crest be known as the neurocristopathies,[2] but whether the emphasis in classifying these endocrine disorders should take account of the presence of neurofibromata is not clear. Riccardi when reviewing von Recklinghausen's neurofibromatosis did not find substantial evidence for endocrine dysfunction as a feature of neurofibromatosis with perhaps the exception of phaeochromocytomas.[3] Multiple endocrine neoplasia type I and multiple endocrine neoplasia type IIa (Sipple's syndrome), like neurofibromatosis, show an autosomal dominant inheritance pattern, but only careful family studies will confirm whether there is a true association between neurofibromatosis and the features of the newly described multiple endocrine neoplasia type IIIa.

A note of caution in the search for further cases of multiple endocrine neoplasia type IIIa (or whatever the nosologists finally allow it to be called) is that the average age of the first three patients described by Dr Griffiths is 60. The emergence of all three features of this syndrome may be age dependent, thereby complicating family studies through an ascertainment bias.

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[1] Schimke RN. Syndromes with multiple endocrine gland involvement. *Proc Med Genet* 1979;**3**:143-75.
[2] Bolande PR. The neurocristopathies: a unifying concept of disease arising in neural crest maldevelopment. *Hum Pathol* 1974;**5**:409-29.
[3] Riccardi VM. Von Recklinghausen neurofibromatosis. *N Engl J Med* 1981;**305**:1617-27.

The big spenders

SIR,—Dr G D H Shephard (26 November, p 1630) sounds a rare note of good sense: would that there were more people who thought like him.

Having worked in a number of hospitals in different parts of Britain, as well as in several practices, I can come to no other conclusion than that large amounts of money are wasted on unnecessary investigations and irrelevant, or excessively expensive, drugs that a little thought would have shown to be avoidable. General practitioners are known to be more influenced in their prescribing habits by the seductive advertising of drug companies than by evidence of the advantages of one drug over another. We are all ignorant of the costs of the drugs we prescribe.

If the intention of doctors is to provide the best care for their patients and the responsibility of the Department of Health is to provide the best system for the delivery of this care within the inevitable constraints of a limited budget, then has the time not come for a new Proplist or equivalent? I can already hear the howls of "Threat to clinical freedom," but to those who feel this I would ask two questions: Do they think it is better to have their prescribing habits determined by the commercial practices of drug companies or by a committee of experienced doctors? And do they think it is better for their patients to have "that new expensive drug" or a regular home help, a visit from a district nurse, domiciliary occupational therapy, or just a few weeks off the waiting time to go into hospital? We delude ourselves if we think we can have both.

D R T GUNDRY

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Payments to doctors and the responsibilities of ethics committees

SIR,—The General Medical Services Committee and the Association of the British Pharmaceutical Industry have separately debated the recommendation from the General Medical Council that payments to doctors for clinical trials should be stated in the protocols of such studies and submitted to ethics committees (2 July, p 58). Independently, we have arrived at similar conclusions, which are as follows.

Firstly, there are no objections on ethical or other grounds to doctors accepting payments commensurate with the work involved in undertaking clinical trials provided that all the procedures in those trials are clearly explained in protocols and approved by an ethics committee. Appropriate levels of such payments for general practitioners are adequately outlined by the code of practice for the clinical assessment of licensed medicinal products in general practice (16 April, p 1295).

Secondly, the primary concern of an ethics committee is the welfare of the patient and it therefore concentrates its attention on what the doctor proposes to do to the patient and whether the patient is sufficiently informed. Hence, financial relations between doctors and pharmaceutical companies in these circumstances are outside the remit of ethics committees.

Thirdly, the question of payments may be raised in principle by either the doctor undertaking the clinical trial or the ethics committee, but it would be invidious for any ethics committee to discuss and rule on the exact amount that is appropriate for a particular study. Such payments should not, therefore, feature in the protocol.

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British Medical Association,
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ERIC S SNELL
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Junior doctors' hours of work

SIR,—We were deeply disturbed by the total inaccuracy of Dr Philip D Welsby's letter (26 November, p 1631) concerning the reduction of junior doctors' hours of work.

