Dr Allen is not entitled to do is to impose a burden on others in the guise of "personal liberty."

Is he prepared to carry the full cost of plastic surgery when he breaks his windscreen with his face, or the cost of an intensive care unit (in the region of £100 a day minimum) when he stoves his chest in against his steering wheel? Can he and his family carry the financial burden of caring for him for the rest of his life as a paraplegic or quadriplegic? And has he made complete provision for the welfare of his widow and children, if any?

If Dr Allen is not prepared to accept the full financial responsibilities for his exercise of personal liberty, then he must be prepared for a "justifiable intrusion" into that liberty by those of us who will have to carry the burden of his own crass stupidity. Perhaps if his nanny had knocked a little sense into him when he was a small boy he would talk less nonsense about the "Nanny State."

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Cimetidine and duodenal ulcer

SIR,—In their letter (3 March, p 618) Drs N R Peden and K G Wormsley express shock at my suggestion (10 February, p 410) that cimetidine might have a place in the diagnostic armamentarium. I did not state, as they say, that "it should be used as a diagnostic rather than a therapeutic drug." Neither is the case they quote of a patient receiving three separate month-long courses of cimetidine and subsequently being found to have a gastric lymphoma relevant to my suggestion of a single seven-day course.

The primary physician's diagnostic pathway is necessarily different from that of the hospital doctor. Heaven help us if all patients with upper abdominal pain were referred for endoscopic and radiological diagnosis even if every general practitioner had access to radiology and it was diagnostically reliable. The therapeutic trial has a long and valuable tradition in medicine. Of course, it does not give a definitive diagnosis. It is one step along the way. While a careful history is usually enough there remain a small number of cases in which differentiation of, say, oesophageal from cardiac pain, or gall bladder from duodenal pain, is difficult. It is in these that a short course of cimetidine may give added information if only in that it helps to indicate the direction in which further steps must go.

The case that Drs Peden and Wormsley make is surely against the use of cimetidine as a therapeutic agent without proper diagnosis, and this is a warning that general practitioners would wisely follow; but their case against using it as a diagnostic aid is much less secure.

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SIR,—With reference to Mr A S Bulman's letter (10 February, p 409), I should like to add a further report to the increasing number suggesting rebound cimetidine ulceration and complications.

A 34-year-old woman (weight 65 kg) was admitted for assessment for surgery following six months of ineffective cimetidine therapy (1 g per day) for a duodenal ulcer proved by barium examination. The cimetidine was discontinued on admission and at endoscopy four days later multiple gastric and duodenal ulcers were seen. There were two chronic and two acute ulcers in the duodenum and eight acute ulcers over the antrum and pylorus. The acute ulcers varied in diameter from 4 to 8 mm. Acid studies on the day of endoscopy showed a basal output of 0·58 mmol (mEq) per half hour and a pentagastrin-stimulated peak acid output of 15 mmol per half hour. Three weeks later repeat endoscopy showed only four acute ulcers remaining and repeat acid studies showed basal output of 0·6 mmol per half hour and a stimulated output of 14·5 mmol per half hour. At surgery after a further three weeks all the acute ulcers were healed. Gastrin levels were without our normal range.

The finding of multiple acute gastroduodenal ulcers in an otherwise healthy patient suggests that the sudden cessation of the cimetidine therapy may be incriminated in their aetiology. The failure in this case to demonstrate any evidence of rebound hyperacidity is consistent with previously published findings.[1] Peptic ulceration is the result of alteration of the delicate balance of acid and mucosal resistance. The cimetidine-rebound phenomenon may be due to alteration of the latter rather than the former. The acid-lowering effect of cimetidine may, over a period of time, result in decreased mucosal acid resistance. When the drug is discontinued the increase in acid output to previously normal levels may be sufficient to cause ulceration of the mucosa, which has become unaccustomed to such acidity. Failure to demonstrate rebound hyperacidity does not exclude the postulated rebound phenomenon.

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[1] Aadland, E, and Bedstad, A, *Scandinavian Journal of Gastroenterology*, 1978, **13**, 193.

The new consultant contract

SIR,—We are shocked and appalled by the new draft contract for consultants. It reflects a complete lack of understanding of the flexibility required by most consultants' work. It would destroy our professional status. We would have a legally binding contract to be in a particular spot at every given time in the week, with no regard to changing clinical pressures or emergencies, and we could be held in breach of contract for any transgressions. No apprentice in the 18th century ever had to sign so enslaving an agreement.

It is divisive among colleagues in a complex hospital environment where good professional relationships are crucial to the provision of continuity and excellence of care. They are now to be reduced to arguing among themselves whether X or Y should have extra NHDs, with all the bitterness this would provoke. The contract is also unrealistic. Most specialists in both medicine and surgery have experience and expertise that cannot be replaced by that of a colleague in the same hospital. If a cardiological registrar is having difficulty with a pacemaker it is no use calling the endocrinologist or the gastroenterologist or the geriatrician. Yet the contract specifically states that it is policy to reduce paid on-call commitment.

Though provision is made to allow consultants to do private practice and specific research projects, many other areas of work, some paid and some unpaid, crucial to the functioning of the medical community are not mentioned. Is regular cateogry II work private practice? When do we do domiciliaries, examine in qualifying or higher examinations, interview applicants for a job, edit journals, referee papers, work as an officer in a royal college, or lecture to nurses or postgraduates at other hospitals—to mention only some of the necessary functions of many consultants? The extension of this principle to university and Medical Research Council staff could be quite unworkable.

The only thing wrong with our present contract is money. To sell our professional status for this new contract in the *hope* of sustained better pay would be an irreversible disaster for all consultants and for the eventual "care" of the community. The BMA must convince the Government that it needs a profession and not hourly paid plumbers, and pay us appropriately. This contract is a disaster whatever the immediate bribe to enslavement, and we have no wish to be party to it.

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D S SMITH
A M HEWLETT
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J COLEMAN
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M CRAWFURD
A D B WEBSTER
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J S MILLEDGE
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J N BLAU
D PINTO
T J CROW
I R MACFADYEN
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**A letter by Mr David Bolt on some aspects of the contract was published in last weeks *BMJ* (10 March, page 688).—ED, *BMJ*.

Proposed consultant contract—equal pay for equal work?

SIR,—The new consultant contract proposed by the health departments discriminates against those consultants who work the largest number of scheduled clinical and laboratory sessions each week. Two notional half days (NHDs) are to be allocated without assessment, one in respect of a consultant's continuing responsibility for patients in his care and for his department and one in recognition of all administrative and management functions not separately remunerated. However, while the two additional NHDs are to be reduced pro rata for scheduled NHDs less than eight, they are not to be increased for scheduled NHDs in excess of eight. Thus scheduled sessions above eight will be remunerated at 80% of the basic rate. The effect on the value of all sessions that are worked is illustrated in the figure: as the number of timetabled sessions increases above eight the overall rate of remuneration for all active sessions declines. If the maximum of 13 scheduled sessions is allocated the remunera-