some of Dr Craig's group would consider repeating it. If doctors are going to state, and even more important to teach, that patients benefit from long consultations they must be able to show that this is so. If our methods of treatment and management are not based on objective evidence, then general practice will not become a scientific discipline. It will remain an art form in which symptoms and situations are interpreted in different ways by different doctors under the influence of changing fashions.

K B THOMAS

Portsmouth,
Hants

¹ Buchan, I. C. and Richardson, I. M., *Time Study of Consultations in General Practice*. Edinburgh, Scottish Home and Health Department, 1973.

² Thomas, K B, *British Medical Journal*, 1974, **1**, 625.

"Human Milk in the Modern World"

SIR,—We thank Dr J D Baum for his comprehensive review of our book¹ (9 September, p 758) but we would like to clarify a few points.

Firstly, Dr Baum questions our mentioning some conditions, including coronary artery disease, sudden infant death syndrome, etc. We did so because absence of breast-feeding has been reported by some workers (to whose work references were given) as sometimes playing a role in the aetiology of these multifactorial syndromes. In view of present-day interest in the consequences of infant nutrition on subsequent adult health we believe that such links need further exploration. We are sure that Dr Baum would agree.

Perhaps an important point to put over is that our perspective has been conditioned by our own experience—that is, in less developed countries, where very severe conditions bring out universal issues more vividly. For example, the infant's need for the extra iron from the placental transfusion and the relationship between maternal diet and nutrition and low birth weight are beyond doubt. The latter, for example, is a major public health problem² and yet seems to be unappreciated by the medical profession in well-fed Western countries, as judged by Dr Baum's comments. It is because of our prolonged work in traditional cultures and because we have personally observed the ill effects of changes from breast-feeding to bottle-feeding in some of these communities that we are "enthusiastic" and "earnest." Should we be lukewarm and lighthearted? Is marasmus a joke?

The "repetition" cited by Dr Baum in the last part of our book has been included advisedly to indicate the range of international and national organisations concerned and active in this matter. As a follow-up it may be noted that the WHO-inspired movement towards "primary health care," as epitomised by the recent International Conference at Alma Ata,³ is built round community self-reliance, with the nutrition of mother and young children as a major focus. Breast-feeding is plainly a key approach, especially in developing countries—the role of costly imported processed formulas (and other infant foods) in primary health care seems highly debatable, at best.

Dr Baum suggests that we might have been wiser to have attempted a less comprehensive publication. We agree that a wide-ranging review must carry one into areas distant from personal experience and knowledge and hence

be less watertight. We recognise this in our book. Nevertheless, this subject is usually dealt with in a narrow, highly specialised, "monovalent" way—for example, concerned with levels of a specific nutrient or some particular aspect of mother-baby interaction. This is, of course, needed, but even greater is the need to appreciate that breast-feeding is a matter of concern in both industrialised and developing countries because it has such a wide range of often underappreciated consequences.

We learnt nothing about this subject in any part of our formal training in different parts of the world. We hope that our book, with all its imperfections, will focus attention on the significance of breast-feeding and human milk in the modern world and stimulate a greater degree of emphasis in the curricula of medical students, nurses, and nutritionists and in the awareness and practice of obstetricians and paediatricians.

D B JELLIFFE
E F P JELLIFFE

Division of Population, Family,
and International Health,
School of Public Health,
University of California,
Los Angeles

¹ Jelliffe, D B, and Jelliffe, E F P, *Human Milk in the Modern World*. Oxford and New York, Oxford University Press, 1978.

² *Birthweight Distribution: An Indicator of Social Development*, ed G Sterky and L Mellander. SAREC Report No 2. Stockholm, SIDA, 1978.

³ *Lancet*, 1978, **2**, 666.

Progesterone nasal spray contraceptive

SIR,—With regard to Minerva's comment (16 September, p 836) on the WHO trial of a progesterone nasal spray contraceptive and her curiosity as to what is the advantage of this method of administration over "pills," she would appear to have missed the point that the hormone progesterone is inactivated in the liver and for this reason is not effective when administered in the form of tablets to be swallowed.

F P DIGGINS

Pabyrn Laboratories,
Perivale,
Greenford, Middx

Prescribing information for patients

SIR,—I was interested to see the article by Professor Freya Hermann and her colleagues (21 October, p 1132), which I am sure will generate further discussion.

The information leaflet shown in the article may well satisfy a reference function for the more literate patient. However, should a situation paralleling NP labelling be contemplated I feel that a very much simplified and less "in depth" document would better meet the needs of the average patient. This is particularly so if the patient requires advice on more than one drug.

I am currently conducting a controlled pilot study in which drug information leaflets are used as a framework for patient counselling by pharmacists. This particular study involves the discharge drug therapy of dental patients attending for surgery. For a variety of reasons this approach has an appeal for many patients. One aim is the simplicity of the leaflets, which are assessed by the two methods of Flesch and Fog.¹⁻³ Roughly speaking, this encourages the use of short words and short sentences.

