patient and his relatives are caught between a crossfire of irrelevant arguments, causing much distress.

The result is, of course, that the patient is cared for with love and devotion in the community hospital. Should we therefore dispense entirely with psychogeriatricians and geriatricians and turn their beds over to the general practitioner?

PETER CATLIN

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Methadone and the elderly

SIR,—I was fascinated to read the letter from Mr S T Leslie and others (5 February, p 375) on the accumulation of methadone. We noted this phenomenon in clinical practice on the date of publication of the letter.

The patient was an 81-year-old woman suffering pain from bony metastases from carcinoma of the breast. She has no clinical or biochemical evidence of hepatic metastases. She was given 5 mg of methadone three times a day for two days. After six tablets of this drug the patient was deeply unconscious, the clinical picture being compatible with narcotic overdose. She awoke immediately after an intravenous injection of 0.4 mg of naloxone. By telephone Dr P Routledge, of the Newcastle Poisons Bureau, gave the half life of the drug as 18-97 hours.¹ Our patient's rate of metabolism seems to be at the slow end of this range.

In view of the long half life of methadone and the known intolerance of opiates among the elderly methadone should be used with great caution in these patients.

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¹ *Drug Treatment*, ed G S Avery. Sydney, Addis Press, 1976.

Scoring of erosions in rheumatoid arthritis

SIR,—We read with interest the paper by Dr R S Amos and colleagues (22 January, p 195) in which serial measurements of erythrocyte sedimentation rate and C-reactive protein in rheumatoid patients are correlated with radiological progression of the disease. However, we feel that minor differences in the number of erosions should be interpreted with caution.

Two trained observers scored coded radiographs of 10 pairs of rheumatoid hands on two separate occasions at three months interval for six separate parameters of rheumatoid disease, including erosions. Each metacarpophalangeal and proximal interphalangeal joint (200 joints in all) was graded separately on a 0-3 scale—namely, 0=normal, 1=doubtful or minimal change, 2=definite erosions, 3=erosive disease. For each joint we noted the number of grades of difference on the two separate occasions. The comparison between these scores for erosions is given in the table. The scores were the same in 133 joints but differed by 1 grade in 63 and by 2 grades in 4.

As there is considerable variation in the scores obtained on the same film examined on two separate occasions it becomes more

difficult to assess the significance of the different scores obtained on serial films.

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MALCOLM I V JAYSON

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Mechanism of acupuncture analgesia

SIR,—Dr F S Rickards's account of "techi" (29 January, p 291) is of considerable interest in that it supports the current view of the mechanism of acupuncture analgesia. This is that the stimulation of proprioceptive neurones tends to inhibit pain neurones in the adjacent segments; in fact, collateral axons which carry the inhibitory impulses can be demonstrated histologically.

To obtain the most effective analgesia it is therefore necessary to select a muscle in the vicinity of the painful region which is plentifully supplied by proprioceptive nerves, such as the opponens muscles of the thumb. Physical stimulation with a needle requires some accuracy in its placement; however, electrical stimulation avoids this difficulty. The sensation of "techi" that Dr Richards describes is evidently the subjective impression of a strong proprioceptive stimulation. When one has a painful tooth, the pain is often relieved by biting firmly on a solid object or even clenching one's teeth. Probably the mechanism here is the same inhibition of pain by strong proprioceptive stimulation.

B JAMES

Marlow, Bucks

Payments by patients

SIR,—I have read Dr J D Jackson's letter on this matter (22 January, p 236) with great interest but total disagreement. For he has trotted out yet again the woeful and inaccurate arguments that have bedevilled the NHS since its inception and has given it the reputation of "perhaps the worst system in the world." His arguments require to be challenged.

He states that a "very considerable increase in paper work will be necessary to administer the scheme." This may be true of any scheme he has in mind, but it is manifestly untrue for a simple scheme such as the special date-stamping of the patient's medical card. In this scheme a special date stamp (issued by the NHS) would be used to date-stamp the patient's medical card at each attendance, such a date-stamping sufficing as a receipt from the patient. Say that a total charge of £5 pa were to be the rule: then five date-stampings per annum (at £1 per consultation) would be placed on the medical card and after that all subsequent treatment would be free, or domiciliary visits at £2.50 each would terminate liability to pay after two such visits.

Dr Jackson says there would be "exempted classes." Of course there would be "exempted classes"; these would be given a Barclaycard-type card and we would send the Barclaycard-type bill to the NHS for redemption. I find no difficulty at all in using my Barclaycard. As to his 80% of attendances coming under the cover of "exempted classes," I can only say "rubbish." In our practice the converse might well be nearer the truth.

As to his comment that the small payment will deter a number of patients from coming,

this is just about the worst argument of all. I have now done over a quarter of a century in a "free for all" NHS and, quite frankly, a bit of a deterrent is exactly what I am after. And cash is the one thing to do it. Nor do I believe for one moment that a cash fee of £1 would really deter anyone who was anxious to come to see me.

As to his comment that a nominal payment would tend to devalue the service, are we not totally devalued already? We are wholly free; is it possible to devalue zero? As to his point about the 20p for medicines, I have long thought this to be as ridiculous as the rest of the NHS. Clearly, in my view, *National Formulary* drugs should be dispensed wholly free under the NHS and all other drugs paid for in full (as they used to be) by the patient. This one idea alone would produce a massive saving in the NHS deficit.

There is only one system that is as bad as (or worse than) the American "fee for all" system and that is the British "free for all" system. It is high time we thought again—and try to get it right this time without benefit of political dogma.

TOM RUSSELL

Hayes, Middx

Loss of doctor in the course of duty

SIR,—First to declare my interest. I am Chairman of the Torbay District Community Health Council; I am also Honorary Medical Secretary of the Devon Local Medical Committee and they agree that the two posts are not incompatible.

On the television programme "That's Life" on Sunday 16 January it was reported that a general practitioner (Dr A) had requested one of his patients, the secretary of a community health council, to find another doctor. The reason given was that this officer, in doing the duty laid upon him by virtue of his office, had appeared as "patient's friend" in a medical service case involving Dr B, Dr A's partner. It was also stated that the administrator of the family practitioner committee concerned did not appear to be disturbed by this despite the fact that the secretary of a CHC is a fellow officer of the same employing authority. I have personally ascertained that the facts as presented in the programme are substantially true.

I hope, sir, that you and the General Medical Services Committee will condemn such action by any GP and that the FPC will do its best to protect any patient from similar victimisation.

Is it not time that we all, from chief officers in the DHSS to domestic workers, remembered ourselves that our only function is to serve the patient, without whom there would be no need for the service?

G COLIN C MACVICKER

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Working after retirement: a raw deal

SIR,—The retired general practitioner's earning potential highlighted by Dr J M B Morwood (22 January, p 236) is only one problem encountered by the GP in relation to the rules governing his pension and pension rights. The fact is that there are many anomalies