tricyclic and, if that should fail, of an MAO inhibitor. I have been impressed with the good response of about half of these very severely affected patients to such therapy.

Elithorn¹ stated that migraine is "undeniably a hunting-ground for the drug-happy physician." This, of course, is true, but such a statement should not deter efforts to find an effective treatment for this distressing and persistent disorder.

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¹ Elithorn, A, *British Medical Journal*, 1969, **4**, 411.

² Gomersall, J D, and Stuart, A, *Journal of Neurology, Neurosurgery, and Psychiatry*, 1973, **36**, 684.

³ Couch, J R, Ziegler, D K, and Hassanein, R, *Neurology*, 1976, **26**, 121.

⁴ Anthony, M, and Lance, J W, *Archives of Neurology*, 1969, **21**, 263.

⁵ *Lancet*, 1974, **2**, 703.

Sex and prognosis in adult acute lymphoblastic leukaemia

SIR,—A relationship of sex to prognosis in acute lymphoblastic leukaemia (ALL) was shown in the last report to the Medical Research Council by the Working Party on Leukaemia in Childhood, the girls faring significantly better than the boys (16 September, p 787). This report suggested that testicular relapse accounted only partly for the observed difference. The same relationship had been observed by Baumer and Mott¹ but was lately denied by Evans *et al.*²

All these studies were concerned with childhood ALL. We would like to add information on the relationship of sex to prognosis in adult ALL based on 137 cases (32 patients treated in our division from 1972 to 1977 and 105 patients reported in detail by others³⁻⁵). The distribution of these patients according to age and peripheral blood blast cell count was similar for both sexes. All patients had been treated for remission induction with vincristine and prednisone and

many of them had also received 2-4 doses of daunorubicin or doxorubicin. Most of the patients who had achieved complete remission had received cranial irradiation and intrathecal methotrexate and maintenance chemotherapy with daily 6-mercaptopurine and weekly methotrexate. The complete remission rate was almost identical for males (69/89 or 77.5%) and females (38/48 or 79.1%). Survival and duration of complete remission were also very similar for the two sexes (see figure). No testicular relapse was recorded in the 89 males during the observation period. These data suggest that at present sex has no prognostic value in adult ALL.

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¹ Baumer, J H, and Mott, M G, *Lancet*, 1978, **2**, 128.

² Evans, D I K, *et al*, *Lancet*, 1978, **2**, 522.

³ Willemze, R, *et al*, *Blood*, 1975, **46**, 823.

⁴ Scavino, H F, *et al*, *Cancer*, 1976, **38**, 672.

⁵ Lister, T A, *et al*, *British Medical Journal*, 1978, **1**, 199.

Minimum information needed by prescribers

SIR,—Mr P W Golightly and Dr D C Banks (11 November, p 1366) make a rather doubtful claim when they state that "the number of drugs in routine use is constantly increasing." Although this was probably true a few years ago, the number of medicines in this country now seems to be falling. For example, *MIMS* lists approximately 1000 commonly used prescription drugs. Last year (1977) they recorded only 43 additions to their list, while at the same time they recorded that 97 of their listed drugs had been discontinued.

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SIR,—The article by Dr A Herxheimer and Professor N D W Lionel (21 October, p 1129) elucidates a problem faced by all health practitioners dealing with drugs. The authors' examination of the present void of adequate sources of drug information should be lauded, but their proposal for a manual of minimum information inadequately fills that void.

If, as the authors point out, the manufacturer's current data sheets (package inserts in the United States) are inadequate in disseminating important clinically relevant material, then the concept of providing practitioners with minimum drug information to supplement the information from the manufacturer perpetuates the problem. For example, in the authors' draft of minimum information on tetracycline why are peak plasma concentrations, minimum inhibitory concentrations, half life, protein binding, and metabolism excluded from the section on pharmacology? Similarly, why is erythromycin not mentioned as a first choice of therapy along with tetracycline for mycoplasma? Other areas could be cited, but the emphasis should be to encourage necessary additions which are important when imparting clinically relevant drug information. But even the lack of data in the draft is not as serious as the omission of

the references used in compilation of the data. Possibly owing to space considerations in the journal the authors found it necessary to delete them and I hope this was the case.

