large number of regional consultants resigned from the N.H.S. in favour of private practice it would be easy to fill their shoes.

Furthermore, it seems to me that the insistent complaint of the R.H.C.S.A. that most of their clinical tasks are "sub-consultant work" further weakens their position. For example, in general surgery there are roughly one million admissions in England and Wales per year. About one-half are emergencies whose primary treatment is supplied by registrars. The bulk of the other half consists of varicose veins, herniae, interval appendices, and piles, which are also operated on by registrars. If two-thirds of all surgical work can be adequately done by registrars at £2,850-4,395 per annum each, why pay for consultants who cost £5,085-7,599 per head to do this sub-consultant work? Any Government which did so would be stupid.

I expect I have missed some vital point in the R.H.C.S.A. case, and that is why I am writing.—I am, etc.,

F. S. A. DORAN

Bromsgrove General Hospital,
Bromsgrove, Worcs

SIR,—Political conservatism and apathy among hospital consultants towards their own affairs and those of junior doctors and G.P.s must be admitted, though signs of change have appeared at last. Nonetheless the B.M.A. must accept a substantial share of responsibility for the present consultant unrest.

Last year I resigned from the local Regional Committee for Hospital Medical Services for two reasons. (1) Many of my colleagues and myself had totally lost confidence in it. The committee's huge size, poor communication between it and the doctors it purports to represent, and the general lack of strong leadership coupled with the stranglehold of antiquated B.M.A. procedure make the whole H.M.S. committee system ineffective. (2) The C.C.H.M.S. appeared to have swept under the carpet the resolution of the Annual Representative Meeting in 1973 (passed by an overwhelming majority) that merit awards should no longer be secret. This was quite indefensible in my opinion and was symptomatic of the C.C.H.M.S.'s disregard of and contempt for the views of the majority of consultants and other hospital doctors.

The present H.M.S. committee structure is a disaster and always will be. Hospital doctors will never be political committee men and women, and the B.M.A. should long ago have recognised this and altered the system instead of allowing it to bumble along towards extinction. Hospital doctors must have adequate leadership and be properly consulted and it is obvious that the Regional Hospitals' Consultants and Specialists Association has now found a much simpler and more effective formula than the B.M.A.

Regional consultants have now had enough of both H.M. Government and the B.M.A. (1) Their incomes have plummeted, and the loading of remuneration towards our G.P. colleagues has not in fact helped to solve the G.P. recruitment problem. (2) Hospital training posts have been frozen and existing posts deprived of suitable applicants by grandiose rotational (or

vertiginous) training schemes in major teaching centres. (3) Agreements such as the increase in the number of paid domiciliary visits are an insult to many regional consultants who do considerably less than 50% of the maximum number anyway. (4) Consultants are being plagued by demands for attendance on increasingly large numbers of committees, including valueless and repeated consultations with social service and other departments. (5) Merit awards over the years have caused a great deal of unnecessary bitterness. The C awards and possibly even B awards should be abandoned altogether and replaced by seniority payments. (6) Reorganization of the Health Service and the caring professions seems only to have succeeded in increasing the recruitment of and incentives to administrative staff and lowering those for medical, nursing, and ancillary workers in the Health Service. The B.M.A. hereto has only made polite and gentlemanly noises as usual.

I have now resigned from the B.M.A. and as Chairman of the Mid-Northumberland Division.—I am, etc.,

A. O. A. WILSON

St. George's Hospital,
Morpeth,
Northumberland

*. We understand that the working party appointed by the C.C.H.M.S. after the A.R.M. in 1973 to examine the whole subject of merit awards is to present an interim report on the question of secrecy to its parent committee later this month.—Ed., *B.M.J.*

SIR,—We appreciate the discontent of our consultant colleagues in Wolverhampton (23 February, p. 330) but fail to understand why they should use the B.M.A. as their "whipping boy." The Central Committee for Hospital Medical Services is their own creation and as it is an autonomous body the Representative Body and Council are not encouraged to dictate its structure and its actions. If they are unhappy they should blame the creature they have built. G.P.s are also not immune from criticizing the B.M.A. for the faults of the General Medical Services Committee. Praise, of course, goes to the autonomous bodies. Perhaps even at this late stage further consideration without emotion should be given as to the wisdom and logic of expecting the B.M.A. to take responsibility for autonomous bodies over which it has little control and which indeed are trying to control it for sectional interests.