I usually impose a maximum of three syllables per word. The leaflets currently on trial are rated as understandable to 86% of the population. (A nursery rhyme would rate about 90%.) Although approximate, it is a valuable guide when transforming a document from technical to lay terms. Some workers have found the use of leaflets alone to be counter-productive; hence our discussion approach. This provides a flexibility denied by documents.

Since this is a field requiring much further study Professor Herman is to be thanked for raising this important topic.

JACQUELINE WILLIAMS

Sefton Area Drug Information Service,
Pharmaceutical Department,
Fazakerley Hospital,
Liverpool

¹ Flesch, R, *Journal of Applied Psychology*, 1948, **32**, 221.

² Ley, P, *Journal of the Institute of Health Education*, 1973, **11**, 17.

³ Gunning, R, *Techniques of Class Writing*, New York, McGraw Hill, 1952.

Quality control

SIR,—The Department of Health and Social Security, the Royal College of Pathologists, the Association of Clinical Pathologists, and the Institute of Medical Laboratory Sciences are all rightly concerned that laboratory work should be precise and accurate and controlled by quality-control procedures. Paradoxically, many clinicians are now demanding pieces of apparatus in the side-rooms of wards whereby staff not trained in laboratory work can, they think, perform a function such as estimating blood sugar with the use of such apparatus by a skin-prick technique.

We feel that there is a case to be made against such demands, especially in hospitals where there are laboratories where the staff accept the responsibility for accurate work not only in the daytime but out of hours also.

C A K BIRD
C B BROWNHILL

Macclesfield Hospital,
Macclesfield, Cheshire

Naming of drugs

SIR,—I must take issue over Dr S A MacGregor's letter (18 November, p 1433) and its editorial footnote concerning the vexed question of names of drugs.

Confusion is by no means confined to proprietary names: BPC approved names are liable to be mistaken one for another, especially if handwriting is indistinct. Examples are numerous: bethanecol and bethanidine, chlorpheniramine and chlorphenetermine, chlorpromazine and chlorpropamide are a few. Approved names tend to be difficult to remember and clumsy to pronounce in comparison with the often euphonious character of their proprietary counterparts.

The idea that prescribing by proprietary name guarantees a product of high quality is supported by recent revelations about bio-availability, and doctors have not yet forgotten the occasion some years back when supplies of tetracycline, bought cheaply by the Government from abroad, turned out to be seriously under strength.

Patients find it much easier to remember the average proprietary name than the average

approved name of their medication, and what busy general practitioner is going to write "dextropropoxyphene hydrochlor 32.5 mg, paracetamol 325 mg tablets" when what he means is Distalgescic?

WILLIAM E BENNEY

Cheltenham, Glos

Controversies in WHO tumour classification

SIR,—The World Health Organisation and those concerned with the production of the 18 "blue books" on the classification of tumours in different sites have done a great service. There has been a reduction of multiplicity of names and presumably improved communication.

However, histological examination and reporting are interpretative and subject to observer variation and do not have the degree of specificity implied by Professor L. Kreyberg and Dr W F Whimster (28 October, p 1203). Two cancers could differ only in their histological appearance and two other cancers with the same microscopic appearance may be very different. To place too much emphasis on histological typing is detrimental to the development of non-histological tests, which may be clinically useful and also have specificity.

"When I use a word," Humpty Dumpty said . . . 'it means just what I choose it to mean—neither more nor less.'" To define precisely in histological terms is not to define precisely, and the words often mean just what the histologist chooses them to mean.

J M GRAINGER

Department of Pathology,
National Women's Hospital,
Auckland, New Zealand

¹ Carroll, L., *Through the Looking Glass*. London, Dent, 1871.

Serious verapamil poisoning

SIR,—With reference to Dr C M Perkins's article on this subject (21 October, p 1127) we would like to comment on some of his statements. The author suggests that his is the first description of pure verapamil intoxication since in the two previous reports that he cites the poisoning was caused by Isoptin S dragees (verapamil 40 mg and pentobarbitone 20 mg). He describes a 19-year-old woman with a history of ventricular extrasystoles and a prolapsing mitral valve who suffered adverse effects from self-poisoning with 3.2 g of verapamil. She was successfully resuscitated by the intravenous administration of calcium gluconate.

In the *European Journal of Cardiology* last year¹ we described a case of attempted suicide in a 28-year-old woman who was admitted to hospital after she had taken 5.6 g of verapamil in the form of 70 80-mg tablets of Isoptin (verapamil without pentobarbitone). On admission she exhibited bradycardia and pronounced hypotension. An electrocardiogram showed atrioventricular dissociation which persisted for 7½ h after admission. She was discharged 36 h later. In our patient the pronounced negative inotropic effects appeared early but were short-lived. The transient hypotension responded well to an intravenous infusion of sodium chloride. The administration of β -adrenergic amines was not considered necessary in our case.

