There have been no further episodes of skin lesions or systemic upset.

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Hazard of chemical sympathectomy

SIR,—The essential requirement in performing injections with neurolytic solutions is firstly to ensure correct needle placement and secondly to make sure that the solution spreads in the correct tissue plane so as to destroy only the intended nervous tissue. Drs J M B Burn and L Langdon (29 April, p 1143) deny the need for radiological control for chemical sympathectomies on the grounds of expediency and on the basis of their own experience. They miss the point that cases of paraplegia, including the one described by Dr R C Smith and others (4 March, p 552), have occurred for the very reason that the operator was unaware of any error in the needle placement or aberrant spread of solution. The potential for inaccurate needle placement is well illustrated in the study by Brechner and Brechner,¹ who showed that even with technical proficiency check x-rays after final positioning will show up to 40% error in needle placement.

When x-ray control with an image intensifier is used from the start accurate placement of the needles is very rapid, reducing patient discomfort to a minimum. The satisfactory position of the needles having been seen, subsequent injection of radio-opaque solution then determines the accuracy and extent of spread, allowing for minor adjustments when an occasional intravascular dispersion is seen. We therefore strongly recommend, as the safest practice, that all neurolytic injections in the region of the vertebral column should be made under x-ray control.

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¹ Brechner, T F, and Brechner, V L, in *Advances in Pain Research and Therapy*, ed J J Bonica and D Albe-Fessard, vol 1, p 679. New York, Raven Press, 1976.

Treatment of ulcerative colitis

SIR,—The article "Ileostomy or ileorectal anastomosis for ulcerative colitis" (3 June, p 1459) was a most interesting discussion of the surgical controversy. Given such a theme, it is understandable that only lip-service was paid to medical aspects of treatment and no reference whatsoever was made to psychological approaches.

Psychological factors have a significant effect in the onset of the individual exacerbation and in determining the patient's response to and the handling of this illness. The evidence for the effectiveness of psychiatric

intervention has been comprehensively reviewed.¹ If more patients with ulcerative colitis were to receive psychiatric help it may well be that there would be no need for such papers and I would appeal to all doctors concerned with such patients to consider psychiatric referral.

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¹ O'Connor, J, in *Modern Trends in Psychosomatic Medicine*, 2, ed O W Hill. London, Butterworths, 1970.

A Russian visit

SIR,—Dr John Coope (Personal View, 20 May, p 1343) seems to display a measure of impatience with the Russian doctors and staff who were good enough to show him their polyclinic and discuss their work with him.

I would suggest that if a group of Russian doctors without a word of English between them were to knock at the door of a British health centre they would be fortunate to receive such courteous treatment. Also there might be many a "chief" who felt as strongly as the Russian that the local doctors of his team are not employed to sit around discussing the British and Russian medical systems.

There may be something to be said for a direct approach to investigating medical systems in other countries. There is also something to be said for at least informally spying out the land first, and certainly for arranging for one's own interpreter.

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Heart-rate response to standing as a test for automatic neuropathy

SIR,—We were interested in Dr W J MacLennan's observation of an abnormal heart-rate response to standing in seven elderly subjects (25 February, p 505), and its confirmation by Mr D J Oliver (20 May, p 1349). As autonomic dysfunction in the form of postural hypotension occurs quite commonly in the elderly,¹ our "30:15 ratio" may provide a simple way to confirm it. In reply to Mr L Oppenheimer (25 February, p 505), who wonders whether the blood pressure was taken into account in our observations (21 January, p 145), the mean blood pressure of the 15 diabetics with autonomic neuropathy was 146 ± 37 mm Hg (systolic) and 87 ± 10 mm Hg (diastolic). Although higher than in the group of 10 "older normals" (124 ± 12 systolic, 80 ± 6 diastolic), this difference was not statistically significant. Thus his suggestion that there might be baroreflex resetting related to hypertension, leading to an "apparent" neuropathy of the baroreflex arc, is not borne out by the blood pressures of our diabetics. Moreover, our subjects had severe generalised peripheral and autonomic neuropathy as shown by a number of tests in addition to those testing the integrity of the baroreflex arc.

