paid by the Government or commerce," but it is sometimes equally difficult to avoid the impression that the Government is reluctant to give as much publicity to facts which weaken its case as to those which enhance it. It is a sound principle that justice must not only be done but must be seen to be done, and this is not the case when the Government appears to be advised only by those with a vested interest in nuclear technology.

JACQUELINE ORMAN

Chepstow, Gwent

Surgical emphysema during dental treatment

SIR,—A 31-year-old housewife visited her dentist, who drilled a cavity in her left upper seven. As he used the compressed air drier she suddenly experienced severe pain in the left side of her face to the temporal region and down into the left anterior triangle of her neck.

On his advice she consulted me within 30 minutes, when she had marked surgical emphysema extending from the left temporo-parietal region down the side of the face and into the subcutaneous tissue of the left anterior part of her neck. The only abnormal finding in the mouth was a small ulcer in the gingival sulcus lateral to the offending tooth. This presumably could have arisen as a friction burn during drilling and was presumably the site of entry of the subcutaneous air. The condition was extremely painful and tender, but with penicillin cover it subsided completely within 48 hours.

I can find no precedent in the literature and should be interested to learn whether this has been previously reported.

JOHN B WILLIAMS

Reading, Berks

Advisory Committee on Borderline Substances

SIR,—Professor Barbara E Clayton (24 September, p 834) draws attention to the Advisory Committee on Borderline Substances (ACBS) and states that it is always ready to reconsider any of its decisions in the light of new evidence. I would like to ask whether it will reconsider some of its decisions in the light of long-existing evidence or alternatively explain how they came to be made in the first place. I give just a few examples.

(1) Casilan for biochemically proved hypoproteinaemia. Hypoproteinaemia is due either to excessive loss, as in nephrotic syndrome, or deficient manufacture, as in liver disease. It does not occur in ordinary starvation. Whatever the cause, no amount of Casilan or other protein given by mouth can raise it unless that cause can be cured. It follows that Casilan can have only a nutritional effect in such cases and indeed in others. What line of reasoning decides that it may automatically be considered a drug in hypoproteinaemia and presumably not in others?

(2) A list of gluten-free products for gluten sensitivities and other foods for cystic fibrosis, malabsorption of protein, steatorrhoea, etc, may automatically be regarded as drugs—but not carbohydrate-free (or -reduced) foods for diabetics. Is diet considered less important for the treatment of diabetes? Or has the committee arrived at its decision, not on grounds of sound medical reasoning, but on cost to the Health Service? Will it please say why diabetics suffer this kind of discrimination?

(3) Corn oil for familial hypercholesterolaemia. Has corn oil some totally different action in other

kinds of hypercholesterolaemia—or are the familial cases less likely to fry fish and chips in it?

I have always thought that the chief object of the ACBS was to give guidance not so much to manufacturers as to the prescribing practitioner. It has always been understood that the general practitioner, unlike the hospital doctor, cannot prescribe food (including special diets), clothing, heat, light, household disinfectants, or detergents even if these are necessary to save the patient's life. If the patient cannot afford any of these things he is expected to apply to such public resources as are available to assist him. By departing from this principle in a series of decisions, through which no thread of logic can be detected, in an apparently arbitrary selection of conditions and foods this committee, far from providing guide lines, has merely confused the issue still further.

I would strongly advise the prescribing practitioner in doubt to apply not to the ACBS but to his local medical committee. The secretary will often be able to give on-the-spot advice. Alternatively, he can prescribe a limited amount of the doubtful substance and argue his case personally before the LMC, whose decision is subject to appeal, when the referees will not only give a decision but also their reasons for arriving at it—which is more than the ACBS or any of its predecessors have done. Your estimable journal used to publish some of these decisions, which, unlike the ACBS, did give the prescribing practitioner some kind of guidance. Fortunately neither the prescribing practitioner nor the local medical committee is obliged to take any notice of the advisory committee's recommendations. I sincerely hope they won't. That committee's usefulness is, to say the least of it, doubtful.

A A LEWIS

London W1

Whole-timers and the new consultant contract

SIR,—There are a number of aspects of the present negotiations between the Central Committee on Hospital Medical Services and the Department of Health and Social Security about the new consultant contract that I find disquieting, but one particularly which I think should be brought to the notice of whole-time consultants.

The original CCHMS proposals as published (11 September 1976, p 655) proposed the abandonment of the 2/11ths differential between whole-timers and maximum part-timers, but I had assumed that the DHSS would strongly resist this proposal. The Linkman letter of 17 August about the negotiations, however, says that "the Government takes the view that the maximum number of notional half days which a consultant can be expected to work should be higher if he does not propose to do private practice. The professions do not consider that such a proposal would be fair to the individuals concerned and they expressed complete opposition to the concept."

It seems, therefore, that the DHSS negotiators have already partly accepted the CCHMS line in that whole-timers would be able to receive their differential only if they did extra work and that this has given a peg for the CCHMS to "protect" us—a protection which we could well do without.

If other whole-timers believe as I do that it is the whole-time consultant who is the back-

bone of the NHS and that an increase in the proportion of whole-time consultants will be achieved only via an increase in the differential, then this watering-down of the current opposition by the DHSS is a retrograde step and one of which all whole-time consultants should be aware.

SAM BAXTER

Department of Psychiatry,
Charing Cross Hospital,
London W6

SIR,—The latest BMA Linkman letter reports progress in the new consultant contract negotiations. The Government view, stated in the appendix, is that the maximum number of notional half days which a consultant can be expected to work should be higher if he does not propose to do private practice, a differential which has existed for nearly 30 years. Where has the statement that the professions do not consider such a proposal to be fair and express *complete* opposition to it come from? Many whole-time consultants, academic staff, community physicians, etc, if asked, might disagree.

A N G CLARK

Geriatric Unit,
Brighton General Hospital,
Brighton, Sussex

*.*The Secretary writes: "The financial differential between the 'whole-time' and 'part-time' consultant has been carefully preserved by the availability in the basic contract of two unscheduled notional half days which the previous whole-timer can work and be paid for. All that the CCHMS is seeking to eliminate is the enforcement of a legal restriction upon what a consultant does in his free time."—ED, *BMJ*.

Deputising services: charges to subscribers and pay of deputies

SIR,—Although considerable publicity has been given to the medical and ethical implications of commercial or BMA-sponsored deputising services, one aspect which in our opinion has attracted inadequate debate is the cost to the subscriber in relation to the payment of the deputy.

We note that more and more doctors find the cost of night and weekend cover so attractive and the thought of actually working for the service so unappealing that they choose to opt out of on-call work entirely. Surely this is to the detriment of themselves as general practitioners—but that is another story. The sombre fact is that tired GPs can set aside the cost of providing emergency cover as an "expense" against taxation while their less fortunate surrogates may be braving wintry storms or facing distraught patients only to find that their well-earned pittance is further diminished by income tax.

For five hours' work on a Sunday morning, seeing, for example, 10 patients, a deputy would collect £14.25, which gives an hourly rate of £2.85. If he manages to cope with 20 calls he will have earned £20.85, a rate of £4.17 an hour, although some patients may reasonably wonder whether they have been "seen" at all. Fees and costs are, we believe, fixed by negotiations between the Central Advisory Committee of the BMA and the various commercial firms involved. It is some indication, if nothing else, of how badly some doctors are paid if they are prepared to sacrifice their free time "moonlighting" for such