etc. I can assure them that regional centres are not the only neonatal units that have such attributes.

In summary, where the neonatal unit is over 2½ h from the regional centre I cannot agree that babies with respiratory distress syndrome (RDS) should be transferred to the regional centre. By the time the infant is one that requires ventilation the risk of travel is much greater than the risk of staying. I do agree with the standards Professor Davis and Dr Chiswick lay down for the care of these babies and agree that any unit treating RDS babies should adopt them. I also agree that, if fit to travel, babies with surgical and cardiac problems should be transferred to the regional centre.

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"Salt tablets"

SIR,—I was interested to read the article by Drs I Wallace and J W Davie on improving drug compliance in the elderly (5 February, p 359).

I notice that on both their drug calendar and their tablet identification card with which they illustrate their article they refer to Slow-K (slow-release potassium chloride) as a "salt tablet." This is potentially confusing to the elderly patients it is intended to enlighten, as the following anecdote illustrates. When I was a medical student I once accompanied a consultant in geriatric medicine on a domiciliary visit to an elderly man. While we were there the patient's wife asked us about the "salt tablets" which were making her sick. She showed us her supply of Slow-K. She was not taking them, but instead she was putting extra table salt in her cooking. Of course, she was still taking her frusemide.

The obvious consequence of her misconstruction of the nature of these tablets was that she was unprotected from hypokalaemia while her increased sodium intake exacerbated her fluid retention.

To people with no knowledge of chemistry the term "salt" refers to what we know as sodium chloride. Potassium supplements should be given with the advice that they are intended to stop the "water tablets" from causing muscle weakness.

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Drug compliance in the elderly

SIR,—With reference to the article by Drs I Wandless and J W Davie (5 February, p 359), many general practitioners like myself who see patients in their own homes are often conscious of the small proportion of the prescribed drugs which are taken by patients, especially those who are elderly. In my opinion, every attempt should be made to restrict medication to not more than three different preparations, even if this means using one of the combined preparations which are so unpopular with the pharmacists and academics.

Normally, in my experience, I have found it very useful to try to make sure that when a number of drugs are prescribed these have distinctive colours. For instance, on occasions I prescribed cedilanid (lanatoside C) instead of digoxin so that there is a distinctive pink

tablet which is different in colour and appearance from the diuretics which are frequently taken at the same time.

If these two simple rules are adhered to a simple list of the drugs with their identifying characteristics, such as shape or colour, does help to improve compliance.

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Low-dose progestogens and ectopic pregnancy

SIR,—Confirmation by Drs P Liukko and R Erkkola (5 February, p 379) that the three groups in their study (20 November, p 1257) on the relative risk of ectopic pregnancy with different progestogens were of a comparable nature re-emphasises the greater efficacy and safety of 0.5 mg lynoestrenol as a progestogen-only contraceptive. The delay in the diagnosis of ectopic pregnancy in association with continuous low-dose progestogen therapy^{1,2} adds to the dangers of this condition and increases the importance of considering the relative risk of this complication when choosing a progestogen-only contraceptive.

In response to the comments of Drs Liukko and Erkkola concerning the relative progestational activity of the three agents used in their study, we did of course consider this aspect. Using the comparative data obtained from assessing the relative progestational activity of different progestogens by the postponement of menses test³⁻⁵ we could find no correlation between the relative potency of the three progestogens in the Finnish study and the observed risk of ectopic pregnancy. This feature, however, would support the inference by Drs Liukko and Erkkola that the increased efficacy of lynoestrenol lies beyond a "conventional" action on the uterine endometrium and cervical mucus. Their reference to an ovarian effect is of considerable interest, but perhaps even more so is the indication by Friederich and his colleagues⁶ that lynoestrenol has a particularly competent influence at the central level, possibly from a blockade of the oestradiol receptors of the pituitary and/or hypothalamus.

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¹ Bonnar, J, *British Medical Journal*, 1974, **1**, 287.

² Corcoran, R, and Howard, R, *Lancet*, 1977, **1**, 98.

³ Greenblatt, R B, and Mahesh, V B, *Metabolism*, 1965, **14**, 320.

⁴ Greenblatt, R B, *Medical Science*, 1967, May, p 37.

⁵ Macdonald, R R, *Scientific Basis of Obstetrics and Gynaecology*, p 356. London, Churchill, 1971.

⁶ Friederich, E, et al, *American Journal of Obstetrics and Gynecology*, 1975, **122**, 642.

Complaints against family practitioners

SIR,—Mr Rudolf Klein's comments in his article "The Health Commissioner: no cause for complaint" (22 January, p 248) act as a goad to anybody with experience in the administration of the procedure for investigating complaints against family practitioners.

Mr Klein quotes the incidence of about 70 complaints against family practitioners which were raised with the Health Commissioner in each of the years 1974-5 and 1975-6,

and rejected as outside his jurisdiction. He goes on to say:

"These figures . . . suggest that the machinery for dealing with complaints against family practitioners may not be working as well as it should, though ignorance as well as dissatisfaction may help to explain the number of cases affecting GPs referred to the Health Commissioner. This seems to support the case for changing the current family practitioner committee procedures for dealing with complaints along the lines proposed by the Council on Tribunals, by introducing independent, legal chairmen and neutral clerks."

It does not "seem to support" any such thing. There is, for a start, no indication of how many of these, if any, had any bearing on the practitioners' contract nor how many concerned doctors. There are 90 family practitioner committees in England and thus an average of less than one complaint about family practitioner services for each area was lodged in error with the Health Commissioner rather than with the appropriate committee. This incidence is extremely low and could quite well be explained by ignorance; but ignorance would not be cured by Mr Klein's suggestion.

Presumably still referring to the recommendation for introducing "legal chairmen and neutral clerks," Mr Klein says:

"... the experience of the Health Commissioner would suggest that a judicious style of investigation offers as much protection to the health care professionals as to consumers."

It is, in my view, infamous for Mr Klein to suggest that the impartial advice given to would-be complainants and the careful consideration given by lay chairmen of service committees throughout the country and by lay and professional members of service committees themselves to the investigation of complaints in any way fails to be judicious. Even if Mr Klein meant to say "judicial" the introduction of a judicial investigation along these lines would be far from a step forward; but it would introduce an expensive, unwieldy, and over-legalistic element into what is essentially a procedure designed to elicit facts and make recommendations based on common-sense principles and impartial arbitration. The legal profession does not have a monopoly of these essentials.

Sometimes I feel the need for a procedure for investigating complaints against self-styled, self-appointed experts in procedures of which they have no practical experience.

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* * * We sent a copy of this letter to Mr Klein, whose reply is printed below.—ED, *BMJ*.

SIR,—I entirely agree with the concluding paragraph of Mr Wright's letter. I too would welcome a procedure for investigating complaints against "self-styled, self-appointed experts." As one myself, I believe that this would offer me protection against ill-informed and ill-tempered criticism of the kind offered by Mr Wright. For my credentials in writing about this subject I would only refer him to my book *Complaints against Doctors*.¹ This was based on conversations with a great many executive council clerks (as they were then) and I may therefore have a rather wider perspective on the subject than Mr Wright himself.