20-month-old baby, who developed a roseolar rash at the same time. Among the types of virus isolated from throat or faecal specimens from my patients at the time of their roseolar reactions were adenovirus 2, 3, and 14, echovirus 9, 11, 27, and 30, Coxsackie A6 and 9, Coxsackie B2, 4, and 5, and parainfluenza type 1.

Most children who received the earlier, less attenuated, measles virus vaccines developed a roseolar reaction as their fever subsided. This rash differed from that of measles in two respects: it began on the trunk instead of the face and it appeared as the temperature dropped and not at the start of the secondary fever.

Children who undergo either the fast ("one-spike") or the slow (roseolar) febrile immunizing reaction are as a rule otherwise healthy and free from any localizing signs of infection in the ears, nose, throat, chest, abdomen, or urine. The younger the child, the higher is the temperature likely to be. Presumably the roseolar rash is due to virus particles being neutralized in the skin at the end of a period of viraemia. Perhaps viraemia does not occur in the "one-spike" fever and so no rash appears.

Please may sixth disease now disappear from the next edition of textbooks?—I am, etc.,

G. I. WATSON

Peaslake, Surrey

1 Watson, G. I., *Journal of the College of General Practitioners*, 1966. **11**, Suppl. 1, p. 15.
2 Watson, G. I., *Proceedings of the Royal Society of Medicine*, 1969, **62**, 1135.

Hernias in Children

SIR,—Your leading article on this subject (31 August, p. 540) was moderately distressing to me since I described the transperitoneal probing technique 11 years ago.[1] Shortly after the article appeared I was informed by a colleague from New Jersey that he had published such a procedure in an earlier article in that state's medical journal. More recently a U.S. naval surgeon exhibited a film at a clinical congress of the American College of Surgeons without prior reference.

I suppose what this represents is an unfortunate tendency for good ideas to become buried under the tons of more current literature, so I would not be surprised to learn that some canny Scot had described the same technique in an obscure journal around the turn of the century. But, for the moment, the Colonials have it over the Danes three to one.—I am, etc.,

EDWARD O. GOODRICH JR

Santa Fe,
New Mexico

1 Goodrich, E. O., jun., *Surgery*, 1962, **54**, 432.

In Arduis Fidelis

SIR,—As a medium-brass regular R.A.M.C. officer, may I express my admiration for Sir George McRobert's fine review of Lt. Gen. Sir Neil Cantlie's stirring *History of the Army Medical Department* (12 October, p. 111) and may I express my gratitude to you, Sir, for the generous allocation of space for the review.

I write, however, to take sharp exception to a sentiment expressed in the first paragraph—"the modern view . . . that defence medical services should consist of a regular 'core' of doctors highly trained in logistics, administration, and military planning and that consultants and clinical doctors should be obtained on a temporary basis from civil sources seems to be gaining ground." I think this view may be losing a little ground. It is most important that doctors considering joining the R.A.M.C. be not misled. The great majority of R.A.M.C. officers are engaged in the clinical care of the wounds, diseases, and injuries of members of the Army, their wives and children, and a large number of other persons entitled to treatment who include such sufferers from exotic diseases as the Chinese, Nepalese, and Cypriots.

In my experience the very highest posts in the Army Medical Service are filled by the appointment of Army doctors of clinical skill and experience who also happen to possess skill in administration, logistics, etc., whether natural or acquired. That experience in military surgery and tropical medicine is still acquired by the Army's consultants is fortunate, for these are the injuries and diseases of disasters, famines, wars, and social collapse; knowledge and experience that it is important for all ranks of the Army Medical Service to possess.

I had better add that these represent my own views and are not to be construed as the views of the Service.—I am, etc.,

D. HAMILTON

British Military Hospital,
Hong Kong

Medicine and the Common Market

SIR,—Perhaps some of the least publicized features emerging from the E.E.C. regulations on social security are the reciprocal medical treatment arrangements. These regulations go some way along the road to dispelling public sensitivity over the hitherto unilateral United Kingdom N.H.S. "good Samaritan" service. In particular, they provide that worker nationals (and members of their family) of the U.K. and other community countries who are on holiday or otherwise staying temporarily in a community country will be entitled to medical treatment for sickness or accidents which require urgent attention, on the same basis as insured nationals of that country, subject to their being armed with appropriate documentation. A welcome reciprocal tit-bit. The experiences to date of U.K. hospitals and general practitioners on this front would doubtless be interesting—or perhaps the experiences of the British public in the other member states would prove more interesting. However, nestling in the related E.E.C. regulation is a more intriguing, thought-provoking provision which demands precise quotation.

"A worker, and any members of his family . . . who is authorized by the competent institution to go to the territory of another member state to receive there the treatment appropriate to his condition, shall be entitled . . . to benefits in kind provided on behalf of the competent institution by the institution of the place of stay (or residence) in accordance with the legislation which it administers . . . the length of the period during which benefits are provided shall be governed, however, by the legislation of the competent state . . . .

"The authorization required may not be refused where the treatment in question cannot be provided for the person concerned within the territory of the member state in which he resides." (Article 22 of Regulation/E.E.C./No. 1408/71 of the Council of 14 June 1971).

