recommendations of the Clinical Pharmacology Committee of the Royal College of Physicians of London that such information should be given by specialised medical staff. Pharmacists are aware of their limitations clinically and would normally refer such inquiries to a poisons centre or to the appropriate medical specialist. I note that a pharmacist is now greatly involved in the provision of drug information in Newcastle and he will refer to clinicians when a clinical opinion is needed. There are so many problems arising with the use of drugs that both factual information and clinical opinion are needed, and such co-operation between pharmacists and clinicians in providing information services is essential if safe and effective use of medication is to be achieved.

I agree with Dr Davies and his colleagues that there is definitely a need for an improved drug information service in its widest context to be available, though not only to doctors who prescribe medication but also to pharmacists for monitoring prescriptions for interactions or overdoses and to nurses and patients who must administer the medication correctly and note possible side effects.

H McNULTY
Principal Pharmacist,
Regional Drug Information Service

Bristol Royal Infirmary,
Bristol

¹ *Pharmaceutical Journal*, 1976, 217, 454.

Future of child health services

SIR,—We write as general practice vocational trainees to resist the recommendations proposed by the Court Committee¹ to establish general practitioner paediatricians (GPPs).

The developing specialty of general practice is in danger of being fragmented by these proposals. A general practitioner will have two choices. He can opt to continue looking after the children on his list, in which case, having successfully completed appropriate training, he would be designated a GPP and his work would take on a more or less heavy paediatric slant. Or he can decide not to become a specialist, to remain a GP, in which case his general practice paediatric work will pass substantially to a colleague, possibly (in a rural area such as this) neither a member of the practice nor even working in the same place. In either case the ideal of family medicine for which we have been specifically trained and to which we aspire, with paediatric as well as geriatric training, will be lost. No doubt once it has become established that paediatrics is too important for an ordinary GP other specialties will make similar decisions.

We intend to be generalists. We have paediatric training and intend to look after children in a primary care setting. Professor Court, himself a specialist, proposes a specialist solution to an undoubted problem. It is now for the generalists, established and aspiring, to demonstrate the general practice answer.

R WESTCOTT
GMSCT Trainee Subcommittee
Representative for the South-west

STEPHEN HALL
Chairman,
Exeter Vocational Trainee Group
and 10 others

Essex Postgraduate Medical Centre,
Exeter

¹ Committee on Child Health Services, *Fit for the Future*. London, HMSO, 1976.

Beauty spot or blemish?

SIR,—It is difficult to believe that any pathologist, dermatologist, or surgeon would accept the unqualified statement in your leading article on naevi (15 January, p 126) that "curettage, cautery, or shaving flush with the skin are reasonable alternatives" to excision in managing pigmented naevi. Surely histological confirmation of clinical diagnosis with assessment of the amount of junctional activity and adequacy of excision are essential.

Today a significant percentage of patients are sufficiently well educated on this topic to be aware of the fact that pigmented lesions should not be tampered with. Curettage, cautery, and shaving flush with the skin come under the heading of "tampering" and to encourage this would be a retrograde step.

IAN MCGREGOR

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. Obviously when the diagnosis and the nature of a lesion are in doubt it would be wise to seek advice of one especially trained in the clinical diagnosis of skin lesions such as a dermatologist before embarking on treatment. It is also good practice to send all pathological material for histological examination, but to insist on full excision of all blemishes for which patients are seeking cosmetic advice would result not only in many ugly scars but also in many dissatisfied patients. Furthermore, apart from anecdotal evidence, there is no scientific basis for the commonly held view that "tampering with pigmented lesions has a deleterious effect on their subsequent course." —ED, *BMJ*.

Snow-shovelling and coronary deaths

SIR,—On Thursday 13 January 1977 there was a considerable fall of snow in Birmingham, starting in the morning and continuing right through the day. That evening five men collapsed and died within minutes outside their homes shovelling or otherwise clearing snow. All of these deaths were reported to the coroner, and at subsequent post-mortem examination they all had considerable atherosclerotic coronary artery disease and associated myocardial fibrosis, together with a varying degree of enlargement of the heart. Their ages varied from 52 to 76 years. All had been well in the morning, but three had a history of previous episodes of ischaemic disease.

