detected by the Ouchterlony technique in the IgG fraction of the first serum sample of the mother with anti- α - and β -lipoprotein serum we still believe that this was a case of reinfection.

J A M SNIJDER

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Patient acceptability and drug effectiveness

SIR,—In your leading article (12 March, p 668) you state that the dangers of dextropropoxyphene overdosage have to be set against "its popularity based, presumably, on doctors' and patients' clinical impression of its effectiveness."

It is my impression, based on patients' remarks—and intuition—that the popularity of the most widely prescribed proprietary preparation containing the drug—namely, Distalgesic—is based primarily on its shape, size, and coating, which render it easy to swallow and tasteless. Many other analgesics, such as the once popular compound codeine tablets, are large, bitter, and granular when crushed and taken with water—that is, bulky, offensive, and troublesome in comparison with the small, smooth, rounded, oblong tablet with a non-powdery surface, easily slipped into the pocket or handbag as well as the mouth.

On two occasions I have been presented with two compound codeine tablets with the remark: "These have passed right through my body without disintegrating." This of course is due to overcompression in the manufacturing process by small, inexperienced firms and is probably rare. Such observations, however, highlight possibilities which do not occur to the average medical mind.

Patient acceptability in itself will often enhance the effectiveness of any drug or preparation and thus increase patient demand for it, especially when price does not concern them. It would be interesting to issue Distalgesic tablets without dextropropoxyphene.

T H H GREEN

Wallasey

Alcohol-induced Cushingoid syndrome: a false diagnosis

SIR,—Following the reports by Dr A G Smals and others (27 November, p 1298) and Dr A Paton (18 December, p 1504) a similar case presented to this hospital recently. Biochemical evidence of Cushing's syndrome was observed in a plethoric, obese alcoholic who in addition was mildly hypertensive and had glucose intolerance. The tests were carried out, however, while the patient was receiving spironolactone and this led to a false diagnosis. Several weeks later the tests were repeated with the patient no longer receiving spironolactone and were within the normal range.

A 57-year-old man with a long history of alcohol abuse presented with atrial fibrillation and congestive cardiac failure. In addition he was noted to be plethoric and moon-faced, with mild hypertension and glucose intolerance. He had evidence of mild hepatic dysfunction (raised prothrombin time and plasma bilirubin and gamma-glutamyl transpeptidase levels) although a liver biopsy was reported as being within normal limits. His congestive cardiac failure was treated with frusemide

40 mg, digoxin 0.2 mg, and spironolactone 50–100 mg daily. Two weeks after admission the plasma cortisol concentration at 8 am after an oral dose of 1 mg of dexamethasone given at midnight was $1.03 \mu\text{mol/l}$ ($37.3 \mu\text{g/100 ml}$) (normal level after dexamethasone suppression $<0.10 \mu\text{mol/l}$ ($<3.6 \mu\text{g/100 ml}$)). With the improvement of his heart failure spironolactone was discontinued and he was discharged. Four weeks later after a midnight dose of 1 mg of dexamethasone his plasma cortisol level at 8 am was $0.09 \mu\text{mol/l}$ ($3.3 \mu\text{g/100 ml}$).

The fluorescence emission spectrum of spironolactone is identical with that of cortisol and this explains the abnormal results obtained while the patient was taking the drug.¹ In addition, all the previously reported cases of alcohol-induced Cushingoid syndrome improved after a short period of abstinence from alcohol, whereas in the above case the (false) diagnosis was made two weeks after admission to hospital. This case illustrates how important it is to check that concurrent therapy does not interfere with planned investigation. If this had been done in the above case time, money, and effort would have been saved.

JOHN M MAHOOD

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¹ Lunde, A O, *Journal of the American Medical Association*, 1970, **211**, 1851.

Metabolic effects of liquorice

SIR,—Dr M T Epstein and his colleagues speculate that small quantities of liquorice might cause hypokalaemia in certain susceptible subjects (19 February, p 488). They demonstrate the effects of liquorice ingestion in normal subjects and they warn against its use in patients at special risk—that is, those with hypertension and other circulatory disorders. They also state that a serious metabolic crisis is a possibility in some people.

I have previously described a patient who was admitted to this unit moribund, severely dehydrated, and areflexic, with flaccid paralysis.¹ Her plasma electrolytes at this time were: sodium 148 mmol (mEq)/l , potassium 1.2 mmol (mEq)/l , and bicarbonate 23 mmol (mEq)/l , and her blood urea concentration was 12 mmol/l (72 mg/100 ml). She had previously been given spironolactone and potassium supplements. Despite the very low plasma potassium concentration, she was not conserving urinary potassium. This woman also showed myoglobinuria, which has been previously reported in patients with severe hypokalaemia due to treatment with carbenoxolone.²

It was found that before admission she had been taking liquorice in the form of a mixture containing liquid extract of liquorice BP, liquid paraffin, and cascara in a dose of 5 ml three times weekly. This had not induced diarrhoea. She made a complete recovery following potassium repletion. She has subsequently been readmitted to the unit for detailed studies of the renin/angiotensin/aldosterone axis under controlled conditions. Measurements were made of the above substances and of plasma electrolytes before and after administration of a similar preparation of liquorice when on a fixed normal intake of sodium and potassium throughout. During the 10 days that she was given liquorice her plasma potassium level fell from 4.1 to 2.7 mmol (mEq)/l , while total body sodium

rose and total body potassium fell. Full details of this study will be reported at a later date. The findings clearly indicated that this woman was abnormally sensitive to liquorice.