Providing clinically relevant drug information to practitioners prescribing and/or administering medication is a necessity governed by the inadequate data published by pharmaceutical manufacturers. Providing minimum information with lack of suitable references as a substitute for or companion to data sheets (package inserts) is perpetuating the problem.

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Opportunity in health visiting

SIR,—It was with some pleasure that I read the proposed Nursing Bill currently passing through Parliament. There is tremendous need to review the training requirements of those working in the health professions. General practice is half way through that review and nurses have only just started.

May I use your columns to question the assumption that the right basic training for a health visitor is a nurse training course to SRN level? Historically, health visitors started separately and only relatively recently became part of the nursing profession. The present situation often encourages a nurse who, after gaining her SRN, has realised that she has made a wrong career choice to change direction and to train to become a health visitor. This surely must be the wrong reason for entering the profession of health visiting. Perhaps poorly motivated health visitors are in large part to blame for the frequent disparaging remarks made by general practitioners and district nurses about health visiting.

I would like to see health visiting as a separate profession with its own defined area of responsibility. I do not doubt that there may be a need for a basic health/nursing training as a component of a health visitor's course, but there should be the opportunity for young people at school to elect to enter either profession, health visiting or nursing. Thus we might see the emergence of a strong professional body of health visitors, willing and able to work in primary care, to provide a lead in tackling the modern epidemics of accidents, alcoholism, coronary heart disease, lack of exercise, smoking, and over-eating. I for one would welcome the opportunity to work with such colleagues.

MICHAEL HALL

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General practice records

SIR,—I would like to congratulate Dr Christopher Maycock (25 November, p 1510) and his partner on their system of record-keeping, but having looked at many general practice records throughout the country I would like to point out that they are enthusiasts and not therefore representative of most GPs. I disagree with Dr Maycock's reasons for preferring the existing medical record envelope (MRE) format to the A4 records. I note, however, that after stating his reasons he adds the rider that the structuring of the MRE records will make any future con-

Life-table analysis of survival and remission by sex in 137 adult patients with ALL.

version to A4 folders or computer records easier.

I am in a three-man practice in which we use A4 folders in a health centre and MREs in our other premises. I have therefore been able to compare the two types of record over a five-year period while using a similarly structured form to that of Dr Maycock. My partners and I are so convinced of the value of the A4s that we are willing to pay the increased cost of extra shelving and convert our MREs to A4s. The other 30 GPs in the health centre have stated that they also greatly prefer the A4 though their records are unstructured.

The complicated case with multiple problems is the one in which a structured record is of most benefit and it is these cases that have multiple insert sheets and letters. With MREs unfolding the letters and unshuffling the various insert sheets is more time-consuming than flicking over the pages of an A4. Also, no matter how careful one is using MREs, insert cards get lost or misfiled. Dr Maycock states that brevity is an advantage of the MRE format. I compared our practice entries in both types of record and found no difference in the length of notes, but the entries in the A4 were more legible. This was probably because writing does not need to be so cramped. Portability is also no problem. In fact, because of their size A4s are less likely to be lost in the car or a patient's home.

Like Dr Maycock my experience is that the first priority is some form of structured record, but given a choice between the A4 and MRE the former is vastly superior for helping the management of patients' problems in general practice.

NEIL M MACLEAN

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Wales under the Act

SIR,—The Welsh Council of the BMA recently considered the Wales Act 1978, which, as you will know, remains inoperative until such time as the referendum takes place. This will be on 1 March 1979 and for the Act to become enforceable 40% or more of the people of Wales will have to give approval.

The Welsh Council has taken a lead on the issue of devolved forms of government, having given evidence to the Royal Commission on the Constitution of the United Kingdom early this decade. One aim we had was to ensure that we maintained a United Kingdom profession, and this aim has been achieved. Another was to ensure free movement of doctors within the United Kingdom, not only by the aim expressed above but also by ensuring uniform standards of remuneration and conditions of employment within the NHS.

While the Act confers no powers to modify within the field of remuneration, the same cannot be said of conditions. It may be that the phrase "remuneration and allied matters" used by ministers secures those conditions which have a direct bearing upon remuneration. What does remain extremely uncertain is the power to vary conditions of service, which can be construed as "day-to-day" matters of management. This shows itself particularly when one considers three important statutory instruments. These relate to advisory appointment procedures for consultants, the general medical service regulations, and the regulations governing medical service committee procedures.

