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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

The NHS is dead: long live the NHS

SIR,—My attention has been drawn to an "open letter" to me in your issue of 4 December (p 1376) in which Dr Terry Davies declares that in the Earl Grey lecture I gave in Newcastle earlier this year my "message was to beware of the malicious influence of the Civil Service on, not only Ministers of the Crown, but also on nominated advisory bodies, of which you have had considerable experience."

That is, I am afraid, a complete travesty of what I said. I can best illustrate this by quoting merely one paragraph from my lecture, which occurs after a lengthy account I had given of the decision of the Secretary of State for the Environment, in which I had been very much concerned, to impose traffic restrictions on steel box girder bridges on 16 June 1971. The paragraph runs:

"Then there were his [the Secretary of State's] officials who again had acted correctly and honourably throughout and, with one exception, had acted with good judgment. That exception was of course on the question of whether, in the rather crude knowledge we had, further measures were needed to protect the public safety. It was a matter of judgment and I believe they got it wrong."

How that can be translated into "malicious influence" I cannot for the life of me imagine. We all of us make mistakes—even Dr Davies, I am afraid, since his table of mortality of myocardial infarction patients in various hospitals is wholly without meaning until one has the numbers (not percentages) of patients

treated so that one can at least judge the statistical reliability of his table. Even with that knowledge the cases would have to be subjected to a good deal of clinical analysis before one could draw the conclusions which Dr Davies is after.

All this is rather a pity since I have found this series of open letters which you have been running most helpful and illuminating—as I am sure my fellow Commissioners have, too.

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Molar dosage of calcium chloride solutions

SIR,—Mrs S M Roden and Mr G A Mander (20 November, p 1255) illustrate how confusing calcium chloride preparations are for clinicians and pharmacists but overlook the point of our letter (30 October, p 1068). There are now preparations in different strengths and different degrees of hydration; moreover, different manufacturers use different conventions on their labels. They quote the Evans label, while our objections are to that of McCarthy Laboratories, on one of which is printed only: "2.5 mmol of calcium ions in 5 ml." There is no mention of the metric or percentage equivalent and the manufacturers assume that the prescriber has used the SI derived unit on

the prescription sheet or drug record. The DHSS circular on the introduction of SI units into the NHS (HSC (IS) 140) gives no authority for this, stating that doses are to be in metric (SI) units (appendix I, p 7); the use of molar (SI) units clearly contravenes this instruction. When we asked who initiated the change we were informed that it was instigated by several area pharmacists. In Brighton as elsewhere we have used SI units for 20 years; our objections, as clinicians, are primarily with the *derived* units and now with the unauthorised molar form for prescribing, dispensing, and dosage. This is the result of absurd and uncontrolled adumbrations in the adoption of a derived unit of the Système International.

We suggest that the concentration of calcium chloride solutions should be expressed in weight/volume terms in respect of the anhydrous compound. This would have the virtues of simplicity, uniformity, and safety. It would also conform with the current SI instructions. Unfortunately we practise in days in which the simple and rational seem to be unacceptable.

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SI: two years on

SIR,—In spite of all the kicking and screaming a year or two ago SI units have been introduced into over 90% of chemical pathology laboratories in the United Kingdom and the topic is, if not a dead duck, certainly a moribund one here. Before we bury it, though, we should remember that the "I" in SI stands for

Use of SI units by laboratories participating in an international quality control scheme, November, 1976

	No of participants	SI units	Traditional units
<i>Europe</i>			
France	80	0	80
Holland	52	49	3
Belgium	33	0	33
Eire	19	5	14
Sweden	13	12	1
Norway	5	0	5
Italy	5	0	5
Poland	4	1	3
Switzerland	3	0	3
Germany	3	0	3
Greece	2	0	2
Finland	1	1	0
Iceland	1	0	1
Total	221	68	153
<i>North America</i>			
Canada	115	0	115
USA	56	1	55
Total	171	1	170
<i>Australasia</i>			
Australia	174	106	68
New Zealand	46	40	6
Total	220	146	74
<i>Africa</i>			
South Africa	32	10	22
Nigeria	5	1	4
Zambia	4	1	3
Uganda	1	0	1
Total	42	12	30
<i>Asia</i>			
Japan	2	0	2
Hong Kong	1	1	0
India	1	0	1
Jordan	1	0	1
Singapore	1	0	1
Syria	1	0	1
Total	7	1	6
Overall total	661	228	433

"international" and that was what it was all about.

There are 661 laboratories outside the United Kingdom which participate in the Wellcome Group International Quality Control Programme. The accompanying table shows how many of them had changed their reporting units by November 1976. The only uniformity, if one excludes the single participating laboratories in Finland and Hong Kong, is found in those countries where not one laboratory has changed, which include Canada, France, Belgium, Norway, Italy, and, with the exception of one rogue laboratory, the USA. Perhaps all members of expert panels on international standardisation should go home now.

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Propranolol absorption in Crohn's disease and coeliac disease

SIR,—Since we have studied the absorption of several drugs with a variety of physico-chemical properties in different types of malabsorption syndrome for the past five years¹⁻⁶ we were glad to see that Dr R E Schneider and his colleagues (2 October, p 794) have found a similar increase in the mean plasma propranolol concentration in coeliac and Crohn's diseases. We have also found gross changes in the shape of the plasma concentration/time curve after oral administration of several other drugs in Crohn's disease.⁷⁻⁹

Dr Schneider and his colleagues found that the increased mean plasma propranolol concentration in their coeliac patients was not statistically significant. However, they studied only eight coeliac patients, all of whom were in remission. Thirteen coeliac patients participated in our study of propranolol absorption in coeliac disease.¹⁰ We then compared the results from six patients who had taken a gluten-free diet for less than 12 months with those from seven who had taken the diet for more than 12 months. The increased mean plasma propranolol concentration and area under the curve were most marked in the first group. These abnormalities were less apparent (and statistically not significant) in those who had taken a gluten-free diet for more than 12 months.¹¹ This explains the apparent discrepancy between the findings of Dr Schneider and his colleagues and ours.

