indicate disease. The distinction between subjects with precipitins who have disease and those who have not must be made by clinical, radiological, and physiological means, but the presence of precipitins in a subject with a clinical picture consistent with allergic alveolitis is an important guide to the diagnosis.

The scope of our leading article did not allow full discussion of the immunological mechanisms of extrinsic allergic alveolitis, though, as we pointed out, the Arthus concept is insufficient to explain all the features of the disease. Dr Penny and his colleagues have shown lymphocyte transformation in patients already selected on clinical and radiological grounds but none in asymptomatic subjects with precipitins. Alternative approaches have been to look for immunological abnormalities in subjects without precipitins[1] or to measure complement (C3) consumption[2] in order to detect disease at an earlier stage. Moreover patients have been described in whom precipitins and a positive response to challenge with pigeon serum are present, but lymphocyte reactivity to the serum is absent.[3] For the moment the clinician must still make the diagnosis on clinical and histological criteria, supported but not overinfluenced by those immunological tests that are available to him.
—ED, *BMJ*.

[1] Boyd, G, and Parratt, D, *Thorax*, 1974, **29**, 417.
[2] Berrens, L, and Guikers, C L H, *International Archives of Allergy and Applied Immunology*, 1972, **43**, 347.
[3] Moore, V L, *et al*, *Journal of Allergy and Clinical Immunology*, 1974, **53**, 319.

Doctors, contraception, and sterilisation

SIR,—In these days when so much time is expended through the media of broadcasting and publications on the subject of the reproduction of the human species and its control it is not unreasonable to pause for thought and review the situation.

Our vocation as doctors is to the prevention and treatment of disease and injury; a full-time occupation and one not adaptable to regular hours. We are therefore responsible people and as such should be applying ourselves to administering drugs to control infections and correct deficiencies or deviations from the norm in those who need them. Similarly, when the case requires surgical intervention, operation is undertaken with a view to cure or alleviation.

What justification, therefore, have we in prescribing "the pill" to disrupt the normal hormone rhythm in the female and what right to mutilate the male to the end that he be rendered sterile?

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Dosage of neomycin sulphate

SIR,—We have noticed a discrepancy in the dosage of neomycin sulphate quoted for use as an intestinal antiseptic between the *British Pharmacopoeia* and the *British Pharmaceutical Codex*.

The dosage range suggested in the *BP* is 2-8 MU, whereas that in the *BPC* is 2-8 g. Since there is 1·5 g of neomycin sulphate in each megaunit the *BP* dose is 3-12 g, half as much again as that suggested in the *BPC*. To complicate the matter further, the *Extra Pharmacopoeia* (Martindale)[1] and Goodman and Gilman,[2] both respected texts, follow the *BPC* and suggest a dosage of 2-8 g while the *British National Formulary* follows the *BP* in giving a dosage of 2-8 MU.

Since neomycin sulphate is available as a standard preparation of the *European Pharmacopoeia*, monographed as containing not less than 650 international units of activity per milligram, it must be accepted as a substance that can be determined by weight alone. It would therefore seem that dosage ranges should be given by weight rather than in units.

The discrepancy between the various respected authorities should, perhaps, be explained.

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[1] *Martindale: The Extra Pharmacopoeia*, ed N W Blacow, 26th edn. London, Pharmaceutical Press, 1972.
[2] Goodman, L S, and Gilman, A, *The Pharmacological Basis of Therapeutics*, 5th edn. New York, Macmillan, 1975.

Measles encephalitis during immunosuppressive treatment

SIR,—Your recent leading article on this subject (26 June, p 1552) draws attention to an important problem of management. However, while appreciating the importance of T-lymphocytes in the immune response to viral infection, we feel that the statement that "prophylactic irradiation of the central nervous system selectively reduces T-lymphocytes" is perhaps too dogmatic and that the relative radiosensitivities of T- and B-lymphocytes are far from clear. Our own experience[1] and that of others[2 3] shows that B-lymphocyte numbers are reduced relatively more than those of T-lymphocytes during remission and we have demonstrated the possibility that radiotherapy may be responsible for this reduction. There is also evidence that, in mice, B-lymphocytes may be functionally more sensitive to ionising radiation than at least one subset of T-lymphocytes.[4]

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[1] Reid, M M, Craft, A W, and Todd, J A, *Archives of Disease in Childhood*. In press.
[2] Sen, L, and Borella, L, *Cellular Immunology*, 1973, **9**, 84.
[3] Winterleitner, H, *et al*, *Päediatrie und Pädologie*, 1975, **10**, 237.
[4] Carlson, D E, and Lubet, R A, *Radiation Research*, 1976, **65**, 111.

United profession

SIR,—Reports of the Annual Representative Meeting in the general press and in your pages convey the impression of a solidarity in our profession which does not exist. In more than 40 years I have not known a time of comparable dissatisfaction—not only with the actions of Government but even more with the lack of clear purpose in the profession. There are too many separate groups, from royal colleges to junior hospital staff, each pursuing limited, sometimes conflicting, ends.

The most recent casus belli concerns extra duty payments for junior hospital doctors. These payments might not have been introduced had the basic salaries of those staff been sufficient and their career development promoted as it should have been. These questions are partly, but not wholly, pertinent to the union-style activities of the BMA. I deplore the action accepted by the ARM, as do many —perhaps most—of the profession.

My concern now is with the other, greater interests of the profession as a whole which seem likely to go by default while the battles about money and pay-beds continue. We need a body which is able to present a broad medical view to Government. Sir John Richardson, Sir Thomas Holmes Sellors, and others advocated this three years ago.[1] Royal colleges, specialty associations, even this Association, have their own special fields of concern. At this time a Royal Commission is sitting and the Health Departments have published consultative documents; if we as a profession fail to offer coherent and unselfish advice on these proposals we shall have lost an opportunity which may not recur.

The Committee of Presidents of Royal Colleges and Deans of Faculties have a joint committee which made sound and welcome proposals to ministers nearly two years ago. That was a beginning, but it is not enough. A group of young doctors, starting from the Royal Marsden Hospital,[1] tried to present alternative views about career development late last year (15 November, 1975, p 412). We must have a body responsive to the views of the younger members of the profession and able to help in their presentation. It must relate to the other health professions also. The National Academy of Sciences of the USA has an Institute of Medicine with these objectives. Sweden has the Swedish Medical Society. We need to follow those.

The NHS, for all the harm done to it by the recent conflicts of personality and the years of inadequate funding in England, is still an asset to the public and profession alike. It cannot be isolated from our national financial problems. But it is surely our duty and self-interest to help it to survive as best it may. The priorities consultative documents are not "a policy of despair" as you described them (3 April, p 788) but opportunity for survival, as your conference on priorities (12 June, p 1447) shows.

GEORGE GODBER

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[1] Sellors, T H, *et al*, *British Medical Journal*, 1973, **1**, 737.

Staffing in the hospital service

SIR,—With reference to your leading article on this subject (19 June, p 1492) the BMA through its Commonwealth Bureau has indeed helped 60 000 overseas trained doctors in guiding them to suitable employment, but has anybody followed their fate as to what happened throughout this period?

If you would initiate a follow-up research on the fate of the overseas doctors you will be surprised how correct the statements in the Community Relations Commission report are. Moreover, if you refer to BMA policy as reflected in motions passed by the Representative Body in 1970[1] and 1972[2] you will see that the whole overseas doctors problems were indeed initiated by the BMA.

Your veiled criticism of the formation of the Overseas Doctors' Association is, I think, unjustified. The Overseas Doctors' Association