One has to accept that certain reserve powers are proposed as being held by the Secretary of State. What concerns the Welsh Council is that these powers are the weakest which can be devised. Thus I, under the instructions of the Welsh Council, wish to record that while the Welsh Council has taken no stand on the principle of devolution, it considers that the Wales Act 1978 contains the seeds of many and diffuse problems for doctors in Wales. The Council wished to find more effective safeguards to the standards of medical services and failed to observe them in this Act.

G MURRAY JONES
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Welsh Council, BMA

BMA Welsh Office,
Cardiff

Private practice and the reduction of pay-beds

SIR,—In reply to Mr D E Bolt, chairman of the Subcommittee on Independent Practice (18 November, p 1438), we would emphasise the following points which we hope will vitalise and extend the subcommittee's activities.

It has been accepted politically that where public demand for private facilities cannot be met they should be provided in NHS hospitals. It must be accepted and emphasised that such demands may vary with movements of people, changes in economy, cost of beds and facilities, different times of the year, etc. Irrevocability of decisions where they are spuriously based must be changed: we are unable to accept illogical procedures.

Again, now that three years have elapsed it is obligatory that some effort be made to assess the result of the exercise. If all the procedure has done is to result in separating the two systems, with the attendant costly duplication of services, it is mandatory for those in power to reconsider the decision and cancel it before further harmful effects result.

What compensation is offered to those consultants who, as a result of these enforced closures, have suffered a major loss of income? The unions representing the car workers obtain extra wages for those they represent despite government ruling; some consultants have taken irreparable losses and nothing is done.

We, the part-timers, are of the opinion that small modification of a totally illogical concept is inadequate.

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Remuneration of NHS occupational health physicians

SIR,—With reference to the letter from Dr James Gregory (18 November, p 1437) it will be remembered that when the Government accepted in principle the setting up of an occupational health service for the NHS it was made quite clear that there would be no extra money available to do this.

These financial constraints are causing considerable difficulty in negotiations with the Department of Health and Social Security. Meanwhile ad hoc appointments are being

made which cause us serious concern. Until negotiations with the DHSS can be successfully concluded occupational medical officers employed by the local authorities are being advised to negotiate their salaries in accordance with addendum No 3 to "The Doctor in Industry." Employing authorities in the NHS are being told by the DHSS that they may appoint such officers on the senior clinical medical officer scale, if appropriate, and that the Department will look favourably on variation orders which would place them at a point of the scale which would reach almost to that of a consultant in the NHS.

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Payment of allowances and back pay

SIR,—The medical profession has rather harshly been regarded as "semiliterate and innumerate." This view is evidently shared by the finance departments of the Department of Health and Social Security.

There must be many doctors (and others) who go without the extra allowances to which they are entitled under agreements made with the profession's negotiators because the onus is on the doctor to claim these allowances and he is often given little or no guidance from his employers. Similarly with back pay following recent pay awards, if the doctor has moved from his hospital arrears are paid only on application, even though he has already earned his money.

We are familiar with this method of saving by "survival of the fittest" in other spheres of Government activity, exemplified by the social security and rate rebate systems. Is it not time that this method of saving was discredited, at least within the NHS, and the employing authority made responsible for informing its employees of their full entitlements? Such would be the only course for any "good" employer and any other would be poorly tolerated outside a "nationalised industry" staffed by workers reluctant to strike.

J N THOMPSON

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The Safety Net and preregistration posts

SIR,—Dr G A Mogey's article "The Safety Net and preregistration posts" (21 October, p 1136) has prompted us to write to you.

We are representatives of the medical students at Nottingham University Medical School who will graduate in 1980. In that year, for the first time, the number of preregistration posts in the Trent Region will be less than the anticipated number of graduates from the region's three medical schools. This is mainly due to a doubling of the previous number of Nottingham graduates (from 48 to 96) accompanied by the graduation of the first cohort of Leicester students (48). It follows that competition for the region's preregistration posts will be more severe than in the past.

We are interested in the method of allocation of preregistration posts in the Nottingham area. The mathematics of the situation dictate that if in 1980-1 every Nottingham area post