After a series of mild winters this was one of the first significant falls of snow in the area. During that day 9 cm of undrifted snow fell and the Edgbaston Observatory in Birmingham reported that the air temperature was -0.2°C at 1500, $+0.2^{\circ}\text{C}$ at 1800, and $+0.7^{\circ}\text{C}$ at 2100. This was not particularly cold, but the wind speeds at the corresponding times were 32, 22, and 20 kph (20, 14, and 12 mph) from a south-easterly direction. It was this cold wind rather than the air temperature which gave a high chill factor that particular afternoon and evening.

It is interesting that, in a report from the United States,¹ there was an association of the incidence of coronary heart disease with a low mean temperature, but this was more apparent when there was a snowfall and it was suggested that the shovelling of snow may have been a relevant factor.

As has been pointed out recently in this journal,² elderly people are particularly liable to succumb to hypothermia. I wish to bring to the notice of readers this other form of sudden death due to coronary heart disease in elderly persons when exposed to the physical rigours of clearing snow. I cannot do better than to quote the pathologist who gave evidence at the inquest on one of these victims. He said, "The problem is that many people over the age of 50 do have unsuspected coronary artery disease and shovelling snow with the combination of severe cold and unaccustomed physical exercise can precipitate a fatal heart attack. I think the clearing of snow should be left to teenagers and healthy adults who are accustomed to strenuous physical activity."

RICHARD M WHITTINGTON
HM Coroner for District of Birmingham,
West Midlands

Birmingham

¹ Rogot, E. and Padgett, S. J., *American Journal of Epidemiology*, 1976, 103, 565.

² *British Medical Journal*, 1977, 1, 336.

Who is at risk of a coronary?

SIR,—The impressive paper on coronary risks by Dr T Khosla and others (5 February, p 341) needs reduction to a quick formula for everyday use. If their risk factors are equated and added rather than multiplied the resulting curves are flattened, but calculation is simplified and the message remains. If an overweight factor is included the relative loadings on the other factors are probably recovered, the effect of any untypical reading is lessened, and an item of clinical relevance is not forgotten.

So perhaps an ASHCO score would be useful, à la Aggar, with 0, 1, or 2 scored for each of age, smoking, hypertension, cholesterol, and overweight, low scores being best. Ranges to count 1 might be age 45-55, smoking 1-20/day, hypertension 130-160 mm Hg systolic, cholesterol 6-7 mmol/l (230-270 mg/100 ml), and overweight 10-20% (say, 6-12 kg or 1-2 stone). Scores over 4 would sound the alarm.

J F WALKER

Lowestoft, Suffolk

Neonatal respiratory intensive care at local level

SIR,—I write to support Drs J M Davies and Janet L P Hunter (25 December, p 1557) and to disagree strongly with Professor J A Davis and Dr Malcolm Chiswick (5 February, p 380). Where the distance between the peripheral unit and the regional centre is over 2½ h it is simply not a practical proposition to transfer newborn infants in respiratory failure. When this has been done from this unit with babies who are suffering from cardiological problems the infants have invariably suffered grievously during the journey (and many die).

Professor Davis and Dr Chiswick refer frequently to babies on ventilators. With early and well-timed intervention with continuous positive airway pressure very few infants require ventilation. If they do require ventilation they certainly would not survive the journey of 2½-3 h to our regional centre.

Professor Davis and Dr Chiswick stipulate various requirements for the treatment of infants with respiratory failure—"staff round the clock, an adequate number of ventilators,"

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.

R H DAVIES

St David's Hospital,
Bangor, Gwynedd

"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.

S MICHAEL CRAWFORD

Liverpool

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.

E MALCOLM FOX

Macclesfield, Cheshire

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.

R CORCORAN
M W RIZK

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Birkenhead, Merseyside

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.

R WRIGHT

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Croydon Family Practitioner Committee

Croydon, Surrey

* * * 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.