that compression of the oesophagus by the rigid aorta was the cause of her symptoms.

A man of 68 had noticed for a month that after the first few mouthfuls of each meal he had a vague epigastric sensation and then vomited the food without any acid taste. The remainder of the meal could then be swallowed normally. He had not had any difficulty in swallowing liquids. The "ultrasound swallow" gave a long, steady, squirting noise, easily imaginable as a narrow stream under pressure. He is well three months after resection of an oesophageal carcinoma.

A group of patients with symptoms such as sticking of food, retrosternal pain on swallowing, or acid regurgitation have been examined. Many showed swallowing patterns which were irregular in the number, timing, and volume of the pulses and in these patients the symptoms cleared spontaneously, which suggests that the upset was functional. These patients, who are usually rather anxious, have been reassured to hear the evidence that the water reaches the abdomen. This technique may provide reliable positive evidence of oesophageal incoordination and save some patients the ordeal of a barium swallow.

DOMINIC STEVENS

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Naming of drugs

SIR,—I refer to the letter from Dr G A MacGregor (18 November, p 1433) in which he points out that the same preparations (drugs) may be marketed under different names. You comment that his letter favoured the use of BPC approved names.

I have recently examined several aspects of the question of availability of drugs in third world countries. Another phenomenon of the naming of drugs has come to light. The same proprietary preparations made by the same manufacturers may have significantly different compositions depending on whether they are marketed in Britain or in Africa. Sonalgin in Britain contains paracetamol; in Africa this is replaced by phenacetin. Again, the paracetamol in Veganin in Britain is replaced by phenacetin in Africa. Saridone in the United Kingdom contains propyphenazone, but in Africa this is replaced by isopropylantipyrine. Are these compounds the same or different? The busy prescriber will have to find out for himself.

J M KOFI EKUE

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Frusemide and renal enzyme excretion

SIR,—It was with interest that we read the recent letter from Drs S M Harding and A J Munro (18 November, p 1431) reporting the effect of frusemide on urinary *N*-acetyl- β -glucosaminidase (NAG) excretion. This has not been our experience in similar unpublished work in mice or man.

We have given 80 mg of frusemide at zero

time (9 am) to six healthy male volunteers aged 22-31. The subsequent mean urinary volumes and NHG content are shown in the table. Our results do not show any significant difference ($P < 0.1$) in outflow of urinary NAG in response to oral frusemide. We feel it is therefore unlikely that the increased urinary NAG found by Drs Harding and Munro can be explained by the normal tubular action of frusemide.

It is our conclusion that random urinary NAG estimation remains a sensitive indicator of renal tubular cell damage even after consideration of drug therapy.

J PETERSEN

P WHITING

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Nitrites—to ban or not to ban?

SIR,—Many thanks for publishing the article by Miss Barbara J Culliton and Mr Wallace K Waterfall (9 December, p 1613) on the banning of nitrites. The antics of the American Food and Drug Administration are frequently good for a laugh—or would be were it not for the possibility of the formation of a pressure group in this country to follow its example; witness the absurd banning of cyclamates.

There are thousands of angina sufferers the world over who in addition to their regular daily dose of nitrites in vegetables (80%) and smoked meats (20%) could easily consume as much again and more in the form of tablets to relieve their pain. So far as I am aware, although they have been doing this for over 50 years, there has been no suggestion that they are more liable to lymphomas or lymphoreticular changes than anybody else. Will someone with access to a sufficient number of cases please take the trouble to confirm (or refute) this before we get the formation of an NBG (nitrite banning group)?

A LEWIS

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Car doors

SIR,—The illustration (2 December, p 1552) of a cyclist swerving to avoid an opening car door depicts a hazard all too familiar, but please do not put all the blame on the motorist. Through no fault of his own it takes quite a long time for the less agile driver to climb out *after* he has made certain that nothing is about to overtake him. Car body designers appear to ignore ease of entry and exit, while most of the test drivers of motor journals are young and active and seldom mention such mundane matters, though hailing the cutting of 0.1 s from the 0 to 60 mph acceleration time as a major advance.

I personally have driven since the end of the first world war (certainly over half a million miles) and until I had recently to sell an old Mark VI Bentley I and any passengers had no difficulty in getting out of either side of the car.

