that this has been seen as a regional responsibility. Instead it should be viewed as a duty of the health district or short stay hospital to provide the service. Every district general hospital in Britain should have a computed tomography scanner in the 1990s if it is to practise effective medicine.

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1 Hewer RL, Wood VA. Availability of computed tomography of the brain in the United Kingdom. *Br Med J* 1989;298:1219-20. (6 May.)

Junior doctors' hours

SIR,—Dr Nigel F Perks's letter raised some interesting points.¹ I too find it difficult to understand how hours of work as well as numbers of middle grade staff can be reduced without reducing the service commitment.

The often repeated implication that shortening working hours necessarily requires a lengthened training programme, however, is, I believe, incorrect. This assertion is based on my recent experience of a four year residency training scheme at a Canadian teaching hospital. There residents had no service commitment as all cases had to be attended by staff anaesthetists and surgeons. In contrast, the hospital departments have a commitment to teaching the residents. Thus all clinical work was routinely supervised, and the residents were almost always free to take part in the regular organised academic teaching sessions. How many British junior doctors can claim similar postgraduate training opportunities?

The recently published confidential inquiry into perioperative deaths has identified cases of junior doctors taking on cases beyond their competence, often outside "office hours."² This does not constitute proper training, and we should not delude ourselves that working excessive hours can compensate for it. With the ever increasing cost of litigation and the complexity of modern medicine the days of the attitude "see one, do one, teach one" should be behind us. It is unlikely to be purely coincidental that the pass rate for the Canadian anaesthetic fellowship examination approaches 80% whereas that for the final examination for fellowship of the College of Anaesthetists is below 20%.

A health service "working for patients" seems to require more fully trained doctors for both improved patient care and junior staff training.

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1 Perks NF. Junior doctors' hours. *Br Med J* 1989;298:1314. (13 May.)

2 Buck N, Devlin HB, Lunn JN. *Confidential inquiry into perioperative deaths*. London: Nuffield Provincial Hospital Trust, 1987.

Parable of the £10 000 general practitioner

SIR,—May I correct a false impression that John Warden may have left in his account of general practitioners' evidence to parliament's social services committee?¹

Mr Warden reported that I was the only one to oppose completely general practice budgets "given [my] position as a rural general practitioner." In fact, I opposed the budgets on two grounds. Firstly, budgets will sour the relationship between doctors and patients; doctors will cease to be the advocates of patients and will become brokers for the state. Secondly, from an analysis of present

incentives in the United Kingdom and of health care markets in the United States I believe that there is no evidence that budgets would improve choice or efficiency but that evidence suggests that they would increase administration costs. I referred to my written submission to the committee, which contained a fuller critique of the practical consequences of budgets. (It also exposed how the white paper is based on untested assumptions and showed that the evidence that exists suggests that the proposals will have the opposite effect to the aims the white paper espouses.) I also pointed out that there is little opportunity for competition among general practitioners and among hospitals in many parts of the country, using my own area purely as an example.

I must clarify that my objections to budgets are not parochial but principled. Budgets are an integral part of the government's attempts to introduce a health care market. Two of the general practitioners who spoke in favour of budgets claimed that they could provide a better service to their patients. They may be right (though I believe that they have some rude surprises in store), but the point is that this would not be the case for the whole nation. This is no time for parochialism: we must fight to preserve what is best in the NHS and do so in unity.

I would like to see general practice reformed so that we stop thinking about only the patients in our own patch and start thinking about all patients. The two essential principles of such reform are accountability and planning. Neither budgets nor markets make general practitioners truly accountable because consumer sovereignty does not exist in health care. We need accountability to a body that both represents patients and can assess our work; we need a new type of family practitioner committee whose remit extends beyond the financial policing planned in the white paper and encompasses an assurance of quality.

Budgets would fix general practice in entrepreneurial units; planning would allow it to evolve. General practice has moved from treating problems to caring for the person; from there it has taken on prevention within the practice; the future lies in planning medical care for a population. For this we need coordination on a level higher than the individual practice: we need family practitioner committees that are primary care authorities.

