who continued treatment with tamoxifen alone did not have a response.

We agree that tamoxifen-induced hypercalcaemia probably is not uncommon, but as yet there is no firm evidence to support the suggestion that induced hypercalcaemia is indicative of a good response to tamoxifen or other additive hormones used in the treatment of breast cancer.

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A protection against beriberi

SIR,—In their article "Gastrology, the use of culinary terms in medicine" (22-29 December, p 1636), the authors venture that "throwing away excess water from parboiled rice must be a British trait."

This is in fact an age-old practice prevalent in Southern India and no doubt acquired by the British in the days of the Raj. The rice is boiled in an earthenware pot and the excess water put to a variety of uses or just discarded. It formed an excellent starch in the laundering of clothes. It was also the original base for the celebrated mulligatawny (Tamil pepper water) soup, which in its original form is a fiery liquid seasoned with chilli and garlic and recommended as an aid to digestion.

The pernicious habit of discarding the excess water from the rice is in fact contributory to the beriberi prevalent in the area, later aggravated by the introduction of machine polishing of rice. This is highlighted by an interesting episode from the Carnatic Wars. Robert Clive, a few English officers, and a force of native sepoys were besieged for a prolonged period at Trichinopoly. The sepoys, as a token of their loyalty, gave the officers the rice and subsisted on the congee or excess water in which it was cooked. The English began to develop symptoms of beriberi while the sepoys remained relatively healthy.

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Thrombocytosis, circulating platelet aggregate, and neurological dysfunction

SIR,—Although the connection between neurological dysfunction and platelet dysfunction described by Dr F E Preston and others (15 December, p 1561) is most probably vascular, the possibility of a common cause in an abnormality of prostaglandin production has not been excluded. Prostaglandins are known to have effects on platelets and on neurones and to respond to treatment with aspirin, which these patients all received. Perhaps a continuation of their studies accompanied by prostaglandin estimations may elucidate the question.

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If I was forced to cut

SIR,—The articles published by a special correspondent in the series "If I was forced to cut" have all produced suggestions for making savings and also drawn attention to aspects of the individual specialties of the doctors interviewed which they feel must be protected or expanded.

The "more penetrating analysis" by Dr D L Freedman (15 December, p 1589) suggests that the first method to make overall savings of Health Service finances should be to reallocate available resources to departments which are economically essential. The only example quoted is the withdrawal of rehabilitation resources from geriatric medicine. Less than 5% of patients referred to an active department of geriatric medicine will require long-stay care. This is one of the more expensive forms of treatment provided by the NHS and your leading article (p 1532) states that it probably costs more for each long-stay patient than for a heart transplant. Withdrawal of rehabilitation services from geriatric medicine will lead to a marked increase in the numbers requiring long-stay hospital beds.

The rising proportion of the very old in the population, with their higher need for institutional care,[1] makes efficient use of hospital beds essential. It is not simply the number of beds which is important but the quality of hospital care and of supporting services. Scotland has a geriatric bed norm of 15 beds per 1000 over 65,[2] compared with the unmet English norm of 10 beds per 1000 over 65. Even where departments of geriatric medicine in Scotland have this greater number of beds, waiting lists for transfer from other hospital departments and from the community exist.[3 4]

It has been clearly shown in England that in active departments of geriatric medicine which have less than 10 beds per 1000 over 65 but whose beds have full access to district general hospital rehabilitation and investigatory facilities it is possible to provide a full service without a waiting list.[5-7] This both benefits the ill elderly person and produces considerable financial savings for the NHS. It has also been achieved without excessive provision of community supporting facilities and is not simply a case of transferring the cost to a different authority.

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Medical audit and clinical competence

SIR,—I was interested to read Dr I J T Davies's comments on audit (5 January, p 49). He writes, "We should realise that audit as generally understood denotes the process of identifying individuals whose standards of practice fall below the minimum acceptable to the majority. It has little or nothing to do with promotion of the highest standards of competence. . . ."

If looked at in the manufacturing context of quality control, I agree with him. But in the medical sense it is too narrow a definition. Audit may be concerned with the structure surrounding, the process of, and outcome derived from medical decision making. Whatever method or methods of audit are used, they should certainly expose substandard situations. However, in addition, for those whose standard of practice is already satisfactory, audit allows an appraisal of their work in the hope and expectancy that the mere satisfactory may be converted into good or excellent. The word audit is as good a word for expressing this as any other. I accept that many have been doing this for years.

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Payment for general practitioners in hospitals

SIR,—I fail to understand how the chairman of the GMSC Hospitals Subcommittee (5 January, p 51) can claim that Circular HC(PC)(79)5 was "overwhelmingly welcomed" by the Conference of Local Medical Committees since it was not published until two months later.

My own recollection is that representatives barely had time or opportunity to study the report of the Review Body, which gave the first official indication of what was to come. That report commented adversely on the lack of sufficient information on which to price satisfactorily the new arrangements but gave only the barest outline of what the arrangements were. Maybe there was some cause for congratulation at progress made after 30 years, but in the absence of detailed information this can hardly be interpreted as unqualified approval.

If "the vast majority of general practitioner hospitals have provided a casualty service for which they received no payments," talk of increased payments, many "of the order of several hundred per cent," is meaningless. What is important is that the new arrangements should provide the proper rate for the job. My LMC is not convinced that this is possible within the framework laid down in the circular and has sent the GMSC a detailed list of criticisms.

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Pay of related ancillary workers

SIR,—My wife and I should like to thank publicly Michael and Mary Glanvill for their spirited and courageous fight for related ancillary pay. That it has been curtailed by the decision of the Court of Appeal (15 December, p 1595) does not detract one iota from the determination they have shown over 13 long years, despite the dejection and frustration felt by the lack of support from the BMA and GMSC.