Mr Oliver raises the question of individual beat-to-beat variation, which could invalidate the "30:15 ratio." In our experience, based on computer analysis of the individual R—R intervals, beat-to-beat variation usually disappears on standing only to reappear some 30

beats later; but his letter underlines the need for some flexibility in the interpretation of the ratio. We found in any individual that the maximum tachycardia was not necessarily at exactly the 15th beat, or the relative bradycardia at exactly the 30th beat; and in practice it is also sometimes not possible to press the ECG marker button at exactly the point at which the subject starts to stand up. Because of this, in our routine ECG-measured 30:15 ratios we now take the point of maximal shortening of R—R that occurs at or around the 15th beat. In Mr Oliver's example, if he had taken any of the beats 11-14 he would have obtained a "normal" 30:15 ratio.

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¹ Caird, F I, Andrews, G R, and Kennedy, R D, *British Heart Journal*, 1973, **35**, 527.

Surgical haemorrhage in patients given prophylactic heparin

SIR,—I was interested to read the paper by Mr N H Allen and others (20 May, p 1326) and was impressed by their method of assessing interoperative and postoperative blood loss following transurethral resection of the prostate. However, I find their interpretation of the results a little worrying.

In their table they state that the mean postoperative blood loss in the controls was 71 ml with a range of 0-351 ml, while in the heparin group the mean value was 135 ml, and the range 0-774 ml, and they state that these values are significantly different from each other. They do not, however, state what statistical test was applied to obtain their P values and I fear that as they have quoted mean values they have used a parametric test. With the mean values and ranges quoted the distribution of data is obviously grossly abnormal and the higher mean value in the heparin group could well be due to one or two higher results. Therefore the values given for the postoperative haemoglobin (12.1 g/dl in the control group, 11.8 g/dl in the heparin group) may give a truer picture of the actual situation.

A better comparison for the postoperative blood loss between the two groups would be obtained by using the median value and obtaining statistical probability using the Mann-Whitney or Wilcoxon tests.

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The other crisis of health care

SIR,—In 10 major points Dr A E Finnegan (6 May, p 1211) has tried to show that the French system of health care is "infinitely better" for the average "Frenchman in the street" than is our own. He says this on the basis of a year's experience in France and Belgium. May I reply on the basis of what I saw during a year spent in France? I particularly had the opportunity to look at the care of the old, the poor, and the chronically sick. I will take some of his points individually first.

Dr Finnegan's first point is the freedom of choice of the French patient to visit any

doctor. There are qualifications which have to be made to this freedom. Firstly, the freedom is limited for the poor because not all doctors will see Aide Sociale clients. Secondly, has it been shown actually to be a benefit to health to be able to visit several family doctors or even a specialist by self-referral? Thirdly, it seems certain that such a system will be more expensive.

I do not see why it is so obviously an advantage to the French for family doctors to work very much longer hours than the British GP and to earn so very much more. It makes me fear that "All work and no play. . ."

The system of payment for care is complicated. The existence of a complicated system in a country as bureaucratic as France frightens me. I have no experience of the speed with which Sécurité Sociale repayments are made but ample experience of the maze which has to be negotiated to get payment provided for long-stay institutional care even before the patient gets on to the waiting list for this.

Dr Finnegan states that home nursing is available at any time. How does this fit with the explanation often given in France that many old people have to be institutionalised because of lack of home-care services? Could it be that the French community nurse with her self-employed status has been too highly trained technically to be prepared to do any nursing? I think it is significant that Dr Finnegan has not told us about the availability of home helps, meals on wheels services, etc. The less such social services are available the more will the old, the poor, and the handicapped need to use both inappropriately and wastefully the expensive medical services.

Obviously Dr Finnegan and I have formed our own rather different impressions. I accept the implication of his second point that British waiting lists are unacceptably long and that our higher infant and perinatal mortality rates are disquieting. But I must question the relevance of most of his other points. Certainly I returned from France thinking that, after all, the average Briton did get quite a good deal for relatively little money. If Dr Finnegan simply wants more money for health care the best answer may lie in an increase in gross national product. Klein¹ has argued that the amount countries spend on health reflects much more closely the GNP per head of population than their different ways of financing their health services.

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¹ Klein, R, *British Medical Journal*, 1977, 2, 1492.

The "Medical Directory"

SIR,—In the days before the introduction of the General Medical Council's annual retention fee the *Medical Directory* was a more or less comprehensive index of British qualified doctors; now only those doctors who pay the retention fee in order to engage in actual clinical practice are allowed to have their names in the *Directory*.

