material and distributed on two separate occasions during an eight week period. The 108 participating laboratories were asked to interpret their results on a scale from negative through low titre, medium titre, to high titre positive. The table shows the interpretative result plotted against the mean cardiolipin antibodies titre expressed as the all laboratory trimmed mean. With all 16 cells of the matrix occupied there is clearly room for improvement not only in the means of analysis of this family of autoantibodies but also in their interpretation. Even the highest dilution of this series, with a mean of 28 GPLU (IgG phospholipid units) would be considered as a moderate titre positive result by the criteria of Greaves,⁵ yet eight laboratories (9%) considered it to be negative. Also, 9% and 5% of laboratories considered samples with 57 and 76 GPLU to be negative or at best only weakly positive.

Matrix of interpretative comment and all laboratory trimmed mean of cardiolipin antibodies

	Positive			
	Negative	Low	Medium	High
76 GPLU/ml	2	2	19	65
57 GPLU/ml	5	3	36	44
41 GPLU/ml	3	7	57	22
28 GPLU/ml	8	15	57	9

GPLU=IgG phospholipid units

On the basis of the evidence there seems little room for confidence in the concordance of numeric values for cardiolipin antibodies, and only slightly more confidence in their semiquantitative interpretation.

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Herbal medicines should be in child resistant containers

EDITOR,—The recent accidental ingestion of a diuretic herbal medicine by a two year old, requiring admission and electrolyte monitoring, prompted me to examine the wider implications of this case.

In 1976 the introduction of child resistant containers in the United Kingdom resulted in a reduction in the accidental ingestion of paracetamol and aspirin by children.¹ These containers are, however, compulsory only for solid prescribed medication, and poisoning with other drugs such as herbal and veterinary preparations should not be ignored. The use of childproof containers for liquid medication still remains an important topic for discussion, and as yet an acceptable design has not been finalised.²

The degree of control demanded of prescribable drugs does not extend to those of herbal type. In view of the increasing use of such medicines, there is likely to be an increased risk of accidental ingestion.

Some herbal medicines have been adulterated

with heavy metals, leading to potential toxicity in overdose, the signs and symptoms of which are often recognised late.³ Childproof containers should be a legal requirement for herbal medicines. This would facilitate the implementation of the government recommendations with respect to the reduction in childhood accidents.⁴ Meanwhile, parents should be cautioned to store such medicines out of the reach of children.

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Priority setting processes for health care

EDITOR,—My review of *Priority Setting Processes for Health Care* made two criticisms.¹ Firstly, the authors failed to discuss the policy and political contexts in which priority setting is taking place. For example, the Oregon system, with which they open the book, was about redistributive justice—that is, politicians recognising the need to extend health care to large sections of the community which formerly had little or no access to care. In contrast, priority setting in the remaining health care systems is concerned not with extension but with decreasing the availability of health care to some groups in society.

Johann Calltorp and colleagues seem impervious to the effects of the market both as a resource allocator and in priority setting at district and subdistrict level.² To neglect how markets can impinge on local priority setting processes is to assume that health care decisions operate in a vacuum at local level. Redmayne and Klein have shown that in Britain health authorities are muddling through³; others, including myself, suggest that the vacuum in planning which has resulted from the fragmentation of the market and the loss of a population focus is leading to greater irrationality and new inequities in decision making.⁴ As the Select Committee on Health reported, "support for priority setting must go beyond the dissemination of good practice . . . at a minimum the NHS Executive should ensure that epidemiological profiles including variances from national averages, analyses of need, and details of current provision are open and accessible to public scrutiny."⁵

My second criticism related to the lamentable failure of the authors to subject the priority setting exercises to critical evaluation. The book makes a virtue of the pseudoscience of the priority setting industry. Given the vogue for effectiveness and efficiency, what is the public to make of the thousands of pounds that are spent on priority setting exercises instead of patient care—especially when those exercises provide no useful results?

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Fees for postgraduate medical education lectures

EDITOR,—In the current wave of popularity for postgraduate education we are daily made aware of an increasing number of commercial conference organisers who make a profit from the time contributed by the lecturers. Recently I found myself agreeing to participate, assuming that a fee or at least some recognition would be forthcoming. I did not even receive a letter of thanks until I wrote to the company, who then said it had been a successful evening, providing me with a copy of the delegates' assessment. I was informed that their events "provide the opportunity for consultants to gain quality exposure to a relatively high number of GPs." I am not sure what benefit is supposed to come from this—more outpatients to see?

I write this letter to warn others and to pose the question as to whether a blacklist of firms profiting from our giving up free time should be established?

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Training doctors

EDITOR,—Isobel Allen's report on doctors and their careers¹ should stimulate a serious assessment of how we train doctors in Britain. As a female surgeon I can only despair at my own specialty, orthopaedics, where women represent less than 2% of consultants and around 3% of trainees. This is probably the worst record among the major specialties for the recruitment and training of women in hospital medicine.

My own experiences as a trainee would hardly encourage other members of my sex. The worst episode occurred in 1991 when I was a career registrar in Scotland expecting my first child, and my professor informed me that I would not be regarded as a "doctor in training" for the purposes of maternity employment rights. I received my P45 in the post. After a lengthy appeal I was reinstated and completed my registrar rotation. When I returned to work I was not made welcome and no apology was forthcoming.

Subsequently I was very fortunate and obtained a part time senior registrar post in England, 200 miles away from my home and family. Although the travelling was difficult, I did manage to complete my training and obtain a consultant post.

I would not ask a sane person of either sex to repeat my experience of surgical training. I love my job but I hate the system that made it so difficult for me to become a surgeon. Radical change is required in both regimes and attitudes if we want to give our young doctors the careers they deserve.

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Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.