in this case begins with the weaker dose of 10 mg. working up to the larger one of 50 mg., whoch dosage was continued at weekly intervals after routine investigation of the urine for proteinuria.

In the far-off days before 1945 various clinicians at the Charterhouse Rheumatism Clinic who had been using gold injections for over 12 years (aurocalcium) found that after testing for sensitivity to gold the best results were obtained by giving the highest dose of 50 mg. initially, the second dose 25 mg., and the subsequent weekly doses of 10 mg. until a remission occurred and if there was no evidence of toxicity by blood, urine, and clinical tests. It was considered unwise to continue the gold injections when the patient went into remission. The course was repeated if a relapse occurred, and very often two courses only were given, and then usually for a period of several months only.

I am aware of the disfavour with which gold injections were regarded soon after 1945 owing to reports of severe toxic reactions. Only in the past 10 years has its popularity in therapy reappeared. However, a survey of its uses for over 12 years at the Charterhouse Clinic revealed no severe gold reactions. A reminder of the good results of gold therapy may not be out of place.—I am, etc.,

MARJORIE M. DOBSON.

London W.1.

Treatment of Rabies

SIR,—In your leading article on this subject (27 June, p. 742) you indicate that advice, antiserum, and vaccine are available from me at the Virus Reference Laboratory, Colindale.

I think it is very important to point out that advice plus the antiserum and vaccine are obtainable at any time through the medical staff of this laboratory, one of whom is always available. Also, as is indicated in the *Notes on the Prophylaxis of Rabies in Man*,[1] advice, antiserum and vaccine are obtainable from the Public Health Laboratories in Cardiff, Liverpool, and Newcastle.—I am, etc.,

A. D. MACRAE.

Virus Reference Laboratory,
Central Public Health Laboratory,
London N.W.9.

REFERENCE

1 *Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service*, 1967, **26**, 201.

Treatment of the Nephrotic Syndrome

SIR,—Your leading article on "Treatment of the Nephrotic Syndrome" (11 July, p. 58) implies that unpublished results of the Medical Research Council's controlled trial of azathioprine in patients with proliferative glomerulonephritis shows a slight but statistically significant benefit to the treated group. In fact there is no evidence of benefit, significant or otherwise. Mortality is actually higher among the patients who received azathioprine and prednisone.—I am, etc.,

GEOFFREY ROSE,

Co-ordinator, M.R.C. Trial of Azathioprine in Chronic Renal Disease.

London School of Hygiene and Tropical Medicine,
London W.C.1.

**We regret the error.—ED., *B.M.J.*

Primary Medical Care

SIR,—There is much to be said about the report of the B.M.A. Planning Unit which you summarized (30 May, p. 535). It talks of "inadequate medical equipment," but a primary physician does not need much medical equipment. Next, "virtual exclusion from the higher status work of hospitals" is mentioned. But perhaps some of us do not want to be going to hospital several times a week, and would actually prefer to be in our consulting room and visiting patients in their homes. Some of us feel that this work has just as high a status as that of our hospital colleagues.

"A specialty of primary medicine" is another phrase used. Cannot the writer of the report see that the world is crying out, not for more specialists, but for more ordinary, human, humane generalists, who are able to sit down alone with a patient in a room and deal with all the simple medical needs of the patient. Much of the social work that the report talks about is best done *en passant* when the patient has used the occurrence of a physical complaint to present himself to the doctor. Many medical consultations are a form of *double entendre*, and a tremendous amount can be done if the doctor is ready, willing, and able to pay attention to the patient's other problem. Thus it would be disastrous to good primary medical care "to narrow the front on which he works."

The report says "The primary physician's contribution to preventive medicine and family planning should also be increased." On the contrary, in my view if the primary physician is to have the time to do his generalist work in his consulting room he would be wise to delegate preventive medicine and family planning to his skilled colleagues who work in public health and in family planning.

Sir, anyone who looks at the history of medicine will know that at all times there have been peculiar fads and fashions that have been quietly discarded by the next generation. It seems to me there is a present fashion, afflicting both hospitals and general practice, which I will call "supermarket medicine." Unfortunately, if we all adopt it, it will be much more difficult to undo the effects of it.

I am sorry to have written at such length, but as you said in your leading article (30 May, p. 493) "In the last 20 years general practice has been the subject of countless articles and at least ten major investigations."

Considerations of space prevent my taking the subject further, but it is time that the views are aired of someone who feels patients in the supermarket world of the 1970s will be very glad of the individual personal attention provided by the traditional small practice.—I am, etc.,

J. G. BANCROFT.

London E.C.1.