Thus doctors who are in administrative, commercial, or academic positions or who practise abroad or have retired no longer have a directory for themselves, as all other professions have, and the value of the *Medical*

Directory is accordingly diminished as a reference book. The general public are in fact inclined to assume that doctors whose names are no longer in the *Directory* are either dead or no longer doctors.

The essential qualification for a doctor's name to appear in the *Medical Directory* should surely be the possession of a British qualifying degree. The present administrative difficulties have been caused by the GMC's policy of creating two classes of doctors—the registered and the unregistered; and if our profession is once again to have a comprehensive directory of its qualified members it would seem essential for the GMC to create a register of doctors not engaged in clinical practice. I write in the hope that you may give your support through your columns to the restoration of this invaluable work of reference.

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Future of British anaesthetics

SIR,—Money is a powerful incentive for recruitment to the most unattractive posts and I regret that Dr E Ll Lloyd (10 June, p 1555) dismisses the idea of a special premium for anaesthetists.

Anaesthetics is the largest single specialty group in the NHS and is also one of the few in which no significant additional income may be obtained from the NHS to add to the basic consultant salary. Not for the anaesthetist the worry of exceeding the number of paid domiciliaries which yield £3000+ pa or the pleasure of receiving fees for insurance company reports culled from the patients' hospital notes. No category II fees are payable in respect of anaesthetics, and even the anaesthetic fees paid for family planning operations are lower than the equivalent surgical fee.

Add to this catalogue the lowly percentage of anaesthetists with distinction awards and it is not surprising that the future of British anaesthetics, "the envy of the world" (Dr P K Schütte, 6 May, p 1285), is in doubt and that it is impossible to fill a large number of consultant posts.

Perhaps an incentive premium would not be unreasonable and might be beneficial in raising the expectations of junior anaesthetists to the level of most of their other colleagues.

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Private outpatient diagnostic services

SIR,—I write to draw your readers' attention to a possible danger in the latest Health Services Board proposals of 6 June in relation to revoking authorisations for private outpatient diagnostic pathology and radiology in certain hospitals [see p 1712].

My hospital is listed as one in which no returns were made on Form SH3 in respect of private outpatient radiology attendances in 1976 and 1977, although 389 patients were seen in 1976 and 317 in 1977. On inquiry of the hospital administration our records officer quite rightly pointed out that there is no specific query on Form SH3 to list the numbers of such patients, for either radiology

or pathology; a telephone call to the department of the Department of Health and Social Security responsible for this form confirms the fact that they do not keep these numbers separately. A further telephone call to the Health Services Board resulted in the information that they expected the number of such attendances to be included in the total number of attendances during the year by private outpatients in part I of that form (but that they did not expect to have the breakdown between clinical attendances on the one hand and pathology and/or radiology attendances on the other).

Under these circumstances it is clear that a large number of hospitals (listed in column 2 of the appendix to HSB11 of 6 June) whose authorisations for private outpatients for pathology and radiology it is proposed to withdraw (on the grounds that they have not been seeing any) are in fact at risk—as is this hospital. I would like to voice my anxiety that my colleagues in these disciplines in other hospitals may find such authorisations withdrawn simply because the information which the HSB has obtained from NHS administrative sources is flawed and incomplete.

R EBAN

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Area Medical Advisory Committee

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Money for old rope

SIR,—I write to support the views of Dr M H Owen and others (3 June, p 1491) and to contrast the recommended increase in pay for trainee general practitioners of about 2% with the rise in the training grant paid to our trainers from £1300 to £1625 per year (in addition to the reimbursement of the trainee's salary and the employer's superannuation and National Insurance contributions).

This sum is paid for the "extra responsibility" involved in supervising a trainee, who often sees almost as many patients in surgery as his trainer and shares his on-call responsibility. In return for this many trainees receive less than one hour's formal training each week. The trainer is therefore being paid £1625 each year in return for a substantial reduction in his work load.

A comment made to me by a recently appointed trainer illustrates the way in which this system may be abused. He remarked that he hoped to appoint an assistant in addition to his trainee and that he would then be able to retire. Clearly this does not reflect the attitude of all trainers, but the payment of a training grant makes the system wide open to abuse and I feel that it should be abolished. General practitioners interested in training should, like hospital consultants, expect a reasonable amount of work from their trainee but no additional payment.

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Preregistration posts

SIR,—Your leading article (27 May, p 1371) focuses attention on the plight of preregistration doctors during the completion of their medical training.