At the time of the Chambers and G.M.S.C. controversy one of the newer G.P. members of the local divisional executive argued that the executive discussed nothing but consultant matters. So both consultant and G.P. at times think that the B.M.A. is the spokesman of the opposite discipline. How foolish can we be?

A lively memory of 1946-8, in which some of us were deeply involved, recalls that there was unity in the profession as a whole against certain aspects of the N.H.S. as it then stood, and amendment might have been secured had not elements in the royal colleges approached Mr. Bevan behind the back of the B.M.A. With disunity the day was lost. Cannot the lesson be learnt? In confrontation with Government the big

battalions count and we are convinced that a strong central body of all professional interests is essential if we are to retain any long-term influence.

G.P.s have had more than 30 years more experience than consultants with state involvement and have learnt that this means descent into the market place. Our consultant colleagues are discovering that they also must descend from their ivory towers and we appreciate their feelings of confusion and disillusionment. If mere G.P.s may make suggestions, our colleagues need at local level some body financially independent and not part of the hospital structure.—We are, etc.,

ROBERT S. V. MARSHALL
Past Chairman

ALLAN WALKER
Chairman

NORMAN MCEVOY
Past Chairman

H. R. CHAPMAN
Past Chairman

VICTOR RUSSELL
Past Chairman,
South Staffs Division, B.M.A.

Wolverhampton

SIR,—To the small proportion of the general public who have any interest in its fortunes the profession must appear to be again in serious disarray. The disunity presented contrasts sharply with that of any trade union. Squabbling over who is to present the case provides a government and its executive with heaven-sent opportunities for endless delaying action. The new Government will have little inclination to agree, in the present economic situation, to increases in pay for a class of persons popularly regarded as wealthy and privileged. It is all the more necessary that consultant representation should be both astute and united. It may be that the correct tactic is to proceed with a pay claim and even to use this as a bargaining counter to obtain an acceptable contract of service.

I feel strongly that the contract should include, in every case, the right to private practice from the Health Service appointment. I am fully aware that this would be opposed most bitterly in some quarters, but unless this right is obtained the consultant will be completely identified with any other public employee and his individual independence will be lost for all time. Perhaps I should declare that I am a retired whole-time consultant who was never at any time engaged in private practice.—I am, etc.,

F. PYGOTT

Rugby

Medical Audit

SIR,—The conditions of medical practice in the U.S.A. and Australia are so very different from those in Britain that any attempt to adapt American or Australian schemes of peer review and recertification is bound to be clumsy and likely to be irrelevant to our needs. The scene in the U.S.A. differs from our own in two very important respects. The first is the method by which the doctor is paid for his services. The second is geographical. One can readily understand how in the vast land mass of North America, with thousands of doctors

practising in isolated communities and where control of a doctor's extravagance and the vagaries of his therapy is vested in a remote insurance company or the patient's lawyer, it is essential for the profession itself to devise ways and means of improving an image which in the past 20 years has become tarnished and in some areas corroded beyond repair. At present Australia, kin to the U.S.A. in its vast land mass and swollen cities, is enthusiastic to adopt or to adapt every American practice.