He states that the Department of Health and Social Security used an informal meeting to issue circular PM(82)37. This is not true. The February 1982 conference, which was attended by all sections of the profession and the NHS, resulted in a joint working party with representatives from the Hospital Junior Staff Committee, the Central Committee for Hospital Medical Services, and the Joint Consultants Committee. Only decisions fully supported by all three sides were written into this circular.

To suggest that any changes have been rushed through is also inaccurate. It is almost two years since the exercise began.

Again, Dr Welsby is wrong in stating that the government refused salary protection. This has never been discussed with the government. The Doctors' and Dentists' Review Body did refuse to introduce protection last year, asking for evidence of increased workloads, but it was not even this that was the subject of "a quick ring round." Members of the Hospital Junior Staff Committee were asked whether they wanted to accept the 1983 pay award that gave some juniors an increase of 18%. They were unanimous in their reply, and the method of communication was merely to expedite payment of the award at a time when there was a real risk of it being lost by the general election.

The idea that the hours of work exercise is linked with consultant expansion is yet another figment of Dr Welsby's imagination. The two are entirely separate. We find it difficult to understand his argument concerning the lack of a jobs freeze, as such a freeze predated the present discussions over hours of work.

Finally, Dr Welsby laments the lack of continuity of care among junior doctors. We understand that continuity of care is something held by consultants. No junior, unless he is working a one in one rota, has ever provided continuity of care. To suggest that if consultants have to provide continuity of care they will not be able to attend a myriad of "necessary committees' is, in our view, an insult to the position of consultants and a total surrender to bureaucracy.

The Hospital Junior Staff Committee, which is the sole representative body for junior doctors, is unanimously behind the present exercise. This is the first attempt to reduce hours since 1948, and progress reports received from six regions show that the proportion of juniors working more than a one in three rota has dropped from 45% to 24%. It is sad, therefore, that a consultant physician such as Dr Welsby gains such prominence with an inaccurate and unrepresentative letter that might appear to some to be the views of a junior doctor.

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Negotiating chairman

MICHAEL REES
Immediate past chairman

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*** We sent a copy of this letter to Dr Welsby, who replies below.—ED, *BMJ*.

SIR,—I am misquoted as stating "the DHSS used an informal meeting to issue circular PM(82)37" and it is then stated that this misquotation is not true. I said "the DHSS used the informal conclusions of a conference. . . ." The two are *very* different. The circular states: "there were no formally agreed conclusions." To be misquoted, to be thereby accused of lying, and then to be accused of inaccuracy within 30 words is surprising.

I never suggested changes had been *rushed*. I did say that the DHSS *pushed* through changes in junior rotas (the authors' second inaccuracy). "Rushed" and "pushed" have different meanings. The DHSS circular (PM(82)37) is in effect a command and thus the word "pushing" is rather mild.

"Dr Welsby is wrong in stating that the government refused salary protection." I quote: "Dr Rees accepted the government's decision not to provide full salary protection for juniors moving from one-in-two to one-in-three rotas . . . 'we couldn't deliver because the minister was saying no.'"[1] It is difficult to reconcile these two quotations: one must be inaccurate (their third inaccuracy). (The authors also state that salary protection "has

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never been discussed with the government." Good heavens!)

I did not say that the "hours of work exercise is linked with consultant expansion." *I said the opposite*: "the discussions before the changing of the junior rotas seemingly did not include the possibility of a jobs freeze" (their fourth inaccuracy).

I did not "lament the lack of continuity of care among junior doctors" (continuity of care is the responsibility of consultants). I did say "continuity of patient care has been adversely affected. As the result of the new rotas there will have to be more cross cover at a junior level." (Their fifth inaccuracy). More cross cover inevitably affects patient care, including continuity.

My views "might appear to some to be the views of a junior doctor." I am relieved and flattered by this: consultant views of matters involving junior doctors are often held to be biased, emanating as they do from a relatively privileged position. If my views are unrepresentative, which I doubt, that does not make them wrong.

The letter to which I reply, which is full of inaccuracy, has not changed my opinions. I would advise Dr Bristow and Dr Rees to read my previous letters with care (12 March, p 895; 26 November, p 1631). The contents are relevant to all hospital doctors, not just to the juniors.