The floors were flat and unobstructed and no one had to alight in the traffic stream. Two developments now prevent this. Firstly, it became illegal to fit rear-hinged doors to avoid any risk of their being blown open if they were not properly closed and the safety catches were not functioning. This was a good idea but made a rapid exit more difficult for the unathletic, especially in two-door models. The second and more dangerous trend is to divide a car into four rigid compartments by a high transmission tunnel often mated with an instrument console beneath the dashboard. This combination with gear and brake levers makes it virtually impossible for the driver to slide over and emerge from the near side on to the pavement and quite difficult for the off-side rear passenger to do the same. Anyway, why do front-wheel-drive cars have a tunnel at all? If there is no prop shaft a vestigial hump would be all that is necessary to convey rods, wiring, and pipelines.

What would we think of London Transport if buses were introduced which decanted their passengers into passing traffic instead of on to the pavement?

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Children with small stature

SIR,—We applaud Dr R R Gordon's plea (18 November, p 1434) for more height measurements on children, but we find his other remarks somewhat puzzling in the context of this plea.

We know of no evidence that parents of children with Turner's syndrome or growth hormone deficiency are short. However, the correlation between parental heights and those of their children with Turner's syndrome is maintained¹ so that affected children of short parents will certainly become apparent earlier.

In investigating short stature, as Dr Gordon implies, the crucial measurement is that of height velocity. If this is normal over a period of a year further investigations are unnecessary and likely not to be helpful, regardless of the height of the child on a height distance chart. Conversely, children with low growth velocities may well be within the centiles at the time of referral yet have a diagnosable condition requiring investigation and treatment. A single height measurement hardly ever constitutes an indication for investigation.

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¹ Brook, C G D, *et al*, *Archives of Disease in Childhood*, 1974, **49**, 789.

General practice records

SIR,—Your leading article on this subject (9 December, p 1587) is almost defeatist in tone. That good medical records contribute to good standards of care is a widely held belief in all branches of clinical medicine; it is more than an assumption. General practitioners have far too long laboured under the constraints of an out-of-date and outmoded official records system. It is greatly to their credit that an increasing number of GPs are breaking away from these constraints and introducing A4 records at their own expense.

Mean (± 1 SD) urinary volume (ml) and NAG excretion (mIU/h/mg urinary creatine) following 80 mg oral frusemide

Time (h)	Control (2 h)	0-2	2-4	24-26	26-28
Urine volume	114 $\pm$ 52	1377 $\pm$ 308	596 $\pm$ 178	45 $\pm$ 21	38 $\pm$ 41
NAG excretion	71 $\pm$ 12	65 $\pm$ 28	106 $\pm$ 70	58 $\pm$ 28	70 $\pm$ 44

Why should general practitioners be expected to continue to use an archaic system of medical records that is manifestly inefficient? It is time that the Department of Health and Social Security got its priorities right. The cost of implementing an A4 system has been regarded as an insurmountable barrier for too long. Sufficient money to introduce the system several times over has been frittered away on other projects in recent years. If the cost criterion had been universally applied we would still be travelling at sea under sail and no doubt I would be sending you this letter by left stick.

To say, as some have done, that A4 records should not be introduced for general practice because computerised systems are imminent is meaningless. The A4 system encourages better records and is an essential preliminary to any more sophisticated system.

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Nomen proprium—an unusual side effect

SIR,—One of our patients was diagnosed 18 months ago as having chronic lymphatic leukaemia. We did not feel it appropriate to tell her the precise diagnosis but spoke in terms of a chronic anaemia. Recently, as her white cell count was rising, a course of chlorambucil was decided upon. A prescription for "chlorambucil, 2 mg daily NP" was written. Unhappily the pharmacist wrote on the bottle both "chlorambucil" and the brand name "Leukeran." Being an intelligent woman the patient guessed that Leukeran implied a diagnosis of leukaemia. This discovery has had unfortunate results in that the patient feels her doctors have deceived her (though she is too polite to say so) and that since she also has the widely held view that leukaemia is necessarily a disease for which there is no effective treatment she has become nihilistic about her future and unwilling to accept therapy.

Although Leukeran is a particularly unfortunate example, one can conceive of other circumstances in which the writing of a brand name on a medicine bottle may have undesirable consequences. One example is the use of ascorbic acid as a placebo where brand names may be familiar to the patient. We consider that if the "nomen proprium" convention is used the pharmacist should not use any terms other than those in which the drug has been prescribed by the doctor.

J GRIMLEY EVANS

J R ELLIOTT

Newcastle upon Tyne

A national medical service

SIR,—May I seek your readers' reactions to my plea for a national medical service,^{1,2} based on relatively small changes in present National Health Service organisation, to restore a leading role to the medical profession and to emphasise the prime importance of clinical work. The pattern I suggested was a cross between public corporations like the BBC (private medicine being equivalent to ITA) and local government as in district councils.