Few could deny the laudable intentions of such philosophy but, in turn, few could fail to detect palpable fundamental attendant difficulties. Inherent in such a system is the need for prearranged admission to hospitals, exchange of medical histories, the related hazards of "queue-jumping," language difficulties, disclosure of patients' records, etc. Other questions spring readily to mind. Who decides whether the treatment is appropriate to the condition—indeed, what medical significance has the expression "appropriate"? Could, for example, a rejection by one member state that certain treatment was "appropriate," though successfully practised in another member state, perhaps sour European medical rapport to some degree? Doubtless few cases have surfaced since our entry into E.E.C., but such is the profundity of the doctrine of this feature of the regulation and its practical possibilities that it seems to me timely to inquire of hospitals, consultants, and general practitioners what their experience has been in terms of general difficulties, documentation, the overall mechanics of such exercises, how much awareness they had of the regulations, and the reaction from the patients. Perhaps these columns would be a convenient vehicle for such information.—I am, etc.,

KEITH LIDDELL

Royal South Hants Hospital,
Southampton

Ethyloestrenol

SIR,—With reference to your leading article on "Fibrinolysis and Venous Thrombosis" (16 November, p. 365) I would like to correct the error made in calling ethyloestrenol an oestrogen. Though I appreciate its name may falsely suggest it to be oestrogenic, it has been shown by Junkmann and Suchowsky[1] to possess primarily anabolic, some progestogenic, and slight anti-oestrogenic properties.—I am, etc.,

C. J. MUGGLESTONE
Medical Adviser,
Organon Laboratories, Ltd.

Morden, Surrey

1 Junkmann, K., and Suchowsky, G., *Arzneimittel-Forschung*, 1962, **12**, 214.

Agoraphobia

SIR,—Your leading article on this subject (26 October, p. 177) dismisses the use of tricyclic compounds in the treatment of this condition somewhat abruptly, yet these compounds are frequently effective in agoraphobic conditions and they are often the first line of therapy in both general practice and psychiatric clinics. Two preparations in particular are of value—namely, clomipramine and opipramol.

In the treatment of agoraphobic patients in a busy outpatient clinic Harding[1] reports favourably on the use of oral clomipramine, describing this drug as being useful in these circumstances. Marshall and Micev[2] have shown the effectiveness of intravenous infusions of clomipramine in phobic disorders. No controlled trial of the use of clomipramine in phobic states has, however, been reported.

Capstick and Rooke[3] in a double-blind trial of opipramol in comparison with a

combination of phenelzine and chlordiazepoxide in depressive states demonstrated that both trial preparations were effective against phobic anxiety symptoms but that there was a statistically non-significant advantage to phenelzine and chlordiazepoxide.

I would agree with your emphasis upon the need for the G.P. to obtain a psychiatric opinion on patients who do not respond rapidly to treatment in order to avoid chronicity, but before the psychiatrist considers such methods as leucotomy the use of tricyclic compounds in adequate dosages should be considered.—I am, etc.,

NORMAN CAPSTICK

Graylingwell Hospital,
Chichester, Sussex

1 Harding, T., *Journal of International Medical Research*, 1973, **1**, 425.
2 Marshall, W. K., and Micev, V., *Journal of International Medical Research*, 1973, **1**, 403.
3 Capstick, N., and Rooke, K. C., *Journal of International Medical Research*, 1974, **2**, 293.

SIR,—In your leading article (26 October, p. 177) it is stated that "tricyclic compounds are ineffective, though no controlled trial has yet been reported."

Tricyclic drugs have been widely used in phobic states and there is in fact growing and extensive evidence of the value of clomipramine in the treatment of such disorders. The value of this drug was first reported in 1971[1] and subsequent work[2-4] has substantiated these findings. In an interim report on the use of clomipramine in phobic and obsessional disorders[5] I stated that in the 15 cases reviewed phobic anxiety showed an improvement of 60% after six weeks. A further report is awaiting publication on 32 patients suffering from phobic anxiety who were admitted to an open multicentre trial. There was an improvement in all phobias, in situational anxiety, in interference, and in autonomic side effects in all the 27 patients who completed the six-week period of the trial.—I am, etc.,

D. WAXMAN

Department of Psychological Medicine,
Central Middlesex Hospital,
London N.W.10

1 Marshall, W. K., *British Journal of Psychiatry*, 1971, **119**, 467.
2 Collins, G. H., *British Journal of Psychiatry*, 1973, **122**, 189.
3 Walter, C. J. S., *Journal of International Medical Research*, 1973, **1**, 413.
4 Harding, T., *Journal of International Medical Research*, 1973, **1**, 425.
5 Waxman, D., *Journal of International Medical Research*, 1973, **1**, 417.

Consultant Contract

SIR,—Nearly half of the nation's consultants have decided against private practice and for them the Owen proposals represent a welcome improvement in working conditions and remuneration. Doubtless, however, many support the right of their part-time colleagues to continue private work, not only because many patients desire it but also because of the importance of preventing a State monopoly. In medicine, as in education, an element of choice is vital for the nation and the profession.

