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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

As stated each week in "Instructions to authors" no letter will be acknowledged unless a stamped addressed envelope or an international reply coupon is enclosed.

Subscriptions to medical defence societies

SIR,—Today I received a copy of the Medical Defence Union Annual Report. Enclosed within the report was a notice that the annual subscription is to rise to £70 for doctors and to £30 for dental surgeons on 1 January 1979. This rise of 43% for doctors and 50% for dentists must raise some fundamental questions about the whole problem of protection from litigation.

It would be foolish to practise medicine or dentistry without suitable insurance, and membership of a defence organisation is necessary for all and mandatory for medical staff employed in hospital posts within the NHS. Doctors and dentists are therefore a captive group as far as this type of indemnity is concerned.

In the past eight years defence organisation subscriptions have risen by 1000% for dentists and even more for doctors. While the demon inflation can, and no doubt will, be blamed for some of this rise, it can in no way be incriminated for all of it. So what are the possible causes for this astronomical increase in charges?

(1) An increasingly litigation-conscious public? There has been, it is true, a marked increase in medical education over the past few years, but the population at large still seem to have a blind faith in their doctor. In any case the medical profession seems to close ranks very efficiently (and probably rightly) against any sort of legal intrusion.

(2) More accident-prone practitioners? There has been no suggestion of this.

(3) Incompetent management either of

finance or legal representation by the defence organisations? The very high calibre of medical and legal practitioners involved in the running of and employed by the societies makes this alternative incredible.

(4) The price of litigation? The report of the Royal Commission on Civil Liability and Compensation for Personal Injury,¹ chaired by Lord Pearson, illustrated an interesting difference between medical negligence and other personal injury litigation. For the period covered by their report compensation was paid in only 39% of medical negligence claims and in 86% of other personal injury claims. However, the average payment in those medical cases was eight times that in other personal injury cases. This seems rather unreasonable, since an injury is an injury however caused. In any case wounds, however negligently inflicted by a doctor or a dentist, are not perpetrated with malice aforethought and are presumably incurred while trying to remedy some medical or dental disability. I wonder if it would be unduly cynical to suspect that judges regard medical injuries as "insurance cases" and treat them accordingly by awarding large damages, secure in the knowledge that the doctor or dentist will not suffer personally because of his unlimited indemnity.

While I accept that patients must be adequately compensated for injuries sustained at our hands, it seems wrong that doctors and dentists should be penalised for using their skills. Let us hope that the publication of the report of the Royal Commission may itself result in fairer compensation assessment. Out-

landish settlements cannot be entertained from society funds when the premiums are being paid by such a relatively small group of the population.

I am sure that virtually nobody can criticise the functions of the societies. They provide a valuable support to anyone accused of any form of negligence and are a useful source of advice in a multitude of medical dilemmas. The medical and dental professions will undoubtedly continue to subscribe to the society of their choice and the societies will, with equal certainty, continue to give the professions the service that they require. Nevertheless, medical salaries have not increased tenfold over the past few years and the amount demanded by the defence societies now represents a significant proportion of that income. Have we reached the stage where indemnity for doctors and dentists employed within the Health Service either at a hospital or in general practice should be paid by the employing area health authority? The answer must be yes, not only to bring us in line with most other professions, in which insurance is paid by the employer, but also because we cannot allow our low incomes, obtained by working excessive hours, to be further eroded, not only by the inevitable inflation but also by these hidden charges on our skills.

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¹ Royal Commission on Civil Liability and Compensation for Personal Injury, *Report*. London, HMSO, 1978.

Shortage of cocaine hydrochloride

SIR,—I should like through your columns to draw attention to the worldwide shortage of cocaine. The Department is making every effort to maintain supplies, but the shortage, which is due to changes in manufacturing processes, is likely to last for some time.

The Department understands that in general the shortage is not expected to be troublesome but may cause difficulties in some fields of surgical or medical practice where alternative drugs are less satisfactory.

The decision as to the most appropriate treatment for particular patients rests, of course, with the doctor responsible. I believe, however, that in the circumstances all doctors will wish to do all that they can to preserve the limited stocks of cocaine by using alternative drugs wherever possible.

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Medicine or meetings

SIR,—Professor J Dobbing's excellent letter (16 September, p 827) debunks the cult of holding international medical meetings at other people's expense. He invokes a plague on such gatherings. However, he closes his letter by listing the eight countries he has visited in the last year and the further eight to which he has committed himself. I have reread his letter to see if this is facetious hyperbole, but I am still not sure if this is the case. Professor Dobbing must either be joking or his life contradicts his views and he holds a post that is clearly redundant.

D E B POWELL

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SIR,—I wish to express my complete support for all that has been said concerning medical meetings by Professor J Dobbing (16 September, p 827). The great majority of such meetings, both national and international, are very useful from a social and get-together point of view, but the actual material presented in a great many or even most of the meetings very often leaves much to be desired. I very much doubt if more than 10% of all material presented at a great many symposia would ever be considered for publication in a reputable journal. Small meetings of experts and active negotiators should be encouraged, as meetings hastily convened very often are sterile in the actual end result so far as material on medical advances is concerned; serious thought should be given to whether or not meetings on a large scale are in fact essential. The money spent every year by various bodies on these conventions must be quite staggering.