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[1] Anonymous. A quiet crusader quits. *World Medicine* 1983 Oct 1:36-7.

Points

Early trials of streptomycin

Dr J G SCADDING (Beaconsfield, Bucks HP9 1SU) writes: Dr David H Spodick (12 November, p 1470) seems to be labouring under some misconceptions about the "early British trial of streptomycin in meningeal tuberculosis." I was a member of the MRC committee which planned the early streptomycin trials and should like to dispel two of these.

Firstly, the trial was not "forced on the investigators by a shortage of streptomycin." In fact, we grasped the opportunity provided by this shortage to plan an ethically acceptable controlled trial in patients with a carefully defined sort of pulmonary tuberculosis; an opportunity that we recognised as dependent on a probably temporary shortage.

Secondly, all cases of tuberculous meningitis were accepted for treatment. We were all too familiar with the 100% mortality of this disease in those prechemotherapy days and saw no need for controls when a single survival was significant in any sense of that awkward word.

The end of clinical freedom

Professor DAVID H SPODICK (Saint Vincent Hospital, Worcester, Massachusetts 01604) writes: Professor J R Hampton's leading article (29 October, p 1237) is right on target and will be welcomed most warmly by those of us who have tried to make comparable points.[1 2] Professor Hampton is actually dealing with physicians' behaviour, which has been largely unacceptable in the matter of what he terms "clinical freedom." As that behaviour is only sometimes in accordance with ethical conduct and with the scientific quest for truth, constraints (such as imposed by our Food and Drug Administration) have forced acceptability for many trials of medical treatment. Yet, somehow, surgical trials continue to escape.... The onus of ensuring appropriate design of clinical trials should be on the medical journals—both because others in authority are not insisting on it and because publication is virtually always necessary for investigators to thrive. Journal editors and reviewers have measured up quite well in terms of trials of pills and injections, but have maintained the curious double standard for surgical trials. Surgery has somehow always been a sacred cow to both hospital staffs and scientific journals. I suppose we will always have sacred cows but we need to control the sacred cowboys who market the products.

[1] Spodick DH. The randomized controlled clinical trial: scientific and ethical bases. *Am J Med* 1982; **73**:420-5.
[2] Spodick DH. Randomize the first patient: scientific, ethical and behavioral bases. *Am J Cardiol* 1983; **51**:916-7.

Unreviewed reports

Mr C S GOOD (Roussel Laboratories Limited, Wembley Park, Middlesex HA9 0NF) writes: I am delighted that you have introduced the section for unreviewed reports, particularly as this will give those wishing to report possible adverse reactions a chance to publicise their findings without giving the impression that the report has been confirmed and has the endorsement of the *BMJ*. Now, as always, doctors must be aware of their obligation to report adverse reactions, preferably to the company supplying the product, who will pass the information to the Department of Health and Social Security. Care is required in interpreting results, however, particularly after problems with a product have been sensationalised by the media.

Unsolicited mail

Dr R C GUPTA (S M S Medical College, Jaipur, India) writes: Dr Malcolm Kerr's suggestion (12 November, p 1473) of individual action by doctors is unlikely to have much effect on the volume of unsolicited mail they receive. Most doctors ignore such mail, and the manufacturers, instead of being discouraged, are responding by increasing production of promotional mail, if the American experience is any guide.[1] Personal audit, as suggested by Dr Kerr, may be effective but doctors will be hard put to find time to go through the voluminous promotional mail. . . . Some time ago the government of India imposed a ceiling on expenditure on publicity. Excess expenditure cannot be included in the cost of production and is taxable. This has had a salutary effect on the printing of publicity material. Furthermore, though this measure was strongly resisted by the manufacturers it does not appear to have had any adverse effects on their sales.

[1] Connors JM. More on junk mail. *N Engl J Med* 1983; **309**:673-4.