In our report we suggested that oral verapamil is relatively non-toxic but that this

is possibly only the case in patients with a normal heart and circulatory system. A more serious course may be expected in cases of concomitant β -adrenergic blocking therapy or digitalis therapy. The report by Dr Perkins confirms our suggestion and stresses the importance of an increased awareness of the adverse effects of these drugs and their treatment, especially in patients with a disturbed circulatory system.

ULF DE FAIRE
TORBJÖRN LUNDMAN

Department of Medicine,
Serafimerlasarettet,
Stockholm, Sweden

¹ de Faire, U, and Lundman, T, *European Journal of Cardiology*, 1977, 6, 195.

Royal College of Surgeons of Edinburgh: reform of fellowship examinations

SIR,—Without wishing to add to any misunderstanding about any proposals made by the Council of the Royal College of Surgeons of Edinburgh, there should be some form of reply to Professor Andrew Wilkinson's letter (4 November, p 1301).

The resolution was passed by a "large majority" of fellows present, but the voting body consisted only of 55 for and 19 against. For such an important decision to be made a "large majority" should be more representative of the college. Surely the large number of Edinburgh fellows throughout the world should have been consulted by some form of postal vote, if not some forward notice requesting comment. Although the council last year did consult widely about the possibility of a substitution of a new Part II, there has been no attempt this time to gather in opinion for or against the new additional examination, Part III. Certainly, as a fellow of one of the larger UK specialist associations and an ex-officio member of its executive committee, I know that we have not held any discussions about this.

The declared advantage of this new fellowship examination of not disturbing the present diploma examinations is true, but is this reason enough to add another patch to John Knox's breeches? The introduction of the new specialist diploma in order to secure reciprocity with other colleges and bodies in this and other countries is also not fully explained. What really are the advantages or otherwise of reciprocity? It certainly will not increase, in orthopaedics at any rate, the flow of postgraduates who still come here for advanced surgical and research experience from most of the English-speaking world, many of whom have already taken their specialist qualification in their own country. A few of these still take one of the college examinations—as they stand at present—as an additional challenge to achieve some extra standing. If on the other hand the passing of the new third FRCS examination implies greater opportunities of specialist appointments abroad this also has to be questioned. In North America recruitment from non-Americans into orthopaedic posts is rare and very much related to academic achievement and not surgical qualifications. In Australasia they too have frozen their training programmes because of overproduction. As regards the EEC, the various specialist associations and the Higher Surgical Training Committee are already negotiating recognition based on our

present specialist training and assessment programmes. Being optional surely does not give it much authority in the world. One cannot really see who is going to gain from a third examination. Certainly it is not reciprocity in any way when our young surgeons will have to interrupt their surgical training for three major examinations rather than using their enthusiasm, skills, and learning to contribute to their surgical discipline by research and writing.

I would suggest that we should be considering critically how to maintain our recruitment into surgical specialties at present-day standards as well as providing greater opportunity for the young surgeon to be creative in his ideas, rather than adding further examinations.

ROBERT B DUTHIE

Nuffield Department of Orthopaedic
Surgery,
University of Oxford

SIR,—I was interested to read Professor Andrew Wilkinson's justification for introducing a higher examination in the surgical specialties (4 November, p 1301) and I wonder whether other senior registrars will share my revulsion at the prospect of yet another hurdle to jump during training. We already have two highly selective barriers in the form of the primary FRCS, with a pass rate of about 20%, and "final" fellowship with a similar pass rate. The training programmes administered by the Joint Committee for Higher Surgical Training ensure that future surgeons will have adequate clinical experience, and finally appointment committees are free not to appoint candidates to consultant posts who fall short of the desired standards. Are further selection procedures really necessary?

Some indication of the price of yet a further examination can be gauged from a consideration of the present final fellowship examination in one specialty, ophthalmology. Some 250 candidates a year currently sit this examination at one or other of the four centres. On average each candidate probably misses eight clinics during the course of the examination, involving the cancellation of perhaps 20 (a conservative estimate) appointments per clinic. Thus a total of 40 000 appointments are cancelled annually in ophthalmology alone for the sake of the final fellowship. Vast amounts of operating time are also lost and the cost to the area health authorities who reimburse candidates' expenses is likely to be around £50 000 a year. An even greater loss of clinical time is incurred while these candidates take study leave to prepare for the examination.

Any move which serves to raise standards, of course, deserves serious consideration, but the existing strict criteria seem perfectly adequate and I suspect that the overall benefit to the community from these proposals will be nil. Motivation and a willingness to keep abreast of recent developments and techniques are at least as important qualities in a surgeon as the ability to pass examinations and diplomas, however "voluntary." I confess to a sneaking feeling that the interests of our patients might be better served by fostering these qualities and perhaps even adopting some means of monitoring them throughout a surgeon's later career.

ROBIN BOSANQUET

Manchester Royal Eye Hospital,
Manchester