were found in one family and one more (in a girl of 15) in the other family. The parents did not consider there was anything wrong with the child, but both the girls complained of low backache and vague limb pains for which they had been taking aspirin tablets. Serum calcium and phosphate levels were within the normal range but all had markedly raised serum alkaline phosphatase levels.

Rickets during rapid pubertal growth has also been frequently reported^{1,2} in Asian immigrants, especially in young girls. In addition to the language problems the customary seclusion of young girls in Pakistani families put them at additional risk of missed diagnosis till the appearance of deformities of the legs and pelvis or perhaps even later.

A case, I think, therefore exists for the routine screening of young immigrant girls for rickets before leaving school and also for the screening of other children in the family when a case of rickets is found. There may be a genetic predisposition to rickets.—I am, etc.,

S. A. HAIDER

Department of Paediatrics,
Bury General Hospital,
Bury, Lancs

¹ Ford, J. A., et al., *British Medical Journal*, 1972, **2**, 677.

² Moncrieff, M. W., Lunt, H. R. W., and Arthur, L. J. H., *Archives of Disease in Childhood*, 1973, **48**, 221.

Treatment of C.N.S. Involvement in Systemic Lupus Erythematosus

SIR,—Dr. P. H. Feng and others (29 December 1973, p. 772) reported central nervous system (C.N.S.) involvement to be the main cause of death in patients with systemic lupus erythematosus (S.L.E.). Their observation is in accordance with another recent report by Estes and Christian¹ and in contrast with previous series in which the most common cause of death was renal. Thus it seems that the pattern of death in S.L.E. has changed in the past few years.

Similar observations were reported in patients with acute lymphatic leukaemia (A.L.L.) who developed serious and fatal complications due to C.N.S. leukaemia after complete haematological remission had been achieved with modern methods of chemotherapy. To explain this phenomenon it was suggested that antileukaemic drugs failed to diffuse into the C.N.S. so that residual leukaemic cells in that site continued to replicate while their growth was controlled elsewhere. On the basis of this hypothesis treatment specifically aimed at the C.N.S., such as irradiation and intrathecal administration of methotrexate, was initiated and this treatment has proved to be highly effective in reducing C.N.S. morbidity and mortality.²

As in A.L.L., the treatment given to S.L.E. patients (in which the same drugs, corticosteroids and cytotoxic drugs, are used) does not control C.N.S. involvement as successfully as it does involvement of other systems or organs such as the kidneys, suggesting that residual C.N.S. disease in S.L.E. is probably due to ineffective levels of drugs being achieved in the C.N.S. We therefore believe that therapy directly aimed at the C.N.S., such as the intrathecal administration of immunosuppressive drugs, should be considered in these patients and might be given as preventive treatment even before the appearance of overt neurological manifestations.

Such therapy might reduce the recently observed increased mortality from C.N.S. involvement in S.L.E. patients.—I am, etc.,

YORAM LEVO

Beilinson Hospital,
Petah Tiqva,
Israel

¹ Estes, D., and Christian, C. L., *Medicine*, 1971, **50**, 85.

² Hustu, H. O., et al., *Cancer*, 1973, **32**, 585.

Disruption of the Family

SIR,—I was irritated by Dr. W. J. Reilly's Personal View (17 August, p. 465). He bases his case on a social stereotype in which father dies at 60-odd leaving a selfish, introspective, and complaining old misery of a mother to be looked after by her middle-aged children who will thereby have their "freedom" curtailed. He adds that he hopes that his own sudden death will solve the problem for him.

For 3 years I had charge of the psycho-geriatric unit at Nottingham. I did not find many selfish old people, though of course those few did have the excuse of their age and waning powers. Rejection by selfish middle-aged relatives was a considerable problem and produced a good deal of misery. The reason old people objected to entering the workhouse in the past was, in my opinion, less to do with the fact that the workhouse was not up to the standard of a private hotel than with their unhappiness at losing their family, friends, and possessions. Similarly, the stigma on the family was in part due to the implication that they were not prepared to look after their old relatives and safeguard the family as a social unit. The alternative of rootless people attaching themselves to this or that mass movement is not, I would have thought, one which we would wish to encourage. Sainsbury¹ pointed out the higher suicide rates in areas with a shifting and rootless population.

