variety of clinical performance tests. One finding of particular interest at that time was that levodopa caused an easily appreciable reduction in the severity of tremor—to an extent that was valued by the patients—in addition to its well-known effects on rigidity and akinesia. The mean Webster rating⁶ for tremor ($\pm$ SD) during a control period was 1.434 ± 0.71 (30 patients), and during treatment with levodopa it fell to 1.030 ± 0.67 (29 patients). Thus a definite improvement in tremor was obtained which was statistically significant ($0.0125 < P < 0.025$) and was of great value to the patients in about one-third of the entire group. The use of levodopa with decarboxylase inhibitors appears to be of similar value in respect of tremor.

It is suggested that when confronted by patients complaining of tremor alone or suffering from the effects of a varying admixture of tremor, akinesia, and rigidity one should commence treatment with levodopa and decarboxylase inhibitor. The dosage should be increased cautiously until a maximum degree of improvement is obtained in all three pathophysiological features. There are some patients, unfortunately, in whom levodopa seems to aggravate the tremor even when at the same time rigidity and akinesia are being improved. The place of thalamotomy should now be restricted to those patients whose tremor fails to respond satisfactorily—or is exacerbated—in response to levodopa.

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Trial by traction

SIR,—With regard to your leading article (3 January, p 2) I would support the need to mount bigger and better trials of lumbar traction but would make a plea for two conditions; firstly, to stop regarding traction as a single treatment, and secondly, for more accurate selection and diagnosis of cases.

Traction is not a single treatment. To prescribe traction is similar to prescribing aspirin. Traction is available in many different forms, different forces in relation to the body weight, different positions of the patient, lumbar flexion, lumbar extension, lateral flexion, etc. It is available in intermittent, continuous, or pulsed variety, and even the periodicity of the pulsing can be different. Future trials should more accurately discuss the reasons for the choice of the method of traction used, together with a detailed description of its procedure and control. Incidentally, in all traction treatments it is necessary to be sure that the harness is such that it applies the traction in the correct or chosen direction and does not slip.

In your article there was mention of a "suggestion that traction might help more when root signs were present,"¹ surely a significant statement when taken with the other report² that "no advantage for this form of treatment [was shown] in patients with lumbago and sciatica," both of which terms

are blanket and ill-defined description of symptoms and not diagnoses. It appears to me that rather more patients with "lumbago" and "sciatica" do not have their symptoms caused by discopathy than do from other causes. Indeed traction may help patients with a nipped synovial fringe in an apophysial joint (as does sometimes manipulation), but there are many causes of both these conditions, which, although mechanical, traumatic, or degenerative in origin, are unlikely to be affected in any way by traction save by the fact that traction is a time-consuming treatment which allows the passage of time. This time may enable nature to effect the healing or cure of symptoms.

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Thrombocytopenia, haemolytic anaemia, and sarcoidosis

SIR,—We read with interest Dr P d'A Semple's case report (22 November, p 440). His patient's clinical features overlap in part with our report¹ of a 63-year-old woman in whom sarcoidosis and idiopathic (immunological) thrombocytopenic purpura (ITP) coexisted. Dr Semple and Dickerman *et al*² seem to suggest that the occurrence of ITP in patients with sarcoidosis may reflect an underlying autoimmune diathesis in sarcoidosis. However, we are impressed by the paucity of reports of serological manifestations of autoimmunity and of clinical autoimmune diseases in patients with sarcoidosis.

We believe that the onus of proof is on those who claim an increased incidence of autoimmune diseases in sarcoidosis to demonstrate that such an association does not simply result from hospital patient selection bias.³

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Low-protein diets in chronic renal failure

SIR,—In your excellent leading article (29 November, p 486) emphasis was given to nutritional deterioration of patients with chronic renal failure. We have found that all prolonged dietary regimens of less than 40 g protein/day, despite a high intake of calories, are subject to this hazard and should be avoided when dialysis and transplantation facilities are available.

Plasma albumin and body weight are unsatisfactory markers of nutritional status but have been used to support short-term nitrogen balance data in the formulation of many low-protein diets. Consequently the progressive malnutrition caused by these diets

may remain undetected until severe clinical symptoms occur. However, some indication of nutritional deterioration is given by the decrease in plasma essential amino-acids^{1,2} and in certain plasma proteins such as transferrin^{3,4} and complement C3.^{2,5} These indices also show increases in response to improvements in nutrition.

