Jaundice after Halothane

SIR,—I have noted with some interest the response in your correspondence columns to the article by Dr. W. H. W. Inman and Professor W. W. Mushin (5 January, p. 5).

To some it may appear that the defence of halothane rests on shaky ground. To others it is equally apparent that the "allergic" theory of halothane hepatotoxicity lies in tatters for it accounts for none of the observed facts of the matter. One would have to rewrite the principles of allergy to account for so many cases of "allergy" with the first exposure and the apparent disappearance of this "allergy" after 1-3 months. Also, reliable tests for cell-mediated immunity in this condition have not been forthcoming. It should be mentioned that inappropriate controls are frequently used in these tests since what constitutes a "normal" immune response in the immediate postoperative period is not really known. Controls would, ideally, be patients suffering from hepatitis following non-halothane anaesthetics.

As I have reminded readers elsewhere the occurrence of signs of hypersensitivity with hepatocellular jaundice should not occasion fancies of a new disease; they have been ably described in cases of viral hepatitis.[1] The final embarrassment for the hypothesis is, of course, the negative halothane challenge. The original premise on which the hypothesis is based (that is, that multiple halothane anaesthetics are more hepatotoxic than multiple non-halothane anaesthetics) has yet to be substantiated. I believe a study is at present being conducted in the U.K. to settle this matter.[2] Its results are eagerly awaited.

I am surprised none of your correspondents showed more concern for the two anaesthetists (cases 33 and 83 in the article by Dr. Inman and Professor Mushin) who allegedly became allergic to halothane. I feel it is important for us to know more about the fate of these unfortunate gentlemen. Have they been forced to abandon the use of halothane or indeed the practice of anaesthesia for this reason? The authors' conclusions suggest an incidence of halothane allergy of 1 in 6,000-20,000 in people who receive multiple exposures. I believe in the U.S. there are over 300,000 operating room personnel of all types. All are exposed to small but presumably "sensitizing" doses of halothane every working day of their lives. From Dr. Inman and Professor Mushin's figures, between 15 and 50 of these people should be afflicted with "halothane hepatitis." This may be true, but if so it is strange that no one has brought any verified cases to our attention.—I am, etc.,

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1 Morley, T. S., *Journal of the American Medical Association*, 1973, **225**, 1659.
2 Strunin, L., and Simpson, B. R., *British Journal of Anaesthesia*, 1972, **44**, 919.

Biochemical Basis of Maligant Hyperpyrexia

SIR,—The paper by Drs. R. F. W. Moulds and M. A. Denborough (4 May. p. 241) suggesting that the distribution of calcium ions in the cell is important in this condition was most interesting.

Calcitonin may well act at this level.[1 2] The questions arise: (1) Will human calcitonin prevent malignant hyperpyrexia? (2) Is deficiency related to the disease? (3) Will the animal or fish calcitonins now available, which have different effects on electrolyte handling, prove useful in the treatment of malignant hyperpyrexia? (4) Will the isolated muscle fragment experiment so elegantly conducted by these authors shed any light on these questions? —I am, etc.,

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1 Foster, G. U., in *Recent Advances in Clinical Pathology*, ser. 6, ed. S. C. Dyke. Edinburgh, Churchill Livingstone, 1973.
2 *Lancet*, 1971, **1**, 1168.

Tests for Immigrant Doctors

SIR,—The General Medical Council has decided on a test of English and medical competence for foreign medical graduates who apply for temporary registration. From a stand less than a year ago when it denied that such tests were necessary this is indeed progress. It may be that some of the stimulus for this change derived from the impact of my article on "The E.C.F.M.G. and its Relevance to British Medicine" (*Supplement*, 8 December 1973, p. 65) on your readers, who in turn influenced the G.M.C. One could say: "You've made your point; let them now get on with it." If the recent proposals inspired confidence I would be very much in favour of them, but they do not for the following reasons:

(1) They are to be applied only to those who seek temporary registration, and though we are now told that last year those who succeeded totalled 2,500, those graduates of 76 medical schools who enjoy reciprocity are still exempt. As my article was primarily concerned with the present defects in the system of reciprocity, this aspect is left unchanged.

(2) Candidates will not be screened prior to their arrival in this country, which means that many, if not most, will be put to the tremendous expense and inconvenience of coming here to be turned away empty-handed, unless we contemplate a further lowering of standards.

(3) To provide a separate examination for the 2,500 per year who apply for temporary registration and the 1,500 or so admitted under reciprocity would entail an expansion of the examination and assessment industry which we cannot meet at this particular time, if ever. There are some who would rather examine than teach, research, or practise, but that is not their primary occupation and additional examining can be undertaken only by neglecting their salaried duties. It was stated that the examining bodies welcomed this additional load with enthusiasm. No doubt, but it is surely not the purpose of the G.M.C. to expand this industry needlessly.

(4) As a corollary to this expansion there will be an equal expansion of tutorial classes and clinical instruction to equip the candidates. While this could be lucrative for some, it can only divert medical men from more essential work.

(5) As most overseas doctors already prepare themselves for the E.C.F.M.G., we would be adding to their burden an entirely different examination with different reading matter and different emphasis and for candidates who may have already failed the E.C.F.M.G. This is unfair.

(6) At a time when most examinations in this country have moved more towards the multiple choice questionnaire (M.C.Q.) as the sheet-anchor of the screening process, the G.M.C. has rejected the most validated M.C.Q. in the world—namely, the E.C.F.M.G.—in favour of an old-fashioned short test, yet to be devised.

There have been criticisms of the E.C.F.M.G., but not that it is too difficult. The G.M.C. may justly feel that British medicine should have a more searching test. By all means, but at least screen the candidates first so that we reserve the special test for those who have passed the E.C.F.M.G.

If your readers feel these points are valid I advise them to lobby the G.M.C., the B.M.A., and everybody else who can bring influence to bear. I have a feeling that the G.M.C. is now more susceptible to sensible criticism.—I am, etc.,

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Hospital Complaints Procedure

SIR,—The Davies Report[1] is such an odd document that I am not sure what any administration will do with it. There are, however, several features which are quite clear. Firstly, it concerns every individual working in the hospital service and could by extension affect every individual working in the field of health care.

The second important point is that it bases its philosophies on particular catastrophes which occurred in specific areas of health care which were in fact due largely to financial restrictions which the country by means of the Government and the Treasury imposes on the service. There is a very real danger that this document could be used to direct irritation with the service against the individual working within the service when the individual himself is working under impossible conditions.

Furthermore, the report may cause funds to be directed away from one area of health care into another, and whereas I would accept that priorities in the service may be inappropriate, when the service as a whole is grossly underfinanced in both current and capital accounts reallocation of funds can only mean lower standards of care in the areas from which funds are diverted.

To accept or reject this report is to plead guilty to a situation which is outside the control of those who work in the service. It asks a question of the type "and when did you stop beating your wife?" If the report is implemented in any form it follows a long line of similar documents which advise us how to conduct our affairs and which for the sake of our patients we have tended to ignore, for were we to follow them waiting lists would increase enormously, as would the time taken for any individual procedure. Furthermore, these circulars tend to deprive us of our rights as employees