Specifically I propose that district medical committees (DMCs) cease to be purely

advisory and be given the decision-taking and policy-making role formerly played by hospital management committees. Health district administrators would then be in a relation to DMC members similar to that of district council officers to elected councillors. The level of national insurance contributions could be decided by negotiation with the Government, as with radio and television licence fees, and these contributions could continue to be collected centrally; but money would then be allocated to health districts (roughly per head of population served) to spend in the main as they saw fit, with the annual publication of accounts, somewhat as is provided on the back of rates demands, for public information and comment.

This plan would largely remove medicine from politics³ and bring the needs of patients closer to important decision-taking by those responsible daily for their clinical care. The effect should be to sharpen the thoughts of clinician and administrator, adding greatly to the interest and drive of both.

There are other precedents for putting professional people in charge of their own national services with minimum government control. Legal aid, for example, I am told, is administered by the legal profession, although the total sum of money allocated remains for the Government to decide. So far as the medical profession is concerned there should be no danger of its becoming excessively autocratic, since it is additionally under the control of Government through the General Medical Council by Act of Parliament.

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¹ Crawford, J P, *Lancet*, 1978, **1**, 213.

² Crawford, J P, *Hospital Doctor*, 4 October 1978, p 10.

³ Mackintosh, J P, *British Journal of Hospital Medicine*, 1974, **11**, 166.

Staffing of accident and emergency departments

SIR,—Your resumé of Mr Walpole Lewin's inquiry into the medical staffing of the accident and emergency services (18 November, p 1447) sets some puzzles.

Firstly, appointment of consultants is to be supported "provided that as with other specialties there is a training programme for future consultants." A few paragraphs later: "A grade of registrar on the establishment of an A/E department is not recommended at present." How is training to be achieved if there is no position giving progressive training and responsibility?

Secondly, "the consultant should take his place on the rota for on-call." Many A/E consultants are *always* on call and a single night away from the phone leaves them with feelings of apprehension and guilt. I have been away for five nights in five years. If "the moratorium on medical assistant posts" is confirmed their perpetual on-call will continue.

The suggestion that "principals in general practice may be able to make [a contribution] to an A/E department, with mutual agreement, particularly from those in practices nearby" is as impractical as it is inappropriate. GPs are far too fully committed and their experience is increasingly remote from ours.

In a special box-enclosure the consultant's work is described as "to organise, diagnose, resuscitate, teach, and liaise." No treatment? No follow-up? No research? What sort of men

or women will accept posts in A/E services on such terms? Certainly none who could organise, diagnose, resuscitate, or teach.

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Chaos caused by maternity leave regulations

SIR,—I would support strongly what Dr Anne L Grüneberg (2 December, p 1575) writes about maternity leave for women doctors. It seems to me quite illogical that when 18 weeks' paid leave has been granted 11 of these weeks must be taken before the date of delivery, leaving only 7 weeks to get used to coping with the hard work entailed by a new baby. Even more important is the effect this has on breast-feeding. Obviously, if a woman is unwell in her pregnancy she may have to stop early, but for the normal, fit, young married woman doctor surely she can be allowed the choice of when she finishes work?

A great deal of lip-service has been paid to improving the provisions to enable married women doctors to continue to work, but in fact very little is done to help them. There are very few crèche facilities in hospitals, and paying someone to look after a small child is not allowable against tax. Before one talks about "wastage" in women doctors some thought should be given to the difficulties they face.

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Non-emergencies out of hours

SIR,—I have noted the discussions of the General Medical Services Committee (2 December, p 1584) and also the reports of the press conference held on 5 December to publicise the commercial deputising services. Nowhere have I seen any comments on the demands made by the unthinking and unnecessary requests for out-of-hours visits.

During a recent and relatively quiet weekend on call for this practice of 11 500 patients I received 13 requests for visits before 10.30 on the Saturday or 11.30 on the Sunday; these were attended without question. There were a further 17 requests for visits, of which four could be acknowledged as emergencies. Three of the remainder (two in the middle of the night) were deferred to the following morning, while the rest were seen at various times. All could have been dealt with earlier in the week, earlier in the day, or next day.

I make a point of answering the telephone myself when I am at home and on call. I try to assess the urgency of the problem and give appropriate advice. The requests range from "Send the doctor . . ." (as if I were a sack of potatoes) to the more courteous "Good evening, doctor, I am sorry to disturb you but . . ." Real emergencies are usually announced in terms which leave no doubt of the problem; non-urgent problems are wretched in tissues of half-truths and prevarications.

If I, knowing the practice patients, have difficulty in separating the sheep from the goats how much more difficult is it for a commercial