We were also interested to learn from the letter from Dr B T Cooper and others (6 November, p 1135) that abnormalities have been found in the acid microclimate in untreated coeliac disease and Crohn's disease. On the basis of their suggestion it might be expected that the absorption of drugs with low pKas such as folic acid (pKa 3.5),¹² aspirin (pKa 3.5), and indomethacin (pKa 4.6) would be impaired in coeliac disease. We have measured the plasma concentration/time curve of salicylate and indomethacin and have found that this does not occur. After soluble aspirin the values in the coeliacs for the peak plasma salicylate concentration and the area under the curve were normal.¹³ The timing of the peak salicylate concentration, however, was significantly earlier in the coeliacs. Computer analysis of the raw data suggested that this was due to faster absorption. After oral indomethacin the shape of the plasma concentration/time curve and the area under the curve were the same in both groups.

These findings confirm that the oral bioavailability of salicylate and indomethacin in coeliac disease is normal. The earlier time of the peak plasma salicylate concentration may be due to faster gastric emptying, which is known to occur in coeliac disease.¹⁴ Thus the changes in the acid microclimate do not entirely account for the abnormalities of drug absorption that occur in coeliac disease.

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¹ Parsons, R L, et al, in *Progress in Chemotherapy*, ed G K Daikos, vol 1, p 499. Athens, Hellenic Society for Chemotherapy, 1974.

² Parsons, R L, et al, *ibid.*, p 507.

³ Parsons, R L, et al, *ibid.*, p 534.

⁴ Parsons, R L, and Kaye, C M, *British Journal of Clinical Pharmacology*, 1974, 1, 348P.

⁵ Parsons, R L, et al, *Journal of Antimicrobial Chemotherapy*, 1975, 1, 39.

⁶ Parsons, R L, et al, in *Chemotherapy*, Vol 4, ed J D Williams and A M Geddes, p 191. New York and London, Plenum Publishing Corp, 1976.

⁷ Parsons, R L, and Paddock, G M, *Journal of Antimicrobial Chemotherapy*, 1975, 1, suppl, p 59.

⁸ Parsons, R L, et al, in *Chemotherapy*, Vol 4, ed J D Williams and A M Geddes, p 219. New York and London, Plenum Publishing Corp, 1976.

⁹ Parsons, R L, *Hospital Update*, 1976, 2, 221.

¹⁰ Parsons, R L, et al, *Gut*, 1976, 17, 19.

¹¹ Parsons, R L, *Clinical Pharmacokinetics*. In press.

¹² Blair, J A, and Matty, A, *Clinics in Gastroenterology*, 1974, 3, 183.

¹³ Parsons, R L, et al, *European Journal of Clinical Pharmacology*. In press.

¹⁴ Moberg, S, and Carlberger, G, *Scandinavian Journal of Gastroenterology*, 1974, 9, 17.

Saving money by self-help

SIR,—In your leading article on this subject (11 December, p 1408) it is stated that doctors give prescriptions for self-limiting conditions because it is quicker and easier to prescribe than to explain that no treatment is necessary. You go on to comment that "it may take longer to explain the nature of his illness and its management to a patient, but one session of explanation may prevent a whole lifetime of visits for self-limiting disease." How true this is!

For 20 years I have practised thus. As an assistant I was instructed by two principals to issue a prescription at every consultation. In my own practice in 1959 my costs were 80% of average and yearly that figure was reduced to 20% as I understood more the nature of consultations and got to know patients. Yet several letters and articles sent to the Department of Health on this topic drew no response.

Only one person can hold the reins of consultation. Treatment implies a desire to cure and confirms that something needs curing. Educating the patient (doctor—from *docere*, to teach) clarifies the situation. It is not trivia that bring a patient to a doctor but a change in the patient's attitude from tolerance to anxiety in relation to those trivia that creates the consultation, and it behoves the doctor to understand and interpret this.

Thus I find that prescribing frequency and work load diminish in parallel and that educating and prescribing have an inverse relationship. For 20 years neither my patients nor the DHSS have suffered by this policy.

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SIR,—Your leading article (11 December, p 1408) implies that more thrifty prescribing habits by general practitioners and more health education of the patient at the time of a consultation may spring from a common root—a desire to treat the whole person and not merely his self-limiting disease or minor symptoms. This, you suggest, could flower in a more self-reliant patient and a considerable saving on money. I agree.

I fear that the continual rise in prescribing costs may lead to curtailment of our liberty to prescribe and that the profession should look to ways of encouraging economy. I propose that any practitioner whose prescribing costs per head fall below 80% of the area average for four consecutive years should have the chance to claim the percentage saving of one year for reinvestment in his practice, subject to appropriate safeguards.

For 23 years the cost of prescribing in this practice has not been above 75% of the area average—in which time the practice population has increased 3½ times and has changed from mainly British working class to having a substantial minority of new Commonwealth immigrants. For example, last June the average cost per person on our NHS prescribing list was 0.38p compared with 0.55p per head average for the area. Taking our list as 10 500 patients and projecting this (a quiet month of the year) over a period of 12 months our practice has saved at least £21 420 compared with the average cost of prescribing for a similar number of patients. Some part of these savings should