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SIR,—Professor J Dobbing (16 September, p 827) is a leading authority in a field which attracts much international interest, and evidently he goes to far too many international meetings which he believes are a waste of time and money. He wants to know why they should be organised at all.

I think it is obvious that the point of meetings (instead of printed publications) is that they give one a chance to press the author on points which are glossed over and to find out why he prefers one interpretation of data to another. Of course Professor Dobbing is right about small specialist meetings being the only type at which this is

possible at the highest level among experts, and it would be astonishing if he learnt anything new about his own subject from review lectures given to audiences of hundreds, or even thousands, of non-experts.

Few of us are leading experts in anything and none are expert in everything. It is useful to young researchers, or those who are changing their field of interest, to go to a good meeting at which the field is generally reviewed and the experts can be tackled on specific points. If, in the original communications session, a tyro presents a "puny paper" or "meaningless slides" he is entitled to constructive criticism from experts like Professor Dobbing. I hope the organisers of the eight meetings he went to in the past year and the eight to which he is committed paid his fare out of the registration fees of non-expert delegates and that they got their money's worth out of him. And surely in so many meetings there were *some* non-puny papers, even from people he had never heard of. If he learnt nothing he probably wasn't listening.

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Children who cannot read

SIR,—Your leading article on this subject (1 July, p 3) seems to have generated considerable correspondence. I would not have thought that the concept of developmental dyslexia was medically unacceptable. However, as the BMA Council (22 April, p 1077) states, "there is likely to be a consensus among doctors that a group of children exists who are disabled by severe reading difficulties (and often problems of writing and spelling) which are sufficient to impair their ability to benefit from ordinary schooling, and to impose limitations on their educational achievement and enjoyment of life. . . . In common with other handicapping conditions in childhood, the needs of the child with reading disability are best served by early identification of the problem, comprehensive interdisciplinary assessment, and remedial management, with reassessment at appropriate intervals."

Identification of the problem should not prove insurmountable,^{1,2} but the question of suitable remedial management is beginning to cause me some concern. It has been brought to my notice recently that there are a number of persons setting themselves up as "dyslexia therapists" with nothing more than a 2-4-day workshop as a training qualification. It is not suggested that these short courses should not be run, because they obviously promote further knowledge and understanding of the problem, but it is felt that the organisers should make it clear to the participants that such courses do not constitute a training qualification. The dyslexia clinic at this hospital has been running a one-year training course in the teaching of children with specific learning difficulties since 1973. It has been our experience, however, that even one year is insufficient for a full understanding of the problems these children are encountering and a further period of 1-2 years' teaching experience is necessary before one can be said to be a specialist teacher in this highly specialised field.

The matter is of some urgency for teacher training establishments, especially since the

publication of the Warnock Report³ on special education which recommends many amendments to teacher training curricula. Since so many of these children have earlier speech and language difficulties it is felt also that the College of Speech Therapists should be considering an addendum to their training programme, especially in the area of prophylaxis.

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¹ de Hirsh, K, Jansky, J J, and Langford, W J, *Predicting Reading Failure*. New York and London, Harper and Row, 1966.

² Hornsby, B, MSc thesis, University of London, 1973.
³ Department of Education and Science, *Special Educational Needs*, Report of the Committee of Enquiry into the Education of Handicapped Children and Young People. London, HMSO, 1978.

Use of digitalis in general practice

SIR,—I feel that the study by the Liverpool Therapeutics Group (2 September, p 673) is a useful and praiseworthy one and surely will help "to promote a more critical attitude to prescribing widely used drugs such as digitalis."

The results of the assessment were necessarily determined by the decisions made to continue digitalis therapy, discontinue it, or adjust the dose. The authors rightly point out that their criteria for discontinuation did not enable them to say how many of the patients could have had the drug withdrawn. The decision to continue digitalis therapy unchanged involved the largest group of patients (231 (59.1%)).

Evaluating the need for continued digoxin treatment is a difficult matter, especially so in patients with sinus rhythm and no signs of overt cardiac failure. The authors quote some studies demonstrating successful discontinuation of digoxin in the majority of patients with sinus rhythm, and I should like to add our own study¹ concerning discontinuation of maintenance digoxin therapy in 22 elderly cardiac inpatients with sinus rhythm and no overt cardiac failure. A comparison was made between clinical and radiological symptoms and signs indicating congestive heart failure before and after discontinuation of digoxin. Of the 22 patients, 16 tolerated discontinuation without detriment. Treatment was resumed in five cases but only three of these five patients presented unequivocal clinical or radiological evidence of deterioration following discontinuation of digoxin. One patient died suddenly of myocardial infarction.

There appears to be some doubt as to whether an initial inotropic action of digitalis is sustained during maintenance treatment. One study² demonstrated that in patients with cardiomyopathy or coronary artery disease and chronic congestive heart failure acute digitalisation does not necessarily lead to marked or lasting haemodynamic improvement. Another study³ concluded that chronic digoxin administration did not appear to cause a significant increase in left ventricular contractility. It was recently demonstrated⁴ that both acute and chronic digitalisation reduce myocardial blood flow and previous work⁵ showed that myocardial oxygen consumption is increased by digitalis unless increased contractility is counterbalanced by a reduction in heart size. In our study¹ mean