I think that it is arguable that many of our psychiatric and social troubles stem from disruption of the family and denigration of the elderly. People would find the future much less gloomy if status and affluence increased with age. The riddle of the Sphinx should be reinstated.—I am, etc.,

LINDSAY HURST

Moorhaven Hospital,
Ivybridge,
Devon

¹ Sainsbury, P., *Suicide in London, an Ecological Study*, p. 70. London, Chapman and Hall, 1955.

B-Lymphocytes as Target Cells for E.B. Virus Transformation

SIR,—Though several investigators¹⁻⁴ have recently suggested that B-cells may be the possible target for Epstein-Barr (E.B.) virus transformation, direct evidence has not yet been achieved.

We prepared T- and B-cells from human umbilical cord blood lymphocytes as described by Yata et al.⁵ The separated T- and B-cells were exposed to E.B. virus derived from a B95-8 cell line⁶ and then seeded in semisolid agar medium according to the method of Hinuma and Grace.⁷

About 200 colonies developed in each agar dish when 1×10^5 infected B-cells were seeded. These colonies were composed of lymphoblastoid cells with B-cell markers⁵ and positive for E.B. virus-associated nuclear antigen.⁸ No colonies were seen in T-cell dishes exposed to the virus. Infected B-cells also grew readily in fluid culture, forming clumps but not T-cells. Even early events of E.B. virus transformation,⁹ such as cellular DNA synthesis and mitosis, were not evident in T-cells.

Thus we feel that our findings indicate that B-cells are exclusively responsible for the target for E.B. virus transformation.—We are, etc.,

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T. AYA
T. OSATO

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Cancer Institute,
Hokkaido University School of Medicine,
Sapporo, Japan

¹ Pattengale, P. K., Smith, R. W., and Gerber, P., *Lancet*, 1973, **2**, 93.

² Pattengale, P. K., Smith, R. W., and Gerber, P., *Journal of the National Cancer Institute*, 1974, **52**, 1081.

³ Jondal, M., and Klein, G., *Journal of Experimental Medicine*, 1973, **138**, 1365.

⁴ Moore, G. E., Minowada, J., *New England Journal of Medicine*, 1973, **288**, 106.

⁵ Yata, J., Desgranges, C., Tachibana, T., and de The, G., *Biomedicine Express*, 1973, **19**, 475.

⁶ Miller, G., and Lipman, M., *Proceedings of the National Academy of Sciences of the United States of America*, 1973, **70**, 190.

⁷ Hinuma, Y., and Grace, jun., J. T., *Cancer*, 1968, **22**, 1089.

⁸ Reedman, B. M., and Klein, G., *International Journal of Cancer*, 1973, **11**, 499.

⁹ Aya, T., and Osato, T., *International Journal of Cancer*. In press.

Emergency Bed Service

SIR,—I would heartily disagree with Dr. C. J. Bennett's proposal (17 August, p. 469) to abolish the Emergency Bed Service, since this fulfils a most valuable role in enabling us to continue visiting other patients rather than sitting on the end of a telephone while the hospital tries to bleep the house officer or his deputy. I think many of us will have found that if the patient is turned down on a direct inquiry to the house officer he is often sent through the E.B.S. into the same hospital.—I am, etc.,

C. D. WALKER

Eltham,
London S.E.9

Meeting the Need for Doctors

SIR,—Attention is drawn intermittently to the situation in Britain where we have fewer doctors than we need, so that we have to fill the gap by importing doctors from developing countries whose need is already greater than our own. The situation becomes tragically absurd when we realize that at the same time our universities will have just rejected over 6,000 students who achieved adequate "A" level results and whose wish was to start studying medicine this September.

