(3) Dr Woodcock's point about the effect of the failure rate had been considered. In any experimentation on human subjects missing data from subject loss tend to occur; there is no way of completely overcoming this problem, either clinically or statistically. We believe our analysis provided the most reasoned assessment of the data by (1) analysing between group failure rates and (2) analysing the existing data while explicitly acknowledging the possible effects of missing data. Furthermore, both sets of data are presented and both show small positive effects for antimicrobials, so there is little chance of the reader being misled. At worst he may feel, as Dr Woodcock appears to, that we have shown that antimicrobials are effective.

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¹ Davis, S D, and Wedgwood, R I, *American Journal of Diseases of Children*, 1965, **109**, 544.

² Gordon, M, Lovell, S, and Dugdale, A E, *Medical Journal of Australia*, 1974, **1**, 304.

³ Soyka, L F, et al, *Pediatrics*, 1975, **55**, 552.

Teaching general practice

SIR,—While welcoming your promotion of general practice teaching in medical schools (22 October, p 1042) and agreeing that "academic investment should not be made conditional on service-earning capacity," I must take issue with you concerning "continuing genuine service role" for academic general practitioners.

Few would agree that in any aspect of life—least of all medicine—teaching can be divorced from practice. While all other departments in medical schools acknowledge the need for teachers to be clinically competent and active, let us not deny the same criteria to the developing teaching of primary care. Of course, clinical activity must not be maintained at the expense of providing teaching and research. But all three roles are essential to academic general practice. Sacrifice of the service role will be as damaging to the "academic general practitioner" as it would be to his hospital colleague.

GODFREY FOWLER

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Indomethacin-induced asthma in aspirin-sensitive patients

SIR,—We have recently had under our care a 43-year-old nursing sister with a two-year history of intrinsic asthma. She was known to be allergic to penicillin (rash) and aspirin (asthma). Her general practitioner prescribed indomethacin for musculoskeletal pains in her left leg. On 17 October at 5.30 pm she took a 50-mg capsule of indomethacin and within an hour started to wheeze. The bronchodilators she had at home (salbutamol inhaler and tablets and sodium cromoglycate) did not help her, so she called her general practitioner. On the GP's arrival at 8.15 pm the patient was found to be extremely short of breath and two repeated subcutaneous doses of adrenaline were given together with 40 units of corticotrophin (ACTH). A little improvement followed and the patient was referred for hospital

admission. On arrival at 9.10 pm her peak flow rate was 170 l/min. This improved to 200 l/min by 10.30 pm after the patient had received a further 200 mg of hydrocortisone intramuscularly and 4 mg of salbutamol by mouth. She continued to improve overnight and by the next morning her chest was clear and peak flow rate was normal at 370 l/min.

This case illustrates the potential dangers of prescribing indomethacin to patients known to have aspirin-induced asthma. This was first described by Vanselow and Smith.¹ The nature of this cross-reactivity between indomethacin and aspirin is unknown; because of the dissimilar molecular structure it is unlikely to have an immunological basis and prior skin testing is known to be unhelpful. It is also important for doctors to remember that indomethacin is not the only analgesic which should be avoided in aspirin-sensitive asthmatics—paracetamol, mefenamic acid, and dextropropoxyphene are also known to induce asthma in this group of patients.²

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¹ Vanselow, N A, and Smith, J R, *Annals of Internal Medicine*, 1967, **66**, 568.

² Smith, A P, *British Medical Journal*, 1971, **2**, 494.

Pathogenesis of osteoarthritis

SIR,—Your leading article on this subject (15 October, p 979) makes no mention of the importance of joint laxity. Although congenital dislocation of the hip,¹ recurrent dislocation of the patella,² and familial hypermobility³ may all predispose to osteoarthritis, attention has traditionally been directed towards repetitive impulsive loading. The most severe example of osteoarthritis in a group of professional footballers occurred in one with abnormally lax ligaments.⁴ Assuming this to be related to collagen structure, which is inherited, rather than muscular hypotonia, which may be acquired, joint laxity, which has a Gaussian distribution throughout the population,⁵ may be a potent factor in the aetiology of osteoarthritis. Moreover, this can be reconciled with Muir's explanation of the predisposition of some people to develop osteoarthritis on the basis of inherited collagen structure.⁶

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¹ Carter, C, and Wilkinson, J, *Journal of Bone and Joint Surgery*, 1969, **46B**, 40.

² Sutro, C J, *Surgery*, 1947, **21**, 67.

³ Beighton, P A, and Horan, F T, *Journal of Bone and Joint Surgery*, 1970, **52B**, 145.

⁴ Adams, I D, *Clinics in Rheumatic Disease*, 1976, **2**, 523.

⁵ Moll, J M H, and Wright, V, *Annals of the Rheumatic Diseases*, 1971, **30**, 381.