Multiple endocrine neoplasia associated with von Recklinghausen's disease

Dr A BOISSONNAS, Dr P KHALIFA, and Dr O MEYNIARD (Department of Internal Medicine, Hôpital Cochin, Paris, France) write: Dr D F R Griffiths and others (5 November, p 1341) report two new cases of duodenal carcinoid tumours with von Recklinghausen's neurofibromatosis and phaeochromocytoma and suggest that this combination of tumours is probably genetically determined. We have seen a 52 year old man with ampullary carcinoid shown by obstructive jaundice and widespread cutaneous non-familial neurofibromatosis. Plasma serotonin, vasoactive intestinal peptide, parathormone, catecholamine, insulin, and calcitonin concentrations after operation were normal, as were 24 hour urinary excretion of 5-hydroxyindoleacetic acid and vanillylmandelic acid. Peripheral and central neuroendocrine cells, including carcinoid cells and melanocytes, have a common molecular marker: neurone specific enolase.[1 2] This does not prove a common embryologic origin but identical expression of a common gene. We agree with Dr Griffiths and others that more reports are needed to understand whether or not this rare association is fortuitous.

[1] Schmechel D, Marangos PT, Brighiman M. Neurone specific enolase is a molecular marker for peripheral and central neuroendocrine cells. *Nature* 1978;**276**: 834-6.
[2] Tapia FJ, Barboso AJA, Marangos PT, Polak JM, Bloom SR, Dermody C. Neurone specific enolase is produced by neuroendocrine tumours. *Lancet* 1981;i:808-11.

Villa Serbelloni

Dr ALRED WHITE FRANKLIN (London W1N 2DE) writes: Professor L J Bruce Chwatt's account of his experiences of the Villa Serbelloni (26 November, p 1624) caused me an acute attack of nostalgia. My delectable visit was to attend the small conference in 1975 at which was founded the International Society for the Prevention of Child Abuse and Neglect (ISPCAN). The director at that time had been dean of the medical school in Denver and our host was Dr Henry Kempe.... We were given an anecdote about the Principessa Torre e Tasso, a lady of great wealth. She had been staying at the villa when it was still a hotel. Brought her bill before leaving, she complained that it was not enough. When told that it was the usual rate she replied: "You do not understand—I wish to buy the hotel."

Candidiasis in heroin abusers

Dr MICHAEL MACKAY (Kaitaia Hospital, Kaitaia, New Zealand) writes: Dr Peter Colligon and Dr Tania Sorrell describe a distinctive syndrome of disseminated candidiasis in heroin abusers (24 September, p 861). Dr Jennifer Hoy and Dr Bryan Speed suggest that the origin of this infection may be from lemon juice used to dissolve the heroin (19 November, p 1549). In 1976 four drug addicts presented to a hospital in Wellington with similar histories of a one to two week illness consisting of rigors, fever, headache, and myalgia. In each case the appearance of painful small lumps in the scalp, and in one case also in the axillary and pubic regions, led to presentation to hospital. *Candida albicans* was cultured from skin lesions in all four patients, and in one endophthalmitis was present. These addicts were known to each other and all dissolved their heroin in lemon juice, often from the same lemon. They were aware of other addicts with the same illness, and two were seen briefly at hospital, *Candida* being grown from the blood of one and from scalp lesions of the other. It seems likely that lemons are the source of *Candida* in this distinctive syndrome.

Association between use of cotton tipped swabs and cerumen plugs

Mr P D BULL and Mr A S JONES (Children's Hospital, Sheffield S10 2TH) write: Dr D Kumar (26 November, p 1628) seems to have missed the point of Dr Peter Baxter's useful report. The mechanism of the formation of wax plugs is not unknown but perfectly clear if consideration is given to the relative diameters of the child's external auditory canal and the cotton bud. . . . Further, it is common experience that the wax plug, often concave on its outer surface, extends into the bony meatus; it can only have arrived there by having been pushed from the outer canal, as the bony meatus contains no wax-producing glands. The constant impaction of wax by the ramrod effect of the cotton bud defeats the normal cleansing mechanism of epithelial migration, and accumulation of wax is inevitable. Dr Kumar's advice to use organic wax solvents before further probing the ear with cotton buds can only compound the problem and increase the incidence of otitis externa. More useful advice would be to leave the ears alone apart from cleansing the outer most visible part of the ear canal and the concha for aesthetic reasons only.

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