Composite diets based on essential amino-acids¹ and keto-acids⁷ are frequently nitrogen-deficient, unappetising, and not readily available. However, there are advantages in supplying essential amino-acids in a palatable form as a supplement to restricted protein diets where nitrogen may be inadequate or marginally adequate (that is, less than 40 g protein/day). This therapy may improve nitrogen balance,⁸ increase the synthesis of liver proteins,² and in the long term minimise uraemic neuropathy⁸ and other symptoms associated with nutritional deterioration.

Further investigations are necessary to prevent the nausea that occurs in some patients and also to evaluate certain semi-essential amino-acids. Studies with our own formulation of essential amino-acids and, more recently, with a commercial product taken as a drink (Nephranutrin, Geistlich and Sons Ltd, Chester) show that tyrosine should be given.² Histidine is also necessary when protein intake is less than 20 g.⁸

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Incurable Patients Bill

SIR,—In your issue of 17 January (p 165) you publish the details of Lady Wootton's Incurable Patients Bill which is expected to receive a second reading in the House of Lords in February. The Bill sets out the right of a patient (a) to be relieved from the pain and distress of incurable disease, even if unconsciousness results from such relief, and (b) not to be kept alive if the brain becomes so damaged by accident or disease as to render him permanently incapable of giving directions. Undoubtedly this Bill is motivated by compassion for such patients, but I doubt if legislation is the right way in which to protect their rights, for the following reasons:

Firstly, the Bill seeks to regulate treatment by the law (the management of the dying is just as much a matter of treatment as the cure of the living). But however compassionate the reasons may be for doing this in this instance, if the Bill becomes law it will set a precedent which may well be extended into other areas of medical practice. It is fundamental to medical practice that treatment is based upon a doctor's competence and judgment.

Secondly, the relationship between doctor and patient is founded upon trust and responsibility. Most patients believe that

their doctors will always act in their best interests and relieve their suffering. Lady Wootton does not doubt doctors' sincerity or sense of responsibility, but she has produced evidence that severe pain is not always controlled.¹ But are there not other ways of correcting this situation, such as the proper education of doctors in the management of severe pain, rather than resorting to statute?

Thirdly, such law would create many practical difficulties. Take, for example, the case of a patient who has recorded that he does not wish to be kept alive if he ever becomes permanently incapable of giving directions because of brain damage. What would happen if he suffered brain damage and was being kept on a ventilator because the doctors were not sure that the damage was irreversible but the relatives did not agree? Would the matter have to be decided by the courts?

However, although I hope that the Lords will reject this Bill, it does, I believe, sound a warning note to the profession on two matters. Firstly, there is some public anxiety that sometimes doctors may do things not primarily because they are in the patient's best interest but to see if they can be done (although there are occasions when the line between them is much more blurred than the public realise). Secondly, the fact that Lady Wootton has brought in this Bill ought to compel the profession to pay very much more attention to the dying and to incurable patients than is perhaps usual and to ensure that they die in comfort and with dignity.

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¹ *The Times*, 13 December 1975, p 13.

Industrial action

SIR,—I should like to express my complete agreement with Dr P M Vicary's letter (17 January, p 156). Strike action in any sphere of society is, in my opinion, justified only when pay or conditions of service fall below generally acceptable standards. I do not think any reasonable person could honestly say that doctors, high or low, inside or outside hospital, fall into that category. They may not be highly paid, but surely it was not the hope of financial reward that inspired most doctors to take up medicine? Comparison of earnings with other countries is surely like comparing the wage packets of an amateur and a professional. I gather that in certain countries many doctors are professional money-makers and only amateur doctors. In Britain we have always prided ourselves that we are professional doctors while most of us are only very amateur money-makers and are content to remain so. I feel, therefore, deeply distressed that the Council of the BMA, our official organisation, should not only accept strike action but should actively encourage it.

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Non-payment for IUD fitting

SIR,—On 30 December 1975 a patient who is registered with me asked for advice about having an intrauterine contraceptive device

inserted. She was moving to Newcastle in three days' time.

