acute viral infections may be great enough to suppress allergic symptoms partially or even completely. Needless to say, viral infections which produce upper respiratory tract infection may result in a recrudescence of asthmatic symptoms."⁶

¹ Cornil, A, *et al*, *Acta Endocrinologica*, 1968, **58**, 1.

² Ramaekis, L H J, Theunissen, P M, and Went, K, *Archives of Disease in Childhood*, 1975, **50**, 555.

³ Wexler, B C, *Metabolism*, 1963, **12**, 49.

⁴ Cope, C L, and Black, E, *British Medical Journal*, 1958, **1**, 1020.

⁵ Melby, J C, *New England Journal of Medicine*, 1971, **285**, 735.

⁶ Minor, T E, *et al*, *Journal of the American Medical Association*, 1974, **227**, 292.

The end of excellence?

SIR,—I was interested to read the letter from Mr N D W Weaver (1 January, p 47), in which he thought that the output of articles from teaching or university hospitals "seemed to prove" Dr Terry Davies's point in his open letter to Sir Alec Morrison (4 December, p 1376) concerning "the singular contribution of teaching hospitals as centres of excellence and initiation in research and treatment."

Mr Weaver undertook a "random survey" of the contributions (articles) in the 4 December issues of the *BMJ* and the *Lancet*. In point of fact he surveyed the totality of signed articles and the randomness, if any, lay in the selection of the two issues. One would be interested in the method used to ensure that the two journals were truly randomly selected. This is not the type of statistics one would expect from a "centre of excellence." To me only one fact has been established by this survey—that is, that there was a disproportionately large number of articles and letters from teaching hospitals, university hospitals, and research units in those two issues. The reason for this must still be sought. It may be that it is because they are "centres of excellence"; it may be editorial bias; it may be that other centres are not guided by the imperative "publish or perish"; it may be that other medical units do not have the time, personnel concentration, finances, and equipment to be able to undertake the work necessary to author such articles. The use of the term "centres of excellence" implies that all other centres are "centres of non-excellence," but indeed it is such centres which are required to provide a medical service for the main mass of the population. That is the point which the public appreciates—not the efflux of papers from teaching institutions.

If I may conclude by offering a similar type of "deduction" using the 1 January issue of the *BMJ* I note that that issue contains nine obituaries, not one involving a doctor who had worked at a teaching hospital. May we therefore assume that one of the byproducts of working at a "centre of excellence" is immortality?

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SIR,—I too am an advocate of the retention of teaching hospitals as "centres of excellence," but I cannot allow the letter from Mr N D W Weaver (1 January, p 47) to go unchallenged. It would, indeed, be surprising if the teaching and university hospitals did not produce the bulk of published research—it is there that

staff and facilities are concentrated. This proves precisely nothing about their value, in whatever terms this may be assessed, unless one puts a higher worth on knowledge for its own sake than on any other consideration—a position difficult to justify. The country and the world need both doctors who are interested in pushing back the frontiers of knowledge and those whose main or only interest is the welfare of individual patients—just as we need both district general hospitals and "centres of excellence." The problem, to which I do not offer a solution, is to decide on the balance between the two, given that sub-optimal levels of both are unavoidable.

P R FLETCHER

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SIR,—Nearly 20 years ago I heard that in a university hospital in the USA research output was assessed (and charted on a rising graph) by weighing the reprints of publications each year, but I never seriously thought I would see excellence measured by counting publications in the *BMJ* and the *Lancet* by source.

Mr N D W Weaver (1 January, p 47) must remember that just because a teaching hospital writes about a method of treatment (for example, management of Hodgkin's disease) it most certainly does not mean that this treatment is not already being carried out in many non-teaching hospitals.

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The reprint game

SIR,—Especially since the photocopier has become widely available I have been increasingly baffled by receiving postcard requests for reprints from all parts of the world and the United States in particular. Most of these postcards bear every sign of having been filled up by a secretary and many have a printed signature. Recently I was doubly baffled to receive at least 10 requests (four from the UK) for reprints of an article when in fact I had not written an article; there had merely been a short letter from me in a medical journal.

With a photocopier one can be sure of obtaining immediately the desired article. After sending for a reprint there is bound to be a delay, perhaps of many weeks, before it arrives and there is a large chance that it will never arrive, as many requests for reprints go straight into the wastepaper basket. Why do people spurn the certain method of obtaining what they want and instead employ a highly unreliable method which puts authors to trouble and expense?

Can you, sir, explain this remarkable phenomenon? And if you cannot, can any of your readers? Perhaps some of those who instruct their secretaries to send for reprints will answer the points I have made. For I feel sure that I am not unique in wishing for an explanation of this reprint game.

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copyright laws and most medical libraries, including the BMA library, will supply such photocopies on payment of a small fee. Many authors now make it their practice to ignore all requests for reprints other than those from personal friends, libraries, and individuals in remote areas whose access to journals and photocopying services is likely to be restricted. —Ed, *BMJ*.

Thrombosis statistics

SIR,—Dr S E Browne (11 December, p 1452) has made an important point concerning the reliability of statistics on the thromboembolic complications of oral contraceptives. There is little doubt about the under-reporting of such complications to the Committee on the Safety of Medicines.

At the Radcliffe Infirmary, Oxford, during 1972-4 72 women aged 15-45 years were seen with clinically suspected deep vein thrombosis (DVT) of the lower limb. Ascending venography was carried out on all patients. The results were as shown in the table.

Result of venography for DVT	Oral contraception	
	Yes	No
Positive	14 (28%)	6 (26%)
Negative	35	17
Total	49	23

Without venography the number of DVTs that might have been regarded as associated with oral contraception would have been exaggerated almost four-fold. It may be that a DVT is more likely to be diagnosed clinically in a woman with leg symptoms if she is also taking oral contraceptives.¹

The under-reporting of DVTs secondary to oral contraceptives therefore may be balanced partly by a number of unsubstantiated but reported clinical diagnoses.

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¹ Tibbitt, D A, Williams, E W, and Faulkner, T, *British Medical Journal*, 1973, **4**, 737.

BUPA and the long-stay patient

SIR,—The very thoughtful letter addressed to you by Dr R G Cooper and Mrs L A M Ford (18 December, p 1505) calls for some comments for which I hope you will find space.

Able put as it is, their argument is nevertheless based on a false premise. The benefits paid by all the UK provident associations are, and always have been, related to acute medical or surgical illness calling for specialist intervention and usually requiring a short term as an inpatient. History establishes this. When BUPA was first formed the maximum period of accommodation benefit was six weeks in a subscription year. As time went on this was extended to 10, 13, and then 26 weeks. When, a few years ago, it was decided to provide cover for 52 weeks this was intended to apply to the comparatively rare cases, such as severe road accidents, in which active treatment is indeed required for a very long time. It was certainly not in order to provide permanent residential accommodation for elderly people needing custodial care, some nursing, and medication. For this to be made available it would be