Change is not always for the better. Which of us wants a pile of near hospital-sized folders on his desk or in his car? As for the option to use the new size—as soon as patients start to move about the country there will no longer be an option; every doctor will have to use some of the new size. We are being offered a few hours of super-efficient note-finding in the distant future for several chaotic years of mixed sizes and unequal filing systems now. No doubt the planners, after their efforts, wish to achieve something. Let them remember: *Primum non nocere.*—I am, etc.,

R. M. MOFFITT

Lancaster

1 British Medical Association, *Report of the General Medical Services Committee to the Annual Conference of Representatives of Local Medical Committees*, A.C.2, 1970, 71.

Pulmonary Embolism and Bone Cement

SIR,—Dr. J. N. Powell and his colleagues (8 August, 1970, p. 326) reported two cases of cardiac arrest which had occurred during the operative replacement of a femoral head with a Thompson prosthesis. They drew attention to the use of cement during the insertion of the prosthesis and the possibility that cardiac arrest may have been due to absorption of the monomer. The following recent case history is reported because death was due to pulmonary embolism shortly after insertion of bone cement.

A fit woman aged 71 years was admitted to hospital with a subcapital fracture of the neck of the right femur and a Thompson prosthesis was inserted through a posterior approach 24 hours after injury. The operation was initially uneventful and there was no alteration in the blood pressure immediately after insertion of the cement. However, 15 minutes later, after reduction of the prosthesis into the acetabulum and during wound closure, progressive hypotension was noted and electrocardiograph recordings then showed widened QRS complexes occurring at a very slow rate, finally ceasing in asystole.

Postmortem examination showed a large embolus in the right pulmonary artery. There was an extensive deep vein thrombosis of recent origin in the muscles of the right calf. The possibility of fat embolism was specifically considered and some globules were found in the lung and brain, but the pathologist considered that they were minute and certainly not sufficient to cause death.

This case appears to bear some resemblance to the two reported by Dr. Powell and others, as hypotension followed by cardiac arrest occurred 15 minutes after the insertion of the bone cement. A study of the cardiovascular effect of bone cement used during the operation of hip arthroplasty has shown that transient falls of blood pressure do occur but do not continue beyond the fifth minute after insertion of the cement.[1] The case reported here indicates another cause for a fall of blood pressure and cardiac arrest.

When the interval between the insertion of bone cement and hypotension is less than five minutes then the fall of blood pressure may well be due to the monomer. If the interval is longer than five minutes, then the hypotension and cardiac arrest may be due to another cause such as pulmonary embolism. It is also possible in this particular case that manipulation of the prosthesis into the acetabulum released the thrombus resulting in pulmonary embolism.

We are grateful to Dr. N. J. Brown, who performed the postmortem examination and gave us valuable advice on this case.
—We are, etc.,

A. H. C. RATLIFF
J. A. CLEMENT

Royal Infirmary,
Bristol

1 Charnley, J., *Acrylic Cement in Orthopaedic Surgery*. Edinburgh, Livingstone, 1970.

Ethical Conduct

SIR,—The B.M.A. and the profession have expressed grave concern over a breach of confidence by a general practitioner. But I am not aware of any protest over the unethical conduct of several doctors affecting coloured immigrants, including doctors.

A consultant[1] wrote to a patient denigrating his coloured colleague without first complaining to the hospital committee. Now Mr. Enoch Powell is reported as saying[2] that a psychiatrist gave him information about his coloured patients "in confidence" to be used to "prove" his arguments against immigration.

Is the profession going to accept this double standard of ethics?—I am, etc.,

D. R. PREM

Halesowen,
Worcs.

1 *The Times*, 20 February 1969.
2 *The Times*, 21 April 1971.

Designation Payment

SIR,—I have just been advised by my area executive council that the classification of my area is to be changed from "designated" to "open." I will thus lose my designated area payment. In view of the fact that the number of general practitioner principals in my area has remained the same since 1963, that the number of assistants and trainees has fallen by 50%, and the population is increasing by 1,000 per year, this decision by the Medical Practices Committee to cut my income and the income of other practitioners seems incomprehensible to me.

Practice costs are increasing year by year, and this apparently unjust decision is just another blow.—I am, etc.,

J. G. TEES

Southampton,
Hants

White, Green, and Other Papers

SIR,—It is impossible to understand at this stage of state hospital development what is happening to the control. Why is there a complete breakdown of communication between the busy practical consultant and the administration centre, and why are their representatives, albeit inadequate in numbers, unable to counter the plethora of multi-coloured papers churned out by the Department of Health?

The reason for the representatives' failure is attributable to the erosion of their resistance by an endless succession of the same paper dressed in slightly different form. Each subject is re-hashed and re-issued until one specimen is pressurized through. The machinery is then turned to a further series of papers dealing with a new restriction. As the boredom rises concerning any subject it is more than likely to be passed by a committee.

Once a paper such as the Todd report[1] appears, although rejected in the main by the profession, it is kept alive by the inexorable push from the Department and the bureaucrats with their child-like over-enthusiasm to comply. At the various meetings the agendas grow to a preposterous degree so that adequate rational discussion cannot be assured. Furthermore, discussion on general principles are adumbrated by argument concerning appropriate words, designations, and terms.

If the current techniques of bull-dozing papers and built-in control through committees continues the state-controlled medical profession will be led rapidly to disaster.—I am, etc.,

J. J. SHIPMAN

London W.1

1 Royal Commission on Medical Education, 1965-68. *Report*, Cmnd. 3569. London, H.M.S.O., 1968.

Fees for Temporary Residents

SIR,—I understand that the executive councils, in conjunction with the Health Department, are reviving yet again the question of fees for temporary residents in certain areas of the country. The circumstances under which general practitioners will collect the full fee are to be drastically overhauled. It is being seriously suggested that holiday makers in the larger hotels, caravan sites, hostels, etc., will be classed as "half-fee patients". This fee will be irrespective of the general practitioner seeing a temporary resident in his own surgery.

Similarly, with the big holiday camps in coastal resorts where the general practitioners have elected, owing to the problems of inadequate facilities and difficulties with administration, to see these people in their own surgeries, the "half-fee" will again be paid and not the full fee as at present. Further to this, the Health Department, again in conjunction with the local executive council, are suggesting that certain "closed areas" should be made "open areas" during the summer months. This would, according to their argument, enable a doctor, who would be paid by the Department, to be "planted" in the area during the holiday season. This is a very serious matter and, if allowed to be passed, would create an untold number of precedents, apart from depriving the local general practitioners of earning an honest penny during the summer months looking after patients other than their own.

Finally, I would leave your readers with this thought. Our local veterinary surgeon charges a fee of £2 to see to a two-year-old bullock and the visit takes no more than 10 minutes. Are human beings, young and old, with appendicitis, ear infections, and coronary thrombosis, who often require two or three consultations during the week or fortnight in which they are resident in this area, only to be worth 70p each in the eye of the executive councils and the Department of Health?—I am, etc.,

A. R. JORDAN

Minehead,
Somerset