The Central Committee for Hospital Medical Services recently asked for an affirmation of local support in its confrontations with the Government. Such support has readily been given by many whole-time consultants for the sake of professional unity and to maintain this element of choice. But does the C.C.H.M.S. realize what the whole-time consultants are being asked to sacrifice in the cause of unity? Those who have consciously abjured private practice are asked to support the demand that the Government desist from offering terms which would go a long way towards redressing the financial imbalance which has existed between whole- and part-timers since 1948. In giving their support to the C.C.H.M.S. many whole-timers feel that the C.C.H.M.S. has presumed too much upon their goodwill and that it is the part-timers whose interests are being promoted in the main by the C.C.H.M.S.

Can the C.C.H.M.S. state without delay how the whole-timer will benefit from rejection of the Government proposals, except in the knowledge that he has made a unilateral sacrifice for the sake of the profession's independence?—We are, etc.,

R. S. FRANCIS
I. M. GLICK
GILLIAN HANSON
R. S. WINWOOD
F. J. HEBBERT
B. CHATTOPADHYAY
G. MCENERY
J. ENTICKNAP
C. RAEBURN
A. J. E. BRAFIELD
J. S. PORTNOY
V. DALLOS

Whipps Cross Hospital,
London E.11

*** With Dr. Francis's permission this letter was made available for immediate reply on behalf of the C.C.H.M.S. In the absence of the committee's chairman abroad the reply has been provided by the acting chairman of the C.C.H.M.S.'s Negotiating Subcommittee.—ED., *B.M.J.*

SIR,—The representatives of consultants in the Owen Working Party have always taken it as their duty to represent all consultants. Indeed, the composition of the staff side was agreed with this objective, among others, in mind.

The answer to the final question posed by your correspondents is to be found at the beginning of their letter: "the importance of preventing a State monopoly in medicine . . . an element of choice is vital. . . ."

If the Government's proposals had gone through as first proposed, in the view of the staff side a State monopoly would have been merely a matter of time—and not a very long time at that. Consultants who choose to practise only in the N.H.S. are being asked to forego some part of a prospect of benefit in the short term to preserve that vital element of choice—and with it the preservation of some bargaining power in dealing with a monopoly employer.

But this does not mean no financial benefit. The whole exercise is directed at achieving both fairer contracts and better remuneration. The alternatives proposed by the staff side will enable all N.H.S. work to be properly remunerated, including much that is now carried out voluntarily, particularly by consultants whose practice is entirely within the service.—I am, etc.,

E. B. LEWIS
Acting Chairman,
Negotiating Subcommittee, C.C.H M.S.

B.M.A. House,
London W.C.1

SIR,—Having read the letters in the *B.M.J.* and in other newspapers and journals during recent weeks, it seems to me that the profession's negotiators cannot win. If they negotiate hard on our behalf they are accused of being unethical and unprofessional; if they negotiate softly they risk accusations of weakness and lethargy.

Surely the vast majority of consultants have a number of ideas in common. They would like a better career structure in a better health service. They would like to be paid according to what they contribute to that service rather than what they do *not* contribute to some other service. The results of the "Questionnaire to Senior Hospital Staff" (7 December, p. 608) also indicate that the vast majority believe in the principle of private practice, whether within or outside the N.H.S.

Nationwide there can be very few consultants who actually desire to work in a totally salaried service under a monopoly employer. Nor can there be many who would wish to be offered blatant financial inducements to agree *not* to spend their free time in any particular way. Those of us who are whole-time, and particularly those like myself who work in a specialty and an area where there would be no financial risk in being part-time, would greatly appreciate some system which allowed payments for extra sessions over the basic contract at a higher rate than the basic sessions. Those who are so much in love with their present contracts will presumably be able to keep them.

The principles which we hold in common are surely more valuable than those which divide us into sectional subgroups. Our negotiators seem well aware of both. They need our support at this stage of their discussions and not a stream of letters emphasizing sectional differences.—I am, etc.,

P. A. D. WILLIAMS

Brighton

Needs of Junior Hospital Doctors

SIR,—I was concerned to read the letter from the University College Hospital Junior Staff Committee (7 December, p. 595), particularly as it expresses exactly my own views on junior staff representation.

At present negotiations on pay and conditions for junior staff are at the cottage industry level. The very real gains of pay and extra duty allowance in the early 1970s were due to the personal efforts of a small number of individuals, notably Mr. F. J. Bramble, aided by one able but grossly overstretched B.M.A. official—part-time. The prime object of the B.M.A. at this time is to win doctors the pay and facilities they deserve. It must expect a spate of dissatisfaction until it can be shown that its resources have been totally diverted towards delivering the goods. To that end negotiators of all grades need a professional trade union type back-up service able to arm them with the statistics and propaganda that are the weapons in the battle for realistic pay.

The prime weapon of a negotiator is the cohesion and support of his electorate—and here individual hospital junior doctors have a job to do: to find out when and where their regional Hospital Junior Staff Group meets and attend, to make sure that regional representatives attend the Group Council or