In Britain on the other hand we have one of the most complete social health schemes in the world, paid for out of public funds and under the control of the taxpayer through Parliament and the Secretary of State. If we are to have an extension of medical auditing in Britain, and this I agree is desirable, it must be on totally different lines from those devised in the U.S.A. or under consideration in Australia. Like Dr. A. K. Thould (16 February, p. 279) I fear that peer review would stifle original thought, making us as dependent on current doctrine as members of the medieval church or the present inhabitants of the U.S.S.R. It is but a short time since the conventional wisdom was to treat all cases of myocardial infarction with anticoagulants for periods of one month to 10 years. The present compulsion is to reduce everyone's diastolic blood pressure to 90 mm Hg. May the voice of common sense not ask whether the latest doctrine may not go the way of the other? How many vaunted drugs hallowed by Hammersmith and blessed by some sacred college of medical cardinals have, after a few years, sunk into oblivion or been publicly disgraced?

However, Dr. Thould's suggestion of using the divisional system to examine common practices and to decide on the optima of procedure is good and workable. But against the general cry that the profession itself must be solely in charge of its own audit I would like to say with a small voice that the public might be better able to examine certain aspects. A starting point might be the work load of a hospital consultant related to the population at risk and the number of similar consultants to serve that population. If, for example, a consultant was able to run a popular outpatient service without a dangerous waiting list, yet see more patients per week than the natural or local norm, this could be taken by an examining body of lay men as a vote of confidence in outcome. If on the other hand a consultant with equal facilities and population at risk dealt with many fewer patients than the norm, this would to a lay body call in question his ability or his willingness to provide a service. If a surgeon did 30% fewer intermediate-type operations and had a longer waiting list than his peers, the public would also be entitled to ask whether his skill and the resources allotted to him were being properly used.

It is these questions, so different from those that would be asked by a medical inquisition, which the public would like answered. As it is the public who pay for us and the resources we use, they are entitled to answers which at the present moment they are not getting. I happen to believe that the public is collectively a very good judge of the quality of medical care, because it is deeply concerned in the outcome. It will measure the outcome on a

broad profit and loss basis and not on the narrower technological basis which a medically run audit would have to employ. —I am, etc.,

J. M. NAISH

Department of General Medicine,
Frenchay Hospital,
Bristol

Jaundice after Halothane

SIR,—The recent report by Dr. W. H. W. Inman and Professor W. W. Mushin (5 January, p. 5) together with the letter sent out by the Committee on Safety of Medicines has served yet again to focus the profession's attention on the problems of jaundice and hepatitis following anaesthesia. We use the phrase "jaundice following anaesthesia" deliberately, as a recent report¹ suggests that a similar condition may follow enflurane (Ethrane) anaesthesia and the work of Simpson and Walton² has suggested that this may not be a specific entity but may in fact follow anaesthesia using any agents.

It seems to us that this is a controversy³ which is unlikely to be settled unless all cases of jaundice and hepatitis following anaesthesia for surgery are investigated. The National Halothane Study in the U.S.A. attempted to do this retrospectively with results which, unfortunately, were not conclusive and left many questions unanswered.⁴ The Fulminating Hepatitis Study⁵ which followed this was more specifically focused but lacked the broad sweep of the national study. The more tightly knit and better organized hospital service existing in Britain under the N.H.S. would permit the necessary data to be gathered if postoperative jaundice were made a notifiable condition so that all cases, irrespective of anaesthetic used, would be reported and could then be investigated by appropriate experts.

It appears to us that the question might best be answered by treating postsurgical jaundice as a public health problem and applying epidemiological methods. Two or three years of such a study should provide sufficient data to indicate the incidence of postoperative jaundice and whether or not it is related to any particular anaesthetic agent or technique. Without this information we fear we will progress from halothane hepatitis to enflurane hepatitis to Forane (trichlorofluoromethane) hepatitis, and heaven help us if anybody indicts nitrous so that we are dissuaded from using that.—We are, etc.,

LESLIE RENDELL-BAKER
DAVID C. C. STARK

Department of Anesthesiology,
Mount Sinai School of Medicine,
New York

¹ Reid, L., Askin, S., Frecker, G., and Fitzgerald, W., *Journal of the American Medical Association*, 1974, 227, 76.

² Simpson, B. R., and Walton, B., *Bulletin of the New York Academy of Medicine*, 1973, 49, 708.