Dr Epstein and his colleagues also found marked oedema in some of their subjects. This was not a feature in the case reported by me, either when she was acutely ill or during the later controlled study.

I am grateful to Dr K Boddy for the estimations of total body sodium and potassium.

ALISON M M CUMMING

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¹ Cumming, A M M, *Nursing Times*, 1976, **72**, 367.

² Mohamed, S D, Chapman, R S, and Crooks, J, *British Medical Journal*, 1966, **1**, 1581.

Suppressing lactation

SIR,—As a red-haired mother of one, who has had at least six months' experience of obstetrics, I can only agree with Drs D B Jelliffe and E F Patrice Jelliffe (12 March, p 714) that in your leading article (22 January, p 189) you were talking of an unrepresentative group of patients (mothers).

In my recent pregnancy I attended antenatal classes in which the participants were from mixed social backgrounds. Of a dozen or so, only one mother expressed a firm wish to bottle-feed; all others opted to breast-feed. Attitudes varied from extreme keenness to breast-feed to a willingness to give it a fair trial. No pressure was brought to bear on us by the instructors, although the advantages of each were outlined. It was emphasised that one should not feel a failure if breast-feeding was unsuccessful. Those mothers with whom I have since made contact are still breast-feeding.

I also had a chance to talk to the midwives while in hospital. They have noticed a tremendous upsurge in the popularity of breast-feeding, over recent months especially. One even suggested that economic factors are becoming increasingly important, as inflation affects the price of artificial milks as everything else.

I can only suggest that the opening paragraph of your article was written about five years ago, when I was doing obstetrics and bottle-feeding was more popular.

PATRICIA M SANTER

Nantwich, Cheshire

Alcohol and the motorist

SIR,—Your leading article on alcohol and road accidents (12 March, p 665) is timely and informative, yet your conclusions and suggestions incorrect.

The facts are well known and need no further investigation. Alcohol reduces the mental and physical ability of every motorist and there can be no safe level. Surely it is time the medical profession came out clearly and unequivocally in favour of the Blennerhassett Committee's advice "Don't drink and drive" and supported politicians to bring in the only logical law—no level of alcohol in the motorist.

This, if enforced, would solve most of the problems in connection with alcohol and

driving, though there would always be some offenders.

L W LAUSTE

Brighton

Private beds in NHS hospitals

SIR,—I would be grateful for the opportunity to alert all consultants who use private beds in the National Health Service to an important exercise which is being carried out by the Health Services Board.

The schedule to the Health Services Act identified the first 1000 private beds which are to be closed. It then became the responsibility of the Health Services Board to make regular reviews of the remaining beds and to make recommendations to the Secretary of State after due consultation with interested parties. In making their reviews the board must have regard to certain important criteria, including the demands for accommodation and facilities in the area in question and the availability of reasonable alternatives.

In the current review it seems possible that the board may rely on occupancy figures alone. In our view such an exercise would not be proper and representations have already been made centrally to the board on this point. The board has, however, also written to area and regional authorities asking them for their comments on the current exercise and has made specific proposals for a further reduction in the number of private beds. No doubt many authorities will respond to the request for comments, but in our view it is essential that the consultants themselves in every district (through either the medical advisory committee or the district medical committee) should approach the board direct so as to ensure that the local position is fully understood.

There are many factors which the board will need to know, including the reasons for any apparently low level of occupancy—for example, the temporary use of beds for NHS patients, staffing problems, local industrial action, etc. They will also need a full report on any recent changes in staffing and the demand for facilities for day patients, together with an assessment of the availability—or otherwise—of reasonable alternative accommodation and facilities outside the NHS.

In our view the board can carry out its remit in a proper fashion only if adequate information is made available to it. The BMA and the Central Committee for Hospital Medical Services will take action centrally, but it is absolutely essential that consultants at the periphery should play their part in protecting the remaining private facilities. I would therefore strongly advise consultants in every district to examine the proposals which authorities have received from the board and to make representations direct to the Secretary, Health Services Board, 157-168 Blackfriars Road, London SE1 8EU, by 19 May. If there are any especially complex local problems it may be advisable to ask leave to give oral evidence to the board to assist them in their deliberations.

If further advice or help is needed please contact Mr R Woods, Secretary of the CCHMS, at BMA House, Tavistock Square, London WC1H 9JP.