Existing medical schools have increased their intake to the limit (with little or inadequate improvement of facilities) and new medical schools are being suggested to bridge the gap between our needs and our own production. Nottingham and Southampton exist, Hull and Reading are hoping to be approved. But new medical schools require years of planning, they are prodigiously

expensive to build and maintain, and they represent a substantial internal brain-drain of practising specialists into teaching.

In 1965, 26 consultants in Bath devised a scheme¹ which is even more valid today and could train an extra 1,500 doctors a year, starting very rapidly—the equivalent of at least 10 new medical schools. The saving in general finance actually covers the cost. Firstly, it requires courses in human biology outside the preclinical sections of present medical schools. Space for there (a problem in 1965) could now be found in the spare capacity in present science and engineering departments. Secondly, it requires that all existing teaching hospitals should use non-teaching hospitals as clinical training departments, with students spending up to a year in these satellite units. This could start slowly, so that by the time graduates were emerging from the human biology course a 50% increase in clinical students could be achieved, with minimum increase in teaching staff and with little building costs except residential accommodation. All medical schools have, in fact, adopted this idea on a piecemeal basis and the trend is increasing. Properly organized, it could make an immense impact. The clinical experience in district general hospitals is at least as wide and varied as in teaching centres (most students who come to us now admit that it is more varied) and virtually all of the senior medical staff have done their share of teaching in the past and would happily do it again.

The Royal Commission on Medical Education, to whom our original detailed proposals were submitted, considered such a rapid expansion was not necessary. However, technological developments are increasing the need for doctors faster than the rise in intake of our medical schools. We submit that a scheme such as ours is urgently required.

Ultimately, of course, the decision is political and depends largely on finance. We believe that our proposals could enable us to train as many doctors as we need—quickly, cheaply, and without loss of quality. They would also relieve the "sixth form blues," suffered by thousands of gifted young people who have proved they are academically up to standard, know their country needs them as doctors, but cannot get places in medical schools.—We are, etc.,

T. STUART-BLACK KELLY
S. D. V. WELLER

Bath

¹ Kelly, T. S.B., and Weller, S. D. V., *Lancet*, 1966, i, 201.

Doctors' Pay

SIR,—Doctors talk vaguely of the need for injection of at least £500m. into the N.H.S. but feel embarrassed to point out plainly that the important cause of decline in the standard of service is the frustration over pay, expenses, and working conditions, among doctors—especially consultants. Successive governments have largely ignored the problem and the result is that this discontent appears to be getting critical and the frustration is now near to flash point. The basic reason for this is the long-established and continued divisive policy pursued by the Department of Health and Social Security. All consultants working in the N.H.S. should have equal opportunity of earning. Many

working in the N.H.S. are aware that this is not so. Under the existing system of remuneration some consultants are paid more than others. Most of the full-time as well as part-time consultant physicians, psychiatrists, surgeons, and gynaecologists earn over £2,000 a year more from domiciliary consultations, while consultants belonging to specialties like radiology, pathology, and anaesthetics, who in fact are the largest single specialist group in the N.H.S., are unable to earn a single penny from this system of remuneration. Another cause of disparity in the salaries of consultants is the system of merit awards.

In order that all consultants join together to present a united front instead of selfishly guarding their own interests we would like to suggest the following measures: (1) The profession must make it clear that it is concerned with the standards of basic pay at all levels in the N.H.S. (2) A satisfactory uniform contract for all consultants should be negotiated between the profession and the Government at an early date. (3) The system of domiciliary visits should be abolished and patients needing urgent consultation or opinion should be assessed in the casualty or outpatient department of the hospital, as is the practice in other countries like Sweden, etc. The money thus saved could be channelled towards improvement in the basic salary of all consultants. Similarly other extra sources of remuneration should be looked into. (4) There should be a complete rethinking on the issue of merit awards. There should be only a small number of such awards for doctors who have done outstanding work in their specialty, either as a lump sum or for a specified period—say, 2-5 years. The system of merit awards should largely be replaced by seniority awards given at five- or 10-year intervals and adjusted for cost of living rises.