³ Simpson, B. R., Strunin, L., and Walton, B., in *Controversy in Internal Medicine*, vol. 2, ed. F. J. Ingelfinger, R. V. Ebert, M. Finland, and A. S. Reiman, p. 580. Philadelphia, Saunders, 1974.

⁴ National Research Council, Sub-Committee on the Washington, D.C., National Halothane Study, *Report to the Committee on Anesthesia*, Washington, D.C., National Academy of Sciences, 1969.

⁵ Trey, C., Lipworth, L., and Davidson, C. S., *Gastroenterology*, 1970, 58, 306.

SIR,—Professor B. R. J. Simpson and his colleagues, in their letter (16 February, p. 288), are possibly as guilty of using dubious information such as that they complain of in the paper by Dr. W. H. W. Inman and Professor W. W. Mushin (5 January, p. 5). The former stated that in their series 26 patients with postanaesthetic hepatitis did not have halothane at all. We would suggest that this may be an invalid argument. We are given no information as to the anaesthetic machine used for these cases. It is unlikely that an anaesthetic machine delivers no halothane if it has previously been used for that agent.

We have developed analytical techniques based on a gas chromatograph with electron capture detection (Hewlett Packard Model 5713). Analyses were carried out on a glass column (5 m × 0.8 cm outside diameter) packed with Universal support (8-100 mesh) impregnated with silicone oil, D.C. 560 (10% w/w). Argon with 5% methane was the carrier gas at a flow rate of 60 ml/min. This system allowed the detection of less than 6×10^{-7} g/l. of halothane vapour in a gas diluent such as air, nitrous oxide/oxygen, etc.

Even if the halothane vaporizer was physically removed from the anaesthetic machine and the machine had not been used for two months we were still able to detect halothane at 1.7×10^{-7} g/l. from the metal manifold of the anaesthetic machine at a fresh gas flow of 1 l./min. This was shown to come from the Neoprene sealing rings around the rotameters and if a gas not in normal use (in this case carbon dioxide) was delivered there was a 100-fold increase for three minutes in the halothane concentration observed as the Neoprene mounts around the CO₂ rotameter were purged. If the vaporizer was in circuit but switched off and if the machine had been allowed to stand unused for 10 minutes, then the halothane leakage in excess of that obtained from the Neoprene sealing rings from one vaporizer (Fluotec III) in the "off" position exceeded 10⁻³ g/l. during the first five minutes at a fresh gas flow of 1 l./min oxygen which fell to 10⁻⁴ g/l. after 30 minutes, when the value remained constant. However, values of 10⁻³ g/l. were again reached when the fresh gas flow was terminated for 10 minutes and then restarted.

There are reasons for this leakage from vaporizers which we hope to publish shortly together with a discussion of the units of measurement, the results, and conclusions. Meanwhile, if halothane hepatitis is a sensitivity type of reaction, it is not dose-dependent and these leakage rates from vaporizers mean that patients could receive quantities of halothane unbeknown to the anaesthetist which could cause postoperative liver damage. Furthermore, even if the vaporizer is removed from the anaesthetic machine, halothane can still be delivered to the patient. The elution time of halothane in the anaesthetic circuit is very prolonged and the capacity of antistatic rubber for halothane is considerable. However, this was not a factor in the test outlined since the sampling was done only from the metal gas manifold on the anaesthetic machine.

As was said by McIntyre,¹ "until it is shown that the use of other anaesthetic agents results in a comparable incidence of jaundice the defence of halothane rests on very shaky ground." As yet no proof has been adduced that halothane had not been given to any of those patients who developed postoperative hepatitis.—We are, etc.,

JOHN S. ROBINSON R. S. BARRATT
Department of Anaesthetics. JOHN M. THOMPSON
Queen Elizabeth Hospital, Birmingham

¹ McIntyre, N., *Proceedings of the Royal Society of Medicine*, 1973, 66, 62.