A H GRABHAM

Chairman,
Central Committee for Hospital
Medical Services

BMA House,
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Whole-time consultants and the contract

SIR,—The Swindon Whole-time Consultants Group is in agreement with many of the suggestions of the Central Committee for Hospital Medical Services and the Hospital Consultants and Specialists Association for improving the consultant contract. There are, however, certain points with which we disagree and which seem to us important, and from our contacts with similar groups in other districts we believe that our views are shared by many whole-time consultants.

In the whole of the NHS the whole-time consultants make up about 40% of the total consultant body (see table). They are the

*Numbers of consultants employed in the NHS, 1975
(personal communication from the DHSS)*

Whole-timers	4707
Maximum part-timers	2538
Other consultants who do less than a maximum part-time contract	3107
University and honorary contract holders	1133
Total	11 485

largest single group. They hold this type of appointment for a variety of reasons: some because it is their own choice, some because the limited amount of private practice in their area is already in the hands of others in their own specialty, some because the type of work which they do does not lend itself to private practice, and some because the area in which they work is not one in which private practice is viable. Only a small proportion have been appointed to whole-time posts because of regional health authority policy and since 1955 it has been normal for candidates for consultant posts to be allowed to choose either a whole-time or a maximum part-time contract. We believe that unless the NHS is allowed to fail in its purpose there will always be this large proportion of consultants working whole time in the service and that to offer them a 10-session contract on the understanding that in their spare time they can engage in private work is meaningless.

In 1955, when the option agreement was made by the Joint Consultants Committee and the Ministry of Health, it was also agreed that the same amount of NHS work was expected from the maximum part-time consultant as from one holding a whole-time contract, the difference between their two contracts lying in the payment to the maximum part-time consultant of a salary which is two-elevenths less than the whole-time salary in return for the right to engage in private practice. A differential payment for no additional work has therefore been paid to the whole-time consultant ever since then and for more than 20 years has not been disputed by the consultants' representatives. It must be very obvious to them that the abolition of this differential would be very much to the financial disadvantage of whole-time consultants, and if the employing authority is still prepared to offer a differential payment of this type it would seem to us unwise as well as unjust for the BMA and HCSA, acting as they are in a trade union capacity, to refuse it on quasimoral grounds. We believe that their clearly stated acceptance of this view would do much to remove the disappointment and lack of faith felt by many whole-time consultants in their negotiators.

We suggest that before continuing with their policy of, in effect, converting all consultants into part-timers (which, if we wish,

we could already be by foregoing 2/11ths of our salary) it would not be unreasonable for them to ballot the whole-time consultants to see whether they wish their differential to be done away with. The views of the part-time consultants on the differential really ought to have little bearing since we as whole-timers would not wish to interfere with the way in which the part-timer spends his free time.

It is the declared policy of both the CCHMS and the HCSA that they support the principle of the consultant being able to dispose of his free time in any way that he should see fit. It seems, therefore, inconceivable that they are then unable to accept the possibility that an employer might wish to offer, and an employee accept, a financial inducement to alter, by abstaining from private practice, the way in which he uses his free time. Coincidentally, the whole-time consultant is more flexibly available to the Service.

We would hope that like-minded consultants will contact the undersigned for us to gauge the general feeling and inform our negotiators.

J P DONNELLY
Honorary Secretary,
Swindon Whole-time
Consultants Group

Princess Margaret Hospital,
Swindon, Wilts

Plight of young consultants

SIR,—We write as two young consultants. One of us was appointed consultant paediatrician with a whole-time contract six years ago and the other consultant general surgeon with a maximum part-time contract three years ago. We are only too well aware of the financial difficulties currently facing the young consultant and of the signs of frustration, with the feeling that the BMA has apparently been doing nothing to remedy the situation.

However, as members of the Negotiating Subcommittee of the Central Committee for Hospital Medical Services and as members of the small group of consultants who are currently engaged in detailed discussions with the Department of Health and Social Security on the proposed changes in the consultant contract, we are in a position to endorse fully the facts as stated by the Chairman of Council, Dr Cameron, in his letter of 19 March (p 778). The BMA has done everything within its power to convince the Government of the injustice that young consultants have suffered, particularly in the last two years, when the profession has been subjected to the "rough justice" of the Government-imposed "voluntary" pay policy. The Secretary of State has been left in no doubt about the seriousness of the present crisis.

We are sorry to read that young consultants at 17 hospitals no longer have confidence in the BMA as a negotiating body. They have been clearly unaware of the tremendous attempt and effort that have been spent on their behalf. However, we are glad that they feel sufficiently strongly about their present plight to write to the chairman of the Review Body expressing their frustration. Consultants have been apathetic for too long.

We are both well known as having been highly critical of the BMA on occasions, but none the less we realise that the Association is the only representative organisation that has the resources and experience to help the young consultant and which negotiates directly with the DHSS.