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1 Warden J. Parable of the £10 000 general practitioner. *Br Med J* 1989;298:1207-8. (6 May.)

Eye, eye

SIR,—Dr Bashir Qureshi's point about eye to eye contact¹ is a genuine problem faced by doctors from overseas not only in clinical practice but also in examinations.

May I quote my own experience, which is not very different from that of other doctors from overseas? As a Pakistani girl, I was always instructed not to look straight into the eyes of other people, especially parents and teachers, while talking to them. I am thankful that a British well-wisher told me just before I took the primary examination for fellowship of the Royal College of Surgeons that a higher percentage of candidates from Pakistan and India than local candidates fail British examinations. One of the reasons is that Asian candidates when asked a question in an oral examination lower their eyes as a sign of respect despite knowing the answer, which may be interpreted as a sign of not knowing and may not benefit the candidate. I was advised to practise talking while looking into another person's eyes, which was not easy. Furthermore, I was astonished when a German doctor told me that in Germany you

would be considered to be telling a lie if you did not look straight into the other person's eyes.

There are several other cultural differences facing young overseas doctors training in Britain. These include, for example, calling older people by their name and holding the hand of a patient of the opposite sex to express sympathy and concern, which are considered to be offensive in most Asian countries but are cultural norms in Britain.

My little experience in Britain makes me realise that, though the science of medicine is the same all over the world, the art of medicine—that is, being a good clinician—is different, being influenced by local customs, manners, and ways of life. Junior doctors coming from overseas to train in Britain would benefit from guidance on these differences. It would help us to understand our mistakes and save us from many embarrassing clinical experiences.

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1 Qureshi B. Eye, eye. *Br Med J* 1989;298:1230. (6 May.)

Drug Points

Acute hepatitis and exfoliative dermatitis associated with minocycline

Drs M G DAVIES and P J W KERSEY (Plymouth General Hospital, Plymouth PL4 8NN) write: Minocycline is a tetracycline analogue that is often prescribed for acne and other cutaneous disorders. We recently observed two patients with a similar clinical pattern consisting of a severe self limiting skin eruption and acute hepatic failure, which in one case was fatal. Both patients had received minocycline for a skin complaint a few weeks earlier.

Case 1—A 16 year old boy presented with hidradenitis suppurativa and was treated with minocycline 100 mg twice a day. Four weeks later he became unwell with headache, malaise, fever, and rash. The rash was initially erythematous and patchy and later confluent and exfoliative with oozing over the skin of the face. He developed a sore throat and night sweats. Examination showed an ill young man with an enlarged liver and generalised lymphadenopathy. His throat was red with inflamed tonsils. His skin showed generalised dryness and erythema. He was anaemic with a haemoglobin of 108 g/l, a raised white cell count of $25.8 \times 10^9/l$ (66% neutrophils, 20% lymphocytes, 12% eosinophils), and a raised platelet count of $840 \times 10^9/l$. A bone marrow examination showed hypercellularity but no other abnormality. Other investigations, including a test for hepatitis B antibodies, gave normal or negative results. During the course of the illness the streptococcal anti DNAase B became positive, suggesting recent streptococcal infection. Liver enzyme activities, which were initially raised, rose further with a maximum γ -glutamyltransferase of 395 IU/l. His skin exfoliated in sheets. Within a month the skin improved and the hepatic enzymes returned towards normal. The lymph nodes and hepatomegaly regressed. His subsequent recovery was uneventful.

Case 2—A 17 year old girl developed an acneiform eruption on her cheeks and neck and was treated with minocycline 50 mg twice daily. Shortly afterwards she went on holiday to Kenya, where she took proguanil and chloroquine and some tanning tablets containing tyrosine, copper, and para-aminobenzoic acid as well as minocycline. She was immunised against cholera, typhoid, and yellow fever. Twenty nine days after starting minocycline and while still taking it she presented with a high fever and a macular rash. Seven days after admission her rash appeared to clear and her temperature returned to normal. She was dis-