses is through administration; the overtime payment instead of a proper salary for resident medical staff, who are then expected to accept a £2000 pay drop when they achieve their much-worked-for consultant post. Is it any wonder that 330 consultant anaesthetist posts remain unfilled and that there are 600 000 patients currently awaiting surgery?

The attack on pay-beds was the final counterproductive action opening the way for foreign entrepreneurs. The only loser in the nationalised industry of British health will be the quality of health care for the poorer members of the community. The industrial problems of British Leyland and British Steel can be precisely transplanted to the new Health Service to give the outsider some understanding of the prospects for the future. The private operation may well become the equivalent of the German and Japanese car for those who wish to afford quality, but was this really the vision of Beveridge and Bevan, or indeed the objective of medical and non-medical staff who are committed to the concept of an efficient National Health Service?

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Devolution and the BMA

SIR,—Like Dr Ian F M Saint-Yves (1 April, p 860) I have felt concerned about what seems to me the pusillanimous attitude of the BMA's Scottish Council on devolution of Health Service legislation; I find it difficult to explain on any rational grounds. Like him, and indeed like the Kilbrandon Commission itself, I believe that this is an area of legislation in which devolution is particularly appropriate.

A little over two years ago (10 January 1976, p 106) your columnist Scrutator opined, rightly in my view, that one of the important weaknesses of the NHS was its insusceptibility to innovative experiment and that one of the