⁶ Muir, H, *Annals of the Rheumatic Diseases*, 1977, **36**, 199.

Training posts in medicine and allied specialties

SIR,—The Specialty Advisory Committees of the Joint Committee on Higher Medical Training (JCHMT) has been making steady progress in its task of inspection of senior registrar (or equivalent) training posts in medicine and allied specialties. Most of the posts put forward for consideration have now

been inspected and it is hoped that the remainder will be dealt with in the near future. Lists of posts approved for training after inspection are contained in the Second Report of the JCHMT and supplements thereto (available from the address below, price £1.50).

To assist applicants for a senior registrar post to determine its status in relation to JCHMT requirements the employing authorities have been requested to state in the advertisement for such a post that it has been approved (if this is the case) for training by the JCHMT. This is an additional safeguard to applicants who may not have access to a copy of the Second Report.

Applicants should note that the absence of a positive statement of approval in any advertisement does not necessarily mean that the post has been turned down by the JCHMT. It may be a perfectly satisfactory post that has not as yet been visited by an inspection team or it may be a post that has only minor training deficiencies which are in the course of being put right before final approval can be granted. However, the message to applicants is clear. If the advertisement does not include a positive statement of approval by the JCHMT they should in their own interests carefully scrutinise the further particulars of the post provided by the employing authority and, if necessary, pursue inquiries either before or at the interview to determine its training status.

R F ROBERTSON

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Report on first MASC meeting

SIR,—Anyone reading your report (8 October, p 972) of the Conference of Academic Representatives held in Oxford on 26 September would be justified in concluding that the major problem confronting the newly established Medical Academic Staff Committee related solely to clinical academic staff—an impression reinforced by the space devoted (15 October, p 1037) to Dr Robert Lowe's discussion of the remuneration of clinical academic staff. Let there be no doubt that it is in the preclinical field where the most urgent problems lie: unless immediate action is taken to make the rewards of a career in the medical sciences comparable with those in other fields of medicine the effective medical component in many anatomy and physiology departments will have vanished within five years, and, as I write from an anatomy department, the medical science which has over the centuries proved itself concerned with the vocational relevance of teaching will have followed the pathway already taken by biochemistry.

Inquiry reveals that the reason for the failure to report the long deliberations concerning the preclinical problems was that the sole reporter assigned to the activity was available for either the clinical section meeting or the preclinical section meeting but that no way could be found to engage one reporter for each section meeting. The decision made instructing the reporter to cover the clinical debate is likely, therefore, to reflect the priorities of the BMA, which seems to be continuing to pay lip service only to concern for the critical position in preclinical departments while continuing to pursue policies that are

clinically and politically expedient; or as a quasi-trade union is it more concerned with the voting strength of membership?

Whatever the explanation, time has now virtually run out. Using tactics of delay typical in political fields, where the interests of the majority override those of the minority, the BMA along with vice-chancellors and the University Grants Committee have assessed and reassessed the problem for the past 10 years without demanding action that would safeguard the staffing standards and vocational aims of medical science departments. The position of these departments has deteriorated steadily so that the few medical graduates are faced with an ever-increasing teaching load and ever-decreasing time to pursue their essential scientific research, not to mention their ever-worsening financial position relative to both the community at large and other fields of medicine.

For the apportionment of responsibility in this matter the facts must be published, not only for the sake of history, but also in anticipation of the committees that in 10-20 years' time will be set up to investigate the inability of medical graduates to perform simple physical examination and diagnosis of patients.

W S MONKHOUSE

Nottingham Preclinical Representative,
Medical Academic Staff Committee

Department of Human
Morphology,
University of Nottingham

*.*The Secretary writes: "Dr Monkhouse's feeling of frustration over the fate of medically qualified preclinical academic staff is understandable. What is not acceptable is his claim that the BMA has been dragging its feet in supporting them. We have represented on every possible occasion the consequences of ignoring the position and we have carried out several comprehensive reviews of staffing in preclinical departments throughout the country in support of the efforts we have been making on their behalf. I myself regard the matter as so important that I attended the preclinical section of the conference."

Dr Monkhouse is also referred to the editorial footnote to the letter from Dr B A Gooden published in the *BMJ* of 29 October (p 1157).—Ed, *BMJ*.

GPs' ancillary staff

STR,—May I support Dr Michael E Glanvill's observations (22 October, p 1090)? However, with regard to the Secretary's comment, if "there has never been any dispute between the BMA and DHSS about the fact that there are many doctors' wives and their other relatives acting as ancillary staff in general practice," then they have both got it wrong. There are, in fact, probably fewer than 100, which means that the "cost" argument is barely valid.