In discussing payment for this service with my local family practitioner committee I found that if I inserted the IUD on 30 December 1975 and managed to get the claim form to them by 31 December 1975 I might be paid part of the IUD insertion fee. If on the other hand I inserted the IUD on 2 January 1976 and the patient left the area the following day, then because the patient would not be on my NHS list at the end of the quarter—that is, 31 March 1976—I could not be paid. I asked if I could be paid on a private basis and was advised that this was not so. This seems to me an unfair system.

Q G LIVINGSTONE

Wantage, Oxon

Family planning clinic fees

SIR,—In your parliamentary report (20 December, p 715) it is stated that Dr David Owen, Minister of State, in a written answer listed the scale of fees paid for sessions in "many health authority clinics." The fees listed are those paid to Family Planning Association clinics and those FPA clinics taken over on or after 1 April 1975 on a no-detriment basis. The listing of this scale in answer to a question in the Commons would suggest that almost all clinics paid these fees. Some family planning clinics do not pay these sessional rates and there are many anomalies, which only add fuel to much of the dissatisfaction among doctors generally.

In the Huddersfield clinic, under the

Kirklees Authority, doctors who have IUD training and have been instructing doctors under the FPA prior to take-over in 1973 are still receiving only the basic £11.31 per session. The Huddersfield clinic has been a training clinic since 1968 but unfortunately was taken over in April 1973 without any option regarding no detriment. These doctors have continued with in-service and up-dating courses but have received no benefit. Some doctors work for both the Calderdale Health Authority and the Kirklees Health Authority, and as training doctors receive the higher rate when working in the Calderdale area.

Surely if standards are to be maintained and doctors encouraged to undertake further training recognition should be made in the appropriate sessional rate, and these should be uniform throughout the country.

JOYCE M F BRIGG

Mirfield, Yorks

Consultants' ballot

SIR,—I have completed the questionnaire sent out last week by the BMA.

I know of at least six consultants in this district who have not yet received any communication and I wonder how representative any result, be it for resignation or not, can be in these circumstances. I wonder if there is any way of knowing how many consultants have been circularised.

MAURICE WALLACE

Chairman,
Consultants Action Committee,
East Berks District

Windsor

Points from Letters

Medical manpower

Mr F S A DORAN (Bromsgrove General Hospital, Bromsgrove, Worcs) writes: . . . Mr Rudolf Klein (3 January, p 25) makes two very important points, among others. First, that it is not axiomatic that once a particular task has been done by someone medically qualified it must be so for all time; second, that no one can hope to calculate the number of doctors needed, even in the immediate future, until it has been decided how many of the traditional medical tasks can be carried out as well, or better, by nurses or lay technicians. There are two types of clinical work for which Mr Klein did not suggest a lay substitute where it might be successfully introduced—proved functional disorders and geriatrics. I would like him to examine the possibility of handing over to the clergy the huge number of patients in each of these groups, both of which are a frustrating burden to the hospital service and even more so to general practice. . . . The columns of *The Times* reveal that the clergy are deep in discussion about what tasks they ought to do in the community, and they seem anxious to escape from the narrow boundaries of their age-old traditional role. Therefore they might be willing to lift this particular burden off the shoulders of the medical profession. I think they are temperamentally more suited to a task of care and compassion than we are and they have more time for sympathetic listening and personal counselling. . . . The additional

information a clergyman in training would need in medicine and the structure of the social services to fit him for the tasks I have suggested would not be difficult to decide. . . .

Dr A A ROBERTSON (Bourton-on-the-Water, nr Cheltenham, Glos) writes: . . . The greater use of ancillary staff in recent years (leading article, 3 January, p 1) has proved of great benefit and has probably helped to raise the standard of general practice. . . . Would it not therefore be better if such ancillary help could be recognized by, say, the granting of a diploma after perhaps two to three years of training? A person so trained would be an enormous benefit if attached to a doctor or group of doctors and would relieve him of much time-consuming trivia and thereby increase the amount of time available for more highly specialised type of work. At the same time more nurses and health visitors might be freed from practice attachments to work in their own profession of nursing. . . .

Case of the bisected pig

Professor L P GARROD (Wokingham) writes: The mystery of the bisected pig (I believe there was only one) referred to by Mr P G Shute (17 January, p 157) occurred at Penrith, Cumberland, during the 1941 outbreak of trichinosis. I have good reason to remember this since I discovered cases of the disease in