Review Body Valuation

SIR,—I fear in the general explosion following our negotiators' announcement I have failed to discern wherein lies the victory. Is it not so that we have called off our sanctions without obtaining acceptance of the Review Body's advice and on the agreement merely that the Review Body will be reconstituted, when in fact the Government asked it to resign in the first place? Big deal! Principles are all very fine, but are we not concerned with medical staffing and recruitment? I cannot see that this debacle is likely to improve things.

While on the subject of the Review Body, as a regional consultant I am not entirely sure that I have any great faith in it serving my interest anyway. Perhaps it is the best of a number of evils. As I see it, after ten years or so of training my expert opinion and services have been valued up till now at approximately 40s. an hour (allowing for a 40-hour week). Put another way, when a family doctor asks me to see someone in my outpatient clinic for a further opinion I receive something like 20s. for an initial consultation, examination, and opinion, and am expected to see follow-up appointments (as judged by the number the appointments clerk sends me per hour) for about 3s. 9d. The Review Body feels this is not good enough. I am really worth 26s. for an initial consultation and 4s. 10d. for a follow-up.

Am I being conceited if I dare to think that in 1970 my time is really worth a bit more than this?—I am, etc.,

M. T. HASLAM.

Clifton Hospital,
York.

Subconsultant Grade

SIR,—I had hoped to deliver the substance of this letter in a speech at the recent Annual Representative Meeting in connexion with the subconsultant grade, but was prevented from doing so because of the heavy pressure of business upon the agenda. Thank you for giving me the courtesy of your pages.

At the Annual Representative Meeting at Eastbourne in 1968, medical assistants were mischievously referred to as the dead-beats and drop-outs of the profession. I would point out that many of us find ourselves in this grade not because we have failed but because we have changed our discipline, and it is, I believe, current policy that doctors should not be discouraged from taking the lessons they have learned from one branch of medicine into another. Nevertheless, some of the mud slung has

stuck. We have become, I am afraid, the Cinderella grade of the profession and a minority group the B.M.A. can well afford to neglect. Support for this view is found in the Twelfth Review Body Report, paragraph 99, which states that the Association claimed that there should be a differential between the top of the scale of medical assistants and the bottom of the scale of consultants. Fortunately, the Review Body, in its wisdom, rejected this. If any confirmation were needed that ours is a grade despised by its own Association surely this is it. I beg your readers to consider the following facts:

1. Always included among hospital junior doctors in the past, whatever our age and experience, we have recently been promoted to the senior grade so as to qualify for the 15% rather than 30% pay rise.

2. The top grade for medical assistants' salary is very little above the starting salary for consultants, who consider, probably quite justly, that they have a pay grievance.

3. I believe the majority of medical assistants work in casualty and accident departments where the work load is heavy and much responsibility is taken. Admittedly, one has to seek advice and share this responsibility with colleagues at times, but no doctor takes ultimate responsibility for everything that he sees.

I write as one who has been qualified for nearly 25 years, and apart from National Service and a spell demonstrating anatomy all this time has been spent in clinical practice. My time having been divided almost equally between hospital and general practice, I can say, at risk of offending my many general practitioner friends, that I work as hard as a medical assistant as I did as a general practitioner and take very much more clinical responsibility. To anyone who says why does not this chap go back into general practice instead of bellyaching, I would reply that I shall probably have to. This would be a shame, because the need for experienced British graduates in accident departments is probably greater than it is in family medicine.

As a solution I am not suggesting that medical assistants should be automatically upgraded, but that their pay scale should once again be reviewed and should be made commensurate with the work and responsibility undertaken. I believe that this applies particularly to those medical assistants who are working in accident departments, and as a committee is considering this matter and is due to report in the near future, I propose to draw its attention to my letter.—I am, etc.,

FRANK R. GOODWIN.

Good Hope General Hospital,
Sutton Coldfield, Warwicks.

Unexpected Bonus

SIR,—Now that the Government has promised to re-establish the Review Body and to hold talks on the full implementation of its award, some interesting facts may have arisen from the two-week period during which most general practitioners and their hospital colleagues refused to issue National Health Insurance certificates.

I would very much like to know how much, on average, the Department of Social Security paid over and above the amount it usually pays during the period of two weeks when no general practitioner supervised the issue of the certificates. Two conclusions will be possible, depending on whether there was an excess or a saving. I submit that both of these conclusions will be in our favour.