A recent letter we have from the DHSS states that "too little is known about the work that wives actually do in their husbands' surgeries." Of course they don't know if neither the DHSS nor the BMA have asked the people involved—as they have not. The DHSS letter goes on: "The GMSC have always considered that the group of doctors who have the greatest difficulty in obtaining ancillary staff were rural single-handed practitioners." This may be so, but unless and until the BMA produces, as Dr Glanvill suggests, some facts

and figures to support this I shall not believe it. They cannot produce facts and figures because, as a letter I have from Dr J C Cameron in 1967 indicates, the matter has been dealt with largely by the Rural Practices Subcommittee, which is a prejudgment of an issue if ever there was one.

When the matter has been settled I shall join Dr Glanvill in asking the BMA to take me back into its fold. I must first, of course, leave the fold, which I am about to do.

B J STAFFORD

Kirby-in-Ashfield, Notts

*.*The Secretary writes: "We would be most interested to know the basis for the assessment by Dr Stafford that the number of wives employed by their husbands in general practice is fewer than 100. Although the Rural Practices Subcommittee of the General Medical Services Committee has taken a considerable interest in this matter, the discussions have taken place primarily in the full GMSC and also in its General Purposes Subcommittee."—Ed, *BMJ*.

Royal Medical Benevolent Fund Christmas appeal

STR,—May I remind your readers who are intending to respond to the president's appeal (8 October, p 961) that we like to distribute gifts to our beneficiaries in good time for Christmas? I would ask all individuals, societies, and groups who have not yet done so to send their contributions as soon as possible to the Director, Royal Medical Benevolent Fund, 24 King's Road, Wimbledon, London SW19 8QN.

GEOFFREY H BATEMAN
Honorary Treasurer,
Royal Medical Benevolent Fund

London SW19

Points from Letters

Return to work

Dr J D BARRETT (Vauxhall Motors Ltd, Luton, Beds) writes: It was disappointing to read in an article of some 1500 words by such experts in the field of rehabilitation as Drs D A Brewerton and P J R Nichols (15 October, p 1006) not one word about the role of industrial medical officers or occupational health services, which are present in most large industries now. Although available to only a proportion of the work force of this country, surely they have been established long enough to have made some contribution to solving the problem of getting people back to work and to have established some liaison with the NHS. . . .

Bell's palsy and herpes zoster

Dr J B WILSON (Lockerbie, Dumfriesshire) writes: . . . At the time Dr P Grout's letter was published (24 September, p 829) an interesting case of Bell's palsy was under treatment in my practice. This was in a woman of 61 who almost exactly a year ago had had a left-sided Bell's palsy and who two weeks previously had developed a right-sided Bell's palsy. Though this was thought to be an unusual occurrence, my 1942 edition of

Walshe's *Diseases of the Nervous System* mentioned that recurring cases of Bell's palsy did occur. Presumably this was such a case. In view of Dr Grout's letter a blood sample was sent off for virological examination and came back with an antibody titre for herpes simplex of 1/32, which two weeks later had risen to 1/256. I wonder therefore if these recurring cases of Bell's palsy may be due to the presence of the herpes simplex virus. Since the herpes simplex virus often produces a recurrent infection this would appear a reasonable proposition—but why on different sides? . . .

Oust the louse

Miss M TAMBLYN (London N5) writes: One important factor was omitted from your leading article (22 October, p 1043). As chlorine inactivates malathion, patients should not go to the swimming baths for one week after treatment.

Teaching first aid to children

Dr A R KEMP (St David's Hospital, Carmarthen) writes: Dr A W Gardner (22 October, p 1088) would be less concerned about the education of children in first aid if he could see the attendances at St John Ambulance classes in this country. Three sessions an evening were needed recently for the 90 cadets in Llandeilo.

A tennis elbow support

Dr R A STINSON (Ninewells Hospital and Medical School, Dundee) writes: . . . The type of support described by Mr S C Chen (1 October, p 894) is available in Canada, and I presume the US as well, at most major sports shops and private clubs. Because of the often poor amelioration of tennis elbow offered by injections of cortisol many orthopaedic surgeons in Canada wish their patients to try a support first. My understanding is that German-made supports are also available.

Home or hospital confinement?

Dr JEAN LAWRIE (Eynsford, Kent) writes: Your leading article (1 October, p 845) summed up the physical advantages to mother and child of hospital confinements. But what the article ignored was the emotional needs of mother and child and family. It is these needs that are prompting the public to question many current hospital practices.

Exercise-induced asthma

Dr W T NEWMAN (Farnham, Surrey) writes: With reference to Dr G Sheehan's letter (29 October, p 1150) it is my experience that swimming is an effective treatment for asthma. It should be pointed out, however, which strokes are pertinent. To build up the diaphragm the arm and leg of opposite sides should strike simultaneously. Thus the overarm (trudgeon, not crawl) should be used when swimming on the ventrum, and on the back opposite arm and leg together. When cycling, the same contralateral action is undertaken. If this muscle is properly built up it seems to prevent untoward autonomic nerve signals.