We sincerely hope and urge that the joint working party which is considering the terms upon which senior medical and dental hospital staff are employed in the N.H.S. will look into the existing causes of disparity in the earnings of consultants in various specialties before making their recommendations.—We are, etc.,

S. MEHTA
K. LEWIN
J. CHARI

Department of Anaesthetics,
General Hospital,
Burnley

SIR,—When politicians and businessmen initiate the first voluntary pay cuts, then will be the time for us to follow suit. The cost of housing has ridiculed our salaries and forced hardship on anyone deciding to stay in Britain. I would not resent my older colleagues having more, even if they have plenty now, as long as my contemporaries have enough to live and eat properly. Why do they want us to have even less?

Let negotiators get this right. We need more money and ideally fixed-interest housing loans. The N.H.S. is the monopoly employer of all young doctors; it is time it was made to behave with care and concern or let us leave the Health Service en masse and work freely and professionally again for the benefit of our patients and medicine in this country.—I am, etc.,

ADRIAN ROGERS

Exeter, Devon

G.M.C. By-election

SIR,—I fail to see why yet again the General Medical Council is unable to supply some information regarding the candidates for the current by-election to the council. Am I just supposed to stick a pin in the lucky name that gets my vote?—I am, etc.,

GEORGE N. JAMIESON

Radcliffe-on-Trent, Notts

SIR,—I protest most strongly against the unfairness to me and other candidates for not giving us a chance to address your readers while the B.M.A.-sponsored candidate was allowed to do so, even though some of us have been members for many years. This open discrimination against us is deplorable. Why should every candidate not have equal opportunity? How and when did the B.M.A. decide to sponsor or rather favour one against others without giving us prior notice? Is the B.M.A. a trade union? Is it afraid of opposition?—I am, etc.,

M. M. HASAN

Chigwell, Essex

** The Secretary writes: "For many years it was customary for the B.M.A. to sponsor candidates for election to the G.M.C. This custom was interrupted in 1970 by a decision of the Annual Representative Meeting. The next year (1971) the A.R.M. accepted the report of the Brynmor Jones Working Party on the G.M.C., which recommended a substantial increase in the number of directly elected representatives. The A.R.M. resolved that in the new circumstances the Council should prepare a scheme for the selection and sponsorship of the directly elected candidates. Accordingly the Council prepared the scheme printed as Appendix III to the Council's Annual Report for 1971-2 (*Supplement*, 15 April 1972, p. 26). The scheme was approved (with one small amendment) at the A.R.M. in 1972. Among its provisions were the following:

"(3) Standing committees (and the H.J.S. Group Council) and Divisions in England will be invited to propose candidates . . .

"(4) The Welsh Council and Divisions in Wales will be invited to propose candidates . . .

"(8) The requisite number of candidates will be chosen by ballot of the appropriate Representatives . . .

"(9) At the time of the G.M.C. election, the candidates selected by the R.B. will be formally nominated on the appropriate form, and will be recommended to the electorate by: (a) Appropriate publicity in the *B.M.J.*; (Note: Other candidates who, though not selected for the B.M.A. list, are members of the association, should also have their names notified to the electorate in the *B.M.J.*). (b) Appropriate publicity in *B.M.A. News* . . .

"(10) The foregoing scheme, suitably adapted, should be applied also in the event of a by-election."

"When the by-election was announced by the G.M.C. this year the Council accordingly adapted the approved sponsorship scheme, nominations were invited from divisions and branches in England and Wales and from the standing committees of the Association (15 names were proposed), the B.M.A. candidate was chosen by ballot at the A.R.M. at Hull, and the steps mentioned in paragraph (9) above were duly taken."—ED., *B.M.J.*