Should the amount be considerably in excess of the usual amount paid out, this will give the Government an indication of just how much the doctors are saving the country by having, as part of their contract, the obligation to sign certificates. If this is so, then this information will be useful in negotiating further awards.

If the average amount falls considerably below what is normally paid out, or even is the same, then there can be made out a case for self-certification for, at least, short-term illnesses. If this certification saves the Exchequer nothing then there is little reason why general practitioners should have to continue to issue these certificates. I am sure that many general practitioners would give up a percentage of their income if they could be saved this onerous work.

How delightful it was during those glorious two weeks to be assured that the reason why a patient visited you was because of his medical condition only. There was indeed no sneaking feeling by the doctor that the patient was merely attending to get a few days paid holiday or to claim his tax rebate.—I am, etc.,

SIMON JENKINS.

Bury, Lancs.

Allowances for G.P. Trainees

SIR,—I entirely agree with Dr. D. F. Grant's comments (27 June, p. 798), but I have learned to be a cynical realist where minority groups in the N.H.S. are concerned. If the income of the general practice trainee was substantially increased it would tend to attract doctors away from the junior hospital ("training"?) posts.

A strong case could be made, however, for increasing the car allowance, which at £295 p.a. is quite inadequate for its purpose, and for providing the general practice trainee with a lodging allowance in order to give financial parity with his hospital "sibling," where accommodation is provided free, or the rent heavily subsidized by the hospital board. There are sufficient disincentives inherent in general practice without adding a financial one, and it is unreasonable to expect the general practitioner trainee to accept a lower income, for this is the effect, or else to expect the trainer to subsidize the cost of his accommodation, as so often happens.

Financial gain should not be the incentive in a training scheme, but neither should the trainee nor the trainer have to subsidize it.—I am, etc.,

R. S. C. FERGUSSON.

Beauly,
Inverness-shire.

Solving the Staffing Problem

SIR,—The influx of junior doctors from overseas diminishes rapidly, and there is now a shortage of pre-registration posts for the increasing number of home-grown graduates. We are to have talks on overtime payments for house-surgeons and registrars, regarded by my junior colleagues with distaste and a sense of degradation.

Can lunacy go any further? Why not double the number of junior posts in regional hospitals? Are we so institutionalized that we have no imagination with which to set our house in order?—I am, etc.,

E. N. OWEN.

Shrewsbury.

Points from Letters

Campbell de Morgan Spots

DR. R. H. SEVILLE and colleagues (Beaumont Hospital, Lancaster) writes: In commenting on our article in the *B.M.J.* (14 February, p 408) a recent leading article in the *Lancet* (18 April, p. 824) mentioned the wisdom of repeating the alkaline phosphatase results when the opportunity arose. Two rises in ambient temperature before and after Whitsuntide (Max. 27·6° C) were each followed within one to two days by the development of Campbell de Morgan spots. Fourteen out of 28 adult inpatients, and 10 out of 16 adult outpatients were affected. Alkaline phosphatase examinations as well as liver function tests, E.S.R.s, and full blood counts were all within normal limits. Virological studies were undertaken on the inpatients with the same negative findings as previously. The outpatients and those referred to in our article were all from scattered districts. . . .

Retired Doctors

G. R. THOMSON (Medical Mailing Co., London W.13) writes: While sympathizing with Dr. C. Allan Birch (20 June, p. 736), it is simply not a feasible undertaking to communicate individually with retired or retiring doctors, and even if this were possible such a list would be difficult to maintain. Traditionally most mailing lists are compiled on the basis that they include only doctors who are in active practice. . . .

Who Should Do Psychotherapy?

Dr. J. R. SCOTT (London N.3.) writes: Before we ask "Who should do psychotherapy?" (13 June, p. 617) we have to find out how people at present select their psychotherapist. I suppose that when they become aware of a problem for which they feel the need of help they look round at all the possible people and go where they expect to obtain the best effect. Their judgment is influenced by the feeling they have about the individuals available, which partly depends on their own personality. . . . "Does psychotherapy work?" is a meaningless question. It is the counsellor's personality that works; or, rather, the rapport and its effect on the patient's personality. Since there may be several counsellors at work simultaneously—doctor, psychotherapist, priest, friends, relatives, barmen, etc.—statistical proof of cure is unlikely to be obtainable. Psychotherapy has always been partly institutionalized but the bulk of it occurs within the family—this is particularly so in India. In Britain we certainly need more trained people and perhaps more organizations, but it is important to make ordinary people aware of what to do; what is helpful, what is harmful, what is impossible. . . .